

<b>STATE OF NORTH CAROLINA</b>	<b>REQUEST FOR PROPOSAL NO. 30-DHHS-1228-08</b>
<b>Department of Health and Human Services</b>	Proposal Due Date and Time: 2:00 p.m. ET, May 30, 2008
DHHS Office of Procurement and Contracts	Contract Type: Agency Specific
<b>Refer ALL Inquiries to:</b> Susan Lewis Telephone No. 919-855-4086	Date Issued: May 2, 2008. Commodity: 920-Data Processing Services and Software North Carolina Replacement Medicaid Management Information System
E-Mail: Susan.Lewis@ncmail.net	Using Agency Name: Department of Health and Human Services
(See page 2 for delivery instructions.)	Agency Requisition No. N/A

**OFFER AND ACCEPTANCE:** This solicitation advertises the State's needs for the services and/or goods described herein. The State seeks proposals comprising competitive bids offering to sell the services and/or goods described in this solicitation. All proposals and responses received shall be treated as offers to contract. The State's acceptance of any proposal must be demonstrated by execution of the acceptance found below, and any subsequent Request for Best and Final Offer, if issued. Acceptance shall create a contract having the order of precedence among terms set forth in Section 30.3 of this RFP.

**EXECUTION:** In compliance with this request for Best and Final Offer (BAFO), and subject to all the conditions herein, the undersigned offers and agrees to furnish any or all services or goods upon which prices are bid, at the price(s) offered herein, within the time specified herein. By executing this bid, I certify that this bid is submitted competitively and without collusion.

VENDOR: <b>Computer Science Corporation</b>		FEDERAL ID OR SOCIAL SECURITY NO. [REDACTED]	
STREET ADDRESS: <b>3170 Fairview Park Dr.</b>		P.O. BOX:	ZIP: <b>22042</b>
CITY & STATE & ZIP: <b>Falls Church, VA 22042</b>		TELEPHONE NUMBER: <b>301-921-3256</b>	TOLL FREE TEL. NO.
Will any work under this contract be performed outside the United States? Where will services be performed:		YES _____ NO <u>X</u> _____	
TYPE OR PRINT NAME & TITLE OF PERSON SIGNING: <b>Dianne R. Sagner</b>		FAX NUMBER: <b>301-921-9870</b>	
AUTHORIZED SIGNATURE: <i>Dianne R. Sagner</i>	DATE: <b>5/23/08</b>	E-MAIL: <b>dsagner@csc.com</b>	

Offer valid for three hundred and thirty (330) days from date of bid opening unless otherwise stated here: \_\_\_\_\_ days.

**ACCEPTANCE OF BID:** If any or all parts of this bid are accepted, an authorized representative of NC DHHS shall affix their signature hereto and this document and the provisions of the special terms and conditions specific to this Request for Proposal, the specifications, and the ITS Terms and Conditions shall then constitute the written agreement between the parties. A copy of this acceptance will be forwarded to the successful Vendor(s).

**OR NC DHHS USE ONLY**

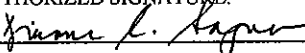
Offer accepted and contract awarded this 22 day of December, 2008, as indicated on attached certification, by [Signature] (Authorized representative of NC DHHS).

<b>STATE OF NORTH CAROLINA</b>	<b>REQUEST FOR PROPOSAL NO. 30-DHHS-1228-08-R</b>
<b>Department of Health and Human Services</b>	Technical Proposal Supplement Due Date and Time: 2:00 p.m. ET, August 4, 2008
DHHS Office of Procurement and Contracts	Contract Type: Agency Specific
<i>Refer ALL Inquiries to:</i> Susan Lewis Telephone No. 919-855-4086	Date RFP Issued: July 7, 2008 Commodity: 920-Data Processing Services and Software North Carolina Replacement Medicaid Management Information System
E-Mail: Susan.Lewis@ncmail.net	Using Agency Name: Department of Health and Human Services
<b>(See page 2 for delivery instructions.)</b>	Agency Requisition No. N/A

**OFFER AND ACCEPTANCE:** This solicitation advertises the State's needs for the services and/or goods described herein. The State seeks Technical Proposal Supplements comprising competitive bids offering to sell the services and/or goods described in this solicitation. All Technical Proposal Supplements and responses received shall be treated as offers to contract. The State's acceptance of any Technical Proposal Supplement must be demonstrated by execution of the acceptance found below, and any subsequent Request for Best and Final Offer, if issued. Acceptance of the Offeror's Technical Proposal Supplement, together with acceptance of the Proposal, shall create a contract having the order of precedence among terms set forth in Section 30.3 of this RFP.

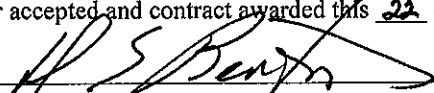
**EXECUTION:** In compliance with this Request for Proposal, and subject to all the conditions herein, the undersigned offers and agrees to furnish any or all services or goods upon which prices are bid, at the price(s) offered herein, within the time specified herein. By executing this bid, I certify that this bid is submitted competitively and without collusion.


Failure to execute/sign bid prior to submittal shall render bid invalid.

VENDOR: Computer Sciences Corporation		FEDERAL ID OR SOCIAL SECURITY NO. [REDACTED]	
STREET ADDRESS: 15245 Shady Grove Road, Suite 200		P.O. BOX:	ZIP:
CITY & STATE & ZIP: Rockville, MD 20850		TELEPHONE NUMBER: (301) 921-3256	TOLL FREE TEL. NO
Will any work under this contract be performed outside the United States?		YES _____	NO <u>X</u> _____
Where will services be performed: North Carolina _____			
TYPE OR PRINT NAME & TITLE OF PERSON SIGNING: Dianne R. Sagner		FAX NUMBER: (301) 921-9870	
AUTHORIZED SIGNATURE: 	DATE: 07/30/08	E-MAIL: dsagner@csc.com	

Offer valid for three hundred and thirty (330) days from date of bid opening unless otherwise stated here: \_\_\_\_\_ days.

**ACCEPTANCE OF BID:** If any or all parts of this bid are accepted, an authorized representative of NC DHHS shall affix his or her signature hereto and the documents identified in Section 30.3 of this RFP as comprising the Contract shall then constitute the written agreement between the parties. A copy of this acceptance will be forwarded to the successful Vendor(s).

<b>FOR NC DHHS USE ONLY</b>
Offer accepted and contract awarded this <u>22</u> day of <u>December</u> , 20 <u>08</u> , as indicated on attached certification, by  (Authorized representative of NC DHHS).

CSC confirms that it has read, understands and agrees to all the provisions of the RFP without qualification, including the addenda. 

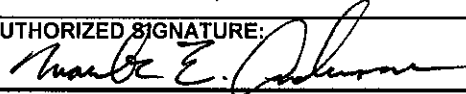
<b>STATE OF NORTH CAROLINA</b> Department of Health & Human Services Office of Procurement & Contract Services	<b>REQUEST FOR COST PROPSAL</b> <b>RFP 30-DHHS-1228-08-R</b>	
	<b>Offers will be received until: 2:00 PM ET, September 23, 2008</b>	
	<b>Contract Type:</b> Agency Specific	
<b>Refer <u>ALL</u> Inquiries to:</b> Susan W. Lewis  <b>Telephone No.</b> (919) 855-4086 <b>E-Mail:</b> Susan.Lewis@ncmail.net	<b>Issue Date:</b> August 18, 2008  <b>Commodity:</b> 920-Data Processing Services and Software North Carolina Replacement Medicaid Management Information System <b>Using Agency Name:</b> NC DHHS	
<b>(See page 2 for mailing instructions.)</b>	<b>Agency Requisition No.</b> N/A	

**NOTICE TO VENDOR** Offers for furnishing and delivering the services as described in the RFP, subject to the conditions made a part hereof, will be received at this office, located at 801 Ruggles Drive, Raleigh, NC, until **2:00 pm** Eastern Daylight Savings Time on the day of opening and then opened. Refer to page 2 for proper mailing instructions. Proposal submission will not be accepted by electronic means.

**EXECUTION**

In compliance with this Request for Cost Proposal and subject to all the conditions herein, the undersigned offers and agrees to furnish and deliver any or all services which are offered, at the prices agreed upon and within the time specified in the Offeror's Technical Proposal. Pursuant to GS § 147-33.100 and under penalty of perjury, the undersigned Vendor certifies that this offer has not been arrived at collusively or otherwise in violation of Federal or North Carolina law and this offer is made without prior understanding, agreement, or connection with any firm, corporation, or person submitting an offer for the same services, and is in all respects fair and without collusion or fraud.


**Failure to execute/sign the Cost offer prior to submittal shall render Cost Proposal invalid. Late offers are not acceptable.**

<b>VENDOR:</b> Computer Sciences Corporation		<b>FEDERAL ID OR SOCIAL SECURITY NO.</b> [REDACTED]	
<b>STREET ADDRESS:</b> 3160 Fairview Park Drive		<b>P.O. BOX:</b>	<b>ZIP:</b>
<b>CITY &amp; STATE &amp; ZIP:</b> Falls Church, VA 22042		<b>TELEPHONE NUMBER:</b> (703) 876-1154	<b>TOLL FREE TEL. NO:</b>
<b>TYPE OR PRINT NAME &amp; TITLE OF PERSON SIGNING:</b> Mark E. Anderson, Director of Contracts		<b>FAX NUMBER:</b> (703) 876-1251	
<b>AUTHORIZED SIGNATURE:</b> 	<b>DATE:</b> 9-23-08	<b>E-MAIL:</b> manderson2@csc.com	

The offer shall remain valid for so long as the Technical Proposal, as amended, remains valid.

**ACCEPTANCE OF COST OFFER**

If the State accepts any or all parts of this offer, an authorized representative of NC DHHS shall affix her/his signature to the Vendor's response to this Request for Cost Proposal. The acceptance shall include the response to this Request for Cost Proposal, and any provisions and requirements of the RFP which have not been superseded by this Request for Cost Proposal. These documents shall then constitute the written agreement between the parties. A copy of this acceptance will be forwarded to the successful Vendor(s).

<b>FOR DHHS USE ONLY</b>  Offer accepted and contract awarded this <u>22</u> day of <u>December</u> , 200 <u>8</u> as indicated on attached certification, by  (Authorized representative of DHHS).
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<b>STATE OF NORTH CAROLINA</b>  <b>Department of Health and Human Services</b> <b>Office of Procurement and Contract Services</b>	<b>REQUEST FOR BEST AND FINAL OFFER (BAFO) RFP 30-DHHS-1228-08-R</b>	
	Offers will be received until: October 27, 2008	
	Contract Type: Agency Specific	
<b>Refer ALL Inquiries to</b> Susan W. Lewis  Telephone No. (919) 855-4086	Issue Date: October 13, 2008  Commodity: 920-Data Processing Services and Software	
E-Mail: Susan.Lewis@ncmail.net	Using Agency Name: NC DHHS	
<b>(See page 2 for mailing instructions.)</b>	Agency Requisition No. N/A	

**NOTICE TO VENDOR** Offers, subject to the conditions made a part hereof, will be received at this office, located at 801 Ruggles Drive, Raleigh, NC, until 2:00 p.m. Eastern Time on the day of opening and then opened, for furnishing and delivering the goods and services as described herein. Refer to page 2 for proper mailing instructions. Proposal Submission will not be accepted by electronic means.

**EXECUTION**

In compliance with this Request for Best and Final Offers (BAFO), and subject to all the conditions herein, the undersigned offers and agrees to furnish and deliver any or all goods and services which are offered, at the prices agreed upon and within the time specified herein. Pursuant to GS § 147-33.100 and under penalty of perjury, the undersigned Vendor certifies that this offer has not been arrived at collusively or otherwise in violation of Federal or North Carolina law and this offer is made without prior understanding, agreement, or connection with any firm, corporation, or person submitting an offer for the same commodity, and is in all respects fair and without collusion or fraud.

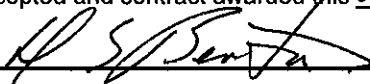
**Failure to execute/sign offer prior to submittal shall render proposal invalid. Late offers are not acceptable.**

<b>VENDOR:</b> Computer Sciences Corporation		<b>FEDERAL ID OR SOCIAL SECURITY NO.</b> [REDACTED]	
<b>STREET ADDRESS:</b> 15245 Shady Grove Road		<b>P.O. BOX:</b>	<b>ZIP:</b> 20850
<b>CITY &amp; STATE &amp; ZIP:</b> Rockville, MD 20850		<b>TELEPHONE NUMBER:</b> (703) 876-1154	<b>TOLL FREE TEL. NO:</b>
<b>TYPE OR PRINT NAME &amp; TITLE OF PERSON SIGNING:</b> Mark E. Anderson		<b>FAX NUMBER:</b> (703) 876-1251	
<b>AUTHORIZED SIGNATURE:</b> 	<b>DATE:</b> 10/27/08	<b>E-MAIL:</b> manderson2@csc.com	

The offer shall remain valid for so long as the Technical Proposal, as amended, remains valid.

**ACCEPTANCE OF BEST AND FINAL OFFER**

If the State accepts any or all parts of this offer, an authorized representative of NC DHHS shall affix her/his signature to the Vendor's response to this Request for BAFO. The acceptance shall include the response to this BAFO, and any provisions and requirements of the RFP which have not been superseded by this BAFO. These documents shall then constitute the written agreement between the parties. A copy of this acceptance will be forwarded to the successful Vendor(s).

<b>FOR DHHS USE ONLY</b>	
Offer accepted and contract awarded this <u>22</u> day of <u>December</u> , 200 <u>8</u> , as indicated on attached certification,	
by 	(Authorized representative of NC DHHS).

**ISSUING AGENCY:** Department: Health and Human Services  
Raleigh, North Carolina

**USING AGENCY:** Department: Health and Human Services  
Raleigh, North Carolina

**DELIVERY INSTRUCTIONS:** Deliver the bid Proposal to Issuing Agency in a sealed package with Company Name and RFP Number clearly marked on the front. The package shall contain five (5) certified signed originals; twenty- seven (27) copies of the same, each with a signature facsimile; ten (10) electronic copies, each on a separate CD; and a total of twenty-two (22) DVD discs, each containing the bid Proposal.

<b>DELIVERED BY US POSTAL SERVICE</b>	<b>DELIVERED BY ANY OTHER MEANS</b>
BID NUMBER: 30-DHHS-1228-08-R Department of Health and Human Services DHHS Procurement and Contracting Attn: Susan W. Lewis 2008 Mail Service Center Raleigh, NC 27699-2008	BID NUMBER: 30-DHHS-1228-08-R Department of Health and Human Services DHHS Procurement and Contracting Attn: Susan W. Lewis 801 Ruggles Drive, Hoey Building Raleigh, NC 27603-2001

Sealed bids, subject to the conditions made a part hereof, will be received at 801 Ruggles Drive, Hoey Building until 2:00 p.m. ET, on the day of opening and then opened, for furnishing and delivering the commodity as described herein. Proposals for this RFP must be submitted in a sealed package with the Execution of Proposal signed and dated by an official authorized to bind the Vendor's firm. Failure to return a signed execution of proposal shall result in disqualification. All proposals must comply with Section 50, Proposal Submission Requirements

Proposal submission will not be accepted by electronic means. This RFP is available electronically at <http://www.ips.state.nc.us/ips/pubmain.asp>. All inquiries regarding the RFP requirements are to be addressed to the contact person listed on Page One.

Written questions concerning the RFP specifications will be received until 2:00 p.m. ET, September 7, 2007. They must be sent via e-mail to: Susan Lewis (see page 1 of the coversheet). Please insert "RFP #30-DHHS-1228-08-R Questions" in the subject matter of your e-mail. A summary of all questions and answers will be posted to the Interactive Purchasing System (IPS) as an addendum to this RFP.

**Addendum to RFP:** If written questions are received prior to the submission date, an addendum comprising questions submitted and responses to such questions, or any additional terms deemed necessary by the State will be posted to the Interactive Purchasing System (IPS), <http://www.ips.state.nc.us/ips/deptbids.asp>, and shall become an Addendum to this RFP.

Critical updated information may be included in these Addenda. It is important that all Vendors bidding on this proposal periodically check the State website for any and all Addenda that may be issued prior to the bid opening date.

The State will provide soft copies of revised RFP Appendix 50, Attachment A and RFP Appendix 50, Attachment C, Exhibit 1 at the Offeror's request. To request a soft copy of these documents, please send an email to [Susan.Lewis@ncmail.net](mailto:Susan.Lewis@ncmail.net).

**Basis for Rejection.** Pursuant to 9 NCAC 06B.0401, the State reserves the right to reject any and all offers, in whole or in part; by deeming the offer unsatisfactory as to quality or quantity, delivery, price or service offered; non-compliance with the requirements or intent of this solicitation; lack of competitiveness; error(s) in specifications or indications that revision would be advantageous to the State; cancellation or other changes in the intended project, or other determination that the proposed requirement is no longer needed; limitation or lack of available funds; circumstances that prevent determination of the best offer; or any other determination that rejection would be in the best interest of the State.

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**NOTICE TO VENDORS:** The State objects to and will not be required to evaluate or consider any additional terms and conditions submitted with a Bidder's response. This applies to any language appearing in or attached to the document as part of the Bidder's response. By execution and delivery of this Request for Proposal and response(s), the Bidder agrees that any additional terms and conditions, whether submitted purposely or inadvertently, shall have no force or effect.

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**Late Proposals.** Regardless of cause, late proposals will not be accepted and will automatically be disqualified from further consideration. It shall be the Vendor's sole risk to ensure delivery at the designated office by the designated time. Late proposals will not be opened and may be returned to the Vendor at the expense of the Vendor or destroyed if requested.

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**North Carolina  
Department of  
Health and Human Services**

**REQUEST FOR PROPOSAL  
30-DHHS-1228-08-R**

**for the**

**North Carolina Replacement Medicaid  
Management Information System (MMIS)**

**Prepared by  
North Carolina Department of Health and Human Services  
Office of Medicaid Management Information System Services**





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## **SECTION 10: STATEMENT OF OBJECTIVES**

### **10.1 INTRODUCTION**

This document is the State of North Carolina's Request for Proposal (RFP) for the development and implementation of a Replacement Medicaid Management Information System (MMIS) by a Vendor, who shall also operate the system and perform other Medicaid-related functions as the State's Fiscal Agent. The Replacement MMIS will replace the State's federally certified Legacy MMIS+.

The Division of Medical Assistance (DMA) within the North Carolina Department of Health and Human Services (NC DHHS) uses the Legacy MMIS+ to process Medicaid claims. Because the existing MMIS interacts with the State's Integrated Payment and Reporting System (IPRS) to process the non-Medicaid claims of NC DHHS' Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH), the State refers to the MMIS and its IPRS-specific business areas collectively as the multi-payer Legacy MMIS+.

The NCMMIS+ Program was initiated to manage the activities related to the procurement and implementation of systems and services for the Replacement MMIS as well as systems and services for Reporting and Analytics (R&A) and an information technology (IT) system for the Division of Health Service Regulation (DHSR), formerly the Division of Facility Services (DFS). This RFP contains information on the Replacement MMIS business areas. Subsequent RFPs will address the requirement for the other business areas in the NCMMIS+ Program.

The Replacement MMIS will expand claims payment functionality to include the Division of Public Health (DPH), the Migrant Health Program in the Office of Rural Health and Community Care (ORHCC), DMA, and DMH. For additional information about all affected NC DHHS divisions, refer to the Procurement Library.

This RFP contains a high-level Statement of Objectives (SOO) section as well as detailed requirements in Section 40. The State encourages Offerors to propose solutions and innovative approaches to achieve those solutions that are consistent with the objectives set forth in this RFP.

### **10.2 NCMMIS+ PROGRAM OBJECTIVES**

The key objectives of this program are to:

- Acquire a multi-payer Replacement MMIS that is certifiable by the Centers for Medicare & Medicaid Services (CMS);
- Acquire an IT system to perform services provided by the DHSR;
- Provide a level of security that will ensure compliance with NC DHHS' Security Policies and Standards;
- Take advantage of advances in health care IT to improve NC DHHS' capabilities and operations (e.g., e-prescriptions, electronic health records, and electronic x-rays);
- Pay claims correctly and in a timely fashion to the appropriate party;





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- Leverage advances in reporting and analytics tools to provide broad business intelligence (BI) capability using pre-configured and ad hoc queries, analyses, and data extracts;
- Issue new Fiscal Agent contracts for the various functional groups of capabilities as described in Section 10.3 below;
- Improve operations of all internal and external stakeholders by increasing the level of automation;
- Acquire systems that can be transferred to and maintained by the State internally or via other vendors for a long enough period to provide a reasonable return on investment;
- Streamline activities and refine teamwork during the Design, Development, and Installation (DDI) Phases to balance risk and the State's fiduciary responsibility with the need to acquire affordable systems in a timely manner; and
- Explore new ways of doing business that tap the experience of the vendor base. (e.g., alternative ways of handling capitated payment and fee-for-service transaction and broadening Point-of-Sale business area capabilities to process other services).

The State requires the implementation of a common, unified, and flexible multi-payer functionality for supporting the business requirements of the NC DHHS divisions involved in administering both Federal and State health care programs. The term *payer* represents any entity responsible for compensating the service provider for the services received: a recipient, Medicaid, or a participating non-Medicaid health benefit program. Accordingly, the Vendor shall provide a single Replacement MMIS solution to coordinate recipient benefit processing among DMA, DPH, DMH, and the Migrant Health Program and to ensure the proper assignment of the financially responsible payer, benefit plan, and pricing methodology for each service tendered in a claim.

The identification of the financially responsible payer, benefit program, and pricing methodology for the claim service(s) shall be conducted using benefits coverage, eligibility, and pricing criteria or rules that can be configured and administered with minimal and limited programmatic changes to the claims adjudication software. The process of identifying the financially responsible payer shall be transparent to a provider to the greatest extent possible. For example, the provider can submit multiple services for a recipient on one (1) claim that is paid by various payers.

Each health benefit program offered and administered by the State shall be realized by one or more concurrent benefit plan(s) that define the scope of benefits, eligibility criteria, and pricing methods applicable to a health benefit program. The selected Vendor shall use a hierarchy of payment criteria to determine the correct payer when multiple payers are involved.

### 10.3 MAJOR PROGRAM FUNCTIONAL GROUPS

The program is divided into major functional groups to allow for flexibility in contracting; to provide the State access to the knowledge and skills of multiple vendors; and to broaden the industry experience base in NC DHHS systems by providing opportunities



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for specialization that might attract new vendors or partnerships not seen in a monolithic acquisition. Below is a description of the functional groups.

### 10.3.1 Replacement MMIS

The Replacement MMIS encompasses the design, development, installation, maintenance, and execution of Fiscal Agent operations for a Replacement MMIS. The mission of these combined efforts is to ensure that authorized providers are performing medically necessary or clinically indicated services; eligible recipients are receiving those services; and payments are distributed following fiduciary guidelines and rules.

North Carolina requires a replacement solution that will support and manage the Medicaid Program as well as other health coverage programs offered across NC DHHS. The successful Offeror shall present a solution to support health coverage programs for DMA, DPH, DMH, and ORHCC that is flexible in technological design. The solution(s) shall provide timely and accurate access to shared information while maintaining multi-payer measurements of recipient health care outcomes and services.

To move seamlessly into a multi-payer operation, the successful Offeror shall coordinate the transition of supporting business processes from operating in silos using legacy systems and/or manual processes to a more streamlined enterprise that leverages technological advances.

### 10.3.2 Reporting & Analytics

The future R&A solution will provide a strategic enterprise-wide infrastructure and will include the NCMMS+ Program entities. The Decision Support System (DSS) functions will be procured and contracted separately within the R&A functional group; however, the Replacement MMIS Vendor shall be required to provide interfacing support to the data warehouse and will participate in and provide technical support and execution in the development of the R&A Interface Plan with the selected R&A vendor during the DDI and Operations Phases. This will include format definitions, content, data extraction, transmission methods and protocols, scheduling, auditing, and transformation validation.

### 10.3.3 DHSR Project

DHSR is responsible for allocating, approving, licensing, and inspecting health care facilities, services, and equipment within the State. Most DHSR-regulated facilities are also MMIS providers. In addition, DHSR health care personnel registry information is essential to MMIS providers. In their respective missions, DHSR and the Medicaid Program collect and rely on similar data but cannot share it efficiently within the current infrastructure. Therefore, an important goal of the program is to incorporate DHSR data within the Replacement MMIS to enable optimal decisions and actions by the Medicaid Program.

DHSR will be acquiring an IT solution with one (1) objective being to support critical processes within several business areas of the Replacement MMIS (e.g., Provider Enrollment, Credentialing, and Claims Payment). Both before and after the new DHSR system is operational, the Replacement MMIS shall interact with DHSR processes and exchange data, beginning with early implementation services (as defined in subsection



10.6 below). To that end, the Replacement MMIS Vendor must collaborate with DHSR during Replacement MMIS development and operations to accommodate the integration of the two functional groups' business needs.

**10.4 NCMMS+ PROGRAM CONTRACT AND PROCUREMENT STRATEGY**

The NCMMS+ Program procurements will be based on the overall Best Value to the State per 9 NCAC 06B.0302, which will include cost, quality, and time considerations. The tradeoff method of source selection will be used. Given the current environment, the State believes that there may be multiple solutions that could meet its needs. The State will competitively procure each of the functional groups separately, and Offerors may compete individually for one (1) or more of the groups or may team with one (1) or more other Offerors and compete for one (1) or more of the groups (as a prime/sub relationship or as a single business entity).

The three (3) functional groups are at different stages in their project maturities, and the State has determined that it would be best to allow each project to operate on its optimum schedule while ensuring that dependencies between the projects are met. The Replacement MMIS is the largest and most critical piece of the program, and the solicitation for this project is first.

The DHSR and R&A functional groups are referenced in this SOO for completeness; however, any future solicitations for these functional groups will be stand-alone RFPs. The DHSR solicitation will be subsequent to the award of the Replacement MMIS contract. The R&A project is critical to the Replacement MMIS project; however, it should take significantly less time to develop. To meet CMS certification requirements, the R&A development must be completed at the same time or before the Replacement MMIS development.

A Procurement Library was established as a repository for information about this solicitation and its dynamic business rules, current operations, and/or related functions. To keep potential Offerors informed on progress and requirements going forward, the State intends to post requirements updates to the Procurement Library from time to time.

The remainder of this SOO applies to the Replacement MMIS project unless otherwise stated.

**10.4.1 Replacement MMIS Contract Strategy**

The DDI portion of the Replacement MMIS project will be contracted via a firm fixed-price contract. Offerors shall propose a pool of software modification labor for use during DDI based on their historical experience. This labor shall be used for additions and changes to the State's requirements that were not previously specified in the Contract. The main effort of the Operations Phase (Fiscal Agent Phase) will be contracted via a fixed price based on the volume of claims as indicated in Section 30 of this RFP. The software modification activities during the Operations Phase will be contracted via a not-to-exceed pool of fixed-price labor cost. Other efforts during the Operations Phase will be contracted via methods described elsewhere in this RFP.



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As of the release date of this RFP, the State does not intend to publish a mandatory implementation date for the Replacement MMIS. Offerors shall propose appropriate implementation dates based on their specific strategies. The Contract term for the Operations Phase of the Replacement MMIS functional group shall be for four (4) years with an additional one (1)-year option.

The evaluation criteria are listed in Section 60 of this RFP.

### 10.5 FINANCIAL OBJECTIVES

The State wants to receive fair prices at the time of the solicitation as well as throughout the development life cycle of the system(s) and their operations. Offerors shall thoroughly describe their bases of estimates in conjunction with all submissions in the Cost Proposal, and the successful Offeror shall continue this practice throughout the life of the Contract. For software development and configuration, the bases of estimates must address software sizing; amount of new, modified, reused, and deleted software; other pertinent measurements of the scope of the work (e.g., evaluations of the scope of the work itself); productivity estimates and how they drive labor estimates; labor costs; and non-labor costs. For operations, the bases of estimates shall include descriptions of how labor quantities and productivities were derived and how prices for material solutions were developed. The State's objective is to have visibility into the calculations of the amount of work being done and the amount of labor required to perform this work so that arriving at a fair price is equitable and repeatable. Inclusion of thorough bases of estimates applies to all activities and phases of the project.

The State requires measuring software size in terms of function points as defined by the International Function Point Users Group (IFPUG) where practical. While there may be substantial software customization and configuration efforts that are not well-represented by function points, the sizing of new, modified, and deleted code shall be measured in function points, wherever practical, for consistency.

Offerors shall define key deliverables and appropriate payments associated with those activities for DDI. All payments shall be associated with milestones or deliverables, and their amounts shall be proportionate to the effort required to achieve those milestones and deliverables (including allocations of level-of-effort tasks, such as project management and systems engineering). Payments shall be scheduled no more frequently than once per month. If multiple milestones or deliverables are scheduled or actually occur more than once a month, they shall be grouped into a single payment. The State shall retain seven (7) percent of the DDI costs until all defects discovered prior to CMS certification are successfully resolved.

Milestone or delivery approval dates shall reflect a reasonable duration for the State to review and approve any necessary items required for payment. If the State identifies shortcomings in the achievement of a milestone or defects that prevent approval of a deliverable that result in the Vendor missing the planned date, the State shall deem that the Vendor has failed to meet the planned date. For example, if the planned date includes only the minimum time for approval, any shortcoming in the milestone or deliverable is likely to result in late completion. Delays caused by the State shall result in adjustments to due dates; however, the State shall not be responsible for collateral

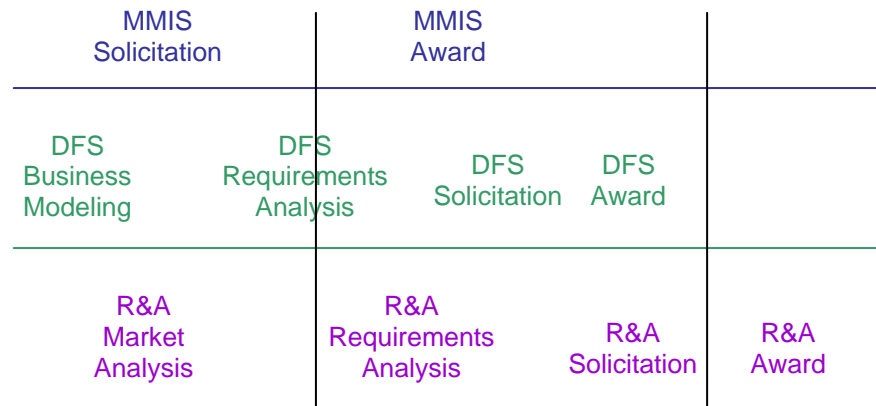
delays caused by systemic Vendor quality issues or Vendor adjustment of internal milestones that result in excessive numbers of artifacts needing State review during a short timeframe. Details concerning reductions in compensation due to late completion of milestones are discussed in Section 30 of this RFP.

The State has Enterprise License Agreements for certain products. If the State awards the Contract for a solution that requires the use of any software products that the State is able to acquire through an Enterprise License Agreement listed at <http://www.its.state.nc.us/servicecatalog/enterpriselicenses.asp> , the State intends to directly procure such software and directly bear its licensing, maintenance, and support costs. Offerors shall not include the licensing, maintenance, or support costs of such software products in its Cost Proposal.

**10.6 SCHEDULE OBJECTIVES**

The Replacement MMIS functionality (to include Medicaid, DMH, DPH, and the Migrant Health Program for ORHCC) needs to be deployed as quickly as is reasonable. This capability is needed to replace the Legacy MMIS+.

Figure 10-1 below shows the relationship between the procurements in the program schedule. While it is at a high level, it shows the basic relationships and phasing between key elements of the program.



**Figure 10-1: General Program Solicitation Schedule**

**10.7 EARLY IMPLEMENTATION OBJECTIVES**

The Replacement MMIS requires additional services and technological enhancements that are not currently offered by the Legacy MMIS+ and/or legacy processes. There is an opportunity to implement some business areas or features earlier than the remainder of the Replacement MMIS; accordingly, the State invites Offerors to make such recommendations in their Proposals. The State is interested in innovative ways to improve business services in a cost-effective manner that does not require extensive legacy system changes and does not result in a delay of the overall Replacement MMIS implementation. Offerors considering early implementation shall detail the options, benefits, costs, risks, and impact on the Replacement MMIS.

System functionality and/or operations proposed for early implementation will be considered by the State. A key factor in assessing the Proposal's value to the State will be the impact on current operations, particularly if it requires interfacing with the Legacy MMIS+ and/or changing legacy Fiscal Agent responsibility.

One key service that is not currently integrated into the legacy operations is provider enrollment, credentialing, and verification. These processes are managed by divisional staff, where parts are performed internally and externally.

The Vendor shall take over responsibility for performing provider enrollment, credentialing, and verification as soon as practical after Contract award and continue throughout the life of the Contract. While the State prefers that the Vendor use its provider IT solution immediately, if that system will not be available for an extended period after Contract award, the Vendor shall initiate the enrollment, credentialing, and verification services manually and migrate the data to the new provider system when it is ready for implementation. The Vendor shall also validate existing provider information with the providers, complete the update of this information, and make this and all new provider information available to the legacy Fiscal Agent.

**Note**

The time spent in operations for early implementation objectives does not count toward the Fiscal Agent Contract duration or start date.

**10.8 DDI PROJECT MANAGEMENT OBJECTIVES**

To ensure an efficient and fiscally responsible implementation, the State must understand the Vendor's execution plans and ongoing status. Offerors shall describe how they perform planning and how they control execution via the use of cost, schedule, performance (scope and quality), staffing, risk, and issue metrics and reporting, as well as the methods they use to ensure the quality of these data. The Vendor shall provide the State on-line access to current versions of all of this information.

At a minimum, the Offerors shall create and maintain:

- An Integrated Master Plan (IMP) that describes events and accomplishments, along with their success criteria and their relationships to other items in the plan;
- An Integrated Master Schedule (IMS) that time phases the IMP elements and identifies dependencies. Dates associated with events and activities resulting in payments shall be contractually binding.
- Financial reporting via an Earned Value Management System (EVMS). EVMS data can provide significant insight into cost and schedule overruns that may either affect the State directly or that could jeopardize the ability of the Vendor(s) to continue the project. Perfect compliance with ANSI/EIA-748A is not required, but Offerors shall identify any elements of that standard they do not meet or do not intend to meet and explain why.



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- ❑ A risk and issue management system in which the State is integrated as a partner. This process shall include elements of risk and issue identification, evaluation, mitigation, and reporting and shall be responsive across the spectrum of risks and issues.

The formats of documents created during DDI are at the discretion of the Vendors; samples shall be provided as part of the Technical Proposals. Per North Carolina statute, the Office of Medicaid Management Information System Services (OMMISS) must report cost, schedule, performance, risk, and issue status monthly. Therefore, at a minimum, these elements must be conveyed no less frequently. Vendors may use additional tools and processes to manage the project, and all results and reports from those tools and processes shall be made available to the State.

The State supports electronic sharing of data in a secure manner (i.e., authorized individuals accessing data they need to perform their work). Vendors shall maintain a collaborative online tool to facilitate information sharing. Whether this is a bulletin board-type system for posting documents or a full content management system/wiki is at the Vendors' discretion. Use of these types of tools will reduce the need for Vendors to provide any data in hard copy format other than those legally requiring physical copies or signatures, documents which drive payments, or for documents that are so large that the State's printing turnaround time would potentially affect project execution. The formats of posted data shall be coordinated with and approved by the State to ensure compatibility with applications used by the State.

The Offerors shall propose a plan for Project Management Reviews to include their planned content and frequency. Additionally, during execution the Vendor shall report all changes to milestones and deliverables for State concurrence sufficiently in advance to allow the State to assess the changes.

The Vendor shall support the State in providing other reasonable data needed for budgeting and reporting. The need for this type of support should normally be infrequent, but it tends to increase if the project experiences cost, schedule, and/or performance problems.

The State requires the successful Offeror to ensure timely and appropriate communications among all stakeholders during DDI, including the provider community. To this end, each Offeror shall propose an overall DDI Communications Approach. After Contract award, the Vendor and the State shall develop a mutually acceptable Joint Communications Plan.

Due to the extended period until an R&A and DHSR DDI, Offerors are not required to propose any statements of work or associated costs for integration of these functional groups in response to this solicitation. These integration tasks shall be addressed via a future CSR, whereupon mutual agreement the Replacement MMIS Vendor shall serve as the system integrator.

Additionally, the Vendor shall support future solicitations for the R&A and DHSR projects by presenting requirements and design information (e.g., database schema, application programming interfaces, etc.) in a timely fashion to allow other vendors,



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under a non-disclosure agreement, sufficient information in order to bid. The Vendor shall provide reasonable support to other potential bidders to understand the nature and contents of this information. The State will provide as much advance notice as practical when requesting this information, and will use draft Vendor documentation consistent with the project progress at the time the information is requested.

The Vendor shall manage the Change Control Board process. Offerors shall propose a process that efficiently and effectively manages technical, programmatic, and operational changes within the overall program. The State shall serve as the chairperson.

### **10.9 SOFTWARE AND SYSTEMS ENGINEERING OBJECTIVES**

The Vendor shall maintain engineering processes that support requirements analysis; design, construction, testing, data conversion and data migration, and implementation of the system. The Vendor shall also establish practices suitable for life-cycle support of the system, including change management. All parties need solid processes and artifacts to understand the requirements, design, testing, and operation of the Replacement MMIS. The Vendor's systems engineering processes should include active management of those technical elements influencing TCO and seek to minimize them while still meeting the State's requirements. Offerors shall describe the State's role in their systems engineering processes.

To reduce risk on the project, the State requires a staged-delivery process. In this process, key elements of the system are completed and tested as development progresses to provide early feedback on requirements, performance, architecture, and design issues and to mitigate specific risks. Staged-delivery assumes that the end state is relatively well-known but that there are risks during development that need to be mitigated. Offerors shall describe their strategies for this process to include the number of stages and their contents as well as the key risks to be mitigated.

The State does not plan to implement any of the early stages at the time they are completed (with the exception of early implementation initiatives), but it does intend to conduct user testing to provide feedback on the product. In order to maintain a constant flow of information on the development of the system, the Vendor shall provide remote access to the software from the latest completed stage to the State. This will facilitate efficient communication between the State and the Vendor on requirements and design issues affecting the system. During requirements analysis, the Vendor shall provide remote access to the baseline system to facilitate the users' understanding of it.

While not mandating any particular architectural solution, the State advocates that the principles described in the North Carolina Statewide Technical Architecture (STA) describe characteristics associated with high-quality software systems (e.g., scalability, adaptability, secureability, availability, manageability, and interoperability). Offerors shall propose systems that align with these principles and practices as much as is technically and fiscally reasonable. The State encourages Web-based solutions that are designed using either a 3/N-tier or Service-Oriented Architecture (SOA) approach. Offerors shall identify any elements of their designs that appropriately would not meet these constraints and explain why this is so.





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North Carolina supports the Medicaid IT Architecture (MITA) initiative by CMS to broaden the application of information technology and system interoperability for Medicaid systems and believes its multi-payer approach moves the State in that direction. North Carolina is in the process of completing its MITA Self-Assessment. Although there is no MITA compliance against which an Offeror could be evaluated, all Offerors are encouraged to consider MITA principles, standards, and architecture configuration in their technical approach to the North Carolina Replacement MMIS.

One of the key architectural aspects of the system will be managing business rules, edits, and other similar control information. The ability to change this information rapidly and cost-effectively provides the opportunity to respond to legislation and programmatic direction while preventing claims being paid using out-of-date rules. Offerors shall propose solutions that externalize the management of these rules as much as practical, such as using a business rules engine. Additionally, Offerors shall propose methods to allow the analysis of changes to these rules without changing the production system and shall describe how changes will be tested thoroughly prior to their implementation in the production system.

The systems built to support each of the three (3) functional groups will have dependencies on each other, and the State recognizes the challenge associated with this integration. This effort will require substantial cooperation among the selected Offerors.

The DDI process must ensure that an adequate level of security is built into the system and supported by secure processes that will ensure compliance with all applicable Federal and State regulations. Breaches of security that compromise these data are unacceptable. Offerors should propose systems and operations that are as compliant with the Statewide Information Technology Security Manual (located at the following URL: <http://www.scio.nc.gov/sitPolicies.asp>) and Federal requirements as is practical. Additionally, to the greatest extent practical, the proposed systems shall use a single sign-on for users, particularly those users who are not State employees (e.g., providers, recipients, etc.).

Because of the need to process and analyze historical data from the legacy systems, Offerors shall describe their strategies for successfully completing data conversion and data migration to support development, testing, certification, and long-term operations. Data conversion and data migration activities include, but are not limited to, analysis of the conversion and migration requirements; design and construction of solutions; testing of those solutions; documentation suitable for ensuring that conversion and migration is being done properly and to support any future similar data conversion and data migration activities; and conducting and verifying the conversion and data migration activities.

The Vendor shall plan and execute complete and coherent testing and quality assurance programs. These efforts shall include process controls, defect removal, and a full range of testing activities from unit testing through system and parallel testing. Additionally, testing within a realistic operating environment—to include load testing and security testing—is required. The testing and quality assurance programs should



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emphasize the removal of defects at the earliest practical stage as well as continual improvement.

The State shall be responsible for the planning and direction of the User Acceptance Test (UAT), with support from the Vendor. This test will occur after the completion of the Vendor's system testing and will include functional testing and operational readiness testing. The UAT will include users from appropriate State agencies and NC DHHS divisions, local government users, providers, simulated recipients, and the Vendor. Other Vendors providing services to the State may also participate to a limited degree, based on availability. Offerors should assume that this testing will take approximately ninety (90) business days, during which the Vendor shall participate by performing the duties of the Fiscal Agent in as realistic fashion as is practical (limited in scope to the testing activities). While the State will plan and direct the testing from a strategic point of view, the Vendor shall be required to perform planning and evaluation on detailed activities normally performed by the Fiscal Agent. Software and system updates will be limited during this test to those required to successfully complete the testing; however, the Vendor will be asked to make a least one (1) change to the system during this test to evaluate the change management process and its impact on operations. User manuals and training will be evaluated as part of the UAT.

To support early testing on the system (not associated with acceptance testing) as well as UAT, the Vendor shall provide facilities, equipment, and support personnel in the Raleigh, NC, area at appropriate times. The Vendor shall support this testing with equipment, data, facilities, and streamlined training during early development as well as the Operations Phase. The Vendor shall provide Internet access at the Vendor's facility for use by State personnel.

### **10.10 LIFE-CYCLE SUPPORT OBJECTIVES**

The Vendor shall provide a warranty after final delivery of the system. The scope and duration of this warranty shall be identified in the Offeror's Technical Proposal and shall include at minimum the provisions set forth in Section 30.21(b) and 30.21(g) of this RFP.

The Vendor shall retain an organizational structure capable of maintaining and updating the system software during the Operations Phase. Offerors shall plan for 100,080 hours per year for software CSRs and indicate the cost of those hours in their Cost Proposals. The dollar value of hours not used by the State during a fiscal year shall rollover to the next year of operations. The State will have no obligation to utilize any hours within this pool and shall pay only those labor charges which actually accrue. NC DHHS reserves the right to obtain competitive bids and award the software modification work to outside vendors if it is advised or directed to do so by other State or Federal authorities or if resorting to the Vendor would be unacceptable due to anticipated problems with scheduling, unavailable resources, unacceptable prior performance, and/or excessive estimated costs.

The State requires a cohesive and responsive training program to ensure that users can be efficient and effective while using the system as well as understand the State-specific policies for claims payment. The Vendor shall develop training materials and



conduct training classes for all types of users to include State employees and contractors as well as external users, such as providers. This training capability must be available in time to support testing and remain current and available throughout the Operations Phase. The State is looking for innovative, yet proven methods of training that will encourage on-demand self-training where practical, backed up with face-to-face training for topics and/or trainees that need this level of contact. This solution shall include online access to materials and training news. Additionally, the Vendor must manage the training program to include identifying and tracking needs and training access for the target audience and evaluating trainee feedback to improve the course materials and methods.

The Vendor shall establish a local facility for its staff to be used during DDI and operations within fifteen (15) miles of the NC DHHS headquarters. This facility shall house the Vendor's key personnel and requirements analysis staff. Due to space constraints, the State is unable to host large meetings at its facilities and, as such, the Vendor shall provide the space. The Fiscal Agent's data center does not need to be located at this facility as long as the Vendor can meet required performance, security, and continuity of operations requirements.

The Vendor shall hire a sufficient number of qualified personnel to support the Operations Phase. The Vendor shall be responsible for all costs associated with operating and maintaining its Fiscal Agent operations.

Offerors shall identify Contract deliverables as required by the RFP or any other data and documents that the Offeror proposes to deliver and deems necessary to perform the services effectively. These deliverables shall be included in a Contract Data Requirements List (CDRL). All data and documents required for the proper operation and maintenance of the system and proper conduct of the Fiscal Agent operations shall be included on the CDRL. In addition, the Vendor shall maintain a Data Accession List (DAL). This list shall include all data and documents (to include software) that have been created under this Contract that are not part of the CDRL.

**10.11 INTELLECTUAL PROPERTY RIGHTS**

The State requires the ability to maintain the acquired systems independently of the original developer. While all realistic systems are likely to have true commercial off-the-shelf (COTS) components for which only commercial licenses are available, the State must secure sufficient rights to all custom and customized software to allow it to support the system internally or via another vendor. Offerors must provide rights sufficient for the State to perform these activities and shall identify all intellectual property for which the State will have less than these rights. Commercial licenses shall be provided for products and services for which the Vendor does not have greater rights. Section 30 of this RFP will discuss the details of intellectual property in greater detail.

**10.12 REPLACEMENT MMIS OVERVIEW**

In addition to the requirements specified in Part 11 of the State Medicaid Manual, additional North Carolina functionality is defined below.



## SECTION 10: STATEMENT OF OBJECTIVES



### 10.12.1 Operations Management

The Vendor shall be responsible for the Fiscal Agent delivery and support of all operational services in the most efficient and effective manner. Since actions taken by the Fiscal Agent reflect directly upon the State of North Carolina, it is imperative the Fiscal Agent uphold the highest standards of performance, integrity, customer service, and fiscal accountability. Offerors shall describe their approach to operations management and how it will succeed.

The Vendor shall acquire and maintain the required staff needed to perform Fiscal Agent duties. This includes hiring key professional staff required to successfully manage Medicaid and other NC DHHS benefit programs. Where specific professionals are identified in the requirements (e.g., Medical Director), these reflect the minimum requirements. If additional staffing capacity is needed in any business area, it is the Vendor's responsibility to acquire this capacity. Additionally, the Vendor shall be responsible for all training and education required to ensure qualified and competent staff. This includes any continuing education and training requirements needed to address future changes.

Offerors shall describe their planned organization, along with the key roles and responsibilities. To facilitate communication and coordination, the State expects a significant amount of collaboration, down to the team lead level, within the Vendor's organization. This collaboration should allow for rapid response to issues and changing needs while maintaining sufficient quality control over operations. To maintain broad-based, strategic communications with the State, Offerors shall propose a plan for operations management reviews, including their frequency and general content.

As with the DDI project management, the State prefers to fulfill its operational management via insight rather than oversight. The standards by which the State will evaluate the selected Offeror's operational performance will be a combination of the performance standards specified by the State in Section 40 of this RFP and those additional standards accepted by the State from the Offeror's Technical Proposal or agreed to by the Parties in the course of negotiations. Offerors shall develop metrics to these performance standards. The Offerors shall describe the methods and metrics to be used for evaluating performance as well as the method for communicating this information to the State. The State favors methods that provide "dashboard"-like reporting capabilities and trend analyses with online access for management staff. The Vendor shall give the State online access to current versions of these performance metrics and the metrics developed by the Vendor as well as its internal performance measurements. The Vendor shall also provide the State with significant visibility into ongoing operations.

The risk and issue management process used during DDI shall continue into Fiscal Agent operations. This process must continue to address those items associated with new software development and modification as well as operational risk and issue management. Operations-unique concerns—such as continuity of operations, disaster recovery, operations security (e.g., data, facilities), and risks to ongoing business operations—must be addressed. Issue management during the Operations Phase must



## SECTION 10: STATEMENT OF OBJECTIVES



be refined to deal with short notice and rapidly changing issues. Mitigation plans of action must be created quickly and effectively and communicated to the State in a timely manner.

The Vendor shall continue the change management process initiated during DDI into Fiscal Agent operations. While the content of the changes is likely to focus on different elements than during the DDI Phase, the purpose still remains to manage the change process and ensure that all affected parties are synchronized in purpose and action. The Vendor shall ensure that all artifacts required to maintain the systems and properly perform operations and training are updated as part of the change management process. The Vendor shall continue to manage the Change Control Board with the State retaining the position of chairperson.

The Vendor shall serve in the role of system integrator during Fiscal Agent operations. As with DDI, the scope of this activity will be defined at a later date; however, during the Operations Phase, this activity will include a greater weight on integration of organizations and business processes and less on the development and technical integration of systems. The Vendor shall also continue to support coordination efforts of organizations and business processes.

The Vendor shall be responsible for initiating and coordinating all workflow processes, including those having responsibilities assigned to the State and external organizations. Consistent with the technical requirements, the State requires automated online management and reporting of those workflows where practical and appropriate. This will allow for greater efficiency by promoting asynchronous operations for many activities.

The Vendor shall be responsible for the scheduling and monitoring of system-related and business-related activities needed to support Fiscal Agent and State operational requirements. Scheduling shall include system job flow activities, distribution activities, and other periodic activities, such as training and audits.

The Vendor shall ensure that product inventories and State-specific forms inventories needed to perform Fiscal Agent operational requirements are maintained at consistent levels.

The Vendor shall staff, operate, and monitor mailroom activity at the Fiscal Agent operational site. The Vendor shall be accountable for all incoming and outgoing mail and shall ensure appropriate workflows are established for the correct distribution of incoming and outgoing material.

The Vendor shall provide and maintain a secure operations environment as defined by the NC DHHS Security Policies and Standards. (See the following Web site <http://www.iso.scio.nc.gov/SecurityDocumentation.htm>). Vendor operations and systems shall be subject to an internal audit any time deemed necessary by the State.

The Vendor shall be responsible for providing accurate monthly invoices to the State for reimbursement of services performed. Invoices shall represent individual cost by NC DHHS multi-payer entity, program, and budget codes and reflect any appropriate Federal financial participation (FFP) splits.

Annually, the selected Offeror will contract annually with an independent qualified audit firm to perform a Statement on Auditing Standards (SAS) 70 audit of the Replacement MMIS and will accommodate and provide information and facilities necessary for the external auditor to complete the audit and produce a SAS 70 Type 2 report. The audit and report shall include the operations of the Fiscal Agent's local site as well as any other sites used by the Fiscal Agent for Replacement MMIS processing or related activities. Specific requirements of the SAS 70 Type 2 report are identified in Appendix 40, Attachment D of this RFP.

### **10.12.2 Deployment/Rollout and Turnover**

Deployment/rollout (beginning the role of Fiscal Agent) and turnover (transferring responsibilities to the State or a successor Fiscal Agent) activities are vital to the startup of a new system or to an entity that assumes responsibility of an existing system. In either case, the new and legacy operating entities must work jointly to ensure that these activities are as transparent to users as feasible. North Carolina considers the MMIS a critical business area; therefore, it shall have no down-time that affects the users' ability to conduct their day-to-day business during such a transition.

Both deployment/rollout and turnover approaches shall be part of the Proposals submitted by each Offeror, followed by completed plans during the DDI Phase. Offerors shall describe the activities that will be performed to ensure that required system and operational documentation will be created, maintained, and available to support a knowledge transfer of the information. Offerors shall propose a high-level timeline that provides for a responsible and successful turnover and/or deployment/rollout with contingency planning. This shall include conversion and migration of all pertinent information—online, paper, in-place work agreements, leases, etc.

Offerors shall define their turnover duties, the structure of the turnover support organization, the roles of the team in this organization, and the workflow between the incoming and outgoing teams to enable the incoming entity to staff and organize at appropriate levels. Offerors shall develop and maintain a separate IMP and IMS for the Turnover Phase and may reuse existing plans as necessary to avoid duplication with the IMP and IMS for the DDI effort.

Offerors shall provide a warranty under which they will provide continuing system operational support to the incoming entity after expiration or termination of the Contract. Offerors shall propose the duration of this warranty, as well as terms that ensure that its expert staff will be on call for a sufficient amount of time to respond to questions or address any issues that arise during the warranty period. The successful Offeror will be responsible for communications to all stakeholders, interface agents, and the user community to present its plans to ensure the continuity of services.

### **10.12.3 Recipient Management**

The Recipient business area serves as an integrated repository for all recipients' eligibility and demographic data. Using demographic and eligibility information from the participating NC DHHS divisions and Medicare entitlement information from CMS, the



## SECTION 10: STATEMENT OF OBJECTIVES



Vendor shall perform managed care and other benefit plan enrollment processing and consolidate the data into a common recipient database. For DPH recipients, the Vendor shall electronically store images of the submitted financial application and accompanying documentation to support online financial eligibility determination, workflow processing, and division updates to recipient records.

The Vendor shall manage processes and activities related to the Medicare Modernization Act (MMA), State Children Health Insurance Program (SCHIP), and the Federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program.

Federal regulations allow states to charge premiums and cost-sharing for certain Medicaid populations. For individuals in those populations, the Vendor shall manage the determination billing and collection of premium payments and cost-sharing amounts. In addition, the system must capture the FFP rate for each recipient based on program eligibility and category of service.

The Recipient business area must include the availability of an Eligibility Verification System (EVS) for use by providers and value-added networks (VANs) to verify recipient eligibility and enrollment information. It must also include an Automated Voice Response System (AVRS) for use by providers and recipients to verify recipient eligibility and enrollment information. In addition, the AVRS must support inquiry by providers for information on claim status, provider checkwrite, drug coverage, prior approval submissions, pricing, and managed care overrides and referrals. This capability must also include the ability to receive and adjudicate prior approval requests.

### **10.12.4 Provider Management**

It is NC DHHS's goal to encourage qualified providers to participate in NC DHHS programs and render care to eligible program recipients. The Vendor shall provide an enrollment process that is streamlined and easy to understand and complete. This includes the Vendor conducting provider enrollment and maintenance activities for NC DHHS health care and atypical providers. Operational activities must include enrollment, disenrollment, sanction updates and related suspend flags, credentialing, verification, and certification for all provider types through the use of online and manual processes.

Enrollment processes must employ a consolidated provider agreement that is flexible and scalable enough for use by all provider types, including atypical providers. Providers must be able to enroll in NC DHHS programs and participate in the management of their provider data through the use of a consistent, user-friendly, Web-accessible interface; however, paper enrollment forms shall also be accepted and processed by the Vendor.

The Vendor shall perform activities that include credentialing and source verification from appropriate licensure, certification, or other authorities to support NC DHHS participation criteria and requirements. Many data elements required to support credentialing processes are not present in the legacy Provider File and must be solicited from the provider. These data must be collected and entered into a database prior to start up of the new solution.



## SECTION 10: STATEMENT OF OBJECTIVES



Provider maintenance processes must include validation that health care providers continue to meet and maintain NC DHHS participation standards. The Vendor shall conduct ongoing recertification of licensing status as provider credentials expire and at regular intervals to assure that credentials are free of adverse actions.

Enrollment and maintenance processes conducted by the Fiscal Agent staff should be enhanced and expedited by automated work queue functionality featuring first-in/first-out processing and correspondence imaging and tracking.

The Vendor shall support continuing provider communication, outreach, and training activities to ensure providers have access to the most current Replacement MMIS information and associated business policies for prior approval and submissions. Vendor representatives shall conduct multiple training workshops; participate in an annual Medicaid Fair; participate in the semi-annual DMH/Local Managing Entity (LME) Finance and Reimbursement Officer (FARO) meetings; and initiate and conduct individual on-site provider training as appropriate and/or as requested by the provider or the State.

The system must support the establishment of provider affiliations within and across lines of business, associating individual providers with provider groups, billing agents, managed care administrative entities, and mental health LMEs. The system must also support the ability to accept provider enrollment records for attending providers from LMEs for participation within the DMH program.

To comply with the NPI mandate to eliminate the use of proprietary provider identifiers and move to the use of NPIs and taxonomy, the system must include conversion of the intelligence embedded in the legacy provider identification numbers and in provider type and specialty categories.

### 10.12.5 Claims Processing

NC DHHS seeks a consolidated claims processing solution that will result in improved customer service, maximized efficiencies, and reduced operational cost to the NC DHHS programs.

The Vendor shall implement claims processing procedures that facilitate processing efficiencies through claims control, data verification, and flexible, business rules management.

The Vendor shall receive and process all claims and encounters in a variety of media, including paper, electronic, Web Portal, and point-of-sale. The Vendor's solution shall support online, real-time adjudication and inquiry of claims.

The system shall:

- Ensure the tracking and timely processing of claims (including crossover and secondary adjustment claims) and encounters while supporting the maintenance of a comprehensive audit history;
- Adjudicate claims by determining service line item benefit plan eligibility, service rules, and limitations;





## SECTION 10: STATEMENT OF OBJECTIVES



- Edit claims using the enrolled providers, benefit plan, recipient history, and correct coding rules;
- Determine claims pricing, funding source, financial encumbrance, and reporting; and
- Process and differentiate the non-claim related transactions that are system generated to capture management fees associated with various types of services.

All claims, including point-of-sale claims, shall be processed in concert with MMIS claims to avoid duplicate payments for the same services.

The Vendor shall support utilization management functions by ensuring that NC DHHS clinical and practitioner coverage policies are applied correctly during the prior approval adjudication process. The Vendor shall provide processing efficiency through the use of online, real-time Web entry and adjudication of prior approval requests in addition to requests received via paper and telephone. The Vendor shall also receive and process managed care referrals, override requests, and crossover claims.

For non-Fiscal Agent directed prior approval requests, the Vendor shall receive and manage adjudicated prior approval information from external interfaces.

The solutions must accommodate the ability to accept, review, and adjudicate claims for non-covered services and services for children covered under the EPSDT requirement.

The Vendor shall ensure that the NC DHHS programs are the payers of last resort, and that real-time information is maintained on third party carriers, facilities, and recipient resources and used in claims processing to cost avoid and to flag for later recovery activities.

EPSDT is a Federal Medicaid requirement that requires the State's Medicaid agency to cover services, products, or procedures for Medicaid recipients under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical, or mental illness, or a condition (health problem) identified through a screening examination (which includes any evaluation by a physician or other licensed clinician). The Vendor shall support these requirements in the system as well as in Fiscal Agent operations.

### **10.12.6 Financial Management**

The Vendor shall provide an enterprise-wide financial management and accounting solution that will allocate all financial transactions by Federal, State, and county shares. The Vendor shall maintain accurate control of payments, reconcile bank accounts, perform internal audits, and process provider payments, refund checks, adjustments, and recoupments across NC DHHS programs.

The system must provide for the integration of current legacy Medicaid Accounting System (MAS) functions and processes in a manner that makes data available system-wide in an online, real-time environment, minimizing duplication of data and interfaces. It must allow authorized users to maintain, track, and recover account receivable balances from providers and provide for the creation and maintenance of NC DHHS-authorized payouts to providers for non-claim-related activity.



## SECTION 10: STATEMENT OF OBJECTIVES



The system shall interface with the North Carolina Accounting System (NCAS) to update financial transactions and determine fund balances.

The Vendor shall perform and manage all processes necessary to produce and submit Drug Rebate invoices and adjustments to drug manufacturers, receive and record payments, and represent the State in disputes related to the invoices. If a manufacturer invoice requires adjustment, the system must ensure that the appropriate claim adjustments are also made.

Regardless of the source, the Replacement MMIS shall be the repository for all Medicaid-related financial transactions (including system-generated management fees) so that all CMS and management reports may be produced with data residing in the Replacement MMIS.

### **10.12.7 Reference File Management**

The Vendor shall maintain the Replacement MMIS Reference File, respond to file maintenance requests from NC DHHS, and perform quality control reviews. The Replacement MMIS Reference File contains benefit plan definitions, rules, and service coverage information needed to process claims for NC DHHS programs using a variety of reimbursement methodologies.

As stated in the Software and Systems Engineering Section, the State seeks a reliable and flexible means to maintain the Reference information required for NC DHHS claims processing. The system should be configurable to adapt to changes in NC DHHS policies and services and must allow for centralized control over data modifications.

### **10.12.8 Surveillance Utilization Review**

The State monitors the integrity of claims adjudication and payments using a variety of analysis tools. Among them is Surveillance Utilization Review (SUR), which will be generated out of the R&A functional group; however, the Replacement MMIS Vendor shall support Medicaid Eligibility Quality Control (MEQC) requirements.

MEQC collects and maintains current and historical information about specific parameters and is used to validate the accuracy of the eligibility determination process for Medicaid. The MEQC function is required by CMS and is used to estimate the dollar amount of claims paid in error due to eligibility errors. The MEQC function includes targeted eligibility samples as well as quality assurance and improvement efforts related to the Medicaid waiver programs. The MEQC activity is based on random-sampling techniques. The Vendor's solution shall support the processing required to accumulate, select, and report the data in the sample.

### **10.12.9 Medicaid Management and Administrative Reporting**

The Vendor shall produce all Medicaid Management and Administrative Reports (MARS) required for CMS certification and quarterly produce the Federal Medicaid Statistical Information System (MSIS) extract files, as required by CMS, using only Medicaid data.



## SECTION 10: STATEMENT OF OBJECTIVES

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For some North Carolina Medicaid programs, both the State and the counties participate in the Medicaid cost; therefore, the State seeks a solution that incorporates this breakdown in MARS reporting.

## **SECTION 20: PROCUREMENT PROCESS**

This section of the RFP contains the requirements related to the Procurement Process. Subsequent sections of this RFP are summarized below.

**Section 30** contains Contract Requirements as well as terms and conditions, including reduction in compensation provisions. All requirements in this section shall be mandatory.

**Section 40** contains a description of the Detailed Requirements and Goals for the Replacement, Operations, and Turnover Phases of the Replacement MMIS. The requirements supplement the Statement of Objectives (Section 10) and provide additional direction to the Offerors to ensure the State's business needs are achieved. The requirements shall be mandatory unless otherwise directed by the State. The goals are not considered mandatory. Offerors shall propose solutions to goals that represent reasonable cost/schedule/performance/risk tradeoffs.

**Section 50** contains the Offerors' Proposal Submission Requirements for this RFP. All requirements in this section are mandatory.

**Section 60** contains the Evaluation Methodology and criteria.

**Appendices** provide supplemental information for the procurement.

**Acronyms** and **Glossary** define the terms used throughout this RFP.

### **20.1 INITIATIVE SCHEDULE**

Appendix 10, Attachment A of this RFP contains the Anticipated Replacement MMIS Procurement Schedule. The State reserves the right to modify the timetable at any time.

### **20.2 RESTRICTIONS ON COMMUNICATIONS WITH STATE PERSONNEL**

From the date of release of this RFP until the Contract has been fully executed and approved, all communications between the Offeror and personnel employed by or contracted to the State of North Carolina who are currently involved in the Replacement MMIS procurement are restricted to the Sole Point of Contact identified on Page 1 of the RFP Cover Page. During the same timeframe, the Offeror shall not approach personnel involved with this initiative employed by or contracted to the State of North Carolina concerning an offer of employment. Violation of these conditions may be considered sufficient cause by the State to reject the Offeror's Proposal, irrespective of any other condition.

### **20.3 PRECLUSION FOR OFFERORS**

If it is determined that an Offeror has been provided information pertaining to this solicitation by any employee or agent of the State (other than solicitation information available through RFI issuances from the State, the State Web site, the State-conducted Offeror presentations, or the RFP issued by the State), the Offeror shall be eliminated from consideration in the Proposal Evaluation.

## **20.4 PARTICIPATION BY HISTORICALLY UNDERUTILIZED BUSINESSES**

Pursuant to N.C.G.S. §143-48 and Executive Order #150, the State invites and encourages participation in this procurement process by businesses owned by minorities, women, disabled persons, disabled business enterprise, and non-profit work centers for the blind and severely disabled. For further information, please visit the following Web site:

<http://www.doa.state.nc.us/hub>

## **20.5 PROCUREMENT LIBRARY**

The State has prepared a set of relevant information to support an Offeror's preparation of its response to this RFP. In lieu of a physical Procurement Library, Appendix 10, Attachment B of this RFP provides a listing of the information/applicable media that shall be forwarded to Offerors upon receipt of a signed non-disclosure agreement for access to the Replacement MMIS Procurement Library. The non-disclosure agreement may be downloaded from the following Web site:

<http://www.ips.state.nc.us>

Signed non-disclosure agreements for access to the Procurement Library shall be sent to:

Susan Lewis, Assistant Director, NC DHHS—Procurement and Contracting Services

See Page 2 of RFP Cover Page for delivery instructions.

### **Note**

Offerors that have already submitted a signed non-disclosure agreement in response to 30-DHHS-Notices issued on March 2, 2007, or July 20, 2007, on the State of North Carolina Interactive Purchasing System are not required to resubmit the agreement, but they must execute an amendment to that agreement pertaining to Protected Health Information.

The State's approach to providing Offerors with information via the Replacement MMIS Procurement Library ensures the same information is made available to all Offerors. Any updates to the Procurement Library throughout the procurement process shall be forwarded upon request directly to each Offeror that has submitted an original request and a signed State non-disclosure agreement.

While a reasonable attempt was made to gather the most accurate information available for this Procurement Library as of the RFP issuance date, the State makes no representation or warranty that all information and data presented are accurate or complete. Without limiting the generality of the preceding sentence, NC DHHS makes no representation or warranty that the material, information, documentation, or data provided in any medium (e.g., DVDs, tapes, hard drives, hard copy, etc.) are accurate or complete.

Notwithstanding the preceding paragraph and except in the circumstances set forth in Section 20.5.1 below, if during the course of its performance under the Contract the

selected Offeror reasonably determines that it will incur substantial, previously unanticipated Contract performance costs due to the inaccuracy or incompleteness of the Procurement Library, then any compensation adjustment for Offeror shall be determined pursuant to the change process that shall have been developed in accordance with Section 30.6.4.

### **20.5.1 Pre-Award Requests for Additions to Procurement Library**

Offerors are advised to carefully review and assess the Procurement Library. The Procurement Library contains all available information that the State considers relevant to the drafting of Proposals, except when the State may have expressly indicated that specific, additional material is forthcoming. If, despite the State's efforts to be thorough, the Offeror determines the Procurement Library lacks material that is substantially necessary for designing, creating, or specifying the Offeror's anticipated Contract deliverables, then as soon as possible prior to the Technical Proposal submission deadline (but in any event no later than two (2) weeks prior to the Technical Proposal deadline) the Offeror should request in writing that the State add such material to the Procurement Library, or the Offeror should include the creation, assembling, or procurement of such material among the Offeror's own tasks and costs in its Technical Proposal and Cost Proposal.

If it becomes apparent after award of a Contract to the Offeror that (a) the Procurement Library lacked such material at the time of the Technical Proposal submission deadline; (b) the Offeror neither requested the State to add the material to the Procurement Library within the timeframe above nor included the creation, assembling, or procurement of this material among the Offeror's own tasks and costs in its Technical Proposal and Cost Proposal; and (c) by its nature the material reasonably could be provided or developed by the Offeror and not solely by the State, then the Offeror, by submitting a fixed-price Proposal for provision of its anticipated Contract deliverables, shall be deemed to have agreed to provide the absent material at no additional cost to the State.

## **20.6 ORAL PRESENTATION AND DEMONSTRATIONS**

By submitting a Proposal, the Offeror covenants and agrees that it shall provide the oral presentation and demonstrations as defined in Section 50 of this RFP.

## **20.7 ADDENDA**

In the event it becomes necessary to revise, modify, clarify, or otherwise alter the RFP for this procurement, revisions shall be made in the form of addenda to this RFP and will be posted to the Interactive Purchasing System (IPS) at:  
<http://www.ips.state.nc.us/ips/deptbids.asp>

All addenda to the original RFP shall become part of the RFP.

## **20.8 QUESTIONS AND ANSWERS**

The cutoff for acceptance of Offeror questions is provided in the RFP Cover Page. All Offeror questions shall be submitted in writing. Offerors shall submit questions via e-mail to the Sole Point of Contact as provided in the RFP Cover Page. Please insert



## SECTION 20: PROCUREMENT PROCESS



“RFP #30-DHHS-1228-08-R Questions” in the subject matter of your e-mail. If Offeror questions are received prior to the cutoff date, an addendum comprising questions submitted and responses to such questions, or any additional terms deemed necessary by the State, will be posted to the Interactive Purchasing System (IPS) <http://www.ips.state.nc.us/ips/deptbids.asp> and shall become an Addendum to this RFP.

Critical updated information may be included in the Addenda. It is important that all vendors bidding on this Proposal periodically check the State Web site for any and all Addenda that may be issued prior to the bid opening date.

Written questions shall be submitted in a document that is compatible with Microsoft Word 2003 (or less) in the format below.

Question Number	Offeror Name	RFP Section Reference	RFP Section Page Number	Question

### 20.9 ORAL EXPLANATIONS

The State shall not be bound by oral explanations or instructions given at any time during the procurement process or afterward.

### 20.10 INSUFFICIENCY OF REFERENCES TO OTHER DATA

Only information that is received within the Proposal in response to this RFP shall be evaluated. Reference to information previously submitted does not suffice as a response to this solicitation.

### 20.11 COST OF PROPOSALS

Offerors shall bear all costs associated with preparing and submitting Proposal responses to this RFP. This shall include any Offeror’s travel or expenses related to this RFP.

### 20.12 RIGHT TO SUBMITTED MATERIAL

All responses, inquiries, or correspondence related to or in reference to this RFP and all other reports, charts, displays, schedules, exhibits, and other documentation submitted by the Offeror shall become the property of the State when received and shall not be returned to the Offeror.

### 20.13 PROPOSAL WITHDRAWAL

Prior to the applicable due date for the Technical Proposal or Cost Proposal, a submitted Proposal may be withdrawn by submitting a request in writing for its withdrawal, signed by the Offeror’s authorized agent, to the State’s Sole Point of Contact as identified on Page 1 of the RFP Cover Page.





## 20.14 NON-ACCEPTANCE OF UNSOLICITED PROPOSAL CHANGES

Pursuant to 9 NCAC 06B.0306, Late Offers, Modifications, or Withdrawals:

*The agency or ITS shall not consider late offers, modifications, or withdrawals unless these would have been timely except for the action or inaction of agency or ITS personnel directly serving the procurement process. Offerors shall deliver all offers on time, regardless of the mode of delivery used.*

## 20.15 BASIS FOR REJECTION

Pursuant to 9 NCAC 06B.0401:

*The State reserves the right to reject any and all offers, in whole or in part, by deeming the offer unsatisfactory as to quality or quantity, delivery, price or service offered; non-compliance with the requirements or intent of this solicitation; lack of competitiveness; error(s) in specifications or indications that revision would be advantageous to the State; cancellation or other changes in the intended project or other determination that the proposed requirement is no longer needed; limitation or lack of available funds; circumstances that prevent determination of the best offer; or any other determination that rejection would be in the best interest of the State.*

## 20.16 NOTICE OF PROPOSAL AWARD

Qualified Proposals shall be evaluated, and acceptance may be made in accordance with Best-Value procurement practices as defined by N.C.G.S. §143-135.9 and applicable administrative rules. The responsible Offeror whose Proposal is most advantageous to the State, taking into consideration the evaluation factors herein, shall be recommended for Contract award. Once NC DHHS management approves the recommendation for the selected Offeror, the NC DHHS Chief Procurement Officer shall forward the recommendation and evaluation results to the North Carolina Office of Information Technology Services (ITS) Statewide IT Procurement Officer for review and approval. Once a Contract has been approved by all parties listed above and signed by the selected Offeror, the State shall send a Recommendation Letter, a copy of the selected Proposal, and the Contract to the Centers for Medicare & Medicaid Services Regional Office for Federal approval of the selected Offeror. The Recommendation Letter shall contain a narrative review of the results of the evaluation and any other pertinent evaluation documentation. After receiving CMS approval, the State shall post the award on the Interactive Purchasing System (IPS) that allows the public to retrieve Proposal award information electronically from the ITS Web site:

<http://www.ips.state.nc.us/ips/pubmain.asp>

Click on the **Search for Bid Number** link, enter the RFP number (**30-DHHS-1228-08-R**), and then click the **Search** button. This information may not be available for several weeks, depending upon the complexity of the acquisition and the length of time to complete the evaluation process.





## SECTION 20: PROCUREMENT PROCESS

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### **20.17 PROTEST PROCEDURES, ADMINISTRATIVE HEARINGS**

Refer to 9 NCAC 06B.1009 for protest procedures that apply to contracts with an estimated value over \$25,000. Offerors may appeal for a final decision by following the hearing request procedures set forth in 9 NCAC 6B.1010 et. seq. and N.C.G.S. § 150B-38.

## **SECTION 30: CONTRACT REQUIREMENTS**

### **30.1 EFFECTIVENESS ONLY UPON FULLY EXECUTED ACCEPTANCE**

For the sake of consistency and simplicity of expression, this Section sets forth the Contract Requirements in the present tense. The terms, conditions, duties, obligations and transfers of rights set forth in the Contract (as defined below) shall become effective between the State and an Offeror upon, and only upon, the State's fully executed acceptance of the Offeror's bid (the "Effective Date").

### **30.2 CONTRACT TERM**

Unless earlier terminated as provided herein, the term of the Contract (the "Term") shall commence on the Effective Date and shall continue until the later of the end of the Turnover Phase or the fourth (4<sup>th</sup>) anniversary of the date on which the State determines in its sole but reasonable discretion that the Replacement MMIS has become operational substantially as a whole and has begun generating official data of record with the approval of the State (the "Operational Start Date"). The State may extend the Term until the later of the end of one (1) additional year or the end of the Turnover Phase. Unless specifically set forth otherwise in the Contract, all terms of the Contract shall apply throughout the Term, including as the Term may be extended.

### **30.3 CONTRACT DOCUMENTS AND ORDER OF PRECEDENCE**

The contract between the State and the Vendor shall consist of the following (the "Contract"):

- Amendments to the Contract in reverse numerical order;
- The Contract signed by all Parties and approved by the United States Department of Health and Human Services (US DHHS), Centers for Medicare & Medicaid Services (CMS);
- Any addenda to the RFP (including without limitation the formal Questions and Answers);
- The RFP, inclusive of appendices, exhibits, documents, and other materials incorporated therein by reference, but excluding the Statement of Objectives (SOO), which is superseded by the Vendor's Statement of Work (SOW);
- The Vendor's Best and Final Offer (BAFO), if a BAFO is solicited;
- The Vendor's Technical Proposal (including the SOW, Integrated Master Plan [IMP], and Integrated Master Schedule [IMS]) and any amendments thereto, as well as any written clarifications or representations regarding Vendor's Technical Proposal that are incorporated as part of the procurement process; and
- The Vendor's Cost Proposal and any amendments to thereto, as well as any written clarifications or representations regarding Vendor's Cost Proposal that are incorporated as part of the procurement process.



## SECTION 30: CONTRACT REQUIREMENTS



The order of precedence among the Contract documents shall be in the order listed above, with the first listed having the highest priority. In the event there is a disagreement as to the obligations of the Parties arising from different terms in the Contract documents, the term in a higher precedence document shall supersede the terms of a lower precedence document to the extent necessary to resolve any inconsistencies between them, but silence on any matter in a higher precedence document shall not negate or modify the provisions of a lower precedence document as to that matter.

If the Vendor has offered in its SOW to meet performance standards or requirements that are more stringent than the minimum specified in the RFP, the State shall be considered to have accepted this offer of more stringent requirements by award of the Contract to the Vendor. Under no circumstances shall requirements that are less stringent than the RFP requirements be accepted or become a part of the Contract unless specifically agreed to by the State in writing.

### **30.4 REORGANIZATION OF STATE GOVERNMENT**

All rights, duties and obligations under the Contract inure to the State as a whole upon NC DHHS's entry into the Contract on the State's behalf. The State's rights, duties and obligations under the Contract shall continue without interruption notwithstanding any reorganization of State government in accordance with N.C.G.S. §143A-6.

### **30.5 ASSIGNMENT BY VENDOR**

The Vendor may not assign, voluntarily or by operation of law, the Contract or any of its rights or obligations hereunder without first obtaining written consent from the State following negotiations in accordance with 9 NCAC 06B.1003. The State shall not unreasonably delay or refuse to enter into such negotiations. Any purported assignment not so approved shall be null and void. The Vendor shall affirm that the assignee is fully capable of performing all obligations of the Contract. Subject to the foregoing, the Contract shall be binding on the State and Vendor and their respective successors and assigns. This Section 30.5 shall not affect the State's right to terminate for Vendor's Change in Control as set forth in Section 30.46.7. Any assignment of the Contract shall be made explicitly subject to all rights, defenses, setoffs, or counterclaims that would have been available to the State against the Vendor in the absence of such assignment. An assignment may only be made, if at all, in writing by the Vendor, assignee, and the State setting forth the foregoing obligations of the Vendor and the assignee.

Notwithstanding the foregoing, the State may, in its sole discretion, modify or terminate the Contract if, in its reasonable judgment, the assignment impairs the performance of the obligations under the Contract.

### **30.6 STATE AND VENDOR CONTRACT ADMINISTRATION AND MANAGEMENT**

#### **30.6.1 State Contract Administration and Management**

The NC DHHS Replacement MMIS Contract Administrator shall administer the Contract for the State throughout the Replacement, Operations and Turnover Phases.

The Replacement MMIS Contract Administrator or a designee shall be responsible on behalf of the State for all contractual matters. The Replacement MMIS Contract Administrator shall establish and oversee Contract management functions, including ongoing monitoring and enforcement of Vendor compliance with performance standards and overall terms and conditions of the Contract. The Replacement MMIS Contract Administrator shall issue all notices regarding the failure to meet performance standards and any assessments of retainages or damages under the provisions set forth in this document and the Vendor's SOW.

Throughout the Replacement, Operations and Turnover Phases, the Director of the OMMISS shall undertake daily communications, contractual negotiations, formal and informal discussions, and other duties in fulfillment of Contract management responsibilities. During the life of the Contract, the Director of the OMMISS shall have day-to-day responsibility for the direction of the project and shall be the Vendor's primary liaison in working with other State staff.

The Director of the OMMISS shall:

- Receive and review all Vendor progress reports and Deliverables;
- Oversee scheduling of meetings with State staff; and
- Maintain first-line administrative responsibility for the provisions of the Contract.

The Director of the OMMISS may issue, from time to time, such written specifications and instructions as may be necessary for the Vendor to carry out its scope of work and performance obligations.

### **30.6.2 Vendor Contract Administration and Management**

The Vendor shall designate a Contract Manager who shall have the authority to enter into any Contract modifications on behalf of the Vendor and otherwise commit the Vendor to any course of action, undertaking, obligation, or responsibility in connection with the Vendor's performance of the Contract.

The Vendor shall designate a Vendor Account Manager who shall have day-to-day responsibility for supervising the performance of the Vendor's obligations under the Contract. The Vendor shall not change the designation of its Contract Manager or its Vendor Account Manager without the State's prior written approval, which shall not be unreasonably delayed or withheld, provided that if either individual becomes unavailable to the Vendor for reasons affecting the basic employment relationship, such as the individual's death, disability, termination for cause or leave from civilian employment to fulfill military duty, Vendor may appoint a temporary replacement to fulfill those duties until a permanent replacement agreeable to the State is found.

### **30.6.3 Notices**

Whenever the State is required or permitted by the terms of the Contract to provide written notice to the Vendor, the Replacement MMIS Contract Administrator shall sign such notice. Any notice required or permitted to be given to a Party shall be in writing and addressed as follows:



## SECTION 30: CONTRACT REQUIREMENTS



- In case of notice to the State:
  - o Replacement MMIS Contract Administrator
  - o Office of Medicaid Management Information System Services
  - o 3101 Industrial Drive
  - o Suite 100
  - o Raleigh, North Carolina 27609
- In case of notice to Vendor:
  - o Contract Manager
  - o \_\_\_\_\_
  - o \_\_\_\_\_
  - o \_\_\_\_\_

Either Party may change its address(es) for the receipt of notices and shall provide the other Party with written notice of the change, transmitted as provided above. All such notices shall be clearly labeled as address change notices.

Notice that is required to be given under this Section shall be transmitted via certified or registered mail, return receipt requested; overnight delivery with proof of delivery; or courier with proof of delivery. Notice delivery shall be prepaid and shall be deemed to have been given at the time indicated on the carrier's or courier service's delivery receipt.

Daily operational correspondence between the Parties shall be addressed as follows:

- State:
  - o Director of the Office of Medicaid Management Information System Services
  - o Office of Medicaid Management Information System Services
  - o 3101 Industrial Drive
  - o Suite 100
  - o Raleigh, North Carolina 27609
- Vendor:
  - o Account Manager
  - o \_\_\_\_\_
  - o \_\_\_\_\_
  - o \_\_\_\_\_
  - o \_\_\_\_\_

### 30.6.4 Change Process

Vendor shall not be entitled to compensation for any services other than or in addition to the Services (as defined herein below) unless the change process is followed, which process the Vendor shall propose in its Change Management Plan. The Change Management Plan shall not become effective until it has been approved specifically in writing by the State or in accordance with the Vendor's Proposal. For purposes of this Contract, "Services" shall mean the services and Deliverables (including, without



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limitation, the hardware, software, tangibles, and intangibles required hereunder) to be delivered by Vendor pursuant to the Contract, including, without limitation, the inherent services described in Section 30.9. The change process, which shall apply to all proposed changes to the Services, shall contain the following concepts:

- (a) All proposals for changes to the Services shall be initiated through a Customer Service Request (CSR).
- (b) Any document resulting from a CSR that is to be binding upon the Parties shall be signed by both the Vendor's and the State's respective representatives with appropriate level of signature authority.
- (c) Any additional or changed Services shall then be deemed "Services" and subject to the provisions of the Contract.
- (d) Proposals that include changes during any Phase to the scope, price or time schedule of the Services, or to any dates in the Contract of significant consequence to performance of the Services, shall be made effective through the Parties execution of a Contract amendment. Proposals that do not include such changes (including, for example and without limitation, clarifications of existing requirements or specifications of no price or schedule impact) shall be made effective through the Parties' sign-off or execution of such documentation as shall be required under the Change Management Plan, except when the Parties may agree in a particular instance that it is appropriate to execute a formal Contract amendment.
- (e) If the new Services are to be provided in exchange for fixed or "not-to-exceed" compensation, the Vendor shall be solely responsible for any costs in excess of the specified compensation.
- (f) The change process shall include procedures through which the Parties interact to propose, refine and, if agreement is reached, sign-off or execute documentation binding them to proposed changes. However, the change process shall not define or direct any aspect of the manner in which each Party seeks internal approval of changes within that Party's own decision making hierarchy.

Routine changes made in the ordinary course of Vendor's provision of Services that neither change service levels nor reduce the Vendor's capacity to attain established service levels (such as, but not limited to, changes to operating procedures, schedules and equipment configurations) and which do not substantially alter Vendor's ability to meet contractual time frames or substantially alter the cost to the Vendor to perform such changes shall be made at no additional cost to the State.

Notwithstanding anything to the contrary in the Contract regarding charges to the State by the Vendor, to the extent the proposed change will materially lower or raise Vendor's cost to provide Services thereafter, the applicable charges payable by the State shall be adjusted to take into account such projected cost savings or loss as agreed by the Parties.

### **30.7 TAXES**

The State of North Carolina is exempt from Federal excise taxes. The State shall have no obligation to pay or reimburse the Vendor for any personal property taxes levied on the Vendor or for any taxes levied on Vendor employee wages. State agencies may have additional exemptions or exclusions for Federal or State taxes. Evidence of such additional exemptions or exclusions may be provided to the Vendor by agencies, as applicable, during the Term of the Contract.

The Vendor shall comply with the provisions of N.C.G.S. 105-164.8, if applicable. By execution of the Contract, the Vendor certifies that it and all of its affiliates, if any; collect(s) the appropriate taxes.

### **30.8 GOVERNING LAWS, JURISDICTION, AND VENUE**

The validity, construction, and interpretation of the Contract and any of its terms or provisions, as well as the rights, duties, and performance of the Parties to the Contract, are governed by the laws of North Carolina, exclusive of its conflicts of laws provisions. The Vendor, by signing the Contract, agrees and submits, solely for matters concerning the Contract, to the exclusive jurisdiction of the Federal or State courts situated in North Carolina and agrees, solely for such purpose, that the only venue for any legal proceedings shall be Wake County, NC. The place of the Contract, and all transactions, agreements relating to it, and their situs and forum, shall be Wake County, NC, where all matters, whether sounding in contract or tort, relating to its validity, construction, interpretation, and enforcement, shall be determined.

### **30.9 INHERENT SERVICES**

If any services, deliverables, functions or responsibilities not specifically described in the Contract are required for the proper performance, provision, and delivery of the services and deliverables (including, without limitation, the hardware, software, tangibles, and intangibles required hereunder) to be delivered by Vendor pursuant to the Contract (the "Solution"), or are an inherent part of or necessary sub-task included within the Solution, they will be deemed to be implied by and included within the scope of the Solution to the same extent and in the same manner as if specifically described in the Contract. Unless otherwise expressly provided in the Contract, Vendor will furnish all necessary management, supervision, labor, facilities, furniture, computer and telecommunications equipment, software, supplies and materials necessary to provide the Solution to be delivered by Vendor.

### **30.10 CONDITIONS AND PACKAGING**

Unless otherwise provided by special terms and conditions or specifications, it shall be understood and agreed that any item offered or shipped has not been sold or used for any purpose and shall be in first class condition. All containers/packaging shall be suitable for handling, storage, or shipment.

### **30.11 OWNERSHIP, PATENT, COPYRIGHT, AND TRADE SECRET PROTECTION**

Definitions: As used in this Section, the RFP and further Contract documents:

“Intellectual Property Rights” comprises

- (i) any patent, patent application, trademark (whether registered or unregistered), trademark application, trade name, service mark (whether registered or unregistered), service mark application, copyright (whether registered or unregistered, or derivative work), copyright application, trade secret, know-how, process, technology, development tool, ideas, concepts, design right, moral right, data base right, methodology, algorithm or invention,
- (ii) any right to use or exploit any of the foregoing, and
- (iii) any other proprietary right or intangible asset (including software).

“State Data” means the following, whether provided or produced before, on or after the Effective Date:

- (a) all information and data (copyrighted or otherwise) developed, derived, documented, stored, by the State under the Contract;
- (b) all data that is provided by or on behalf of the State to Vendor in order for Vendor to provide the Services, including keyed input and electronic capture of information by the Services;
- (c) all records, files, reports and other data provided to Vendor by or on behalf of the State, or otherwise collected or obtained by Vendor, in connection with the Services; and
- (d) all data that is produced by means of the Services as an intermediate step in using or producing any of the State Data, including databases and files containing the State Data; including but not limited to:
  - (i) transaction and history files relating to claims;
  - (ii) provider and recipient demographics and eligibility, code sets, fee schedules, other pricing components;
  - (iii) prior approval, utilization criteria, and service limit data;
  - (iv) names, addresses and social security numbers; and
  - (v) any information derived from the data described in (i) through (iv).

*State Material*

The State shall own all right, title, and interest in and to all actual and prospective Intellectual Property Rights (as defined above) in and to all data, material, proposals, manuals, designs, training documents, other documentation (including working papers), software, and software modifications (including object code, source code, and documentation) upon its creation by the Vendor or its subcontractors for the State pursuant to the Contract, including all Intellectual Property Rights therein, but excluding any Proprietary Vendor Material (“State Material”).

All aspects of the State Material that are copyrightable, and all work in process in connection therewith, shall be considered “works made for hire” under applicable law,





## SECTION 30: CONTRACT REQUIREMENTS



and the State shall be the “author” within the meaning of such laws. All such copyrightable State Material, as well as all copies of such State Material in whatever medium fixed or embodied, shall be owned exclusively by the State upon its creation, and Vendor hereby expressly disclaims any interest in any of them.

In the event (and to the extent) that State Material created by Vendor hereunder or any part or element thereof is either identified and agreed or found as a matter of law, not to be a “work made for hire”, or in the event any State Material is non-copyrightable, Vendor shall and does hereby irrevocably convey and assign to the State all such rights, title and interests in such State Material, and all copies of any of them, without further consideration. To the extent that any State Material is copyrightable and not “work made for hire”, Vendor agrees to assist the State to register, and from time to time to enforce, all Intellectual Property Rights and other rights and protections relating to the State Material created. If any Proprietary Vendor Material is embedded in the State Material, Vendor hereby grants to the State a royalty-free, global, fully paid-up, irrevocable, perpetual, non-exclusive license to use and make derivative State Material, for the State’s internal purposes, of such embedded Proprietary Vendor Material.

Except as the Federal Government may otherwise authorize in exercise of its license rights with respect to the State Material under the following paragraph, Vendor may use, perform, execute, display, distribute, copy and/or create derivative works based on the State Material only in performance of Vendor's duties under the Contract.

In accordance with 45 CFR 92.34 and 45 CFR 95.617, the US DHHS shall have a royalty-free, non-exclusive, and irrevocable license to reproduce, publish, or otherwise use, and to authorize others (including without limitation the Vendor and its customers) to use, for Federal Government purposes the copyright in the State Material and such Proprietary Vendor Material as is newly created for delivery to the State, including without limitation with respect to the software or modifications thereof and associated documentation.

### *Proprietary Vendor Material*

With respect to (a) any Vendor-owned data, information, material, proposals, manuals, designs, training documents, other documentation (including working papers), software, software modifications, and customizations (i) that (1) existed prior to the Effective Date, or (2) are developed by Vendor after the Effective Date without the use of State Material and that are not based upon all or any portion of the State Material (such as a translation, enhancement, extension, modification, correction, extension, upgrade, improvement, adaptation, abridgement, recasting, transformation or elaboration), and (ii) that are incorporated into the Replacement MMIS or otherwise utilized by the Vendor in its performance of the Services with respect to the Replacement MMIS, and (b) any modifications to the materials listed in (a)(i) above created by the Vendor or its subcontractors during the Term (collectively, “Proprietary Vendor Material”), the Vendor hereby grants the State a non-exclusive, perpetual, royalty-free, and irrevocable license to create modifications to the Proprietary Vendor Material, which Proprietary Vendor Material and modifications the State, and others with the State’s authorization and on the State’s behalf, may copy, perform, use, execute, display, and digitally transmit.



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Without limiting the generality of the foregoing, the State or its Contractors may use the Proprietary Vendor Material to maintain, develop, and modify the Replacement MMIS and successor systems, including without limitation in the event that the State awards a contract to a third party for takeover of the Vendor's operations hereunder upon expiration or termination of the Contract. Subject to agreements of non-disclosure and non-use that are reasonably protective of the Vendor's proprietary interests, the State may disclose Proprietary Vendor Material to potential third party offerors in the course of procuring such takeover services.

### *Third Party Material*

Prior to incorporating elements from a non-governmental third party's software code, data compilations or audio/visual/print materials ("Third Party Material") into the Proprietary Vendor Material, the Vendor shall obtain at its sole expense a fully paid, perpetual, irrevocable license permitting the State, and others with the State's authorization and on the State's behalf, to copy, use, perform, display, and digitally transmit such elements in connection with, and coextensively with, the Proprietary Vendor Material, unless the State has independently acquired such rights.

Third Party Material includes without limitation proprietary materials of the Vendor's subcontractors that existed prior to the Effective Date, if any. In addition to the license rights set forth in the immediately preceding paragraph, the Vendor shall obtain at its sole expense the perpetual, irrevocable, and fully paid right for the State to modify and create derivative works with respect to such subcontractor materials, other than COTS Software.

Upon committing to use of stand-alone, non-government-owned third party software code, audio/visual/print materials, or data compilations in its Fiscal Agent operations on behalf of the State, the Vendor shall obtain at its sole expense fully paid, perpetual, irrevocable licenses permitting the State, and others with the State's authorization and on the State's behalf, to continue to use such materials without interruption in the event that the Vendor ceases to conduct Fiscal Agent operations on behalf of the State, unless the State has independently acquired such rights.

### *Public Material*

As an alternative to creating, providing, or using State Material, Proprietary Vendor Material, or Third Party Material, to some extent the Vendor may provide or use materials that are in the public domain or that are available for use by or on behalf of the State after being developed with public funds for a Federal, state or other governmental entity ("Public Material"). To the extent, if any, that the Vendor claims or may have distinct Intellectual Property Rights in or relating to such materials, the Vendor hereby grants the State a non-exclusive, perpetual, royalty-free, and irrevocable license to create modifications to such materials, which materials and modifications the State, and others with the State's authorization and on the State's behalf, may copy, perform, use, execute, display, and digitally transmit. Any such rights must be identified together with the materials in the Inventories and/or Data Accession Lists prepared pursuant to this Section. Without limiting the generality of the foregoing, the State or its Contractors may use such materials to maintain, develop, and modify the Replacement MMIS and

successor systems, including without limitation in the event that the State awards a contract to a third party for takeover of the Vendor's operations hereunder upon expiration or termination of the Contract.

Vendor shall have a perpetual and fully paid right to use, modify and create derivative works from State Materials that are coextensive with the State's rights in and to such State Materials, provided Vendor is not charging for the material itself but only for its services associated with using or modifying the materials to serve public sector clients.

*Intent to Incorporate or Use Third Party Material or Public Material*

The Vendor shall not commit to incorporation or substantial use of any Third Party Material or Public Material in connection the Replacement MMIS without first revealing its intent to do so to the State. The Vendor shall so inform the State in writing (if the Vendor has not already done so through its Technical Proposal, IMP, or other documentation) and within sufficient time for the State to consider the risks and alternatives associated with the Vendor's intention. All licenses for Third Party Material or Public Material held by the Vendor in its own name (to the extent that licenses may be required with respect to the Public Material) must be acceptable to the State. Such licenses also must be in pertinent part assignable to the State on terms acceptable to the State.

*State-Provided Material, Information and Data*

As between the Parties, the State will retain all of its right, title and interest in and to any goods, software, specifications, drawings, records, documentation, know-how, methodologies, processes, technologies, State Data (as defined above), or derivative works thereof, or other materials or information provided by the State to the Vendor in connection with the Contract (the "State Provided Material"), and Vendor shall not acquire any right, title or interest therein.

*Rights in Residual Materials*

The State will own, and have exclusive Intellectual Property Rights with respect to, all non-proprietary or customized materials not otherwise described above that are developed as a result of the Contract.

*Initial, Annual, and Final Inventory*

Upon the State's request, or as established in SOWs, work plans, Deliverable(s) schedules or other similar Contract documents, the Vendor will provide detailed inventories of all State Material, Public Material, Proprietary Vendor Material, and Third Party Material, to the State, specifying the category of each item. With respect to each item that is subject to any extent to an open source software license, each inventory shall also specify the name and version of the applicable open source license together with a risk analysis that assesses the actual or potential impact of such Open Source Software on the rights of the State under the Contract. The Vendor shall provide such an inventory at the beginning of the Contract and annually thereafter. In addition, the Vendor shall provide an inventory as soon as commercially practicable upon initiation of the Turnover Phase, and a final inventory following expiration or termination of the Contract. The inventory for Third Party Material shall indicate with respect to which

items it shall be necessary to transfer or procure a license for the State upon a turnover of operations from the Vendor.

*Data Accession List*

Each month throughout the duration of the Contract the Vendor shall prepare and deliver to the State a Data Accession List (DAL) that sets forth all State Material then in existence and held by or on behalf of the Vendor, other than State Material that is identified in the Contract Data Requirements List (CDRL) or that is created and stored in the ordinary course of day-to-day operation of the Replacement MMIS (such as claims data and the like). The Vendor shall maintain a continuously updated archive of the material listed on the DAL throughout the duration of the Contract. The Vendor shall promptly provide a copy of the archive to the State in each instance that the State may request one. Throughout the duration of the Contract and thereafter, the Vendor shall retain in confidence at least one (1) copy of the archive until the State directs the Vendor to deliver all remaining copies to the State or to destroy the copies then remaining in the Vendor's possession.

*General Skills and Know-How*

Notwithstanding anything to the contrary herein, the Vendor and its subcontractors shall be free to use and employ their general skills, know-how, and expertise, and to use, disclose, and employ any generalized ideas, concepts, know-how, methods, techniques, or skills gained or learned during the course of performing the Contract, provided that the foregoing is acquired and applied without improper disclosure of State confidential information or information protected by the Health Insurance Portability and Accountability Act (HIPAA) or other laws or regulations.

**30.12 INTELLECTUAL PROPERTY INDEMNIFICATION**

The Vendor shall defend, indemnify, and hold the State Indemnitees (as defined in Section 30.23(a)) harmless from and against any and all Losses (as defined in Section 30.23 (a)) resulting from, arising out of, or related to any Third Party Claim (as defined in Section 30.23(a)) that the Proprietary Vendor Material, the State Material, the Services, or any other item, system, Deliverable, software, or service provided or used under the Contract by Vendor (or any Vendor agent, contractor, subcontractor, or representative), or any use thereof, infringes, violates, or misappropriates the Intellectual Property Rights of a third party.

The procedures set forth in Section 30.23(b) shall apply with respect to indemnification for all Third Party Claims arising in connection with the Contract.

Should any such material or intangible or the operation thereof become, or in the Vendor's opinion are likely to become, the subject of any such suit or proceeding, the State shall permit the Vendor, in addition to its indemnity obligations, at its option and expense, either to procure for the State the right to continue using such material or intangible or to replace or modify the same to become non-infringing or non-violative and to continue to meet the Replacement MMIS specifications and the Contract in all material respects. If neither of these options can reasonably be taken, or if the use of such material or intangible by the State shall be prevented by injunction, the Vendor



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shall take back such material or intangible and refund all sums the State has paid the Vendor since the Effective Date, and make every reasonable effort to assist the State in procuring substitute material or intangible. If, in the sole opinion of the State, the return of such infringing material or intangible makes the retention of other material or intangibles acquired from the Vendor under the Contract impractical, the State shall then have the option of terminating the Contract, or applicable portions thereof, without penalty or termination charge. The Vendor shall take back such material or intangible and refund all sums the State has paid the Vendor.

Vendor will not indemnify the State Indemnitees to the extent to which the claim of infringement or misappropriation is caused by:

- (a) such State Indemnitee's unauthorized modification or use of such material or intangible;
- (b) such State Indemnitee's failure to use corrections or enhancements made available by Vendor within a reasonable period of time after such corrections or enhancements were first made available, provided (1) Vendor has informed the State that use of such corrections or enhancements is necessary to avert alleged or actual infringement, (2) implementation of such enhancements or corrections would not result in an adverse impact on the State; or
- (c) a State Indemnitee's use of such item in combination with any product or equipment not owned, developed or authorized by Vendor or Vendor's subcontractor(s); provided that Vendor has notified the State of an actual or threatened claim of infringement or misappropriation arising from the combination use, or when Vendor knew or should reasonably have known that such combination would be used by the State and did not object.

### 30.13 ESCROW AGREEMENT

The Vendor shall comply with the escrow provisions below for all Public Material and Proprietary Vendor Material (including subcontractor-owned materials and other Third Party Material incorporated in Proprietary Vendor Material), except to the extent the Vendor demonstrates to the satisfaction of the State that compliance is not permitted by the nature of the Vendor's limited rights in such material.

Within ninety (90) days after the State's acceptance of the Replacement MMIS, the Parties shall enter into a software escrow agreement ("Escrow Agreement") with a reputable, independent, third party that provides software escrow services among its principal business offerings ("Escrow Agent"). The Escrow Agreement shall provide for the regular deposit into escrow of all source code (including without limitation all make files, configurational files, data tables upon which execution is dependent, and the like, collectively the "Source Code"), object code, and documentation with respect to all Public Material and Proprietary Vendor Material (and cumulative updates thereof), together with (a) continually updated instructions as to the compilation, installation, configuration, deployment, and use of the Source Code, and (b) a list of all non-deposited third party software used in conjunction with the Source Code to provide the full functionality of the deposited materials. In the event of the termination or



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expiration of the initial Escrow Agreement or any successor agreement, with minimal delay the Parties shall enter into a substantially equivalent agreement with a successor provider of software escrow services (who shall then be known as the “Escrow Agent”). The Vendor will make its initial deposit of Source Code within fifteen (15) days after the effective date of the Escrow Agreement. The Vendor shall periodically update the escrow deposit as the Parties shall agree in the Escrow Agreement. In addition to other usual and customary terms, the Escrow Agreement shall provide that the State shall be entitled to obtain the deposited materials from escrow upon the State’s making a proper claim for release from escrow in the event that (w) proper written notice is given the Escrow Agent that release of the copy of the deposited materials is pursuant to 11 United States Code Section 365(n) or other applicable Federal or State bankruptcy, insolvency, reorganization, or liquidation statute; (x) the Vendor files articles of dissolution (but not if the Vendor is consolidated or merged into another entity); (y) the Contract expires or terminates; or (z) the Turnover Phase is initiated. The release of deposited materials from escrow shall not confer upon the State any right of ownership in the deposited materials or the underlying intellectual property embodied therein. In the event of the release of deposited materials to the State from escrow, the State shall use the deposited materials solely for the benefit of the State and its constituents, consistently with the grants of license set forth in Section 30.11 of this RFP. The release of materials from escrow, without more, shall not cause any further amounts to accrue as payable to the Vendor by the State, and the term of the State’s possessory and usage rights with respect to the released materials shall be perpetual. The Escrow Agreement shall provide for its automatic termination upon the earlier of five (5) years after the expiration or termination of this Contract, or, release of all Source Code to the State and the State’s subsequent confirmation of compliance with the terms of the Escrow Agreement. The Vendor shall pay the escrow costs, as well as all costs associated with causing its subcontractors and other third parties to abide by the Escrow Agreement.

### **30.14 ADVERTISING**

Except as may be required of the Vendor to meet Securities and Exchange Commission (SEC) regulations or other legal reporting requirements, the Vendor shall not advertise or otherwise publicly disseminate any information whatsoever concerning the existence or terms of the Contract without prior written approval from the Replacement MMIS Contract Administrator.

### **30.15 ACCESS TO SITES, PERSONS, AND RECORDS**

The State, the State Auditor, or any authorized representative of the State of North Carolina, and the US DHHS, the United States Comptroller General, the United States Government Accountability Office, or their authorized representatives shall have the right, at all reasonable times, to enter the Vendor’s premises or such other locations where duties under the Contract are being performed to inspect, monitor, or otherwise evaluate (including periodic systems testing) the contractual work being performed. The Vendor shall provide to the State upon its request any supporting documentation for invoiced charges, including without limitation personnel time records. The Vendor and

all of its subcontractors shall provide reasonable access to all facilities and assistance to the State and Federal representatives. All inspections and evaluations shall be performed in such a manner as to not unduly delay work.

Pursuant to N.C.G.S. 147-64.7 and 45 CFR 92.36(i)(10), the State, the State Auditor, appropriate Federal officials, and their respective authorized employees or agents shall be authorized to examine all books, records, and accounts of the Vendor insofar as they relate to transactions with any department, board, office, commission, institution, or other agency of the State pursuant to the performance of the Contract or to costs charged to the Contract. Additional audit or reporting requirements may be required by any State or Federal agency, if in the agency's opinion such requirement is imposed by Federal law or regulation or State law or rule.

When disclosing information pursuant to this Section 30.15, the Vendor may designate certain of its information as "Confidential" in accordance with Section 30.27.

### **30.16 RECORDS RETENTION REQUIREMENTS**

The Vendor shall maintain records of all claims received, transactions processed, and adjudication decisions made by the Replacement MMIS until the Vendor executes specific written disposition instructions received from the Replacement MMIS Contract Administrator. The Vendor may convert all such records to an industry standard electronic format for economical storage and retrieval. At the expiration or termination of the Contract, the Vendor shall request disposition instructions if not previously received. If the State does not provide written disposition instructions to the Vendor within five (5) years after such request, the Vendor may destroy or irretrievably purge the records, provided that the Vendor first gives the State written notice of the Vendor's intent to dispose of the records and the State provides no disposition instructions within ninety (90) days of the State's receipt of notice. The Vendor shall comply with any timely received disposition instructions as soon as commercially practicable. The Vendor shall not otherwise destroy, purge, or dispose of records related to the Contract or the Vendor's performance without the State's express prior written approval.

Notwithstanding the Vendor's receipt of disposition instructions to the contrary, should any litigation, claim, negotiation, audit, disallowance action, or other action involving the subject matter of the Contract be commenced, the applicable records shall be retained until completion of any said litigation, claim, negotiation, audit, disallowance action, or other action involving the Contract and resolution of all issues arising thereof. The Vendor shall promptly inform the State that for such reason it has retained the records notwithstanding the State's initial instructions.

### **30.17 FINANCIAL RECORDS REQUIREMENTS**

This Section 30.17 addresses requirements regarding Replacement MMIS financial records. The requirements are in addition to those set forth above.

#### **30.17.1 Financial Accounting Requirements**

The Vendor shall maintain accounting records relating directly to the performance of the Contract. These accounting records shall be maintained in accordance with Generally



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Accepted Accounting Principles (GAAP). Further, Vendor shall maintain the records separately and apart from other corporate accounting records or shall segregate the records within its corporate accounting system such that the financial and cost data necessary to comply with Section 30.17 can be reported and audited.

The Vendor shall maintain, document, and submit operations cost data in accordance with the State Medicaid Manual, Part 11. The Vendor's claims processing cost documentation shall support and differentiate between those Contract operations costs for each State division's services provided by the Vendor that are reimbursable and those that are not reimbursable, or are reimbursable at a different rate, to identify the applicability of varying or matching rates for each North Carolina program for which the Vendor processes claims. For example, when appropriate, the data shall distinguish costs eligible for enhanced Federal financial participation (FFP).

Authorized representatives or agents of the State and CMS shall have access to the accounting records upon reasonable notice and at reasonable times during the performance and/or retention period of the Contract for purposes of review, analysis, inspection, audit, and/or reproduction. The Vendor shall make copies of any accounting records pertaining to the Contract to the State within five (5) calendar days of its receipt of a written request by the State. If such records are not made available as requested by the State, the Vendor shall provide transportation, lodging, and subsistence, at no cost, for the State and other State and/or Federal representatives to carry out their audit functions at the principal offices of the Vendor or other locations of such records. NC DHHS (as appropriate) and other State and Federal agencies and their respective authorized representatives or agents shall have access to all accounting and financial records of any individual, partnership, firm, or corporation insofar as they relate to transactions with any department, board, commission, institution, or other State or Federal agency connected with the Contract.

Financial records (including without limitation audit materials) pertaining to the entire life of the Contract (whether created on the Vendor's behalf or on behalf of the State) shall be maintained for three (3) years following the end of the Federal fiscal year during which the Contract expires or is terminated or during which State and Federal audits of the Contract have been completed, whichever is later. However, accounting records pertaining to the Contract shall be retained until final resolution of all pending audit questions and for one (1) year following the termination of any litigation relating to the Contract if the litigation has not terminated within the above three-year (3-year) period. The content of the accounting records and procedures shall be subject to State and Federal approval. Prior to the expiration of any retention period, the State may instruct the Vendor to continue to maintain records for an additional period. The Vendor shall continue to maintain the records as instructed by the State.

When disclosing information pursuant to this Section 30.17.1, the Vendor may designate certain of its information as "Confidential" in accordance with Section 30.27.

### **30.17.2 Financial Records Supplied to the State**

During the life of the Contract, the Vendor shall, for itself and all its subcontractors, provide the State with copies of its annual report and all disclosure or reporting





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statements or forms filed with the State of North Carolina and/or the SEC as soon as they are prepared in final form and are otherwise available for distribution or filing. In the event that for any reason the Vendor or its subcontractors are not required to or do not prepare either an annual report or SEC disclosure or reporting statements or forms by virtue of being a subsidiary of another corporation, the Vendor shall fulfill the requirements of this Section 30.17.2 with respect to all such documents for any parent corporation which reflect, report, or include any of the Vendor's operations on any basis.

### **30.17.3 Financial Audit Requirements**

The Vendor shall comply with the requirements of Appendix A to 45 CFR Part 74 and shall maintain books, records, documents, and other evidence pertaining to the administrative costs and expenses of the Contract to the extent and in such detail as shall properly reflect all revenues, all net costs, direct and apportioned, and other costs and expenses of whatever nature for which payment is claimed under provisions of the Contract. The Vendor shall provide copies of the foregoing material to the Replacement MMIS Contract Administrator upon request.

Authorized Federal and State representatives, including, but not limited to, NC DHHS (as appropriate) personnel, the State Auditor and other State and Federal agencies providing funds, and the Comptroller General of the United States, shall have access to and the right to examine the items listed above during the Contract period and during the three-year (3-year) post-Contract period or until final resolution of all pending audit questions and litigation. During the Contract period, access to these items is provided at the Vendor's office on any State business day within one (1) State business day of notice. During the three-year (3-year) post-Contract period, delivery of and access to the listed items shall be at no cost to the State.

When disclosing information pursuant to this Section 30.17.3, the Vendor may designate certain of its information as "Confidential" in accordance with Section 30.27.

## **30.18 COOPERATION IN INVESTIGATIONS, HEARINGS, AND DISPUTES**

### **30.18.1 Fraud Investigations**

The Vendor shall cooperate fully with US DHHS, the State, the Medicaid Fraud Control Unit, and any other authorized local, State, and Federal agencies or law enforcement authorities in the investigation, documentation, and litigation of possible fraud and abuse cases or any other misconduct involving any of the duties and responsibilities performed by the Vendor under the Contract. US DHHS, its authorized representatives, and those of any other authorized local, State, or Federal agency or law enforcement agency shall have access to the same records and information as does the State.

### **30.18.2 State Fair Hearings and Provider Disputes**

The Vendor shall cooperate and participate in the resolution of State Fair Hearings and Provider Disputes at the request of the State.



**30.19 COOPERATION WITH OTHER VENDORS AND CONTRACTORS OF THE STATE**

Vendor shall cooperate with other vendors and contractors of the State that are providing goods or services to or on behalf of the State in relation to the Replacement MMIS and the NCMMIS+ Program, including without limitation such vendors or contractors as may be (a) providing goods or services with respect to the Reporting and Analytics system or Division of Health Service Regulation information technology system that the State contemplates shall be developed and operated as part of the NCMMIS+ Program, or (b) engaged by the State to monitor, validate or verify Vendor's Contract performance or Deliverables. With respect to such vendors and contractors who may reasonably be expected to have access to Vendor confidential information in the course of their participation in the NCMMIS+ Program, prior to their participation the State shall cause each of them to enter into a written contract that reasonably limits their disclosure and use of Vendor's confidential information.

**30.20 INSURANCE**

During the life of the Contract, the Vendor, at its sole cost and expense, shall provide commercial insurance of such type and with such terms and limits as may be reasonably associated with the Contract. At a minimum, the Vendor shall provide and maintain the following coverage and limits.

**Worker's Compensation.** The Vendor shall provide and maintain Worker's Compensation Insurance, as required by the laws of North Carolina, as well as employer's liability coverage with minimum limits of \$500,000.00, covering all of the Vendor's employees who are engaged in any work under the Contract. If any work is subcontracted, the Vendor shall require the subcontractor(s) to provide the same coverage for any of its employees engaged in any work under the Contract.

**Commercial General Liability.** The Vendor shall provide and maintain General Liability Coverage on a Comprehensive Broad Form on an occurrence basis in the minimum amount of \$10,000,000.00, Combined Single Limit. (Defense cost shall be in excess of the limit of liability.)

**Automobile.** The Vendor shall provide and maintain Automobile Liability Insurance, to include liability coverage, covering all owned, hired, and non-owned vehicles used in connection with the Contract. The minimum combined single limit shall be \$1,000,000.00 bodily injury and property damage.

Providing and maintaining adequate insurance coverage described herein shall be a material obligation of the Vendor and is of the essence of the Contract. All such insurance shall meet all laws of the State of North Carolina. Such insurance coverage shall be obtained from companies that are authorized to provide such coverage and that are authorized by the Commissioner of Insurance to do business in North Carolina. The Vendor shall at all times comply with the terms of such insurance policies and all requirements of the insurer under any such insurance policies, except as they may conflict with existing North Carolina laws or the Contract. The limits of coverage under

each insurance policy maintained by the Vendor shall not be interpreted as limiting or expanding the Vendor's liability and obligations under the Contract.

The Vendor shall provide a certificate of insurance naming the State as an additional insured with respect to the Vendor's Commercial General Liability and Automobile coverages. The Vendor shall cause the certificate shall be delivered to the State not later than ten (10) days following the date of the Notice of Award issued with respect to the Contract. The Vendor must notify the State immediately of any material adverse change in insurance coverage, including, but not limited to, changes in limits, coverage, or status of the policy.

### **30.21 VENDOR REPRESENTATIONS, WARRANTIES, AND COVENANTS**

Vendor represents, warrants, and covenants as follows:

- (a) **Efficiency and Cost Effectiveness.** With respect to Services that are not being provided by Vendor on a fixed price basis, Vendor will (i) use efficiently the resources and services necessary to provide the Services and (ii) perform the Services in the most cost-effective manner consistent with the required level of quality and performance.
- (b) **Date and Time.** Any Deliverable, whether hardware, firmware, middleware, custom or commercial software, or internal components, subroutines, and interface therein that performs any data and/or time data recognition function, calculation, or sequencing, will provide accurate date/time data and leap year calculations.
- (c) **Viruses.** Vendor will screen any software or data files provided or made available by it to the State hereunder or used by Vendor (or any Vendor agent, contractor, subcontractor or representative) in performance of the Services and will use then-current industry-standard anti-virus software programs for the purpose of avoiding the introduction of any "virus" or other unauthorized computer software routine or hardware components which are designed to disable or damage hardware or damage, erase or delay access to software or data. Vendor will assist the State's recovery from the introduction of any such virus.
- (d) **Disabling Devices.** Vendor shall provide no software code to the State in relation to this Contract that includes any trap door, trojan horse, usage meter or similar device that is coded to impair or disable the operation of any portion of the Replacement MMIS (or to facilitate such impairment or disablement), which device could be used as a means of enforcing Vendor's rights under this Contract or any asserted rights of Vendor's subcontractors or licensors. In the event of any dispute between Vendor and the State, in lieu of using or relying on any such device Vendor shall resort only to those rights and remedies available to Vendor under this Contract or through judicial process. Any device or "door" that may be included in the Replacement MMIS software for Vendor's diagnostic purposes shall not be considered a prohibited device for the purposes of this Section 30.21(d), so long as its use is limited to diagnostic purposes.



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- (e) Data. Vendor will cause all data and information created by it to be timely and accurate. Vendor will use then-current industry-standard software and processes, and such other requirements identified herein, to protect data from unauthorized access.
- (f) Compliance with Immigration Laws. None of the Vendor personnel working under the Contract is an unauthorized alien under, and Vendor will at all times comply with, the U.S. Immigration Reform and Control Act of 1986 and its successor, if any, and any implementing regulations therefor. Vendor will not assign Services to be performed to any Vendor personnel who are unauthorized aliens, and if any Vendor personnel performing any of the Services is discovered to be an unauthorized alien, Vendor will immediately remove such personnel from performing Services hereunder and replace such personnel with personnel who is not an unauthorized alien.
- (g) Services, Deliverables, Systems and Equipment. The services, Deliverables, systems, and equipment used or provided by Vendor will be (i) substantially free of all defects (including defects in material and workmanship); (ii) designed, will function, and will conform with the requirements set forth in the Contract, (including, without limitation, the requirements set forth in Vendor's Statement of Work and Section 40 of this RFP); and (iii) subject to such further warranty provisions pertaining to services, Deliverables, systems, and equipment as are set forth in Vendor's Technical Proposal. The warranty set forth in this subsection (g) shall be in full force and effect from the Effective Date until the termination or expiration of the Contract, or until such later event or date as Vendor may set forth in Vendor's Technical Proposal.

Vendor makes such additional representations and warranties as are set forth in the Vendor's Technical Proposal.

EXCEPT AS OTHERWISE EXPRESSLY PROVIDED IN THIS CONTRACT AND VENDOR'S TECHNICAL PROPOSAL, VENDOR MAKES NO REPRESENTATIONS OR WARRANTIES, EXPRESS OR IMPLIED, REGARDING ANY MATTER, INCLUDING THE MERCHANTABILITY, SUITABILITY, ORIGINALITY, FITNESS FOR A PARTICULAR USE OR PURPOSE OF THE SOLUTION OR ANY OTHER MATERIALS DELIVERED HEREUNDER.

### **30.22 OPERATIONS AND MAINTENANCE DOCUMENTATION, MANUALS, AND OTHER ARTIFACTS**

The State and the Vendor shall identify documentation and manuals in the Contract Data Requirements List (CDRL) that are required for the Vendor to operate and maintain the system and to properly perform its duties as Fiscal Agent. Vendor will be responsible for the preparation, accuracy, maintenance and currency of these documents and manuals. Vendor will prepare and provide to the State, in formats specified in the CDRL, proposed updates to the documents and manuals as necessary to reflect any substantive changes therein within a reasonable time prior to the implementation of such changes, except in those instances that the State agrees in

writing to allow documentation to be delivered after the changes are implemented. The processes, procedures, and system artifacts contained in these documents and manuals shall be of such quality to reasonably ensure that the Services are performed accurately and in a timely manner. Either Party may, from time to time, request updates or amendments to the documents and manuals, and the Parties will work together to implement such changes, provided however, no such changes can occur without the State's specific written approval. Vendor will update the documents and manuals to reflect evolution of the practices used in the industry to provide services similar to the Services, provided however, no such changes can occur without the State's specific written approval. The documents and manuals will describe the manner in which the Services are to be performed, but is not intended to expand or alter the scope of the Parties' responsibilities. Vendor will perform its obligations under this Section 30.22, at no additional cost to the State. All documents, manuals, and other artifacts required for the proper operation and maintenance of the system and for proper conduct of the Fiscal Agent operations shall be included in the CDRL by the Vendor. Should any additional required documents, manuals, or other artifacts be identified after the Effective Date, the Vendor shall provide these items at no additional cost to the State.

### **30.23 INDEMNITY**

- (a) Vendor shall indemnify, defend and hold harmless the State, and its directors, officers, employees, subcontractors and agents (collectively, the "the State Indemnitees") from and against any and all Losses (as defined below) incurred or suffered in respect of Third Party Claims (as defined below) (except in the case of paragraph (a)(i) or (a)(ii), in which the claim may also be made by any of the State Indemnitees), whether based in whole or in part in contract, tort, negligence, statute or otherwise, arising from any of the following:
  - (i) any action or omission of any employee, agent or subcontractor of Vendor in connection with this Contract that constitutes negligence, gross negligence, or willful or intentional misconduct of Vendor or its employees, agents or subcontractors resulting in the death of or bodily injury to any third party or to any State Indemnitee;
  - (ii) any action or omission of any employee, agent or subcontractor of Vendor in connection with this Contract that constitutes negligence, gross negligence, or willful or intentional misconduct of Vendor or its employees, agents or subcontractors and resulting in the loss of or damage to the real or tangible personal property (whether owned or leased) of any third party or any State Indemnitee;
  - (iii) Vendor's failure to pay and discharge any Taxes (including interest and penalties) for which Vendor is responsible pursuant to the provisions of the Contract, including any Taxes resulting from the State's failure to pay, deduct or withhold Taxes with respect to any personnel, agents, subcontractors or suppliers of the Vendor;
  - (iv) any breach by Vendor of its representations, warranties or covenants set forth in the Contract;

- (v) any breach by Vendor of its confidentiality and data protection obligations under the Contract, whether pursuant to Section 30.26 hereof or otherwise, and including as a result of any failure by Vendor to return the State Data pursuant to Section 30.26;
- (vi) Vendor's failure to comply with the Regulatory Requirements (as defined in Section 30.31; or
- (vii) Vendor's failure to meet any Performance Standard in the Contract.

"Losses" means losses, claims, obligations, demands, actions, causes of action, infringements, assessments, fines and penalties (whether civil or criminal), liabilities, expenses, judgments, awards, and costs (including reasonable fees and disbursements of legal counsel, accountants and other advisors or consultants) of every kind and nature.

"Third Party Claims" means any proceeding asserted by a person or entity (including a governmental entity) other than a Party or such Party's affiliates, whether by legal process, inquiry, or otherwise.

- (b) The following procedures shall apply with respect to indemnification for Third Party Claims arising in connection with the Contract:
  - (i) Promptly after receipt by the State of notice of the assertion or the commencement of any Third Party Claim with respect to any matter within the scope of Sections 30.23(a)(or Section 30.12, as applicable), the State shall give Notice thereof to Vendor and shall thereafter keep Vendor reasonably informed with respect thereto; *provided, however*, that the failure of the State to give Vendor such prompt Notice will not relieve Vendor of its obligations hereunder except to the extent such failure results in prejudice to Vendor's defense of such Third Party Claim. Within fifteen (15) days following receipt of Notice from the State relating to any Third Party Claim, but no later than ten (10) days before the date on which any response to a writ, statement of claim, complaint or summons is due, Vendor shall notify the State in writing that Vendor shall assume control of the defense and settlement of such Third Party Claim (the "Assumption Notice").
  - (ii) If Vendor delivers the Assumption Notice relating to any Third Party Claim within the required notice period, and for so long as Vendor diligently conducts the defense of such Third Party Claim, Vendor will be entitled to have sole control over the defense and settlement of such Third Party Claim; *provided, however*, that the State will be entitled to participate in the defense of such Third Party Claim and to employ counsel at its own expense to assist in the handling of such Third Party Claim.
  - (iii) If Vendor fails or chooses not to assume the defense of any such Third Party Claim within the prescribed period of time, then the State may assume the defense of any such Third Party Claim at the cost and expense of Vendor.

- (iv) Vendor may compromise, settle or resolve a Third Party Claim without the State's Consent if the compromise, settlement or resolution involves only the payment of money by Vendor (whether on its own behalf or on behalf of the State) and the Third Party claimant provides the State a release from all liability regarding the Third Party Claim. Otherwise, Vendor may not compromise, settle or resolve the Third Party Claim without the State's Consent.

**30.24 CONFLICT OF INTEREST**

In the preparation of any response to this solicitation, the Vendor shall;

- (a) Provide a statement that no assistance in preparing the response was received from any person currently or formerly employed or engaged by the State of North Carolina whose duties relate(d) to the preparation of this RFP, unless such assistance was provided by the State personnel in his or her official public capacity and that neither such person nor any member of his or her immediate family has any financial interest in the outcome of this RFP.
- (b) State the employing State agency, individual's title at that State agency, and termination date.

As applicable, the Vendor shall comply, or refrain from inducing any employee or contractor of the State to fail to comply, with all statutory prohibitions regarding conflicts of interest, including without limitation N.C.G.S. §§ 147-33.100, 14-234, and 133-32.

**30.25 PROHIBITION AGAINST CONTINGENT FEES AND GRATUITIES**

The Vendor represents and warrants that it has not paid, and agrees not to pay, any bonus, commission, fee, or gratuity to any employee or official of the State of North Carolina for the purpose of obtaining any Contract or award issued by the State. The Vendor further represents and warrants that no commission or other payment has been or shall be received from or paid to any third party contingent on the award of any Contract by the State, except as shall have been expressly communicated to the State Purchasing Agent in writing prior to acceptance of the Contract or award in question. The Vendor and its authorized signatory further represent and warrant that no officer or employee of the State of North Carolina has any direct or indirect financial or personal beneficial interest in the subject matter of the Contract obligation or Contract for future award of compensation as an inducement or consideration for making the Contract. Subsequent discovery by the State of non-compliance with these provisions shall constitute sufficient cause for immediate termination of all outstanding contracts. Violations of this provision may result in debarment of the Bidder(s) or Contractor(s) as permitted by 9 NCAC 06B.1009(f), 06B.1030, or other provision of law.

**30.26 CONFIDENTIALITY AND DATA SECURITY**

- (a) Confidentiality

The Vendor and its agents shall maintain the security and confidentiality of all data (including without limitation State Data), information, working papers, and other documents related to the Contract. Any use, sale, or offering of this data in any form by



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the Vendor, its employees, or assignees without the prior written approval of the State shall be a violation of the Contract. Any violation shall be considered a material breach of the Contract.

The Vendor shall treat all information—including information relating to program beneficiaries and providers—that is obtained through its performance under the Contract as confidential information. The Vendor shall not use any information so obtained in any manner except as provided for herein. The NC DHHS, the State auditors, the NC DHHS Office of Internal Audit, the State Attorney General, and Federal officials as authorized by Federal law or regulations, as well as the authorized representatives of the foregoing, shall have access to all confidential information in accordance with the requirements of State and Federal laws and regulations. No other person or entity shall be granted access to confidential information unless State and Federal laws and regulations allow such access. Each NC DHHS participating entity has the sole authority to determine if and when any other person or entity has properly obtained the right to have access to any confidential information and whether such access may be granted. Use or disclosure of confidential information shall be limited to purposes directly connected with the administration of the Contract.

The Vendor shall safeguard and protect any data, documents, files, and other materials received from the State or the agency during performance of any contractual obligation from loss, destruction, or erasure, including without limitation through Vendor's performance of its duties set forth in Section 30.31.

The Vendor specifically warrants that it, its officers, directors, principals, employees, and any subcontractors shall hold all information received during performance of the Contract in the strictest confidence and shall not disclose the same to any third party without the express written approval of the State.

The Vendor warrants that all of its employees and any approved third party Contractors or subcontractors are subject to a non-disclosure and confidentiality agreement that is enforceable in North Carolina and sufficient in breadth to include and protect confidential information of the State. The Vendor shall, upon request of the State, verify and produce true copies of any such agreements. Production of such agreements by the Vendor may be made subject to applicable confidentiality, non-disclosure, or privacy laws, provided that the Vendor produces satisfactory evidence supporting exclusion of such agreements from disclosure under the North Carolina Public Records laws in N.C.G.S. §132-1 et. seq. The State may, in its sole discretion, provide a non-disclosure and confidentiality agreement satisfactory to the State for the Vendor's execution. The State may exercise its rights under this paragraph as necessary or proper, in its discretion, to comply with applicable security regulations or statutes, including, but not limited to, 26 U.S.C. 6103 and IRS Publication 1075 (*Tax Information Security Guidelines for Federal, State, and Local Agencies and Entities*), HIPAA, any implementing regulations in the Code of Federal Regulations, and any future regulations imposed upon the Office of Information Technology Services or the North Carolina Department of Revenue pursuant to future statutory or regulatory requirements.





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The Vendor warrants that without prior written approval of the State, the Vendor shall not incorporate confidential or proprietary information of any person or entity not a Party to the Contract into any materials furnished to the State hereunder, nor without such approval shall the Vendor disclose to the State or induce the State to use any confidential or proprietary information of any person or entity not a Party to the Contract.

The foregoing confidentiality provisions will not prevent the Vendor from disclosing information that (i) at the time of disclosure by the State is already known by the Vendor without an obligation of confidentiality other than under this Contract, (ii) is publicly known or becomes publicly known through no act of the Vendor other than an act that is authorized by the State, (iii) is rightfully received by the Vendor from a third party and the Vendor has no reason to believe that the third party's disclosure was in violation of an obligation of confidence to the State, (iv) is independently developed by the Vendor without use of the State's confidential information, (v) is disclosed without similar restrictions to a third party by the State, or (vi) is required to be disclosed pursuant to a requirement of law or a governmental authority, so long as the Vendor, to the extent possible, provides the State with timely prior notice of such requirement and coordinates with the State in an effort to limit the nature and scope of such required disclosure.

Except to the extent otherwise required by Law (as defined in Section 30.31(a)) or a Governmental Authority, Vendor shall not withhold the State Data or any other State confidential information or refuse for any reason to promptly return to the State the State Data and any other State confidential information (including copies thereof) if requested to do so on such media as reasonably requested by the State, even if the State is then or is alleged to be in breach of the Contract. As a part of Vendor's obligation to provide the State Data pursuant to this Section, Vendor will also provide the State any data maps, documentation, software, or other materials necessary, including, without limitation, handwritten notes, materials, working papers or documentation, for the State to use, translate, interpret, extract and convert the State Data and any other State confidential information for use by the State or any third party.

Without limiting the foregoing, upon expiration or termination of the Contract, each Party promptly will either (xi) return to the other Party all of its confidential information in the first Party's possession, or (xii) at the other Party's option, destroy all of such other Party's confidential information in the first Party's possession and certify to such destruction in writing; provided, however, the State may retain copies of the Vendor confidential information to the extent required for the State's continuing operations or internal business purposes.

### (b) Security Breach

"Security Breach" means (i) any circumstance pursuant to which applicable Law (as defined in Section 30.31(a)) requires notification of such breach to be given to affected parties or other activity in response to such circumstance; or (ii) any actual, attempted, suspected, threatened, or reasonably foreseeable circumstance that compromises, or could reasonably be expected to compromise, either Physical Security or Systems Security (as such terms are defined below) in a fashion that either does or could reasonably be expected to permit unauthorized Processing (as defined below), use,

disclosure or acquisition of or access to any the State Data or state confidential information. “Physical Security” means physical security at any site or other location housing systems maintained by Vendor or its agents or subcontractors in connection with the Services. “Systems Security” means security of computer, electronic or telecommunications systems of any variety (including data bases, hardware, software, storage, switching and interconnection devices and mechanisms), and networks of which such systems are a part or communicate with, used directly or indirectly by Vendor or its agents or subcontractors in connection with the Services. “Processing” means any operation or set of operations performed upon the State Data or State confidential information, whether or not by automatic means, such as creating, collecting, procuring, obtaining, accessing, recording, organizing, storing, adapting, altering, retrieving, consulting, using, disclosing or destroying.

(c) Breach Notification

In the event Vendor becomes aware of any Security Breach due to Vendor acts or omissions other than in accordance with the terms of the Contract, Vendor shall, at its own expense, (i) immediately notify the State’s Replacement MMIS Contract Administrator of such Security Breach and perform a root cause analysis thereon, (ii) investigate such Security Breach, (iii) provide a remediation plan, acceptable to the State, to address the Security Breach and prevent any further incidents, (iv) conduct a forensic investigation to determine what systems, data and information have been affected by such event; and (v) cooperate with the State, and any law enforcement or regulatory officials, credit reporting companies, and credit card associations investigating such Security Breach. The State shall make the final decision on notifying the State’s persons, entities, employees, service providers and/or the general public of such Security Breach, and the implementation of the remediation plan. If a notification to a customer is required under any Law or pursuant to any of the State’s privacy or security policies, then notifications to all persons and entities who are affected by the same event (as reasonably determined by the State) shall be considered legally required.

(d) Notification Related Costs

Vendor shall reimburse the State for all Notification Related Costs incurred by the State arising out of or in connection with any Security Breach due to Vendor acts or omissions other than in accordance with the terms of the Contract resulting in a requirement for legally required notifications. “Notification Related Costs” shall include the State’s internal and external costs associated with addressing and responding to the Security Breach, including but not limited to: (i) preparation and mailing or other transmission of legally required notifications; (ii) preparation and mailing or other transmission of such other communications to customers, agents or others as the State deems reasonably appropriate; (iii) establishment of a call center or other communications procedures in response to such Security Breach (e.g., customer service FAQs, talking points and training); (iv) public relations and other similar crisis management services; (v) legal and accounting fees and expenses associated with the State’s investigation of and response to such event; and (vi) costs for credit reporting services that are associated with legally required notifications or are advisable, in the State’s opinion, under the circumstances.



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In the event that Vendor becomes aware of any Security Breach which is not due to Vendor acts or omissions other than in accordance with the terms of the Contract, Vendor shall immediately notify the State of such Security Breach, and the Parties shall reasonably cooperate regarding which of the foregoing or other activities may be appropriate under the circumstances, including any applicable Charges for the same.

(e) HIPAA Business Associate Addendum

In the event of any conflict between the terms of this Section 30.26 and the terms of the HIPAA Business Associate Addendum attached to this RFP as Attachment E to Appendix 40, the terms more protective of an Individual's rights with respect to Protected Health Information shall control.

### **30.27 CONFIDENTIALITY RELATING TO COMPETITIVE BIDDING PROCESS AND POST-AWARD VENDOR BUSINESS RECORDS**

In accordance with 9 NCAC 06B.0207 and 06B.1001 and to promote maximum competition in the State competitive bidding process, as well as to facilitate disclosure of materials by the successful Offeror pursuant to Sections 30.15, 30.17, 30.41.2 and 30.42, the State may maintain the confidentiality of certain types of information described in N.C.G.S. §132-1 et. seq. Such information may include trade secrets defined by N.C.G.S. §66-152 and other information exempted from the Public Records Act pursuant to N.C.G.S. §132-1.2. All Offerors may designate appropriate portions of their responses as confidential, and after Contract award the successful Offeror may designate appropriate portions of its materials (and the materials of its subcontractors) disclosed pursuant to Sections 30.15, 30.17, 30.41.2 and 30.42 as confidential, consistent in either case with and to the extent permitted under the Statutes and Rules set forth above, by marking the top and bottom of pages containing confidential information with a legend in boldface type **CONFIDENTIAL**. By so marking any page, the disclosing party warrants that it has formed a good faith opinion, having received such necessary or proper review by counsel and other knowledgeable advisors, and that the portions marked confidential meet the requirements of the Rules and Statutes set forth above. However, pursuant to 9 NCAC 06B.1001, cost information shall not be deemed confidential.

The State may serve as custodian of the Vendor's confidential information and not as an arbiter of claims against the Vendor's assertion of confidentiality. If an action is brought pursuant to N.C.G.S. §132-9 to compel the State to disclose information marked confidential, the Vendor shall intervene in the action through its counsel and participate in defending the State, including any public official(s) or public employee(s). The Vendor shall hold the State and any official(s) and individual(s) harmless from any and all damages, costs, and attorneys' fees awarded against the State in the action. The State shall promptly notify the Vendor in writing of any action seeking to compel the disclosure of Vendor's confidential information. The State shall have the right, at its option and expense, to participate in the defense of the action through its counsel. The State shall have no liability to the Vendor with respect to the disclosure of the Vendor's confidential information ordered by a court of competent jurisdiction pursuant to N.C.G.S. §132-9 or other applicable law.



**30.28 FEDERAL NON-DISCLOSURE REQUIREMENTS**

The Vendor shall notify in writing each of its officers or employees to whom Social Security information is or may be disclosed that Social Security information disclosed to such officer or employee can be only used for authorized purposes and to the authorized extent, and any other unauthorized use herein constitutes a felony punishable upon conviction by a fine of as much as five thousand dollars (\$5,000) or imprisonment for as long as five (5) years, or both, together with the cost of prosecution. The Vendor shall also notify each such officer or employee that any unauthorized further disclosure of Social Security information may also result in an award of civil damages against the officer or employee in an amount not less than one thousand dollars (\$1,000) with respect to each instance of unauthorized disclosure. These penalties are prescribed by IRC Sections 7213 and 7431 and set forth at 26 CFR 301.6103(n).

Additionally, the Vendor shall inform its officers and employees of penalties for improper disclosure under the Privacy Act of 1974, 5 U.S.C. 552a. Specifically, 5 U.S.C. 552a (1) (1), which is made applicable to contractors by 5 U.S.C. 552a (m) (1), provides that any officer or employee of a contractor who, by virtue of his/her employment or official position, has possession of or access to agency records that contain individually identifiable information, the disclosure of which is prohibited by the Privacy Act or regulations established there under, and who knowing that disclosure of the specific material is prohibited willfully discloses that material in any manner to any person or agency not entitled to receive it, shall be guilty of a misdemeanor and fined not more than five thousand dollars (\$5,000).

**30.29 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT**

Activities within the scope of the Contract are subject to the Health Insurance Portability and Accountability Act of 1996, P.L. 104-91, as amended, and its implementing regulations. The Vendor shall comply with the HIPAA requirements and shall execute such agreements and adhere to such practices as the State may adopt from time to time to ensure compliance.

The Vendor will be performing functions on behalf of the State that will make the Vendor a business associate for purposes of the HIPAA regulations. Accordingly, the Vendor and this Replacement MMIS Contract are subject to the terms and conditions of the Business Associate Addendum which is attached to this RFP as Attachment E of Appendix 40 of this RFP.

**30.30 MILESTONES AND DELIVERABLES—SUBMISSION AND ACCEPTANCE**

The Vendor shall achieve the Milestones and provide the Deliverables listed in the Vendor’s SOW and CDRL. The time and procedural requirements for the Vendor’s submission of Deliverables and for asserting achievement of a Milestone, as well as the State’s review and acceptance of them, shall be as set forth in Vendor’s SOW, IMP, and IMS.



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Upon Vendor's determination that a Deliverable has been completed or a Milestone has been attained, in either case so that it materially conforms to all specifications and requirements set forth in the Contract (including, without limitation, the SOW, IMP and IMS) and any other requirements agreed to in writing by the Parties (collectively, the "Specifications"), Vendor shall deliver such Deliverable to the State for acceptance testing or notify the State in writing that such Milestone has been attained. The State shall then review and test the Deliverable or the attributes of the Milestone for compliance with the Specifications. The State may perform such additional testing and evaluation (including without limitation performance and integration testing) as may be set forth in the applicable SOW, IMP, or IMS within the time frames set forth therein. Notwithstanding anything to the contrary in the Contract (including, without limitation, any SOW, CDRL, IMP, or IMS), no Milestone or Deliverable shall be deemed accepted by the State unless the State notifies vendor of such acceptance in writing or in accordance with the Vendor's Proposal.

Subject to the following paragraph, for each full or partial State business day beyond its planned date for acceptance in the IMS that a given Milestone or Deliverable has not been accepted by the State, the compensation to be paid to the Vendor with respect to that Milestone or Deliverable following its acceptance shall become subject to a retainage of one half of one percent (0.5%), up to a total of fifteen percent (15%). The amount retained pursuant to this paragraph shall become payable to the Vendor when the State accepts any subsequent Milestone or Deliverable on or before its scheduled date for acceptance, provided that by such time all previously due Milestones and Deliverables have been accepted by the State (regardless of how late those previous acceptances may have been). After such a retainage becomes payable to the Vendor, a new retainage shall accumulate in the same manner if one or more additional Milestones or Deliverables are not accepted by the State by the planned dates for their acceptance in the IMS. In any event, the State shall not withhold any retainage from the Vendor pursuant to this Section 30.30 beyond the date of the final Replacement Phase payment that is to be made to the Vendor pursuant to Section 30.40.1.

Notwithstanding anything to the contrary in the Contract, the State's failure to perform one of its responsibilities will excuse Vendor's obligation to perform its corresponding obligations under the Contract only if Vendor demonstrates that: (i) the State's failure was the direct cause of Vendor's inability to perform; (ii) Vendor could not have continued performance by using reasonable methods, activities and procedures; (iii) such State responsibility was expressly set forth in the Contract; and (iv) Vendor promptly notifies the State of such failure or unavailability, and the effect on Vendor's ability to meet the relevant obligation. In the event of (i), (ii), (iii) and (iv), Vendor will be excused from performance of those Services impacted by the State's failure to perform only to the extent that, and for so long as, the State's failure to perform its responsibilities prevents Vendor's performance, and provided that Vendor takes reasonable steps to mitigate the effects of the State's failure to perform.

If the Vendor incurs increased costs in attempting to mitigate effects of the State's failure to perform one of its responsibilities as contemplated in the preceding paragraph,



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the Vendor may invoke the change process in Section 30.6.4 to recover its reasonable increased costs.

### 30.31 COMPLIANCE WITH STATE AND FEDERAL LAWS AND REGULATIONS

- (a) Vendor will obtain and maintain all governmental approvals (as defined below) applicable to Vendor in the conduct of its business and will identify, interpret and comply in all material respects with all laws, (including those under common law) statutes, codes, rules, regulations, reporting or licensing requirements, ordinances, and other pronouncement having the effect of law of the United States or any state, county, city, or other political subdivision, including those promulgated, interpreted or enforced by any government or regulatory authority, presently or hereinafter in effect (“Laws”) applicable to Vendor for the provision, receipt and use of the Services, and the consummation of the transactions contemplated by the Contract (the “Regulatory Requirements”). The Regulatory Requirements include all Laws concerning fair employment and employment of the disabled and concerning the treatment of all employees without regard to discrimination by reason of race, color, religion, sex, national origin, or physical disability. Regulatory Requirements also include any guidance, bulletins, white papers, pronouncements, reports or similar communications issued by any Governmental Authority or applicable self-regulatory or industry body, whether or not such items or materials have the force of Law, to the extent determined by the State in its discretion.
- (b) In addition, as part of the Services being provided by Vendor, Vendor will, and will cause its employees, agents and subcontractors to provide, notwithstanding anything to the contrary set forth in the Contract and subject to Section 30.6.4, all assistance reasonably related to the Services provided by Vendor necessary to enable the State to comply with the Regulatory Requirements.
- (c) In providing Services to the State, and without limiting or modifying in any respect the Vendor’s obligations, Vendor shall comply, and shall cause each of its employees and subcontractors to comply at all times, with State policies that are of general application to State contractors or that Vendor has otherwise agreed to comply with, including, without limitation, the Statewide Information Technology Security Manual and the NC DHHS Security Policies and Standards.
- (d) Subject to Section 30.6.4, where any change in Law or Regulatory Requirements impacting the Services, Replacement MMIS or the Vendor’s duties as Fiscal Agent requires a substantial change in the Services or Deliverables to be delivered under this Contract, the State shall pay such amounts as the Parties may agree; provided, however if such change in Law or Regulatory Requirements affects other Vendor customers, then Vendor will use reasonable efforts to allocate that cost of modifications to its Deliverables and performance of services across its affected customers and the State will pay only its pro rata share associated with such modifications. Upon the State’s request the Vendor shall provide documentation to substantiate the Vendor’s allocation of such cost. As an alternative to agreeing to pay additional amounts as set forth above, the



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State shall have the right to cancel those portions of the Contract to which the additional expenses pertain.

### 30.32 ASSURANCES

In the event that during the Term of the Contract the State becomes aware of criminal or civil investigation, litigation, arbitration, or other proceedings that cause the State to be reasonably concerned about:

- (a) The ability of the Vendor to continue to perform the Contract in accordance with its terms and conditions, or
- (b) Whether the Vendor, in performing services, is engaged in conduct which is similar in nature to conduct alleged in such investigation, litigation, arbitration, or other proceedings, which conduct would constitute a breach of the Contract or violation of law, regulation or public policy,

then the Vendor shall be required to provide the State all reasonable assurances requested by the State to demonstrate that the Vendor hereunder will be able to continue to perform the Contract in accordance with its terms and conditions, and the Vendor will not engage in conduct in performing services under the Contract that is similar in nature to the conduct alleged in any such litigation, arbitration, or other proceedings.

### 30.33 PERFORMANCE BOND

Within thirty (30) days of the awarding of the Contract, in accordance with N.C.G.S. §147-33.72C(e) and 9 NCAC 06B.1031(a) the Vendor shall obtain a performance bond at no expense to the State in an amount equal to twenty (20) percent of the total Replacement Phase cost set forth in the Vendor's Cost Proposal. The performance bond shall be in a form and format and issued by an entity that is reasonably acceptable to the State. In the event of default by the Vendor, in accordance with 9 NCAC 06B.1030 North Carolina's Department of Health and Human Services (NC DHHS or State) shall have the right to procure the contractual goods or services from other sources. The Vendor shall be liable for any excess cost reasonably occasioned by the substitute procurement, including amounts in excess of the value of the bond. If the Vendor does not timely respond to a written demand for these costs, the State may demand such amounts from the bonding company in accordance with the terms of the bond.

### 30.34 WAIVERS

No covenant, condition, duty, obligation, or undertaking contained in or made a part of the Contract shall be waived except by the written agreement of the Parties and, when applicable, the approval of CMS. Forbearance or indulgence in any form or manner by either Party, in any regard whatsoever, shall not constitute a waiver of the covenant, condition, duty, obligation, or undertaking to be kept, performed, or discharged by the Party to which the same may apply. No single waiver will constitute a continuing or subsequent waiver.

### **30.35 SEVERABILITY**

If any provision of the Contract shall for any reason be held to be invalid or unenforceable, such decision shall not affect, impair, or invalidate the remainder of the Contract but shall be confined in its operation to the provision of the Contract directly involved in the controversy in which the decision was rendered. The invalid or unenforceable provision shall be reformed so that each Party shall have the obligation to perform reasonably alternatively to give the other Party the benefit of its bargain. In the event the invalid or unenforceable provision cannot be reformed, the other provisions or applications of the Contract shall be given full effect, and the invalid or unenforceable provision shall be deemed to have been deleted.

### **30.36 DISPUTE RESOLUTION**

The Parties shall use their best, good faith efforts to cooperatively resolve disputes and problems that arise during performance of the Contract. When a dispute arises between the State and the Vendor, both Parties shall attempt to resolve the dispute in accordance with this Section 30.36.

When the Vendor wishes to invoke this dispute resolution procedure, the Vendor Account Manager shall send notice to such effect to the State's Director of the OMMISS. When the State wishes to invoke this dispute resolution procedure, the Director of the OMMISS shall send notice to such effect to the Vendor Account Manager. The notice shall specify the disputed issues and the position of the initiating Party. By no later than three (3) State business days following its receipt of such correspondence, the receiving Director of the OMMISS or Vendor Account Manager, as the case may be, shall respond to the sender in like manner, indicating the receiving Party's specification of the issues and its position thereon. The Director of the OMMISS and Vendor Account Manager shall use their best good faith efforts to resolve the dispute within ten (10) State business days after the initiating Party's receipt of the other Party's responsive correspondence.

If the Director of the OMMISS and Vendor Account Manager are unable to resolve the dispute within such ten-day (10-day) period, either Party may escalate the dispute by giving notice of impasse to the Replacement MMIS Contract Administrator. The notice of impasse to the Replacement MMIS Contract Administrator shall be in writing and shall specify the disputed issues, the position of the Party submitting the notice, and the requester's understanding of the relative positions of the Parties. The Vendor shall be afforded an opportunity to be heard and to offer evidence in support of its position. The Replacement MMIS Contract Administrator shall use his/her best good faith efforts to give notice of his/her resolution of the dispute within ten (10) State business days of submission of notice of impasse by either Party.

If the Replacement MMIS Contract Administrator's resolution is not satisfactory to the Vendor, the Vendor may appeal to the NCMMIS+ Steering Committee. Any appeal to the NCMMIS+ Steering Committee shall be filed within five (5) State business days of receipt of the resolution issued by the Replacement MMIS Contract Administrator. The NCMMIS+ Steering Committee shall use its best good faith efforts to give notice of its





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resolution of the dispute within twenty (20) State business days of submission of the notice of appeal.

If any disputes remain, the Parties shall be entitled to pursue their available equitable and legal remedies privately. Except as otherwise specified in the Contract, the dispute process described in this Section 30.36 shall be a condition precedent to any action in a judicial or quasi-judicial tribunal.

Pending final determination of any dispute hereunder, the Vendor shall proceed diligently with the performance of the provisions of the Contract and in accordance with the direction of the Replacement MMIS Contract Administrator.

This term shall not constitute an agreement by either Party to mediate or arbitrate any dispute.

### **30.37 REMEDIES NOT EXCLUSIVE**

The remedies available to each Party under the Contract shall be cumulative and shall not be mutually exclusive. Without limiting the generality of the foregoing, the State's retainage of portions of the Vendor's compensation pursuant to Section 30.30, Section 30.44.10 or Section 30.45 shall not diminish or foreclose any remedies otherwise available to the State with respect to the matter that gave rise to the retainage of compensation; provided, however, that to the extent that the State may be awarded or recover damages from the Vendor for its failure to meet performance standards set forth in Section 30.44.10 or Section 30.45, such damages shall be reduced by the service credit amounts or retainages paid or forfeited by Vendor in relation to those sections.

### **30.38 CONTRACT AMENDMENTS**

The documents listed in Section 30.3 of this RFP constitute the entire agreement between the Parties relating to the subject matter of the Contract. The Contract shall not be amended orally or by performance. All amendments to the Contract shall be in writing and shall become effective only after approval by applicable State or Federal authorities and subsequent execution by duly authorized representatives of the Parties.

The Vendor shall not unreasonably refuse to enter into any amendment proposed by the State for modification of the Replacement MMIS or the Vendor's duties as Fiscal Agent. Without limiting the generality of the foregoing sentence:

The Vendor shall not unreasonably refuse to enter into any amendment, or to sign or adopt any documentation associated with the change process, that is proposed to meet unanticipated changes to State or Federal legal or regulatory requirements impacting the Replacement MMIS or the Vendor's duties as Fiscal Agent.

The Vendor shall not unreasonably refuse to enter into one or more amendments to the Contract pursuant to which the Vendor would serve on the State's behalf as its system integrator for the NCMMIS+ Program. As system integrator, the Vendor would coordinate technical, organizational, developmental, implementational and business process matters across multiple systems and services that the State contemplates shall be developed and operated as part of the NCMMIS+ Program, including without

limitation the Replacement MMIS, a Reporting and Analytics system(R&A), and an information technology system for the Division of Health Service Regulation(DHSR).

Regardless of whether the vendor assumes the role of system integrator, the Vendor shall support future solicitations for the R&A and DHSR projects by presenting requirements and design information (e.g., database schema, application programming interfaces, etc.) in a timely fashion to allow other vendors, under a non-disclosure agreement, sufficient information in order to bid. The Vendor shall provide reasonable support to other potential bidders to understand the nature and contents of this information. The State will provide as much advance notice as practical when requesting this information, and will use draft Vendor documentation consistent with the project progress at the time the information is requested.

As of the Effective Date, Vendor has no knowledge of facts or circumstances which would cause it to request an amendment to the Contract and knows of no information it does not have, the presence of which could reasonably be expected to cause it to request an amendment to the Contract.

### **30.39 ADDITIONAL WORK**

Should the Vendor identify or the State request additional work which is not included within the Services or work that is within the Services, but for which there are insufficient hours remaining within the Replacement Phase Additional Functionality Pool or the Operations Phase Modification Pool, a formal proposal from the Vendor shall be submitted in response to the State's request for the work. Rates for such additional work which is not part of either pool shall not exceed rates for similar services provided using either pool, for the applicable contract year. The State may, in its sole discretion, determine whether any such services are redeemed against either pool or separately charged as set forth above. The Vendor's Proposal for the additional work shall specify any additional staffing and material requirements and shall present a detailed work plan for the effort and an estimated budget. In the event of a State initiated request, the Vendor's Proposal shall be submitted in writing no later than fifteen (15) calendar days after Vendor's receipt of the State's request. Within ten (10) State business days of receipt of the Vendor's Proposal, the State shall (a) begin internal processing and approval of a formal amendment for the additional work, (b) reject the estimate, or (c) deliver a revised request to the Vendor and begin another iteration of the foregoing proposal consideration process.

### **30.40 PAYMENT**

The State shall use various methodologies for payment for Services under the Contract. These methodologies shall take into consideration the differences of Services purchased through the Contract, that is, Replacement Phase, Operations Phase, Turnover Phase, and system modification activities. The payment methodology for the Operations Phase shall take into account the potential fluctuations in transaction volumes, for example, coverage of different populations, increases and decreases in eligible recipients, and changes in the benefits offered. All payments for the Operations Phase shall be subject to retainage as described in Section 30.45 of this RFP.

The final price for each payment category shall be based on pricing tables in the Vendor's Cost Proposal if final price adjustments are not negotiated with the Offeror or BAFOs are not requested; otherwise, the Vendor's final offer for each payment category shall be the final price. Section 30, Exhibit 1 of this RFP presents an overview of the different payment provisions.

**Note**  
References to year refer to Contract Operations Year throughout this Section.

**Exhibit 1: Summary of Payment Methodologies**

Phase/Task	Payment Methodology
Replacement Phase	Upon the achievement of a specified Milestone or the acceptance of a specified Deliverable, the State shall pay the Vendor an agreed percentage of the total firm fixed price.
Replacement Phase Additional Functionality Pool	“Time and materials” or “cost not to exceed” accruing at agreed rates.  Alternatively, a negotiated fixed-price option  Total available dollar value of labor is limited to agreed pool. Unused labor rolls over to Operations Phase Modification Pool. See Section 30.40.1.1 of this RFP.
Provider Enrolling, Credentialing, and Verification	Prior to the Operational Start Date for the Replacement MMIS as a whole, charges shall be invoiced monthly on a per-provider basis. After the Operational Start Date, no distinct payment shall be made for provider enrolling, credentialing, and verification (i.e., compensation is rolled into overall, tiered Operations Phase pricing).
Operations Phase Modification Pool	“Time and materials” or “cost not to exceed” accruing at agreed rates.  Alternatively, a negotiated fixed-price option. Total available dollar value of labor is limited to agreed pool. See Section 30.40.2.6 of this RFP.



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Phase/Task	Payment Methodology
Operations Phase: Operations and Maintenance	Payment is the total fixed price for the anticipated volume range of Contractor Billable Units (CBUs) for a given operations year, adjusted for CBU volume variance, as explained below, for each operations year of the Contract.
Operations Phase: Full-time and Hourly Fiscal Agent Personnel Additions	All-inclusive full-time-equivalent (FTE) and hourly rates (HR) by position for each operations year of the Contract.
Operations Phase: Volume Price for Full-Time and Hourly Fiscal Agent Personnel Performing Modifications	Payment is the volume rate for each staff position for each NC DHHS business unit, for each operations year of the Contract.
Pass-Through Costs during Operations Phase	Actual cost as explained below
Turnover Phase	Upon the achievement of a specified Milestone or the acceptance of a specified Deliverable, the State shall pay the Vendor an agreed percentage of the total firm fixed price.

**30.40.1 Payment for Replacement Phase**

The total fixed price for the Replacement Phase shall be the amount bid by the Vendor, subject to any negotiated final price adjustments or Vendor BAFO accepted by the State. An agreed percentage of the total fixed price for the Replacement Phase shall be paid following the State’s acceptance of each Milestone or Deliverable specified for the Replacement Phase, provided that a final payment shall be made that is distinct from the payment for the last of the Milestones or Deliverables, which final payment shall equal seven percent (7%) of the total fixed price. The final payment shall become payable after the State accepts the final Milestone or Deliverable, and after the State determines that all Replacement MMIS software defects discovered prior to CMS certification in any previously accepted Deliverable have been resolved to the State’s satisfaction.

***30.40.1.1 Payment for Replacement Phase Additional Functionality Pool***

To perform modifications to the Replacement MMIS that add functionality beyond that set forth in this RFP and the Vendor’s Technical Proposal, during the Replacement Phase the Vendor shall stand ready to provide up to the total dollar value of labor indicated in the Vendor’s Cost Proposal for the Replacement Phase Additional Functionality Pool. The State may direct the Vendor to add such functionality to the



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Replacement MMIS at its discretion through Customer Service Requests (CSRs). The State shall have no obligation to use any of the Replacement Phase Additional Functionality Pool labor or to pay the Vendor for non-utilized pool labor. At the conclusion of the Replacement Phase, the State may roll over the unused dollar value of Replacement Phase Additional Functionality Pool labor to increase the total dollar value of the Operations Phase Modification Pool. NC DHHS reserves the right to forego resorting to the pool, to obtain competitive bids, and to award the work to outside vendors if NC DHHS is advised or directed to do so by other State or Federal authorities or if resorting to the Vendor would be unacceptable due to anticipated problems with scheduling, unavailable resources, unacceptable prior performance, and/or excessive estimated costs.

If the Parties agree that work under a particular CSR for pool labor shall be charged on a “time and materials” or “cost not to exceed” basis, the State’s payment obligation shall accrue for hours actually worked at rates bid by the Vendor, subject to any negotiated final price adjustments or Vendor BAFO accepted by the State. If the State’s CSR for Replacement Phase Additional Functionality Pool activity requests or specifies a “firm fixed price” for a result rather than a quantity of labor, that price shall be subject to negotiation.

Regardless of the basis on which the State is charged for activity under the Replacement Phase Additional Functionality Pool, the CSR will specify performance standards and/or Deliverables relating to the activity, as well as a percentage of compensation that is to be withheld until such standards are met or such Deliverables are provided in satisfactory form. Charges and activities under the pool shall be subject to the applicable requirements set forth in Section 40.1.2 of this RFP.

The dollar value of the Replacement Phase Additional Functionality Pool is established as a budgeting and administrative convenience to the Parties, and shall not be construed as a limitation to the Vendor’s obligation under Section 30.38 of this RFP not to unreasonably refuse amendments to the Contract that may involve additional costs.

### ***30.40.1.2 Payment for Provider Enrollment, Credentialing, and Verification; Payment for Certain Other Services prior to Operational Start Date***

Prior to the Operational Start Date for the Replacement MMIS as a whole, charges for provider enrollment, credentialing, and verification shall be invoiced monthly on a per-provider basis at the rates set forth in the Vendor’s Cost Proposal. After the Operational Start Date, no distinct payment shall be made for provider enrolling, credentialing, and verification (i.e., compensation shall be rolled indistinguishably into overall, tiered Operations Phase pricing). If in response to the Vendor’s Proposal the Parties agree to early implementation and of-record operation of any Services in addition to the foregoing provider services, then to the extent such Services are operated prior to the Operational Start Date, the State shall compensate the Vendor for the Services as the Parties shall agree. As shall be the case with the early-implemented provider services, after the Operational Start Date no distinct payment shall be made for such additional Services, and compensation for them shall be rolled into Operations Phase pricing.

**30.40.2 Payment for Services during Operations Phase**

The State shall pay the Vendor monthly in arrears for all Operations Phase services. Payment shall be made using the compensation methodology set forth in the following sections.

**30.40.2.1 Definition of Contractor Billable Units**

The following definitions (subject to the qualifiers below) shall apply for accounting for the number of CBUs processed each year:

Non-Pharmacy:

- A Fee-for-Service Contractor Billable Unit (FCBU) is a fully adjudicated fee-for-service claim (whether submitted as a paper claim or electronic media) that is adjudicated to pay status. A fee-for-service claim that is adjudicated to deny status or that is suspended is not an FCBU. A fee-for-service claim is defined as follows:
  - Inpatient hospital services—a claim (whether submitted as a paper claim or an electronic media) identified by a unique internal control number (ICN) issued for all or a portion of the inpatient hospital stay when that claim is adjudicated to pay status. When a single hospital billing comprises more than one document, the billing shall be counted as a single claim.
  - Long-term care services (nursing facilities, intermediate care facilities-mentally retarded, and adult care facilities)—a claim identified by a unique ICN issued for all or a portion of the long-term care stay when that claim is adjudicated to pay status. When a single billing comprises more than one document, the billing shall be counted as a single claim.
  - All other provider types (other than inpatient, long-term care, and pharmacy)—a claim detail line (whether submitted as part of a paper claim or an electronic media) shall be the identification of a service for a single beneficiary from a single provider with the same date of service or range of dates of services when the document has been processed through the Replacement MMIS for payment.
  - Medicare crossover claims—a claim detail line shall be the identification of a service for a single beneficiary from a single provider with the same date of service or range of dates of services when the document has been processed through the Replacement MMIS for payment.
- An Encounter Contractor Billable Unit (ECBU) shall be a claim shadowing the claim definition for FCBU with the exception of Pharmacy claims submitted by an HMO for reporting purposes only.

Pharmacy:

- A FCBU is a fully adjudicated fee-for-service claim (whether submitted as a paper claim or an electronic media) that is adjudicated to pay status. A fee-for-service claim that is adjudicated to deny status or that is suspended is not an FCBU. A fee-for-service claim is defined as follows:
  - Pharmacy Provider Type—a claim detail line (whether submitted as part of a paper claim or an electronic media) shall be the identification of a service for a single beneficiary from a single provider with the same date of service or range of dates of services when the document has been processed through the Replacement MMIS for payment.

The following types of claims shall not be counted as CBUs:

- Denied claims and/or denied claims details;

- Claims and/or claims details suspended;
- Claim correction transactions;
- Any claim returned to a provider prior to assignment of unique ICN by the Replacement MMIS; this shall apply to electronic transactions that are rejected by the translator as not being compliant with the HIPAA transaction standards;
- Adjustments to paid claims, regardless of the number of adjustments filed to each claim that are not provider-initiated claim corrections;
- All claims that require reprocessing or system-generated adjustments due to errors caused by the Vendor;
- Medicare Part A crossovers showing no deductible and/or no co-insurance due the provider;
- Adjustments to paid claims due to the State-requested re-processing, such as retro-rate adjustments and mass updates;
- Any record which does not contain an ICN or Medicaid ID (MID); and
- Any system-generated claims produced to create financial transactions, e.g., management fees, capitation payments, buy-in premiums, Health Insurance Premium Payments (HIPP).

**30.40.2.2            *Payment Formula for Operations Phase***

The payment for the Operations Phase CBUs shall be a monthly installment of one-twelfth (1/12<sup>th</sup>) of the total fixed price for the anticipated volume range of CBUs for operations and maintenance, for the corresponding operations year, bid by the Vendor, subject to any negotiated final price adjustments or Vendor BAFO accepted by the State.

There shall be no adjustment to the fixed price total for the year unless the volume for any category of CBU falls outside the anticipated volume range of CBUs for that category established by the State.

**30.40.2.3            *Volume Adjustments***

If the actual CBU volume for a given year falls outside the anticipated volume range for any CBU category, a year-end volume range adjustment to the amount payable for that year shall be made using the per CBU volume range adjustment price for the applicable volume range(s) bid by Vendor, subject to any negotiated final price adjustments or Vendor BAFO accepted by the State. In addition, if the actual CBU volumes for the second three (3) months (second quarter) of the Operations Phase, or any quarter thereafter, is less than twenty (20) percent of the lower bound of the quarterly anticipated volume range or greater than twenty (20) percent of the upper bound of the quarterly anticipated volume range for that Contract year, there shall be a quarterly adjustment. When the State solicits Cost Proposals in relation to this RFP, the State shall provide pricing tables that specify certain incremental CBU volume range adjustments. For any annual or quarterly volume range adjustments that result in a reduction of the fixed-price total for a year, adjustment amounts to the operational payment shall be deducted from the invoice for the next payment due to the Vendor. If no payment or insufficient payment is due from which to deduct the volume range



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adjustment amount, the full amount shall be due and payable by the Vendor to the State within thirty (30) calendar days of Vendor receipt of notice of the amount due.

For any annual or quarterly volume range adjustments that result in an additional amount payable from the State to the Vendor shall be due and payable to the Vendor subject to verification of the CBU count accuracy.

When the State solicits Cost Proposals in relation to this RFP, the State shall specify certain thresholds for change in a given year's actual CBU volume which, if exceeded, shall give either Party the right to initiate a re-negotiation of the operations and maintenance total fixed price. To achieve a price change, however, the Vendor must demonstrate the financial necessity for a price change and make any appropriate financial records available to the State.

When the State solicits Cost Proposals in relation to this RFP, the State shall set forth the methodology that shall be used to determine the amount of any year-end adjustment if the actual CBU volume falls outside the base CBU volume ranges established by the State.

### **30.40.2.4            *Payment for Postage***

The State shall pay the Vendor for all direct costs incurred for postage. The Vendor shall submit monthly invoices with supporting documentation for the actual costs incurred each month. The actual United States Postal Service (USPS) postage cost incurred shall be the cost for mailing correspondence, policies, billing instructions, and forms relating to the operation of the Replacement MMIS. The Vendor shall exert all reasonable efforts to employ any commercially available techniques—such as bulk mailing, consolidation of mailing, and zip code pre-sorting, including the use of carriers other than the USPS—to reduce any postage costs assumed by the State. The cost of postage shall include amounts charged by the carriers, except that the Vendor shall not employ the services of commercial carriers without the prior written approval of the State. The Vendor shall not be entitled to any amounts above the amounts charged by commercial carrier.

### **30.40.2.5            *Payment upon Adjustment to Operations and Maintenance Personnel***

The State shall have the right to require the Vendor to add or delete duties and responsibilities described in the Vendor's Statement of Work during the Operations Phase. If the State determines that these revised duties and responsibilities require a change in the operations or maintenance staff, then a Contract amendment shall be required. Payment or reductions for Contract amendments for staff revisions shall be based on rates bid by the Vendor, subject to any negotiated final price adjustments or Vendor BAFO accepted by the State.

### **30.40.2.6            *Payment for Operations Phase Modification Pool***

To perform modifications to the Replacement MMIS during the Operations Phase the Vendor shall stand ready to provide up to the total dollar value of labor indicated for each operations year in the Vendor's Cost Proposal for the Operations Phase Modification Pool. The State may direct the Vendor to add such functionality to the





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Replacement MMIS at its discretion through CSRs. The State shall have no obligation to use any of the Operations Phase Modification Pool labor or to pay the Vendor for non-utilized pool labor. At the conclusion of each operations year the State may roll over the unused balance of Operations Phase Modification Pool dollars to the following operations year. NC DHHS reserves the right to forego resorting to the pool, to obtain competitive bids, and to award the work to outside vendors if NC DHHS is advised or directed to do so by other State or Federal authorities or if resorting to the Vendor would be unacceptable due to anticipated problems with scheduling, unavailable resources, unacceptable prior performance, and/or excessive estimated costs.

If the Parties agree that work under a particular CSR for pool labor shall be charged on a “time and materials” or “cost not to exceed” basis, the State’s payment obligation shall accrue for hours actually worked at rates bid by the Vendor, subject to any negotiated final price adjustments or Vendor BAFO accepted by the State. If the State’s CSR for Operations Phase Modification Pool activity requests or specifies a “firm fixed price” for a result rather than a quantity of labor, that price shall be subject to negotiation.

Regardless of the basis on which the State is charged for activity under the Operations Phase Modification Pool, the CSR will specify performance standards and/or Deliverables relating to the activity, as well as a percentage of compensation that is to be withheld until such standards are met or such Deliverables are provided in satisfactory form.

In the event that the State wishes to add Operations Phase Modification Pool labor beyond the dollar value indicated in the Vendor’s Cost Proposal, the Parties shall negotiate in good faith to determine the number of number of dollars to be added and the cost attributable to various classifications of workers. Charges and activities under the pool shall be subject to the applicable requirements set forth in Section 40.1.2 of this RFP.

The dollar value of the Operations Phase Modification Pool is established as a budgeting and administrative convenience to the Parties and shall not be construed as a limitation to the Vendor’s obligation under Section 30.38 of this RFP regarding amendments to the Contract that may involve additional costs.

### **30.40.3 Payment for Turnover Phase**

The total fixed price for the Turnover Phase shall be the amount bid by the Vendor, subject to any negotiated final price adjustments or Vendor BAFO accepted by the State. The corresponding percentage of the total fixed price set forth in the Vendor’s Cost Proposal shall be paid following the State’s acceptance of each Milestone or Deliverable specified for the Turnover Phase.

### **30.40.4 Vendor Invoices**

The Vendor shall invoice the State for the appropriate amount during the Replacement Phase following the State’s acceptance of each Milestone or Deliverable, provided, however, that the Vendor shall invoice the State for Provider and other early-implemented of-record Services as provided in Section 30.40.1.2 of this RFP, and, for



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work funded through the Replacement Phase Additional Functionality Pool, as specified in the applicable CSR.

During the Operations Phase, the Vendor shall invoice the State no more than once monthly, within the first calendar week of each calendar month, for all services rendered during the previous month. The Vendor shall submit documentation with the invoice to include the following:

- Reporting to meet State cost allocation requirements (see Section 30.17.1 of this RFP); and
- An accounting of the CBUs for each allowable category separated by paying entity and within each category separated by such funding categories as are set forth in the State's solicitation for the Vendor's Cost Proposal.

The Vendor shall invoice the State for the appropriate amount during the Turnover Phase following the State's acceptance of all completed turnover tasks.

Any invoiced service shall have a detailed audit trail that supports the services invoiced and that can be accessed by State Contract monitoring staff and all persons authorized in Sections 30.15 and 30.17 of this RFP immediately or thereafter following the invoice submission. Each invoice shall separately identify the Contract activity to which each charge pertains, and as applicable, the Contract amendment to which each charge pertains. Postage charges shall also be separately identified and verified by submission with the invoice of supportive documentation. Invoiced hourly personnel charges shall indicate hours worked by the individual's name and by activity. The invoice shall list, and the net invoice amount shall reflect, all credits to the State that may have accrued during the period covered by the invoice. The Vendor shall be subject to such additional invoicing requirements as are set forth in Section 40 of this RFP and the Vendor's Proposal.

### **30.40.5 Payments to Vendor**

Subject to retainage of compensation pursuant to Section 30.30, payments for the Replacement Phase shall be made after the State accepts the Milestone, Deliverable, or system modification to which the payment relates and after the State finds that there are no outstanding status reports or IMS updates.

Payments for the Operations Phase shall be made according to the amount the Vendor invoiced for operations services after the State determines that the invoice correctly reflects the monthly base fixed price with any volume range adjustments and adjustment for any:

- Retainage withheld , forfeited, and/or released in accordance with the provisions of Section 30.44.10 or Section 30.45 of this RFP;
- Credits in accordance with Section 30.43.2; and
- Damages in accordance with Section 30.44 of this RFP for which the Vendor is liable.



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Payments for any optional FTE or hourly Fiscal Agent staff shall be made after the State determines that State-approved Deliverables and Milestones have been met.

Payments for the Turnover Phase shall be made after the State has accepted the Vendor's completed tasks and finds that there are no outstanding status reports or Integrated Master Schedule updates.

### **30.40.6 Vendor Income**

The Vendor may not generate income to the Vendor through or in connection with its Fiscal Agent operations (other than amounts paid to the Vendor by the State pursuant to the Contract) except as expressly permitted by the Contract or as the State may otherwise approve in advance in writing. Without limiting the generality of the foregoing, the Vendor may not charge value-added network fees to providers without the prior written approval of the State.

## **30.41 GENERAL PAYMENT TERMS**

### **30.41.1 Time for Payment; Invoicing; Setoff**

Unless otherwise provided in the Contract, payment terms are Net 30 days after the State's receipt of correct invoice or acceptance of applicable Milestones or Deliverables, whichever is later. Payments shall be scheduled to occur no more frequently than once per month. In each instance that multiple Milestones or Deliverables may be achieved or accepted in a given month, the Vendor's invoice shall group them for compensation though a single payment. No additional charges to the State will be permitted based upon, or arising from, the State's use of a Business Procurement Card. The State may exercise any and all rights of setoff as permitted in Chapter 105A-1 et. seq. of the North Carolina General Statutes and applicable administrative rules.

Provided the Vendor requests such action in writing at least thirty (30) days prior to the date on which the Vendor desires for the action to be undertaken, the State may if it deems appropriate:

- (a) Forward the Vendor's payment check(s) directly to any person or entity designated by the Vendor; or
- (b) Include any person or entity designated in writing by Vendor as a joint payee on the Vendor's payment check(s).

In no event shall such approval or action obligate the State to anyone other than the Vendor, and the Vendor shall remain responsible for fulfillment of all Contract duties and obligations.

### **30.41.2 Conditions of Payment**

The State shall not make any payments arising under the Contract or any amendment hereof prior to the State's possession of a fully executed copy of the Contract, as then amended.

Unless otherwise approved by the State, any item of equipment, software, maintenance, training, or other property or services Deliverable by the Vendor under the Contract shall be delivered to the State before any charges may accrue on such items.



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For any third party software licensed by Vendor or its subcontractors for use by the State, a copy of the software license and documentation of license fees paid by the Vendor must be provided to the State before any related costs may be billed to the State. When disclosing information pursuant to this paragraph, the Vendor may designate certain of its information as "Confidential" in accordance with Section 30.27.

### **30.41.3 Equipment, Supplies, and Facilities**

Except to the extent otherwise provided in the Vendor's SOW (a) the Vendor shall be solely responsible for procuring, and bearing the expense of, all equipment and supplies required for the Vendor's performance under the Contract, and (b) the State shall have no obligation to provide offices, lodging, or other facilities or amenities to the Vendor or to reimburse the Vendor for the same.

### **30.41.4 Availability of Funds**

Any and all payments to the Vendor shall be expressly contingent upon and subject to the appropriation, allocation, and availability of funds to the agency for the purposes set forth in the Contract. If the Contract or any purchase order issued hereunder is funded, in whole or in part, by Federal funds, the State's performance and payment shall be subject to and contingent upon the continuing availability of said Federal funds for the purposes of the Contract or purchase order. If the Term of the Contract extends into fiscal years subsequent to that in which it is approved, such continuation of the Contract shall be expressly contingent upon the appropriation, allocation, and availability of funds by the North Carolina General Assembly and the Federal Government for the purposes set forth in the Contract. If funds to effect payment are not available, the State shall provide written notification to the Vendor as provided in Section 30.6.3 of this RFP. The State shall remit payment for Deliverables, Milestones, and services accepted prior to the date of the aforesaid notice in conformance with the payment terms of the Contract.

### **30.41.5 Prohibition against Advance Payments**

No payment shall be made by the State in advance of or in anticipation of services actually performed and/or supplies furnished under the Contract.

## **30.42 SUBCONTRACTORS; PRIME VENDOR CONCEPT**

The Vendor shall remain solely responsible for the performance and payment of its subcontractors.

The Vendor may not subcontract or delegate performance under the Contract with other entities or third parties or change subcontractors without prior written approval of the State. The Vendor shall provide the State with a complete copy of each agreement, work order or other document pursuant to which the Vendor proposes to establish such a subcontracting arrangement, delegation or change. If within seven (7) days of the State's receipt of each such document (or the last of a set of interdependent documents), the State neither issues its written approval of the document(s) nor provides the Vendor with a written objection to the terms of the document(s) or to the choice of subcontractor or delegatee, then the requirement of the State's prior written approval shall not apply to the document(s) or to the subcontracting arrangement,



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delegation or change to be established by the document(s). Notwithstanding the foregoing, all subcontracts included in the Vendor's Technical Proposal or Cost Proposal shall require review and written approval by the State prior to the Vendor's start of work.

When disclosing information pursuant to this Section 30.42, the Vendor may designate certain of its information as "Confidential" in accordance with Section 30.27.

Vendor represents, warrants, and covenants that its services, including the services of its subcontractors, will be provided in a professional manner. "Professional manner" means that the personnel performing the services will possess the skill and competence consistent with the prevailing business standards in, as applicable, the information technology industry or the market for performing Fiscal Agent operations on behalf of state governments. Any contracts made by the Vendor with a subcontractor shall include an affirmative statement that the subcontractor has no agreement with the State, as well as the subcontractor's acknowledgment that it is aware of the Vendor's agreement to indemnify the State with respect to any claim presented by the subcontractor. Notwithstanding any other term herein, the Vendor shall timely exercise its contractual remedies against any non-performing subcontractor and, when appropriate, substitute another subcontractor.

Performance of any work by individually directed "contract employees" hired by the Vendor shall be considered the sole responsibility of the prime Vendor and not be construed as a subcontracting relationship for the purposes of this Section 30.43, except with regard to subsection (a) below.

Among other suitable terms, Vendor shall include in any subcontract(s) that relate to Vendor Services for the Replacement MMIS terms that cause its subcontractors to:

- (a) undertake duties and obligations consistent with, in support of, and, as applicable, necessary to Vendor's compliance with the following sections of this RFP:

Section 30.11	Ownership, Patent, Copyright, and Trade Secret Protection
Section 30.17.1	Financial Accounting Requirements
Section 30.26	Confidentiality and Data Security
Section 30.29	Health Insurance Portability and Accountability Act (as applicable)
Section 30.31	Compliance with State and Federal Laws and Regulations
Section 30.43.1	Independent Contractor

- (b) procure and maintain insurance applicable to the term of their engagement with respect to which the State is named as an additional insured, and which

insurance shall be categorically equivalent to that required of Vendor by Section 30.20 (unless it would not be commercially reasonable to require such insurance of the subcontractor), but in coverage amounts that are commercially reasonable given the nature of the subcontractor and the scope of its undertaking in relation to Vendor's performance of this Contract,

- (c) adhere to the terms of Section 30.17.1 as if that section's references to the "Vendor" were references to the subcontractor and references to the "Contract" were references to its contract with the Vendor, and
- (d) comply with all State, Federal, and local laws, ordinances, codes, rules, regulations, and licensing requirements that are applicable to the conduct of the subcontractor's business and the performance of the terms of its contract with Vendor.

The actual language of the terms required of subcontractors pursuant to this Section 30.42 need not be identical to that of RFP sections specifically identified in this Section, so long as such actual language is no less effective in establishing and protecting the State's pertinent interests.

### **30.43 PERSONNEL**

The following Sections set forth provisions regarding Vendor and State personnel.

#### **30.43.1 Independent Contractor**

The Vendor and its employees, officers, executives, and subcontractors, if any, are and shall be independent contractors and not employees or agents of the State of North Carolina. The Contract shall not operate as or give rise to a joint venture, partnership, trust, agency, or any other business relationship.

#### **30.43.2 Key Personnel**

The services of each individual named in the Vendor's Technical Proposal shall be required unless that individual becomes unavailable to the Vendor for reasons affecting the basic employment relationship, such as the individual's death, disability, termination for cause or leave from civilian employment to fulfill military duty. Staffing shall include named individuals at the level of effort proposed.

If an individual identified by the Vendor to the State as key personnel for the Replacement Phase or Turnover Phase becomes unavailable for such reasons, the Vendor, within twenty (20) State business days of Vendor's receipt of said individual's notice of unavailability, shall give the Replacement MMIS Contract Administrator the résumé of a proposed replacement and offer the State an opportunity to interview that person.

If the Replacement MMIS Contract Administrator is not reasonably satisfied that the proposed replacement meets the job description criteria set forth in the Contract or is not otherwise suitable for the position, he/she shall so inform the Vendor in writing within three (3) State business days after the later of receiving the résumé or completing any interview of the proposed replacement. As soon as commercially practicable after

being so informed, the Vendor shall propose another replacement and the Replacement MMIS Contract Administrator shall have the same right of approval. Such process shall be repeated until a proposed replacement shall be approved by the Director of the OMMISS and the Replacement MMIS Contract Administrator.

With respect to all persisting vacancies of key personnel during all phases, the State shall receive a credit equal to the salary of the unavailable individual, prorated for each day or partial day until the position is satisfactorily filled. For vacancies due to the internal transfer or ordinary course retirement of the applicable individual, the credit shall begin to accrue at the time the vacancy occurs. For vacancies that occur for any other reason, the credit shall begin to accrue on the thirtieth (30<sup>th</sup>) business day after the vacancy occurs.

Temporary or permanent transfer of any of the Vendor key personnel within the Replacement MMIS project or temporary or permanent transfer of any of the above named Vendor key personnel between Vendor projects shall require prior written approval of the Replacement MMIS Contract Administrator, which shall not be unreasonably withheld.

### **30.43.3 Removal of Personnel**

The Replacement MMIS Contract Administrator or his/her designee may monitor the Vendor's efforts and account for all work to be performed by Vendor personnel. The Replacement MMIS Contract Administrator or his/her designee may determine whether Vendor personnel are performing satisfactorily at the appropriate skill levels specified in the Vendor's Technical Proposal and the approved IMP.

The Replacement MMIS Contract Administrator may require the Vendor to relieve any of the Vendor's personnel from any further work under the Contract if in his/her sole opinion:

- The individual does not perform at the applicable skill level specified in the Vendor's Technical Proposal and the approved IMP;
- The individual does not deliver work that conforms to the performance standards stated in the RFP, the Vendor's Technical Proposal, and the approved IMP; or
- The person exhibits personal or professional conflicts with State personnel that hinder effective progress on the project.

Upon being notified in writing by the Replacement MMIS Contract Administrator that a member of the Vendor's personnel is unacceptable, the Vendor shall immediately remove that individual from any assignments on the Contract.

In the event that a member of the Vendor's personnel is removed pursuant to this Section 30.43.3, the replacement provisions of Section 30.43.2 of this RFP shall apply as if the person removed were among the Vendor's key personnel and the vacancy had occurred for a reason other than an internal transfer or ordinary course retirement.



**30.43.4 No Vendor Utilization of Workers outside the United States**

Vendor and its subcontractors may not use workers located outside of the United States of America or its territories to perform Vendor’s duties under the Contract.

**30.43.5 Personnel Turnover**

Vendor agrees that it is in the best interests of both Parties to keep the turnover rate of Vendor personnel, contractors, and subcontractors to reasonably low levels. Vendor shall provide the State with a semi-annual turnover report regarding Vendor’s turnover rate during the applicable period in a form reasonably acceptable to the State, and Vendor shall meet with the State promptly after the provision of each such report to discuss the reasons for, and impact of, such turnover rate. If appropriate, Vendor shall submit to the State its proposals for reducing the turnover rate, and the Parties shall agree on a program to bring the turnover rate down to an acceptable level. Notwithstanding transfer or turnover of Vendor personnel, contractors and subcontractors, Vendor remains obligated to perform the Services without degradation and in accordance with the Contract.

**30.44 FAILURE TO MEET CONTRACTUAL REQUIREMENTS**

The Vendor shall, at all times, comply with all system and operational performance standard requirements and expectations specified in the Contract, with Part 11 of the State Medicaid Manual, and with all related Action Transmittals and Information Memoranda, as well as with any modifications or changes thereto and any changes to 42 CFR, 45 CFR, and 95 CFR as they may refer to the Replacement MMIS and its operations and to the use of Vendor services. In the event that compliance with any modifications or changes to any Regulatory Requirements places a substantial burden on the Vendor that was not reasonably foreseeable on the Effective Date of the Contract, the Vendor shall not unreasonably refuse to enter into such amendments to the Contract, or to sign or adopt any documentation associated with the change process, as may then be necessary to reasonably adjust the Parties’ duties and obligations accordingly. Such amendments shall be subject to the terms of Section 30.31(d).

The Vendor shall meet all performance standard requirements indicated in the Contract during the life of the Contract. Subject to the terms of Section 30.31(d), the Vendor shall, at all times, operate the Replacement MMIS and its activities in conformity with the policies and procedures of the State programs.

All requirements described in the Contract shall be subject to monitoring by the State or its designee. The State shall have the right to monitor performance at its discretion, without notice. In the event of a failure to meet the Contract or performance standards requirements, incentive adjustments to the timing and amount of the Vendor’s compensation shall be made in accordance with the Vendor’s Technical Proposal and Section 45 hereof.



**30.44.1 Targeted Operational Start Date—Contract Requirement**

The Vendor shall have the Replacement MMIS fully operational no later than the Targeted Operational Start Date specified by the Vendor in its Technical Proposal (as such date may be modified in State-approved updates to the IMS).

**30.44.2 Targeted Operational Start Date—Damages**

If the State determines in its sole but reasonable discretion that the Replacement MMIS has not become operational substantially as a whole, or has not begun generating official data of record by the Targeted Operational Start Date, then the Vendor shall be liable for all costs incurred by the State to continue operation of those elements of the Legacy MMIS+ including the cost of the continued operation of OMMISS which must, in the State's reasonable opinion, remain in operation (including possibly all elements of the Legacy MMIS+), less the amount that the State would have paid the Vendor had the Replacement MMIS been timely made substantially operational as a whole.

Notwithstanding the possibility of simultaneous of-record operation of the Replacement MMIS and the Legacy MMIS+ implied by the preceding sentence, the Parties anticipate that the various elements of the Replacement MMIS (except for the provider and other elements that are to be operational prior to the Operational Start Date in accordance with the Vendor's SOW) will be so interdependent in operation that it will not be economically or administratively reasonable for the Replacement MMIS to begin generating official data of record until the Replacement MMIS has achieved such readiness that it is then reasonable to decommission the Legacy MMIS+ as a whole.

If the State nevertheless chooses to generate data of record simultaneously with the Replacement MMIS and the Legacy MMIS+ due to Vendor's performance or non-performance other than in accordance with the Contract, the Vendor shall be liable for the cost of continued operation of elements of the Legacy MMIS+ as set forth above in this Section 30.44.2.

**30.44.3 System Certification—Contract Requirement**

The Vendor shall apply its best efforts in assisting the State to achieve Federal certification approval for the maximum allowable enhanced FFP for the Replacement MMIS within one (1) year of the Operational Start Date, as well as to obtain approval of FFP retroactively to the Operational Start Date. In addition, the Vendor shall apply its best efforts to assist the State in maintaining Federal certification approval for the maximum allowable enhanced FFP for the Replacement MMIS throughout the life of the Contract.

Should certification fail to be achieved within one (1) year of the Operational Start Date, the Vendor shall be liable for damages to the extent they result from its actions or inactions relating to the lack of certification. Should certification fail to be approved retroactively to the Operational Start Date, the Vendor shall be liable for any damages resulting from its actions or inactions relating to the loss of maximum allowable enhanced FFP. Should de-certification of the Replacement MMIS, or any component part of it, occur prior to Contract termination, the Vendor shall be liable for any damages



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resulting from its actions or inactions relating to the de-certification and loss of maximum allowable enhanced FFP.

### **30.44.4 United States DHHS Sanctions—Damages**

If during the Operations Phase CMS imposes fiscal sanctions against the State as a result of the Vendor's or any subcontractor's action or inaction, the Vendor shall compensate the State the entire amount lost by the State by the imposition of CMS sanctions.

### **30.44.5 Correctness of Payments—Contract Requirements**

All payments, adjustments, and other financial transactions made through the Replacement MMIS shall be made on behalf of eligible clients to active enrolled providers for approved services and in accordance with the payment rules and other policies of the State.

The Vendor shall notify the State immediately upon discovery of any erroneous payments, irrespective of cause, and prior to initiating appropriate recovery action. The Vendor shall use the change request process to notify the State of any system errors that result in a potential provider erroneous payment.

The Vendor shall be liable for the actual amount of all detected erroneous payments determined as a result of State or Federal claims reviews or as reported by providers or from other referrals that are a result of incorrect Vendor staff action, the Vendor's failure to meet or adhere to State approved payment processing requirements, or errors in licensed, third party, claims processing reference data that was specified by the Vendor rather than by the State. In each such instance, the Vendor shall bear all costs associated with correcting the erroneous payment, including without limitation costs for re-processing, back-out processing and distribution of corrections. Such liabilities shall reduce amounts paid to Vendor. The Vendor, however, may seek recovery on behalf of the State from providers to whom erroneous payments are made using voluntary refund, offset recovery, or other State-approved methods.

### **30.44.6 Correctness of Payments—Damages**

If an erroneous payment is made to a provider and that payment is the result of incorrect Vendor staff action, the Vendor's failure to meet or adhere to State approved payment processing requirements, or errors in licensed, third party, claims processing reference data that was specified by the Vendor rather than by the State, then the Vendor shall be liable for the un-recovered balance of the erroneous payment when full recovery cannot be made using reasonable procedures. The Vendor shall notify the State immediately upon discovery of any erroneous payments, irrespective of cause. The Vendor shall solely bear any costs associated with system and operations changes associated with fixing the error(s) that caused any erroneous payment for which the Vendor is liable pursuant to Section 30.44.5, including costs the State or its agents incur associated with reprocessing of erroneous data distributed by the Vendor.

The Vendor shall pay to the State any portion of an erroneous overpayment not recouped within one hundred eighty (180) calendar days of its receipt of the direction initiating its recoupment. In addition to the amount of the erroneous payment(s), the



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Vendor shall be liable for interest payments at the prevailing prime rate beginning from the date of erroneous payment through the date of payment to the State. The Vendor shall make such payment to the State within seven (7) calendar days of the expiration of the one hundred eighty (180) calendar-day timeframe.

The State shall not be liable to the Vendor for any erroneous overpayment that is not recovered by recoupment from providers. The Vendor may only initiate independent recovery procedures and actions with the prior written approval of the Replacement MMIS Contract Administrator once the recoupment process described herein has been completed and a repayment amount remains outstanding. The State shall review proposed independent recovery procedures and, if reasonable, shall provide written approval. If the State recovers any erroneous payments for which the Vendor has reimbursed the State, the Replacement MMIS Contract Administrator shall notify the Vendor, who shall then submit a standard State invoice for the returned amount, less expenses incurred by the State during the recovery process.

### **30.44.7 Internal Revenue Service—Contract Requirements**

The Vendor shall produce and mail out 1099 and/or W9 earnings reports with respect to its subcontractors no later than January 31 of each year and timely report to the IRS and the relevant states.

### **30.44.8 Internal Revenue Service—Damages**

The Vendor shall be solely responsible for payment of IRS penalties/damages for late distribution of 1099s and/or W9s with respect to its subcontractors.

### **30.44.9 Delay or Interruption of Operations—Contract Requirement**

The Vendor shall ensure there will be no delays or interruptions in the operation of the Replacement MMIS and related services caused by any failure, act, or omission of the Vendor.

### **30.44.10 Delay or Interruption of Operations—Service Credits**

In each of its monthly invoices during the Operations Phase, the Vendor shall deduct the following service credits from the CBU-based charges that accrued as payable to the Vendor during the month covered by the invoice:

- Per State business day, or partial State business day, that the performance standard set forth in Section 40.14.3.53 remained unmet during the month covered by the invoice, an amount equal to 0.15% of the CBU-based charges accrued as payable to Vendor during that month.
- Per hour, or partial hour, of the Vendor's shortfall in meeting the performance standard set forth in Section 40.1.1.150 for the month covered by the invoice, an amount equal to 0.13% of the CBU-based charges accrued as payable to Vendor during that month.

The foregoing performance standards shall not be among the performance standards that may be subject to retainage pursuant to Section 30.45 below.

**30.45 PERFORMANCE RETAINAGE**

**30.45.1 Performance Report Cards**

The State and the Vendor shall finalize a agreeable performance report card format, content, and process during the Replacement Phase. The State-approved and State-accepted performance report card shall be used throughout the Operations Phase.

All performance standard requirements set forth in the Contract (including the RFP, IMP, and IMS) shall be part of the report card. There shall be two (2) sections to the report card (see example below). The first section shall address all Contract and performance standards set forth in Section 30.43 of this RFP and in the Vendor’s IMP and will not be subject to retainage as defined in this Section 30.45. The second section shall address any and all performance standard requirements set forth in Section 40 of this RFP or offered in the Vendor’s Technical Proposal that are not indicated as subject to Contract damages or service credits, as set forth in Section 30.44 of this RFP.

After each month of operations, the Vendor shall produce and deliver a report card on its actual performance. The State intends to prospectively specify the twenty-five (25) performance standards it shall use to review the Vendor’s actual performance each month and each quarter of the Operations Phase. The State intends, thirty (30) days prior to each quarter, to specify the twenty-five (25) performance standards to be monitored. The State, or its designee(s), shall have the right to audit records and data related to the Vendor’s such performance at any time during the Contract period.

**Note**  
This report card is for example purposes only.

		<b>Monthly Report Card</b>
<b>Section 1</b>		
<b>Report Card: Performance Requirement</b>	<b>Performance This Month</b>	
	Meets	
<b>Section 2</b>		
Performance Standard 1	Meets	
Performance Standard 2	Meets	
Performance Standard 3	Meets	
Performance Standard 4	Meets	
Performance Standard 5	Meets	
Performance Standard 6	Meets	



SECTION 30: CONTRACT REQUIREMENTS



.....	
Performance Standard 25	Meets

30.45.2 Retainage

The State shall withhold initial payment of ten (10) percent of each Operations Task CBU invoice item submitted for payment. Such withheld amounts shall be subject to forfeiture in the event of Vendor's deficient performance in accordance with Section 30.45.3 below.

30.45.3 Forfeiture of Retainage

Each month during the Operations Phase the State shall review the performance report card for performance during the preceding month. In the event of the Vendor's failure to meet the performance standard requirements, the Vendor shall forfeit the retainage then held by the State pursuant to Section 30.45.2 to the extent set forth below:

- The failure to meet one (1) performance standard requirement = forfeiture of five (5) percent of retainage;
- The failure of two (2) performance standard requirements = forfeiture of ten (10) percent of retainage;
- The failure of three (3) performance standard requirements = forfeiture of fifty (50) percent of retainage;
- The failure of four (4) performance standard requirements = forfeiture of seventy-five (75) percent of retainage; and/or
- The failure of five (5) or more performance standard requirements = forfeiture of one hundred (100) percent of retainage.

With each monthly invoice payment, the State shall notify the Vendor of its determination relating to any withheld amounts to be forfeited and, subject to any month-to-month offsetting of withheld amounts, shall remit to Vendor any amounts previously withheld that are not be forfeited.

30.45.4 Performance Surveys

Beginning on the Operational Start Date, once every twelve-month period during the Term, Vendor shall conduct a customer satisfaction survey with respect to any aspects of the Services selected by the State. The survey will, at a minimum, cover a representative sampling of end-users and senior management of the State and Providers, in each case as specified by the State. The timing, content, scope and method of the survey will be as directed by State. Customer satisfaction shall be measured as a Performance Standard.

30.46 TERMINATION OF CONTRACT

The Contract may be terminated as hereinafter provided. Notice relating to termination shall be transmitted pursuant to Section 30.6.3.



## SECTION 30: CONTRACT REQUIREMENTS



The Vendor's default in performance of the Contract may be cause for debarment of the Vendor as provided in 9 NCAC 06B.1030.

### **30.46.1 Termination by Mutual Consent**

The Parties may mutually terminate the Contract by written agreement.

### **30.46.2 Termination for Breach**

The State may, in its sole discretion, terminate the Contract, in whole or in part for cause:

- (a) Immediately upon written notice to Vendor by the State, if Vendor breaches any of its material duties or obligations under the Contract and does not cure such breach within thirty (30) days after notice thereof;
- (b) Immediately upon written notice to Vendor by the State, if Vendor commits a series of non-material or persistent breaches that the State reasonably perceives in the aggregate to have a significant adverse impact on the Services and fails to cure such breaches within thirty (30) days after written notice thereof;
- (c) Immediately upon written notice to Vendor by the State, if Vendor has a total of fifteen (15) or more individual Performance Standard failures in any consecutive three (3) month period;
- (d) If Vendor (i) files for bankruptcy; (ii) becomes or is declared insolvent, or is the subject of any proceedings related to its liquidation, insolvency or the appointment of a receiver or similar officer for it; (iii) makes an assignment for the benefit of all or substantially all of its creditors; or (iv) enters into an agreement for the cancellation, extension, or readjustment of substantially all of its obligations, then the State may, by giving written Notice of termination to Vendor, terminate the Contract as of a date specified in such Notice of termination; and
- (e) As set forth in Section 30.5.

In the event of any termination under this Section 30.46.2, in whole or in part, the State may procure from another vendor or vendors, upon such terms and in such manner as is deemed necessary by the State, supplies or services similar to those terminated, or perform the services similar to those terminated internally without the assistance of a vendor. Under these circumstances, the Vendor shall be liable for: (i) any costs in excess of the contracted costs for such similar supplies or services and all other damages allowed by law; (ii) administrative costs incurred to procure such similar supplies or services as are needed to continue operations, and (iii) costs incurred by the State in transitioning provision of the Services from Vendor to one or more new vendors or to the State.

In the event of a termination for breach prior to the Operational Start Date, the Vendor shall be paid in accordance with the procedures defined in Section 30.46.9 of this RFP.

The rights and remedies of the State provided in this Section shall not be exclusive and are in addition to any other rights and remedies provided by law or under the Contract.

**30.46.3 Waiver of Breach**

Waiver by either Party of any breach by the other Party shall not be deemed a waiver of any subsequent breach and shall not be construed to be a modification of the terms of the Contract, unless so stated in writing and signed by authorized representatives of the State and the Vendor and made as an amendment to the Contract as provided herein.

**30.46.4 Termination for Convenience**

The State may terminate the Contract, in whole or in part, for its convenience by giving the Vendor at least thirty (30) days written notice describing the extent of the termination. Termination for convenience shall be effective at the close of business on the date specified in the written notice. Beginning upon receipt of notice of termination, the Vendor shall comply with all provisions applicable to the Turnover Phase defined in the Vendor's Technical Proposal and the Turnover Plan. Upon termination for convenience, the Vendor shall be paid in accordance with the procedures defined in Section 30.46.9 of this RFP.

**30.46.5 Termination for Unavailability of Funds**

In the event funding from State, Federal, or other sources is withdrawn, reduced, or limited in any manner after the Effective Date and prior to the anticipated Contract expiration date, the State may terminate the Contract by giving at least thirty (30) days written notice. The State's obligation to pay any amounts due for subsequent fiscal years shall be contingent upon annual appropriation, allocation, and approval of State and Federal funds for the purposes of the Contract.

**30.46.6 Termination for Financial Instability**

The State may terminate the Contract by providing written notice to such effect (a) in the event that the State determines in its sole but reasonable discretion that the Vendor has become financially unstable to the point of threatening the ability of the Vendor to perform the Services as required hereunder, (b) upon the Vendor's institution of insolvency, receivership or bankruptcy proceedings or any other proceedings for the settlement of its debts, (c) upon the institution of such proceedings against the Vendor, which are not dismissed or otherwise resolved in the Vendor's favor within sixty (60) days thereafter, (d) upon the Vendor's making a general assignment for the benefit of creditors, or (e) upon the Vendor's dissolution or ceasing to conduct business in the normal course. Such termination shall be effective at the close of business on the date specified in the written notice. In the event that the State elects to terminate the Contract pursuant to this Section, the Vendor shall be notified in writing by the means set forth in the Contract for providing notice, specifying the date of termination. In the event of the filing of a petition in bankruptcy by or against the Vendor or any subcontractor, the Vendor shall immediately advise the State of said action.

The Vendor shall cause each of its subcontracting agreements to provide that the Vendor may terminate the subcontract for, among any other reasons negotiated by the Vendor, the subcontractor's institution of insolvency, receivership, or bankruptcy proceedings or any other proceedings for the settlement of its debts. Upon the



## SECTION 30: CONTRACT REQUIREMENTS



institution of such proceedings, the Vendor shall exercise such a provision and terminate the subcontract if the State so directs.

### **30.46.7 Termination for Change in Control of Vendor**

In the event of a Change in Control (as defined herein below) of Vendor, (a) Vendor will promptly provide notice to the State of such event, and (b) the State has the right, but not the obligation, within thirty (30) days of receipt of such notice, to terminate the Contract by giving Vendor notice of termination at least thirty (30) days prior to the termination date specified in the notice. "Change in Control" means the transfer of the control of Vendor from the person(s), entity or entities who hold such control on the Effective Date of the Contract to one or more other persons or entities. "Control" means direct ownership of more than fifty percent (50%) of the stock or shares entitled to vote for the election of the board of directors or other governing body of Vendor, or of the equity interest of Vendor.

### **30.46.8 Procedures on Termination or Expiration**

Upon receipt of written notice of termination, or upon the expiration of the Contract, the Vendor shall, on the date specified in the notice of termination or on the date of expiration:

- Stop work under the Contract on the date and to the extent specified in the notice;
- Assign to the State in the manner and to the extent (if any) directed by the Replacement MMIS Contract Administrator all of the right, title, and interest of the Vendor under the orders or subcontracts so terminated, in which case the State shall have the right to settle or pay any or all claims arising out of the termination of such orders and subcontracts;
- With the approval of the Replacement MMIS Contract Administrator, settle all outstanding liabilities and all claims arising out of termination of orders and subcontracts that are not assigned to the State;
- Transfer title to the State (to the extent that the title has not been transferred or already vested) and deliver all files, processing systems, data manuals, and other documentation that relate to the work terminated by the notice, as directed by the Replacement MMIS Contract Administrator;
- Not unreasonably refuse to undertake such wind up and transition activities with respect to the terminated portions of the contract as the Replacement MMIS Contract Administrator may request or authorize;
- Complete the performance of such part of the work as shall not have been terminated by the notice; and
- Take action as may be necessary for the protection and preservation of the property related to the Contract that shall be in the possession or control of the Vendor, and in which the State has or may acquire an interest.



**30.46.9 Termination Claims**

If the Contract is terminated during any ongoing task of the Vendor, the Vendor shall be paid an amount equal to the sum of the Vendor's reasonable labor, materials, and overhead costs demonstrably incurred for work performed in connection with that task prior to receipt of the notice of Termination, but in any event an amount no greater than the amount that the State would have been obligated to pay if the task had been completed and its associated Milestones and Deliverables had been accepted. If an interrupted task is one of several tasks to which a Milestone or Deliverable payment would have applied, the limit to the compensation to be paid for the interrupted task shall be proportionate to the amount of work completed by the Vendor toward the Milestone or Deliverable in relation to the total work required to achieve the Milestone or provide the Deliverable. For any work performed in relation to a terminated portion of the Contract after the Vendor's receipt of notice of termination with respect to that portion (including receipt of notice of termination of the Contract as a whole), the Vendor shall be entitled to payment only with respect to such wind up and transition activities as are requested or authorized by the Replacement MMIS Contract Administrator pursuant to Section 30.46.8.

In the event of a failure to agree, in whole or in part, to the amount to be paid to the Vendor in connection with the total or partial termination of work pursuant to this Section, the State shall determine on the basis of information available the amount, if any, due to the Vendor by reason of termination and shall pay the Vendor the amount so determined. Unresolved disputes shall be subject to the provisions of Section 30.36 of the Contract. In no case shall the Vendor's termination claims include any claim for unrealized or anticipatory profits.

**30.46.10 Purchase or Lease of Equipment**

Upon expiration or termination of the Contract, the State shall have the right, but not the obligation, to purchase, directly or through its designee, any equipment owned by Vendor and used by Vendor exclusively to provide the Services. The purchase price for any equipment purchased by the State shall be its net book value (provided the amount booked by Vendor for depreciation is limited to Vendor's direct purchase cost for the equipment). The State shall pay the purchase price to Vendor concurrently with Vendor's delivery to the State of the equipment and a bill of sale acceptable to the State. In addition, the State shall have the right, but not the obligation, to assume any lease of equipment leased by Vendor and used by Vendor exclusively to provide the Services; provided that third parties with lease agreements with Vendor are agreeable to the assignment or assumption of the lease by the State. Purchased equipment shall be free and clear of all liens, security interests or other encumbrances.

**30.46.11 Hiring and Solicitation of Vendor Personnel**

The State or its designee shall be permitted to solicit and hire any Vendor personnel that have been dedicated to, or have been performing, the Services as of the date the State delivers a notice of termination to Vendor, or, in the case of expiration, within the six (6) month period (or longer period requested by the State) prior to expiration. Vendor shall not interfere with the State's efforts, shall not enforce any restrictions

imposed on such Vendor personnel by agreement or policy (i.e., employment contract or covenant) which would interfere with the State's efforts, and shall provide the State access to such Vendor personnel for the purposes of interviews, evaluations and recruitment. Vendor and its subcontractors shall not make counter-offers to such Vendor personnel; provided this provision does not limit a Vendor personnel's right to investigate job postings and other internal job opportunities with their employer. Further, promptly after the State sends Vendor written notice of the termination or expiration, Vendor agrees to supply the State with the names of Vendor personnel performing Services for the State. Any such employment by the State would not be effective until termination or expiration of this Agreement.

### **30.47 SURVIVAL**

All provisions of this Section 30 "Contract Requirements" which by their nature give rise to continuing obligations of the Parties shall survive the expiration or termination of the Contract, including without limitation the terms of Sections 30.3, 30.6.3 (as it pertains to any termination claim), 30.7, 30.8, 30.11, 30.12, 30.13, 30.14, 30.15, 30.16, 30.17, 30.18, 30.21, 30.23, 30.26, 30.27, 30.29, 30.35, 30.36 (as it pertains to any termination claim), 30.37, 30.46.8, 30.46.9, 30.47, 30.50, 30.51, 30.52 and 30.53.

### **30.48 RIGHT TO SUSPEND OPERATIONS**

If, at any time during the Operations Phase of the Contract, the State determines that it is in its best interest to temporarily suspend all operations, or any part thereof, the State may do so by providing the Vendor with a written notice thereof. On receipt of such notice, the Vendor shall immediately cease all specified operations for the period indicated in such notice.

If the suspension is not due to the Vendor's failure to perform or its failure to perform in accordance with the terms of the Contract, the State shall reimburse the Vendor within a reasonable time for any additional costs reasonably incurred by the Vendor as a result of the suspension and reasonably extend any delivery schedules to which the Vendor may have been subject during the suspension.

### **30.49 FORCE MAJEURE**

- (a) Subject to paragraph (b) below, neither Party shall be liable for any failure or delay in the performance of its obligations under the Contract (other than obligations to make payments that have become due and payable pursuant to the Contract) to the extent such failure or delay both:
  - (i) is caused by any of the following: acts of war, terrorism, civil riots or rebellions; quarantines, embargoes and other similar unusual governmental action; extraordinary elements of nature or acts of God (other than localized fire, hurricane, tornado or flood); and
  - (ii) could not have been prevented by the non-performing Party's reasonable precautions or commercially accepted processes, or could not reasonably be circumvented by the non-performing Party through the use of substitute services, alternate sources, work-around plans, the implementation of

appropriate security measures or the disaster recovery procedures required of Vendor.

- (b) Events meeting both of the criteria set forth in clauses (i) and (ii) above are referred to individually and collectively as “Force Majeure Events.”
- (c) If either Party is prevented from, or delayed in performing any of its obligations under the Contract by a Force Majeure Event, it will promptly, or as soon as reasonably practicable, notify the other Party verbally (to be confirmed in writing within twenty four (24) hours of the inception of the delay) of the occurrence of a Force Majeure Event and describe, in reasonable detail, the circumstances constituting the Force Majeure Event and of delays or anticipated delays in the performance of such Party’s obligations. Such Party will continue to use commercially reasonable efforts to recommence performance whenever and to whatever extent possible without delay.

**30.50 DAMAGES AND LIMITATIONS OF LIABILITY**

**30.50.1 Limitation of Liability.**

(a) In no event shall either Party’s liability to the other for any claim (in the aggregate with all other claims subject to this Section 30.50.1(a)) arising out of or related to this Contract which results from any act, event or cause that occurred, or omission that gave rise to substantial impact (regardless of when the omission or its impact may have first become apparent), prior to and until the effective date of certification by CMS of the Replacement MMIS (“Certification Date”), regardless of the form of action that imposes liability, whether in contract, equity, negligence, intended conduct, tort or otherwise, exceed, in the aggregate for all Losses, the greater of: (i) the total amount paid and payable under this Contract to the Vendor by the State with respect to the Replacement Phase; or (ii) \$60,000,000.

(b) In no event shall either Party’s liability to the other for any claim (in the aggregate with all other claims subject to this Section 30.50.1(b)) arising out of or related to this Contract which results from any act, event or cause that occurred, or omission that gave rise to substantial impact (regardless of when the omission or its impact may have first become apparent), on and after the Certification Date, regardless of the form of action that imposes liability, whether in contract, equity, negligence, intended conduct, tort or otherwise, exceed, in the aggregate for all Losses, the greater of: (i) the total amount paid and payable under this Contract to the Vendor by the State in connection with Services performed following the Certification Date for the twelve (12) months immediately preceding the claim (or if twelve (12) months have not elapsed since the Certification Date at the time of the claim, the total charges anticipated to be paid with respect to Services performed following the Certification Date, assuming full completion of all Services); or (ii) \$10,000,000.

**30.50.2 Limitation of Liability Exceptions**

The limitations set forth in Section 30.50.1 shall not apply with respect to: (a) any breach by Vendor of the terms of Sections 30.26 (Confidentiality and Data Security), 30.28 (Federal Non-Disclosure Requirements), or 30.29 (HIPAA); (b) claims relating to



## SECTION 30: CONTRACT REQUIREMENTS



Vendor's fraud, willful or intentional misconduct or gross negligence; (c) claims for indemnification under Section 30.23 (Indemnity), except those claims covered by Section 30.23(a)(iv) or Section 30.23(a)(vii); (d) claims for indemnification under Section 30.12 (Intellectual Property Indemnification); (e) Vendor's failure to perform its duties in the Turnover Phase, including, without limitation those duties set forth in the Turnover Plan; (f) Vendor's wrongful termination of this Agreement; (g) Vendor's breach of its obligations under Section 30.31 (Compliance with State and Federal Laws and Regulations); (h) Vendor's obligations and responsibilities under Section 30.44.5 (Correctness of Payments - Contract Requirements); (i) Vendor's obligations and responsibilities under Section 30.44.6 (Correctness of Payments-Damages); and (j) Vendor's obligations and responsibilities under Section 30.44.8 (Internal Revenue Services - Damages).

### **30.50.3 Exclusion of Certain Damages.**

Except for damages, costs and expenses arising out of or related to:

- (a) (i) Any breach by Vendor of the terms of Sections 30.26 (Confidentiality and Data Security), 30.28 (Federal Non-Disclosure Requirements), 30.29 (HIPAA); (ii) claims relating to Vendor's fraud, willful or intentional misconduct or gross negligence; (iii) claims for indemnification under Section 30.23 (Indemnity), except those claims covered by Section 30.23(a)(iv) or Section 30.23(a)(vii); (iv) claims for indemnification under Section 30.12 (Intellectual Property Indemnification); (v) Vendor's failure to perform its duties in the Turnover Phase, including, without limitation those duties set forth in the Turnover Plan; (vi) Vendor's wrongful termination of this Agreement; (vii) Vendor's breach of its obligations under Section 30.31 (Compliance with State and Federal Laws and Regulations); (viii) Vendor's obligations and responsibilities under Section 30.44.2 (Targeted Operational Start Date - Damages); (ix) Vendor's obligations and responsibilities under Section 30.44.3 (System Certification - Contract Requirement); (x) Vendor's obligations and responsibilities under Section 30.44.4 (United States DHHS Sanctions—Damages); (xi) Vendor's obligations and responsibilities under Section 30.44.5 (Correctness of Payments - Contract Requirements); (xii) Vendor's obligations and responsibilities under Section 30.44.6 (Correctness of Payments-Damages); and (xiii) Vendor's obligations and responsibilities under Section 30.44.8 (Internal Revenue Services - Damages);
- (b) procurement of Services from an alternate source due to Vendor's performance or failure to perform other than in accordance with the terms hereof;
- (c) operation of the Legacy MMIS following the Operational Start Date; and
- (d) Straight time, overtime, or related expenses reasonably incurred by the State, including overhead allocations of the State for its and their employees, wages and salaries of additional employees, travel expenses, overtime expenses, telecommunication charges, and similar charges, due to the failure of Vendor to provide the Services where the State has implemented a work-around as a result of Vendor's failure or incurred in connection with (a) through (c) above,

IN NO EVENT SHALL EITHER PARTY BE LIABLE FOR INDIRECT, INCIDENTAL, CONSEQUENTIAL, SPECIAL, EXEMPLARY OR PUNITIVE DAMAGES, REGARDLESS OF THE FORM OF ACTION, WHETHER IN CONTRACT, TORT OR OTHERWISE, AND EVEN IF SUCH PARTY HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES.

### **30.51 BENEFICIARIES**

The Contract shall inure to the benefit of and be binding upon the Parties hereto and their respective successors. It is expressly understood and agreed that the enforcement of the terms and conditions of the Contract, and all rights of action relating to such enforcement, shall be strictly reserved to NC DHHS and the named Vendor. Nothing contained in this document shall give or allow any claim or right of action whatsoever by any third person. It is the express intention of NC DHHS and Vendor that any such other person or entity receiving services or benefits under the Contract shall be deemed an incidental beneficiary only and not a contractual third party beneficiary.

### **30.52 TITLES AND HEADINGS**

Titles and headings in the Contract are used for convenience only and do not define, limit, or proscribe the language of terms identified by such titles and headings.

### **30.53 FEDERAL INTELLECTUAL PROPERTY BANKRUPTCY PROTECTION ACT**

The State shall be entitled to all rights and benefits of the Federal Intellectual Property Bankruptcy Protection Act, Public Law 100-506, codified at 11 U.S.C. 365(n) and any amendments thereto.

### **30.54 FEDERAL CERTIFICATIONS**

The Vendor shall execute the following Federal certifications (applicable when receiving Federal funds):

- A. Certification Regarding Lobbying (See Appendix 30, Attachment A of this RFP)
- B. Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion—Lower-Tier-Covered Transactions (See Appendix 30, Attachment B of this RFP)
- C. Certification Regarding Drug-Free Work Place Requirements (See Appendix 30, Attachment C of this RFP)
- D. Certification Regarding Environmental Tobacco Smoke. (See Appendix 30, Attachment D of this RFP)

## SECTION 40: REPLACEMENT MMIS REQUIREMENTS

### 40.1 GENERAL REQUIREMENTS

The General Section includes requirements for services and processes that are common to all (or most all) of the business areas required for the Replacement MMIS. The purpose of this section is to eliminate the need for redundant expressions of the requirements within each set of business area requirements. Requirements in this section may be refined and detailed within various business areas, indicating that the general requirements are to be expanded appropriately within one (1) or more business areas. Within this section, words such as “include,” “includes,” “including,” “e.g.,” or “for example” are deemed to be followed by the phrase “without limitation.” General Operational Requirements include activities to be conducted by the Fiscal Agent during Design, Development, and Installation (DDI) as well as activities to be conducted post-implementation.

#### 40.1.1 General System Requirements

Requirement #	Requirement Description	Non-Medicaid Only
<b>Multi-Payer Requirements</b>		
40.1.1.1	Provides capability in a Replacement MMIS to provide a single system process to coordinate recipient benefits among the DMA, DMH, DPH, and the Migrant Health Program in the Office of Rural Health and Community Care (ORHCC) and to ensure the proper assignment of the financially responsible payer, benefit plan, and pricing methodology for each service tendered in a claim	
40.1.1.2	Provides capability to create and maintain each health benefit program offered and administered by the State; health benefit programs shall be realized by one or more benefit plans that define the scope of benefits, eligibility criteria, and pricing methods applicable to a health benefit program	
40.1.1.3	Provides capability to allow recipients and providers to enroll in one (1) or more benefits plans	
40.1.1.4	Provides capability for benefits plan to be implemented through a rule or a design that allows simple and easy implementation of new benefit programs and modifications to existing benefit programs with little or no programmatic changes to the claims processing software	
40.1.1.5	Provides capability for benefits plans to be maintained and administered through user-interface views with entries for defining and configuring the scope of benefits, eligibility criteria, and the pricing method criteria that will be used for determining admissibility under a given benefit plan	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
40.1.1.6	Provides capability for the claims adjudication process to use information from the benefit plans applicable to both the recipient and provider of a submitted claim to identify and assign the financially responsible payer and benefit program applicable to each service tendered in the claim, including retrospective review of eligibility and funding availability	
40.1.1.7	Provides capability for the determination of the financially responsible payer and benefit program for each claim service using a set of payer and benefit program ranking criteria to resolve any potential contention when the claim service is covered by more than one benefit plan	
40.1.1.8	Provides capability for the claims adjudication process to use information from the pricing method criteria tables to identify and assign the pricing methodology applicable to each service tendered in the claim	
40.1.1.9	Provides capability for financially responsible payers, benefit programs, and pricing methodologies assigned to a claim to be used to support and direct various aspects of the claims adjudication process, including the edits, audits, pricing, payment (e.g., checkwrite), and financial (e.g., budget management) functions	
40.1.1.10	Provides capability to track and report current and historical claims detail and associated funding sources	
40.1.1.11	Provides capability for batch and/or online real-time access between external systems and Replacement MMIS functional areas using Application Program Interface (API) -based Service-Oriented Architecture (SOA) concepts	
40.1.1.12	Provides capability to track, report, reproduce, and/or forward recipient mail that is undeliverable	
40.1.1.13	Fiscal Agent shall shred recipient correspondence that is returned to the Fiscal Agent as non-deliverable	
40.1.1.14	Provides capability for data validation editing for all online and Web entry views	
<b>Interfaces</b>		
40.1.1.16	Provides capability to interface in a timely manner "To" and "From" all external interfaces, to include, without limitation, those listed in Appendix 40, Attachment H of this RFP	
<b>Security</b>		
40.1.1.17	Provides capability to adopt current industry and State standards and address the State's Security Program Planning and Management,	



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
	Access Controls, Application Software Development and Change Controls, System Software Controls, and Service Continuity Controls	
40.1.1.18	Provides capability for initial batch loading of security records and profiles prior to implementation	
	<b>User Access Authentication and Authorization</b>	
40.1.1.19	Provides capability for a user interface design to incorporate the North Carolina Identity Enterprise Service (NCID), version 7 (or later), Model 2  Refer to <i>DHHS Application Integration with NCID</i> in the Procurement Library.	
40.1.1.20	Provides capability to adhere to the role-based access control model in compliance with NC DHHS Security policies  Refer to <i>Replacement MMIS Security Business Rules</i> in the Procurement Library.	
	<b>Architecture</b>  Reference <i>Appendix 40, Attachment B, DMA Network Diagram</i> and <i>Appendix 40, Attachment C, DMH Network Diagram</i> of this RFP for information purposes only.	
40.1.1.21	<b>Goal:</b> Provides capability for the architecture to be: <ul style="list-style-type: none"> <li>▪ Adaptable</li> <li>▪ Available</li> <li>▪ Extensible</li> <li>▪ Interoperable</li> <li>▪ Manageable</li> <li>▪ Redundant</li> <li>▪ Resilient</li> <li>▪ Scalable</li> <li>▪ Securable</li> </ul>	
40.1.1.22	<b>Goal:</b> Provides capability for the architecture to align with the principles and practices in the North Carolina Statewide Technical Architecture (STA)	
40.1.1.23	Provides capability for all applicable components of the proposed solution to perform efficiently on State desktop office tools consistent with the current State standards and versions (i.e., no more than [1] major release behind the current supported levels). See Appendix 40, Attachment J for State Standards.	





**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
40.1.1.24	<b>Goal:</b> Provides capability for the client user interface to be decoupled (a clear physical separation) from the business rules layer and limited to presentation of data, capturing of input, and control of application flow	
40.1.1.25	<b>Goal:</b> Provides capability for the architecture to use Web services-based solutions that are designed using either a 3/N-tier or Service-Oriented Architecture (SOA) approach	
<b>System Software Controls</b>		
40.1.1.26	Provides capability to update records to reflect changes such as merging or decoupling of recipient and provider IDs	
<b>User Interface and Navigation</b>		
40.1.1.27	Provides capability for standard user interface characteristics, data accessibility, and navigation across all Replacement MMIS business areas	
40.1.1.28	Provides capability for compliance with language and accessibility requirements as defined in the Regulatory Compliance Section	
40.1.1.29	<b>Goal:</b> Provides capability for a secure, interactive Web Portal for users twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year	
40.1.1.30	Provides capability for a secure, interactive Web Portal to have an informational/introductory Web page twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year	
40.1.1.31	Provides capability for real-time interaction with all business areas, enabling routine inquiries	
40.1.1.32	Provides capability for multiple business area views to be displayed concurrently and to facilitate interaction between business area views	
40.1.1.33	Provides capability for consistency in displaying view/file/report titles, dates, times, and other business area-specific requirements	
40.1.1.34	Provides capability to display error messages, interactive help views and tables, accessible reference files, and hypertext links to appropriate additional files/reports	
<b>Document Management and Correspondence Tracking</b>		
40.1.1.35	Provides capability to electronically store and view online in an easily readable format all inbound and outbound transactions and correspondence within the Replacement MMIS	



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
40.1.1.36	Provides capability for integrated document management and correspondence tracking across all Replacement MMIS business areas	
40.1.1.37	Provides capability for online access to Replacement MMIS and document management and correspondence tracking with a single log-on	
40.1.1.38	Provides capability to capture and electronically store all documents, both incoming and outgoing, including claims, claim attachments, data entry forms, images, medical records, X-rays, correspondence, incoming and outgoing fax documents and system-generated reports, tracking date, and time of receipt	
40.1.1.39	Provides capability to receive, electronically store, and retrieve intraoral/extraoral photographs, digital radiographs, and digital versions of orthodontic models (casts)	
40.1.1.40	Provides capability to link incoming documents, correspondence, and supporting documentation to related documents and correspondence already on file	
40.1.1.41	Provides capability to assign a unique document identifier to each document	
40.1.1.42	Provides capability to retrieve all linked documents with one (1) request	
40.1.1.43	Provides capability for documents to be electronically stored by unique document identifier and accessible by online search via hypertext link from all views that reference the image	
40.1.1.44	Provides capability to retain electronic documents for ten (10) years online; once the electronic document has been verified, it becomes the official copy of the document	
40.1.1.45	Provides capability to archive electronic documents offline after ten (10) years and retrieve them for online viewing within two (2) business days of a request	
40.1.1.46	Provides capability for data retrieved from offline storage to be retained online for ten (10) business days, unless otherwise requested	
40.1.1.47	Provides capability to print hard copies of electronically stored documents	
40.1.1.48	Provides capability to print and fax documents	
40.1.1.49	Provides capability for State and Fiscal Agent staff to retrieve and display any electronically stored documents within eight (8) seconds for the first page, within five (5) seconds for the second page, and within	



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
	three (3), two (2), and one (1) second(s) or less for subsequent pages	
40.1.1.50	Provides capability to make all documents available to the State within two (2) business days of creation	
40.1.1.51	Provides capability to accept input in frequencies as defined in business areas and from multiple sources, types, and formats, including: <ul style="list-style-type: none"> <li>▪ Required electronic transaction formats, (e.g., X12)</li> <li>▪ Scanners (e.g., paper claims/written correspondence)</li> <li>▪ Electronic text (e.g., e-mail, e-fax, voice media files)</li> <li>▪ Paper documents (e.g., correspondence, claims forms, faxes)</li> <li>▪ Portable media (e.g., magnetic tapes, 3.5" floppy drives, CD/DVD drives)</li> </ul>	
40.1.1.52	Provides capability for all data input (e.g., images of scanned paper documents, voice media files, electronic and EDI transactions) to be transformed as needed for further processing	
40.1.1.53	Provides capability to protect all stored images and electronic copies from direct access while allowing authorized copies to be used for further processing	
	<b>Audit Trail</b>	
40.1.1.54	Provides capability to track through audit trail data with date/time stamps: <ul style="list-style-type: none"> <li>▪ All access, activity, and system identifier of users or persons making adds, changes, deletes, or queries</li> <li>▪ All activity that causes any additions, changes, deletions, or queries</li> <li>▪ All transactions that result in a claim being entered into the system, including EDI transactions, a prior approval being entered into the system, Third Party Liability (TPL) transactions, a financial result (incoming and outgoing financial transactions and system-generated financial transactions), adding, changing, or deleting recipient or provider data, adding, changing, or deleting reference or code data, drug rebate activity, financial activity, and reference file changes</li> </ul>	
40.1.1.55	Provides capability to maintain an automated audit trail of all update transactions, both batch and online, including date and time of change, before and after data field contents, and operator identifier or source of the update	
40.1.1.56	Provides capability to create audit trail data that can be accessed online in a user-friendly, indexed, searchable format that has the capability to	



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
	reflect the complete history of the transaction	
	<b>Online Help</b>	
40.1.1.57	Provides capability for selectable online help views for user functionality that duplicate or link to system documentation	
40.1.1.58	Provides capability for online help for all features, functions, and data element fields as well as descriptions and resolutions for error messages, using help features, including indexing, searching, tool tips, mouse-over, field value options, hypertext links to files, reports, and context-sensitive help topics	
40.1.1.59	Provides capability for context-sensitive help to view, window, or dialog	
	<b>Search and Query</b>	
40.1.1.60	Provides capability to allow all records to be selectable and searchable by record elements, as specified within business areas	
40.1.1.61	Provides capability to query and search information based on user-defined criteria or by data elements as specified within the business areas	
40.1.1.62	Provides capability for search by phonetic/mnemonic, full-text, partial-text, keyword, Boolean operators, specific date, date ranges, partial Postal/zip code, and wildcard	
40.1.1.63	Provides capability for users to query via parameterized standard reports and view online production data	
40.1.1.64	Provides capability to generate descriptive alerts that specify any invalid query parameter(s) and to generate alerts when the anticipated return time on a query or search exceeds a defined time limit	
40.1.1.65	Provides capability to permit users to easily locate specific information in the online documentation, e.g., user manual, operating procedures, and online system help	
40.1.1.66	Provides capability to govern queries so that run time does not exceed defined limits	
	<b>Correspondence and Letters</b>	
40.1.1.67	Provides capability to produce system-generated standardized letters as specified in business area requirements and to electronically store saved images of each letter produced	
40.1.1.68	Provides capability to produce updatable, form-based, version-	



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
	controlled, customized templates for letter generation with capability for free-form text as specified in business area requirements and to electronically store saved images of each letter produced from the templates in an easily accessible, searchable format	
40.1.1.69	Provides capability for letter and template generation to comply with US DHHS Title VI Language Access Policy based on flag that defines recipient language preference	
40.1.1.70	Provides capability to create and manage stakeholder correspondence, clinical policy documentation, bulletins/publication, business rules, and business forms	
40.1.1.71	Provides capability to perform desktop publishing of documents for all stakeholders	
40.1.1.72	Provides capability for on-demand and batch-driven correspondence creation and mailing	
40.1.1.73	Provides capability for letter-generation solution that has the flexibility to use form letters and/or on-demand text generation	
40.1.1.74	Provides capability for all stakeholders to create and electronically store correspondence templates for private and community use	
40.1.1.75	Provides capability to use spellchecker functionality	
40.1.1.76	Provides capability to use business rules intelligence to determine the best choice for correspondence communication and allow for the identification of the best selection for combination of address(es), USPS, fax, e-mail	
40.1.1.77	Provides capability to bulk distribute to target populations messages and communications via e-mail, fax, or Really Simple Syndication (RSS) feed	
40.1.1.78	Provides capability to integrate the letter-generation solution with the Replacement MMIS and import required data elements identified in the business rules that must be included in the letter text	
40.1.1.79	Provides capability to send correspondence through workflow management for approval, where business rules require secondary approval	
40.1.1.80	Provides capability to integrate and link all correspondence to the document management solution in real-time from point of origin (State, county, Fiscal Agent, or other State-contracted entity's location)	
40.1.1.81	Provides capability to track the correspondence creator, date, recipient,	



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
	and time stamp and maintain this information historically	
40.1.1.82	Provides capability to enclose attachments to meet recipient's language requirements	
40.1.1.83	Provides capability to create and distribute documents to multiple addresses	
40.1.1.84	Provides capability to redistribute static letters	
40.1.1.85	Provides capability to create performance reporting associated with correspondence	
40.1.1.86	Provides capability to allow user to designate address to be used	
40.1.1.87	Provides capability to enforce security rules to control who issues each type of letter and to designate and enforce a chain of review for certain letters	
40.1.1.88	Provides capability for a user-friendly, English-text index that allows easy access to templates and easy retrieval of initial letters generated per requested parameters: business area, date of generation, topic, recipient name, etc.	
	<b>Reports</b>	
40.1.1.89	Provides capability for system-generated reporting to include, without limitation: <ul style="list-style-type: none"> <li>▪ Federal- and State-required report and distribution</li> <li>▪ Reports identified in Appendix 40, Attachment G of this RFP</li> <li>▪ Fiscal Agent operations and system performance</li> <li>▪ Contract compliance</li> <li>▪ Cost allocation</li> <li>▪ Contract invoicing</li> <li>▪ Standard pre-formatted reports with parameters selection criteria</li> </ul>	
40.1.1.90	Provides capability for online access for users (based on role-based security) to reports, enabling downloads for export/import into multiple software formats and availability for use in multiple media	
40.1.1.91	Provides capability to maintain all reports that cannot be regenerated to reflect the report contents as originally represented	
	<b>Workflow Management</b>	



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
40.1.1.92	<p>Provides capability to maximize work queue technologies that enable a business rule empowered workflow, end-to-end enterprise-wide strategic solution that generates prioritized, sequential first-in/first-out delivery of work items that are generated as either media event or application event work items</p> <p>Provides capability to support:</p> <ul style="list-style-type: none"> <li>▪ Documentation retrieval (link to imaged documentation)</li> <li>▪ Alert agent on events such as work item creation, assignment, work item updates, and status changes</li> <li>▪ Assignment tracking and retrieval</li> <li>▪ Aging report(s)</li> <li>▪ Work item monitoring</li> <li>▪ Work item reassignment</li> </ul>	
40.1.1.93	Provides capability to input requests/inquiries into the workflow/imaging application to enable processing to be automated and forwarded to designated work and print queues	
40.1.1.94	Provides capability to move requests to the next work queue based on expertise required for completion	
40.1.1.95	Provides capability to allow the assignment or routing of tasks by the user	
40.1.1.96	Provides capability for tickler and/or to-do list capability	
40.1.1.97	Provides capability to support the tracking and resolution of contacts, including calls, on-site visits, override requests, prior approvals, and written inquiries	
40.1.1.98	Provides capability for the unlimited entry of notes with date/time stamp, user identity, and categorization as to type of note	
40.1.1.99	Provides capability to designate certain notes as confidential and restrict access to notes to authorized users	
40.1.1.100	Provides capability for automated work load balancing	
40.1.1.101	Provides capability for convenient, instant access to current and historical information without requiring a separate sign-on beyond the initial Replacement MMIS sign-on	
40.1.1.102	Provides capability to produce work management reports to include, without limitation, performance measures online by individual business unit and business process and compare them to actual performance	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
40.1.1.103	Provides capability to use user-defined templates that support various workflow processes	
40.1.1.104	Provides capability for a graphical interface to support the development and maintenance of the business processes; provides capability to allow users to create a visual capability or flowchart that controls the sequencing of manual and automated tasks performed throughout the business cycle	
40.1.1.105	Provides capability of integrating with a rules engine	
40.1.1.106	Provides capability to allow State access to work queue to assist in evaluation and disposition of work queue items	
<b>Rules Engine</b>		
40.1.1.107	Provides capability to register, classify, inquire, manage, and automate date-specific business rules in a graphical, user-friendly rules engine	
40.1.1.108	Provides capability to modify rules, allowing the application to be adaptable with the dynamic rules	
40.1.1.109	Provides capability for generating media events or application events as a result of the execution of a business rule	
40.1.1.110	Provides capability to structure in a modular concept so the same rules engine can be used by different services or be called as a service itself	
40.1.1.111	Provides capability for a debugging process that automatically analyzes and identifies logical errors (i.e., conflict, redundancy, and incompleteness) across business rules	
40.1.1.112	Provides capability to allow for rules to be tested against production data prior to installation	
40.1.1.113	Provides capability for a built-in rule review and approval process that will identify any conflicts in business rules as they are being developed	
40.1.1.114	Provides capability to track and report rules usage	
40.1.1.115	Provides capability to produce and maintain documentation regarding all business rules	
40.1.1.116	Provides capability for integration with a workflow management process	
40.1.1.117	Provides capability to identify impact of business rule changes to claims adjudication	





**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
40.1.1.118	Provides capability to reuse business rules across processes	
40.1.1.119	Provides capability to change business rules independent of process	
40.1.1.120	Provides capability to apply Procedure Code Pricing (PR) File Cleanup business rules against current Procedure Code Pricing (PR) File	
	<b>Integrated Test Facility</b>	
40.1.1.121	Provides capability for an Integrated Test Facility (ITF) with multiple test environments to allow for different phases of testing to be conducted concurrently during the DDI Phase and throughout the life of the Contract	
40.1.1.122	Provides capability for the ITF environment to operate independently from production, either physically or logically separated, so that performance within the production and ITF environments are not adversely affected by the other, regardless of activity level	
40.1.1.123	Provides capability to maintain the ITF environment as a mirror image of the production system environment to be used for testing all Replacement MMIS changes throughout the life of the Contract	
40.1.1.124	Provides capability for the automated migration of new business areas and application fixes between the ITF environments and production environment	
40.1.1.125	Provides capability to perform assessments without affecting production and/or data	
40.1.1.126	Provides capability for State access to all test system files	
40.1.1.127	Provides capability for version control in the ITF	
40.1.1.128	Provides capability to synchronize the ITF with the production environment when updating the Replacement MMIS production system	
	<b>Training</b>	
40.1.1.129	Provides capability for computer-based-training (CBT) courses for all users (State staff, Fiscal Agent staff, county staff, local agency staff, and providers)	
40.1.1.130	Provides capability for online CBT courses for all Replacement MMIS application systems	
40.1.1.131	Provides capability for proficiency testing, quality reviews, and retraining, as needed, for Fiscal Agent staff	



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
40.1.1.132	Provides capability to deliver provider training through Web-based services and electronic media	
40.1.1.133	Provides capability for a Web Portal to access training news, schedules, training registration and evaluation forms, CBT and Web-based training content, provider bulletins, and frequently asked questions (FAQs) by provider type and subject	
40.1.1.134	Provides capability for the Web Portal to include document management, version control, and contextual queries related to Replacement MMIS rules and operations	
40.1.1.135	Provides capability for Web-accessible downloads of training documentation that will be synchronized with provider policy and billing updates	
40.1.1.136	Provides capability for a training evaluation tool to analyze and report to the State on training effectiveness	
<b>Call Center Services</b>		
40.1.1.137	Provides capability for Customer Service Call Center/Help Desk to include, without limitation, hardware, software, and toll-free telephone access to operate the Customer Service Call Center/Help Desk System	
40.1.1.138	Provides capability for an automatic phone attendant that provides a hierarchical, menu-driven capability for directing calls to appropriate Replacement MMIS Program Fiscal Agent or State staff	
40.1.1.139	Provides capability to receive, appropriately route, and manage all telephone inquiries from Federal, State, local, and county workforce members, recipients, and in-state and out-of-state providers regarding prior approval, technical support, provider services, etc.	
40.1.1.140	Provides capability to integrate voice and electronic transactions into a single workflow with integrated queues that allow work blending and load balancing	
40.1.1.141	Provides capability to support requirements of Civil Rights Act for Persons of Limited English Proficiency (LEP) and Hearing Impaired	
40.1.1.142	Provides capability for call monitoring by supervisors and State monitors	
40.1.1.143	Provides capability for automated call-tracking of all calls received to include, without limitation, online display, inquiry, and updating of call records that will also be available to State staff	
40.1.1.144	Provides capability to maintain free-form notes for each call record, coordinate these notes in the document management and	



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
	correspondence tracking business area, and make the notes available for State and Fiscal Agent access	
40.1.1.145	Provides capability for the automated population of call views with relevant recipient and provider information; provides capability for the system to track information such as time and date of call, identifying information on caller (provider, recipient, and others), call type, call category, inquiry description, customer service clerk ID for each call, and response description	
40.1.1.146	Provides capability to automatically fax back (or e-mail back, when there is no protected health information involved) to callers with attachments containing requested information, such as claims histories, copies of pertinent policy or rules, and provider letters	
40.1.1.147	Provides capability to transfer calls, along with all related documentation that was collected	
40.1.1.148	Provides capability for callers to interact with an automated attendant or speak to a customer service representative	
40.1.1.149	Provides capability for technical help desk to support inquiries on system processes and system troubleshooting from providers, value-added networks (VANs), State, and Fiscal Agent users	
	<b>System Availability</b>	
40.1.1.150	Provides capability for the system to be consistently and persistently accessible to authorized users in compliance with the System Availability Policy in Appendix 40, Attachment I of this RFP	
40.1.1.151	Provides capability for the system to be available and substantially compliant with its complete specification for ninety-nine and six tenths (99.6) percent of the time on a monthly basis during production hours of operations, excluding planned system down-time	
40.1.1.152	Provides capability for transaction response time to be consistent for all users directly interacting with the production environment, based on a common Web Portal access for network access point, processed and returned to the network access point; provides capability for: <ul style="list-style-type: none"> <li>▪ Ninety (90) percent of transactions to occur in four (4) seconds or less</li> <li>▪ Ninety-five (95) percent of transactions to occur in five (5) seconds or less</li> <li>▪ Ninety-seven (97) percent of transactions to occur in six (6) seconds or less</li> <li>▪ Ninety-nine (99) percent of transactions to occur in seven (7)</li> </ul>	



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
	seconds or less	
	<b>Customer Service Request Tracking System</b>	
40.1.1.153	Provides capability for online tracking and workflow management of requests for service	
40.1.1.154	Provides capability to track the system Change Management Life Cycle Phases, schedule, and work breakdown structure (WBS) for systems maintenance and modification requests	
40.1.1.155	Provides capability to track resources for all CSR work breakdown structure, including maintenance and modification requests during the DDI and Operations Phases	
40.1.1.156	Provides capability for tracking CSR status by multiple data elements consistent with the Change Management Process	
40.1.1.157	Provides capability to generate reports for request management tracking, with flexibility for variable content, format, sort, and selection criteria to meet State and Fiscal Agent reporting needs	
40.1.1.158	Provides capability to maintain accessibility to all completed project requests for analytical purposes throughout the life of the Contract	
	<b>Web Portal</b>	
40.1.1.159	Provides capability for Web Portal access to the Replacement MMIS by the State staff, providers, government employees, and the general public	
40.1.1.160	Provides capability for a Web Portal that adheres to the State's User Interface and Navigation requirements and simplified sign-on	
40.1.1.161	Provides capability for browser independence and to ensure the browser has broad usage (approximately 500,000 users nationally) and the version is consistent with State usage	
40.1.1.162	Provides capability to post announcements or alerts that are displayed at user sign-on	
40.1.1.163	Provides capability to maintain archives of posted announcements and non-provider specific alerts, including the date and message	
40.1.1.164	Provides capability to access, complete, and submit online surveys	
40.1.1.165	Provides capability to link to CBT course presentations	
40.1.1.166	Provides capability to create, organize by topic, and post FAQs and	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
	responses online	
40.1.1.167	Provides capability to maintain version history of previous forms, user manuals, etc.	
40.1.1.168	Provides capability to create configurable Web pages of Replacement MMIS functions	
40.1.1.169	Provides capability to view and download standard Replacement MMIS reports in a readable format	
40.1.1.170	Provides capability to request and view parameter-driven standard formatted reports	
40.1.1.171	Provides capability to link to stakeholder Web sites	
40.1.1.172	Provides capability to populate user/security profile-related data for Web Portal access prior to implementation	
	<b>Data Integrity</b>	
40.1.1.173	Provides capability for each record or file to be saved as created, not overwritten by updates or changes, to allow a historical review of individually dated versions	

**40.1.2 General Operational Requirements**

Requirement #	Requirement Description	Non-Medicaid Only
	<b>Fiscal Agent Data Center and Offices</b>	
40.1.2.1	Fiscal Agent (DDI and Operations Phases) shall perform all Fiscal Agent functions at State-approved facilities and sites, including the Fiscal Agent’s data center and any subcontractor locations unless otherwise contractually agreed on. These facilities and sites must comply with appropriate State and Federal privacy and physical safeguards.	
40.1.2.2	Fiscal Agent (Operations Phase) shall perform all operations, system maintenance, and modifications or other work under this Contract at prior-approved locations.	
40.1.2.3	Fiscal Agent (DDI and Operations Phases) shall locate its local facility within fifteen (15) miles of the State office at NC DHHS headquarters or as directed by the State.	



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
40.1.2.4	Fiscal Agent (DDI and Operations Phases) shall locate key personnel, business units, and the mailroom at the local site.	
40.1.2.5	<p>Fiscal Agent (DDI and Operations Phases) shall include secure, private office space for three (3) State employees. Fiscal Agent shall also provide assistance and access to any operations, information, or data set elements necessary to support State staff responsibilities. The private office space should include, without limitation:</p> <ul style="list-style-type: none"> <li>▪ Lockable desks</li> <li>▪ Ergonomically correct chairs</li> <li>▪ IBM-compatible PCs, monitors, and printers with appropriate LAN/WAN connections, Internet access, and e-mail access, at a minimum meeting State standards</li> <li>▪ Lockable file cabinets</li> <li>▪ Telephones</li> <li>▪ Office supplies.</li> </ul>	
40.1.2.6	Fiscal Agent (DDI and Operations Phases) shall provide a common area with three (3) or more computers for Internet access for State employees.	
40.1.2.7	Fiscal Agent (DDI and Operations Phases) shall retain ownership of the equipment issued to the State and shall procure, manage, and bear the cost of repairs or replacement, if required, during the life of the Contract.	
40.1.2.8	Fiscal Agent (DDI and Operations Phases) shall upgrade and maintain the personal computers (PCs) and desktop software issued by the Fiscal Agent for State use commensurate with Fiscal Agent PC and software upgrades.	
40.1.2.9	Fiscal Agent (DDI and Operations Phases) shall provide access for the on-site State staff to use copier, scanner, and fax machines.	
40.1.2.10	Fiscal Agent (Operations Phase) shall provide equipment for traveling Fiscal Agent representatives that include laptops and cellular telephones that comply with Fiscal Agent's security plan.	
40.1.2.11	Fiscal Agent (DDI and Operations Phases) shall meet periodically as directed by the State to review programs, issues, and status with State operational area staff.	
	<b>Regulatory Compliance</b>	
40.1.2.12	Fiscal Agent (DDI and Operations Phases) shall ensure that the Replacement MMIS incorporates compliance with appropriate Federal and State regulations, statutes, and policies concerning the protection of	



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
	<p>personally identifiable information and/or financial information. Regulations, statutes, and policies include, without limitation:</p> <ul style="list-style-type: none"> <li>▪ 45 CFR Parts 160, 164 (Health Insurance Portability and Accountability Act)</li> <li>▪ 42 U.S.C. 1320(d) (Public Health, Approval of Special Projects)</li> <li>▪ 42 CFR Parts 2, 51, 431 (Confidentiality of Mental Health and Substance Abuse information)</li> <li>▪ 42 CFR Parts 430-502 (Applicable to Medicare/Medicaid)</li> <li>▪ 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act.</li> <li>▪ Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d et. seq.</li> <li>▪ Title XIX, Section 1903 (42 U.S.C. 1396b) Social Security: Payment to States</li> <li>▪ Title XIX, Section 1927 (42 U.S.C. 1396r-8) Social Security: Payment for covered outpatient drugs</li> <li>▪ Federal MMIS certification standards</li> <li>▪ Financial Accounting Standards Board Generally Accepted Accounting Principles (GAAP)</li> <li>▪ Part 11 of the State Medicaid Manual</li> <li>▪ North Carolina State Plans for Medicaid, Mental Health, Developmental Disabilities, and Substance Abuse, and Public Health</li> <li>▪ US DHHS Title VI Language Access Policy</li> <li>▪ Recipient eligibility policies from the NC DHHS Eligibility Information System (EIS) and the Common Name Data Service (CNDS)</li> <li>▪ NC State Law S 1048 (Identity Theft Protection Act)</li> <li>▪ 10A NCAC Chapters 21 &amp; 22, Medical Assistance</li> <li>▪ 10A NCAC 26B (Confidentiality Rules For Mental Health, Developmental Disabilities, and Substance Abuse Services)</li> <li>▪ 10A NCAC Chapter 45, DPH Payment Programs</li> <li>▪ NC DHHS OSP. 2005. DHHS Application Security Policy.</li> <li>▪ NC OSCIO. 2004. Application Security Policy with Guidelines, Statewide Information Technology Policy.</li> <li>▪ N.C.G.S. §126: State Personnel System</li> <li>▪ N.C.G.S. § 131D: Inspection and Licensing of Facilities</li> <li>▪ N.C.G.S. §131E: Health Care Facilities and Services</li> <li>▪ N.C.G.S. § 132: Public Records</li> </ul>	



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
	<ul style="list-style-type: none"> <li>▪ The Privacy Act of 1974 5 U.S.C. § 552a</li> <li>▪ NCAC 10A Chapter 13 - NC Medical Care Commission</li> <li>▪ NCAC 10 A Chapter 14 - Division of Facility Services</li> <li>▪ NCAC 10A Chapter 26 - Mental Health, General</li> <li>▪ NCAC 10A Chapter 27 - Mental Health, Community Facility and Services</li> <li>▪ NCAC 10A Chapter 28 - Mental Health, State Operated Facilities</li> <li>▪ Government Auditing Standards (<a href="http://www.gao.gov/govaud/yb2003.pdf">http://www.gao.gov/govaud/yb2003.pdf</a>)</li> <li>▪ Information Systems Audit Standards (<a href="http://www.isaca.org/stand1.htm">http://www.isaca.org/stand1.htm</a>).</li> <li>▪ NC DHHS Privacy and Security policies</li> <li>▪ Federal Section 508(<a href="http://www.section508.gov">http://www.section508.gov</a>)</li> </ul>	
	<b>Data Transfer and Conversion</b>	
40.1.2.13	Fiscal Agent (DDI and Operations Phases) shall lead the coordination with the State and the incumbent Fiscal Agent to perform all activities required for the successful transfer and conversion of legacy data for the DDI Phase and ongoing operations.	
40.1.2.14	Fiscal Agent (DDI and Operations Phases) shall provide the converted data to other State users and/or vendors as required for its processing needs identified by the State.	
40.1.2.15	Fiscal Agent (DDI and Operations Phases) shall provide hardware, software, and data support for the State during all phases of conversion and testing during the DDI Phase and throughout the life of the Contract.	
40.1.2.16	Fiscal Agent (DDI and Operations Phases) shall provide capability for storing all conversion-related artifacts in an easily retrievable format for access by the State for the later of life of the Contract or the commencement of processing by a subsequent contractor.	
40.1.2.17	Fiscal Agent (Operations Phase) shall convert all the claim TIFF images with claim numbers and all the associated claim electronic files and related index information from Legacy MMIS+ in an indexed and retrievable format.	
40.1.2.18	Fiscal Agent (Operations Phase) shall transfer, or convert where appropriate, all existing Legacy MMIS+ reports and report-related data, including reports in Legacy MMIS+ and/or stored in Report2Web (R2W).	





**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
40.1.2.19	Fiscal Agent (Operations Phase) shall convert all legacy data from DMA, DMH, DPH, and the Migrant Health Program in the ORHCC.	
40.1.2.20	Fiscal Agent (Operations Phase) shall convert all legacy data from DMA, DMH, DPH, and the Migrant Health Program in the ORHCC to maintain benefit plans and data relationships in a multi-payer aspect.	
40.1.2.21	Fiscal Agent (DDI Phase) shall convert and configure all business rules data into a rules engine.	
<b>Interfaces</b>		
40.1.2.22	Fiscal Agent (DDI and Operations Phases) shall coordinate with the Reporting and Analytics (R&A) Vendor for the activities required for interfacing with R&A system.	
40.1.2.23	Fiscal Agent (DDI and Operations Phases) shall develop and maintain a complete inventory of Replacement MMIS internal and external interfaces with all relevant information throughout the life of the Contract.	
40.1.2.24	Fiscal Agent (DDI and Operations Phases) shall provide the specifications for interfaces that will be created and maintained throughout the life of the Contract.	
40.1.2.25	Fiscal Agent (DDI and Operations Phases) shall maintain data sharing capability, either manual or electronic as required, between the Replacement MMIS and DHSR.	
<b>Security</b>		
40.1.2.26	Fiscal Agent (DDI and Operations Phases) shall be required to test backup and recovery plans annually through simulated disasters and lower-level infrastructure failures and provide awareness training on recovery plans to Fiscal Agent and State staff.	
40.1.2.27	Fiscal Agent (DDI Phase) shall assess and document the security threats and vulnerabilities for the proposed Replacement MMIS and shall implement the recommended controls and countermeasures to eliminate or reduce the associated risks.	
40.1.2.28	Fiscal Agent (DDI) shall develop, implement, and test an approach that will protect individually identifiable health information (IIHI) and protected health information (PHI) exchange during DDI Phase testing and conversion of legacy files, including acceptance and return or disposal of the data or media containing the data.	
40.1.2.29	Fiscal Agent (DDI Phase) shall develop, implement, and test a security incident response plan for responding to and reporting about service	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
	interruptions that do not lead to disaster recovery initiation, including a central means of collection and correlation of events for resolution and prevention of future problems.	
40.1.2.30	Fiscal Agent (DDI Phase) shall prepare for and comply with an internal security assessment/audit performed by NC DHHS representatives, based on documentation assembled during DDI Phase prior to the formal acceptance of Replacement MMIS.	
	<b>Data Protection Assurance</b>	
40.1.2.31	Fiscal Agent (DDI and Operations Phases) shall use commercial best practices to safeguard and protect physical data and media, documents, files, tapes, disks, diskettes, and other materials received from the State or the agency from loss, destruction, or erasure during performance of any contractual obligation. Practices shall include encryption technologies where applicable.	
40.1.2.32	Fiscal Agent (DDI and Operations Phases) shall use commercial best practices to safeguard and protect all information transmitted internally (within the Fiscal Agent Offices and network) or externally (beyond the Fiscal Agent network perimeter), protecting from alteration, capture or destruction. Practices shall include encryption technologies where applicable.	
40.1.2.33	Fiscal Agent shall provide all encryption or identification codes or authorizations that are necessary or proper for the operation of the licensed Software.	
40.1.2.34	Fiscal Agent (DDI and Operations Phases) shall provide audit evidence that all of its employees and third party contractors or subcontractors are subject to a non-disclosure and confidentiality agreement enforceable in North Carolina.	
	<b>Enterprise Security Approach</b>	
40.1.2.35	Fiscal Agent (DDI and Operations Phases) shall establish a technical management organizational structure to manage and protect the system and data for all environments (e.g. development, test, load, UAT, production).	
40.1.2.36	Fiscal Agent (DDI and Operations Phases) shall demonstrate security awareness and provide training to Fiscal Agent and State staff in security policies and procedures.	
40.1.2.37	Fiscal Agent (Operations Phase) shall initiate, implement, test, and document on an annual basis a risk assessment policy and process to mitigate the overall enterprise security risk. This policy and plan shall include, without limitation, security process review, controls testing, mitigation procedures, personnel responsibility, and a process for State	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
	notification.	
40.1.2.38	Fiscal Agent (Operations Phase) shall develop the policy and plans for an annual Business Impact Analysis (BIA) and Business Criticality Analysis (BCA) that shall identify the impacts resulting from major disruptions and set or modify the appropriate Recovery Time Objectives (RTO) and Recovery Point Objectives (RPO). The RTOs and RPOs shall be established in consultation with and approved by the State.	
40.1.2.39	Fiscal Agent (DDI and Operations Phases) shall document policies to implement operational practices preventing any person(s) from establishing unauthorized control over the privacy, security, and processing of critical information. Operational procedures must conform to the NC DHHS Privacy and Security policies and procedures.	
40.1.2.40	Fiscal Agent (DDI and Operations Phases) shall maintain preventive, detective, and corrective audit and control features of the Replacement MMIS for the duration of the Contract in conformance with NC DHHS Privacy and Security Policy.	
40.1.2.41	Fiscal Agent (Operations Phase) shall assist the State in the annual Replacement MMIS security audit in accordance with Government Auditing Standards and Information Systems Audit Standards.	
40.1.2.42	Fiscal Agent (Operations Phase) shall be required to test backup and recovery plans annually through simulated disasters and lower-level failures and provide awareness training on recovery plans to Fiscal Agent and State staff. These tests must include, without limitation, joint participation by the Fiscal Agent and State staff.	
40.1.2.43	Fiscal Agent (DDI and Operations Phases) shall include, without limitation, audit evidence in system testing results (e.g., from system change management, upgrades, backups, etc.) cross-referenced to the expected test.	
	<b>Facility Access</b>	
40.1.2.44	Fiscal Agent (DDI and Operations Phases) shall implement controls to restrict access to data processing facilities and secured electronic or physical storage areas only to authorized individuals.	
40.1.2.45	Fiscal Agent (DDI and Operations Phases) shall provide accountability control to record facility access.	
40.1.2.46	Fiscal Agent (DDI and Operations Phases) shall record and supervise visitor and unauthorized user access to the Fiscal Agent's local site as well as any other sites used by the Fiscal Agent for Replacement MMIS processing or related activities and shall control access by unauthorized persons in conformance with NC DHHS Security Policy.	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
40.1.2.47	Fiscal Agent (DDI and Operations Phases) shall safeguard processor site(s) through provision of uninterruptible power supply, power conditioning, internal environmental controls, fire retardant capabilities, and smoke and electrical detectors and alarms monitored by security personnel.	
40.1.2.48	Fiscal Agent (DDI and Operations Phases) shall restrict access to the facility server area during regular operations and in disaster and emergency situations in accordance with NC DHHS Security Policy.	
<b>New Requirement</b> 40.1.2.49	Fiscal Agent (DDI and Operations Phases) shall document policies to implement operational practices preventing unauthorized access to data or systems and prevent fraudulent activities that may result from the use of this information. Operational procedures must conform to the NC DHHS Privacy and Security policies and procedures.	
<b>User Access Authentication and Authorization</b>		
40.1.2.50	Fiscal Agent (Operations Phase) shall provide all authorized users (employees, contractors, providers, citizens, other government workers) of the Replacement MMIS with access to appropriate business areas, databases, files, reports, archives, etc. through a common, consistent interface that restricts access based on authentication and authorization to appropriate data derived from role-based security.	
40.1.2.51	Fiscal Agent (Operations Phase) shall implement a managed workflow process for user account provisioning to eliminate the use of paper documents, ensure timely response to requests, and retain profiles for each user containing identification, authorization, organizational demographics, group memberships, and functional permissions derived from role-based security.	
<b>Application Systems Change Control</b>		
40.1.2.52	Fiscal Agent (DDI and Operations Phases) shall perform security impact reviews of the change management process and share and collaborate on such reviews with State staff during the DDI Phase and throughout the life of the Contract.	
<b>System Software Controls</b>		
40.1.2.53	Fiscal Agent (DDI and Operations Phases) shall control and monitor global access to systems and files such that no single individual will be able to affect system operations in isolation.	
40.1.2.54	Fiscal Agent (Operations Phase) shall monitor application platforms with industry standard technology and tools (hardware and software) and respond according to agreed-upon Service Level Agreements to developing problems.	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
40.1.2.55	Fiscal Agent (DDI and Operations Phases) shall implement a comprehensive security monitoring solution to include, without limitation, industry standard technology and tools, including monitoring of wireless communication to monitor all aspects of the proposed solution (e.g., perimeter and internal network, server farms, operating systems, application software, and application data). Wireless communication at the Fiscal Agent site shall conform to the established NC DHHS Security Policy.	
40.1.2.56	Fiscal Agent (Operations Phase) shall retain copies of all server operating system and configuration software, system utilities and tools, network device configuration settings, and software license agreements in a location remote from the production server location, updating the copies as the operating environment changes.	
<b>Logging and Reporting</b>		
40.1.2.57	Fiscal Agent (DDI and Operations Phases) shall identify and document all network activity events involved with the non-application operations of the Replacement MMIS.	
40.1.2.58	Fiscal Agent (Operations Phase) shall produce an alert notification for the Operations Incident Management function for follow up and review to every event that precipitates a security incident.	
<b>Service Continuity Controls</b>		
40.1.2.59	Fiscal Agent (Operations Phase) shall initiate and document an Operations Incident Management function and group to act as a single, central point of notification, review, and assessment of all incidents that affect the continuous operations of the production environment and access to the data and information.	
40.1.2.60	Fiscal Agent (Operations Phase) shall respond to each network activity and personally observed incident with a mitigation plan that follows standard data collecting, evidence preservation practices, and organizational escalation procedures in accordance with guidelines established by the NC DHHS Privacy and Security Office	
<b>Data Backup and Recovery</b>		
40.1.2.61	Fiscal Agent (Operations Phase) shall store backup system data and files separately from the production server storage at a remote location sufficiently distant from the production servers to prevent a simultaneous disastrous loss of both environments.	
40.1.2.62	The Fiscal Agent (Operations Phase) shall ensure that individual files, collections of files, data base instances and other production information	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
	can be recovered from the back-up storage to production servers upon inadvertent deletion or corruption of the production information.	
	<b>Records Retention</b>	
40.1.2.63	Fiscal Agent (Operations Phase) shall archive information, including, without limitation, data files, images, transactions, master files, system and source program libraries, and other appropriate records and electronically store the information physically or logically separate from production information in compliance with State Record Retention Policy.	
	<b>User Interface and Navigation</b>	
40.1.2.64	Fiscal Agent (DDI and Operations Phases) shall employ industry standards and best practices for user interface design and navigation consistently throughout the Replacement MMIS throughout the life of the Contract.	
40.1.2.65	<p>Fiscal Agent (DDI and Operations Phases) shall standardize all views, windows, and reports, including:</p> <ul style="list-style-type: none"> <li>▪ Format and content of all views</li> <li>▪ All headings and footers</li> <li>▪ Current date and time.</li> </ul> <p>Zip codes shall display nine digits.</p> <p>All references to dates shall be displayed consistently throughout the system (MM/DD/YYYY).</p> <p>All data labels and definitions used shall be consistent throughout the system and clearly defined in user manuals and data element dictionaries.</p> <p>All Replacement MMIS-generated messages shall be clear, user-friendly, and sufficiently descriptive to provide enough information for problem correction.</p> <p>All Replacement MMIS views shall display the generating program identification name and/or number. The display shall be consistent from view to view.</p>	
	<b>Workflow Management</b>	
40.1.2.66	Fiscal Agent (Operations Phase) shall perform manual workload balancing.	
40.1.2.67	Fiscal Agent (Operations Phase) shall perform work item reassignments.	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
<b>Rules Engine</b>		
40.1.2.68	Fiscal Agent (Operations Phase) shall configure and maintain all business rules in the rules engine throughout the life of the Contract.	
40.1.2.69	Fiscal Agent (Operations Phase) shall maintain up-to-date business rule documentation.	
40.1.2.70	Fiscal Agent (Operations Phase) shall perform business rule changes on a release basis.	
<b>Integrated Test Facility</b>		
40.1.2.71	Fiscal Agent (DDI and Operations Phases) Fiscal Agent shall provide the State with access to the ITF as required for testing on site, from State office, and/or remotely throughout the life of the Contract.	
40.1.2.72	Fiscal Agent (DDI Phase) shall support a minimum of twenty-five (25) simultaneous State testers, either at the local Fiscal Agent site and/or remotely.	
40.1.2.73	Fiscal Agent (DDI and Operations Phases) shall coordinate with State agencies for online and batch testing and execute online and batch testing as required to support State applications throughout the life of the Contract.	
40.1.2.74	Fiscal Agent (DDI and Operations Phases) shall execute online testing and batch test cycles and related activities to support State testing.	
40.1.2.75	Fiscal Agent (DDI and Operations Phases) shall support all ITF functions, files, and data elements necessary to meet the RFP requirements.	
40.1.2.76	Fiscal Agent (DDI and Operations Phases) shall coordinate with the State and DHHS IT system vendor to perform appropriate system tests during implementation of the DHHS IT system.	
<b>Training</b>		
40.1.2.77	Fiscal Agent (DDI and Operations Phases) shall develop training to incorporate policy, procedures, regulatory guidelines, business rules, and claim processes to ensure a comprehensive approach to meeting the training requirements of the State.	
40.1.2.78	Fiscal Agent (DDI and Operations Phases) shall develop State-approved training materials for all users and make them available online.	



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
40.1.2.79	Fiscal Agent (Operations Phase) shall submit the Training Plan to the State no less than ninety (90) days prior to the beginning of each Contract year.	
40.1.2.80	Fiscal Agent (DDI and Operations Phases) shall conduct instructor-led classroom training for all users prior to Replacement MMIS implementation and throughout the life of the Contract.	
40.1.2.81	Fiscal Agent (DDI and Operations Phases) shall provide and maintain a training classroom(s) and equipment within the Fiscal Agent's Raleigh, NC, facility, providing at least one (1) pre-scheduled classroom session per month for all users. Sessions shall accommodate up to fifty (50) attendees.	
40.1.2.82	Fiscal Agent (DDI and Operations Phases) shall monitor, track, and evaluate effectiveness of training using training industry standard methodologies.	
40.1.2.83	Fiscal Agent (DDI and Operations Phases) shall provide blended, consistent training for State, local agency, and Fiscal Agent staff for all Replacement MMIS application systems.	
40.1.2.84	Fiscal Agent (Operations Phase) shall report to the State monthly on Fiscal Agent staff training and proficiencies.	
40.1.2.85	Fiscal Agent (DDI and Operations Phases) shall develop instructor-led classroom and CBT courses for provider education and training for all provider types.	
40.1.2.86	Fiscal Agent (Operations Phase) shall conduct seventy (70) instructor-based training workshops annually on State-approved content in geographical areas across the State after Replacement MMIS implementation.	
40.1.2.87	Fiscal Agent (Operations Phase) shall participate in semi-annual Finance and Reimbursement Officers (FARO) conferences as requested by the State.	
40.1.2.88	Fiscal Agent (Operations Phase) shall plan, organize, and conduct the annual Medicaid Fair.	
40.1.2.89	Fiscal Agent (Operations Phase) shall conduct on-site training sessions based on claims processing performance criteria or requests from providers, billing groups, or State/county staff.	
	<b>Call Center Services</b>	
40.1.2.90	Fiscal Agent (Operations Phase) shall provide sufficient staff for all call centers and help desks so that ninety (90) percent of all phone calls are	





**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
	not on hold for more than sixty (60) seconds before a staff person, not an automated answering device, answers.	
40.1.2.91	Fiscal Agent (Operations Phase) shall provide sufficient staff and phone lines for all call centers and help desks so that less than one (1) percent of all phone calls are abandoned, dropped, or receive a busy signal.	
40.1.2.92	Fiscal Agent (Operations Phase) shall provide technical Help Desk support during all hours of system availability.	
	<b>LAN/WAN Management Operational Requirement</b>	
40.1.2.93	Fiscal Agent (Operations Phase) shall provide technical expertise for the management, performance, and configuration of the Replacement MMIS network, LAN/WAN management, and support.	
	<b>Audit</b>	
40.1.2.94	Fiscal Agent (Operations Phase) shall provide assistance to the State, or any reviewing entity identified by the State, with resources, data, and reports in the audit of Fiscal Agent performance, compliance, and system reviews.	
40.1.2.95	Fiscal Agent (Operations Phase) shall contract with an independent qualified audit firm to perform a Statement on Auditing Standards (SAS) 70 audit of the Replacement MMIS and produce a SAS 70 Type 2 Report. The audit and report shall include the operations of the Fiscal Agent's local site as well as any other sites used by the Fiscal Agent for Replacement MMIS processing or related activities. Specific requirements of the SAS 70 Type 2 Report are identified in Appendix 40, Attachment D of this RFP.	
	<b>System/Software Maintenance</b>	
40.1.2.96	Fiscal Agent (Operations Phase) shall be required to perform system maintenance to the Replacement MMIS based on State-approved CSRs.	
40.1.2.97	Fiscal Agent (Operations Phase) shall develop specifications, impact statements, cost analysis, and consideration as to the long-term value of performing the maintenance requirements for the State's evaluation.	
40.1.2.98	Fiscal Agent (Operations Phase) shall perform timely updates to system and user documentation, desk procedures, provider manuals, and training materials prior to the release of changes into production.	
40.1.2.99	Fiscal Agent (Operations Phase) shall perform maintenance to include, without limitation: <ul style="list-style-type: none"> <li>▪ activities necessary for the system to meet the requirements</li> </ul>	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
	<p>described in the RFP;</p> <ul style="list-style-type: none"> <li>▪ activities related to file growth and partitioning;</li> <li>▪ support of updates to all files and databases;</li> <li>▪ software and hardware updates, as directed by the State;</li> <li>▪ RDBMS routine activities;</li> <li>▪ LAN/WAN administration and maintenance to ensure performance standards are met;</li> <li>▪ activities necessary to ensure that all data, files, programs, utilities, and system and user documentation are current and that errors found are corrected;</li> <li>▪ file maintenance, including manual table entry and programming, to support file maintenance changes, performance tuning, capacity planning, backup and recovery tasks, and archival tasks;</li> <li>▪ all ongoing tasks, such as CPT, Healthcare Common Procedure Coding System (HCPCS), and Diagnosis-Related Group (DRG) International Classification of Diseases (ICD)-9/ICD-10 updates, to ensure system tuning, performance, response time, capacity planning, database stability, and processing conforming to the minimum requirements of this Contract;</li> <li>▪ changes to tables for edit criteria;</li> <li>▪ activities in support of updates to all files and databases, including the rules engine;</li> <li>▪ add new values or changes to existing values found within internal program tables;</li> <li>▪ enact rate changes, individual or mass adjustments, purging of files, research, system recycling, minor modifications, and repetitive requests that are done on a set frequency that have not been incorporated into the system by the Fiscal Agent, e.g., Healthcare Coordinator monthly payments, 1099s, monthly, quarterly, year-end, and fiscal year-end reporting;</li> <li>▪ process improvements;</li> <li>▪ State-approved recoupments and adjustments not related to errors and omissions that are the responsibility of the Fiscal Agent requiring programming support Operations Incident Reporting; and</li> <li>▪ Rules engine configuration and maintenance.</li> </ul>	
	<b>System Modifications</b>	
40.1.2.100	Fiscal Agent (DDI and Operations Phases) shall perform system modifications when the State or the Fiscal Agent determines that an	



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
	additional requirement must be met or that a modification to an existing file structure or current processing (outside of those discussed above as maintenance activities) is needed. Fiscal Agent billing for modification shall be in compliance with Section 30 of this RFP.	
40.1.2.101	Fiscal Agent (DDI and Operations Phases) shall develop specifications, impact statements, cost analysis, and consideration as to long-term value of performing the modification requirements for the State's evaluation.	
40.1.2.102	Fiscal Agent (Operations Phase) shall perform timely updates to system and user documentation, desk procedures, provider manuals, and training materials prior to the release of the modification into production.	
40.1.2.103	Fiscal Agent (Operations Phase) shall allocate system modification tasks against productive hours.	
40.1.2.104	Fiscal Agent (DDI and Operations Phases) shall manage system modification activities using the change management process.	
40.1.2.105	Fiscal Agent shall submit to the State for review and approval all modifications and other work estimate prior to beginning the work.	
40.1.2.106	Fiscal Agent (Operations Phase) shall assess only productive work hours against the modification hour pools, and the hours shall directly contribute to the modification of the Replacement MMIS.	
40.1.2.107	Fiscal Agent (Operations Phase) shall not allocate supervisory or other project work accomplished by key personnel towards the productive hours. The hours devoted to supervision or management by non-key personnel may be counted as productive hours, but they can make up no more than fifteen (15) percent of the total hours reported.	
	<b>Data Integrity</b>	
40.1.2.108	Fiscal Agent (DDI and Operations Phases) shall maintain a copy of all documentation related to all versions of changed records and files that were saved and a mechanism to retrieve in their historical format	

### 40.1.3 Personnel Staffing

Requirement #	Requirement Description	Non-Medicaid Only



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



40.1.3.1	<p>The Fiscal Agent shall maintain documentation regarding current license and certification status for all who are required to be licensed or certified throughout the life of the Contract. The Fiscal Agent shall provide such documentation to the State, when requested.</p> <p>Refer to Appendix 50, Attachment I.</p>	
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### 40.2 RECIPIENT REQUIREMENTS

#### 40.2.1 Recipient System Requirements

Requirement #	Requirement Description	Non-Medicaid Only
40.2.1.1	Provides capability for access to recipient data using any combination of name or partial name, date of birth (DOB), gender, Medicare Health Insurance Claim Number (HICN), and/or county	
40.2.1.2	Provides capability for access to recipient data using any recipient ID number or SSN without other qualifiers	
40.2.1.3	Provides capability for name and partial-name search through use of a proven phonetic/mnemonic algorithm, such as Soundex or a State-approved alternative	
40.2.1.4	Provides capability to maintain an online audit trail of all updates to recipient data and provides online access to audit trail for all State-authorized individuals	
40.2.1.5	Provides capability to support classification of recipients into multiple concurrent eligibility groups by health benefit program and benefit plan based on State entities' concurrency rules	
40.2.1.6	Provides capability to accept and process online and batch update transactions of recipient data for all recipients from the State eligibility systems, EIS, CNDS, local managing entities (LMEs), and other State-authorized users	
40.2.1.7	Provides capability to perform editing of eligibility transactions and report on transactions that updated successfully, transactions that updated successfully but received soft edits, and transactions that did not update due to receiving hard edits	
40.2.1.8	Provides capability to identify and report on exact duplicate and potential duplicate recipient records within and across lines of business	
40.2.1.9	Provides capability for maintenance of current and historical recipient identification numbers	



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
40.2.1.10	Provides capability to de-link recipient data when it is discovered that a recipient's eligibility has been collapsed erroneously into another recipient or re-link recipient's eligibility that has been erroneously split out from the recipient; this includes eligibility data, TPL, buy-in data, prior approvals, service limits, consents, and any other data identified by the State	
40.2.1.11	Provides capability to use Enrollment Database (EDB) information to detect Medicare and Medicare HMO entitlement for use in claims processing	
40.2.1.12	Provides capability to maintain five (5) years of historical recipient information online and five (5) years near-line, including history of changes to name, DOB, SSN, and recipient address	
40.2.1.13	Provides capability for notes tracking by recipient to accommodate tracking of calls regarding claims, complaints, customer service, and TPL, and provides easy access to the call information by authorized users	
40.2.1.14	Provides capability for updating recipient letter templates with free-form text to support cases specific to a recipient data issue or specific applicant/recipient	
40.2.1.15	Provides capability to reconcile CNDS data with Replacement MMIS data each State business day in order to verify that all records and segments received through the CNDS interface are processed or are listed on error reports	
40.2.1.16	Provides capability to reconcile State-entity DMA eligibility data with the Replacement MMIS each State business day in order to verify that all records and segments received through the EIS interface are processed or are listed on error reports	
40.2.1.17	Provides capability to reconcile DMH Accredited Standard Committee (ASC) X12N 834 transactions eligibility data with the Replacement MMIS each State business day in order to verify that all records and segments received via the 834 transaction are processed or are listed on error reports	X
40.2.1.18	Provides capability for State staff to enter online recipient-specific overrides to the timely billing edit for claims processing	
40.2.1.19	Provides capability to receive and process State entities' Eligibility History data from DIRM or ITS prior to operational startup	
40.2.1.20	Provides capability for Recipient/Client Eligibility Cross-Reference data for State entities, including all CNDS updates by participating organizations as appropriate to the State entity	



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
40.2.1.21	Provides capability to allow access to the entire recipient record via a common CNDS ID for recipients with multiple cross-referenced IDs, regardless of the number of cross-references, including claims data, eligibility data, TPL data, buy-in data, prior approvals, service limits, and consents	
40.2.1.22	Provides capability to retain the CNDS ID used for Federal reporting when recipient IDs are combined	
40.2.1.23	Provides capability for online updates to the CNDS for maintenance of cross-reference and demographic information	
40.2.1.24	Provides capability for online updates for performing client “combine” functions when multiple CNDS IDs are identified for a single client, according to CNDS rules	
40.2.1.25	Provides capability to produce a report of CNDS cross-reference ID updates within and across lines of business	
40.2.1.26	Provides capability for online updates of fields not updated through the State’s eligibility update	
40.2.1.27	Provides capability to receive and process deductible information from the recipient eligibility record and make it available for claims processing	
40.2.1.28	Provides capability to process updates to recipients of North Carolina Health Choice for Children (NCHC) as any other recipient eligibility update (NCHC is equivalent to State Children's Health Insurance Program.)	
40.2.1.29	Provides capability to accept recipient eligibility segments from EIS and CNDS with no limitations on the number of eligibility segments maintained within the Replacement MMIS	
40.2.1.30	Provides capability to process and reconcile the full file of EIS and the Replacement MMIS recipient eligibility records	
40.2.1.31	Provides capability for transmission and receipt of buy-in data to and from CMS via DIRM interface in accordance with CMS Redesign practices	
40.2.1.32	Provides capability to produce buy-in update transactions for Warrant Calculation and Previously Unknown County Warrant Calculation for Medicare Parts A and B	
40.2.1.33	Provides capability to edit all buy-in transactions for completeness of required fields, reasonability of dates, accuracy of converted Railroad Retirement numbers, presence on the Replacement MMIS eligibility file,	



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
	and unwanted duplication	
40.2.1.34	Provides capability for online inquiry into buy-in current status and full buy-in history for all affected individuals on the Replacement MMIS eligibility file(s)	
40.2.1.35	Provides capability to automatically create a buy-in deletion transaction in the month in which death of the recipient or termination of the Medicaid case is recorded on the Replacement MMIS file  Date of death and termination of the Medicaid case are included in the eligibility record received from EIS.	
40.2.1.36	Provides capability to process buy-in updates from CMS via DIRM interface in accordance with CMS Redesign practices	
40.2.1.37	Provides capability to produce reports after each buy-in update to identify all transactions received, all transactions that processed successfully, and all transactions that had errors, invalid data, and/or could not be matched to a recipient in accordance with CMS Redesign practices	
40.2.1.38	Provides capability to void eligibility segments	
40.2.1.39	Provides capability for State staff to enter an online request for a recipient ID card	X
40.2.1.40	Provides capability for system notification from MMIS Recipient business area to MMIS Managed Care business area whenever retroactive managed care enrollment/disenrollment occurs	
40.2.1.41	Provides capability to notify TPL electronically whenever retroactive Medicare enrollment occurs	
40.2.1.42	Provides capability to notify claims electronically whenever retroactive Medicaid eligibility occurs for a recipient eligible in another health benefit program	
40.2.1.43	Provides capability to create claim financial transactions for each CMS buy-in update record	
40.2.1.44	Provides capability to allow adjustments to buy-in claim financial transactions	
40.2.1.45	Provides capability to run the final buy-in cycle for receipt by CMS no later than the 25 <sup>th</sup> of each month  Date of final monthly cycle runs shall be directed by the State.	
40.2.1.46	Provides capability upon completion of the final cycle run to immediately	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
	produce buy-in final cycle reports on paper, if requested, and deliver to the State within two (2) business days	
40.2.1.47	Provides capability to accept and process updates to the EDB from CMS via DIRM interface	
40.2.1.48	Provides capability to accept and process updates to the Beneficiary Data Exchange (BENDEX) from the Social Security Administration via a DIRM interface	
40.2.1.49	Provides capability to edit online recipient update transactions for completeness, consistency, and valid values	
40.2.1.50	Provides capability to identify the correct eligibility group and associated premium using information on the recipient's eligibility record	
40.2.1.51	Provides capability to produce and send correspondence related to recipient premiums—including invoices, notices of non-payment, cancellation notices, receipts, and refunds—in the recipient's preferred language	
40.2.1.52	Provides capability to collect recipient premium payments	
40.2.1.53	Provides capability to produce refunds of recipient premiums	
40.2.1.54	Provides capability to process financial accounting records for premium payments and refunds	
40.2.1.55	Provides capability to produce reports for recipient premium payment and cost-sharing processes	
40.2.1.56	Provides capability to apply cost-sharing	
40.2.1.57	Provides capability to ensure cost-sharing does not exceed threshold for the family group	
40.2.1.58	Provides capability to associate multiple cases in a family together to ensure cost-sharing does not exceed threshold	
40.2.1.59	Provides capability to send recipient notices and Explanations of Benefits (EOB) in recipient's preferred language	
40.2.1.60	Provides capability to produce a Certificate of Creditable Coverage (COCC) for each recipient deleted/terminated from specified Medicaid coverage	
40.2.1.61	Provides capability to produce a COCC for a specific period if requested by the recipient/client or by the State	





## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
40.2.1.62	Provides capability for an online request function to allow the State to request a COCC for a specific recipient for a specific period	
40.2.1.63	Provides capability to produce a Monthly Summary Report indicating all COCCs mailed to recipients per month that includes: <ul style="list-style-type: none"> <li>▪ Total number of COCCs mailed</li> <li>▪ Total number of COCCs mailed within five (5) days of date of termination/request</li> <li>▪ Total number of COCCs mailed later than five (5) days from the date of termination/request</li> </ul>	
40.2.1.64	Provides capability to use transfer of assets data on the Medicaid recipient record in claims processing	
40.2.1.65	Provides capability to create a report of recipients with paid claims for targeted services for whom a transfer of assets indicator is not on file	
40.2.1.66	Provides capability to provide DIRM an electronic copy of the report of recipients with paid claims for targeted services for whom a transfer of assets indicator is not on file for publication for county Department of Social Services (DSS) agencies	
40.2.1.67	Provides capability to create a report of individuals with a transfer of assets sanction	
40.2.1.68	Provides capability to provide DIRM an electronic copy of the report of individuals with a transfer of assets sanction for publication for county DSS agencies	
40.2.1.69	Provides capability to create the Medicare Modernization Act (MMA) Enrollment File based on selection criteria provided by the State in the format specified by CMS	
40.2.1.70	Provides capability to include data in the MMA Enrollment File necessary to count the number of enrollees for the phased-down State contribution payment	
40.2.1.71	Provides capability to include records in the MMA Enrollment File for those individuals for whom the State has made an enrollment determination for the Part D low income subsidy	
40.2.1.72	Provides capability to transmit the MMA Enrollment File to DIRM for transmission to CMS	
40.2.1.73	Provides capability to process the MMA Enrollment Response File from CMS transmitted via DIRM interface	



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
40.2.1.74	Provides capability to produce a report of all records transmitted on the MMA Enrollment File	
40.2.1.75	Provides capability to produce a report of all records received on the MMA Response File, identifying any errors, records unable to be matched to a recipient on the Replacement MMIS, and records unable to be processed	
40.2.1.76	Provides capability for online access to MMA Response File records that were in error or unable to be matched with a recipient on the Replacement MMIS	
40.2.1.77	Provides capability for online access to a summary of the recipient's MMA Enrollment and Response File records	
40.2.1.78	Provides capability for online access to the MMA record selected from the summary	
40.2.1.79	Provides capability for online access to Medicare coverage data from EIS for Parts A, B, C, and D for Medicaid recipients	
40.2.1.80	Provides capability to accept and process Medicaid/Medicare coverage data from EIS and make it available for claims processing	
40.2.1.81	Provides capability for online access to add, update, and inquire into Medicare data for DMH and DPH recipients	X
40.2.1.82	Provides capability to produce eligibility extracts for contractors with whom DMA does business	
40.2.1.83	Provides capability to use CNDS governance rules to determine which demographic data has priority when a recipient is enrolled concurrently in multiple lines of business and benefit plans	
40.2.1.84	Provides capability for multiple types of recipient addresses per line of business (LOB)	
40.2.1.85	Provides capability for a Client Services Data Warehouse (CSDW) extract of recipient data	
40.2.1.86	Provides capability to produce letters/notices to applicants/recipients	
40.2.1.87	Provides capability to send, receive, and update Provider data between DHSR and the Replacement MMIS for placement of eligible recipient	
<b>DPH Online Enrollment</b>		
40.2.1.88	Provides capability to accept Web-submitted and hard copy financial	X



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
	eligibility applications (DHHS 3014) for program participation	
40.2.1.89	Provides capability for enrollment instructions and guidelines for supporting functions by selected enrollment options	X
40.2.1.90	Provides capability to accept Web-submitted and hard copy supporting documentation for financial eligibility applications	X
40.2.1.91	Provides capability to upload attachments electronically and associate attachments with submitted financial eligibility applications	X
40.2.1.92	Provides capability to receive paper and facsimile documentation, scan it so it can be viewed online, and associate documentation with the submitted financial eligibility application	X
40.2.1.93	Provides capability to identify and assign the applicant's CNDS ID and associate/link it to the financial eligibility application in accordance with CNDS Governance Rules	X
40.2.1.94	Provides capability for State DPH staff to enter the status of the application as either complete or incomplete	X
40.2.1.95	Provides capability to place all applications in an online work queue for State DPH eligibility staff to review	X
40.2.1.96	Provides capability for State DPH staff to accept, reject, and/or modify income and deductions provided on the application and provides capability to indicate the reason income and/or deductions are rejected or modified	X
40.2.1.97	Provides capability for State DPH staff to indicate if an application is complete and ready for disposition	X
40.2.1.98	Provides capability to calculate recipient income based on information provided on an application and compare it to program thresholds to determine financial eligibility	X
40.2.1.99	Provides capability to electronically store and maintain DPH eligibility data in the Recipient business area	X
40.2.1.100	Provides capability to electronically store and maintain multiple addresses for one recipient, including correspondence mailing, pharmacy mailing, residence, and alternate and to maintain history of addresses	X
40.2.1.101	Provides capability to electronically store and maintain the name, mailing address, and agency of the application interviewer	X
40.2.1.102	Provides capability to electronically store and maintain the name,	X



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
	mailing address, and relationship of an individual other than the applicant/recipient to receive copies of notices and letters if requested	
40.2.1.103	Provides capability to produce system-generated letters/notices of approvals or denials	X
40.2.1.104	Provides capability to maintain the necessary data elements to produce reports on demand with date span parameters based on application and/or recipient characteristics	X
40.2.1.105	Provides capability for inquiry selection for one (1) or more applications/records that meet specified criteria, by any of the following: <ul style="list-style-type: none"> <li>▪ Application/case number</li> <li>▪ Applicant name (partial or complete)</li> <li>▪ Applicant name phonetic (partial or complete)</li> <li>▪ CNDS ID,</li> <li>▪ SSN</li> <li>▪ Date of birth</li> </ul>	X
40.2.1.106	Provides capability to store abandoned or incomplete applications indefinitely	X
40.2.1.107	Provides capability to store and maintain all applications for program participation	X
40.2.1.108	Provides capability to maintain an audit trail to document time stamp and user ID information for all applications added to the application file	X
40.2.1.109	Provides capability to maintain an audit trail to document before and after image of changed data, time stamp of the change, and the user ID information for all changes made to the application data	X
40.2.1.110	Provides capability to document date and time of receipt of supporting documentation for applications	X
40.2.1.111	Provides capability to produce a weekly aging report that lists work queue status	X
40.2.1.112	Provides capability to produce identification cards for approved recipients; the card must identify the recipient, provide the recipient's identification number, and not contain eligibility information	X
40.2.1.113	Provides capability for recipient lock-in/lock-out to a specific pharmacy and/or primary care provider and/or prescriber	
40.2.1.114	Provides capability for recipient lock-in/lock-out from a specific	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
	pharmacy and/or primary care provider and/or prescriber	
40.2.1.115	Provides capability for claims exceptions to process automatically when prior authorized by the lock-in/lock-out primary care provider or prescriber in accordance with State policy	
40.2.1.116	Provides capability for historical begin and end dates for each lock-in and lock-out segment, as well as the reason for lock-in/lock-out	
40.2.1.117	Provides capability for an unlimited number of lock-in/lock-out segments per recipient	
40.2.1.118	Provides capability for multiple concurrent active lock-in/lock-out segments of any type	
40.2.1.119	Provides capability for online inquiry and update into lock-in/lock-out segments	
40.2.1.120	Provides capability to maintain an audit trail of all changes to lock-in/lock-out segments	
40.2.1.121	Provides capability for online inquiry into audit trail	
40.2.1.122	Provides capability for confidential enrollment (when a potential client is unable or unwilling to identify himself or herself) for DMH  These recipients will require separate tracking to avoid potential duplicate enrollment of applicants when they become clients.	X
40.2.1.123	Provides capability to associate an individual with a specific provider, including long-term care and group living arrangements, with a begin and end date for each segment, including sponsoring agency, authorizer, level of care, date certified, date of next certification, and patient share of cost, including deductibles and patient liability	

**40.2.2 Recipient Operational Requirements**

Requirement #	Requirement Description	Non-Medicaid Only
40.2.2.1	Fiscal Agent shall reconcile specified CNDS data with the Replacement MMIS each State business day. This reconciliation process will verify that all records and segments received through the CNDS interface are processed or are listed on error reports.	
40.2.2.2	Fiscal Agent shall reconcile specified State-entity DMA eligibility data with EIS each State business day. This reconciliation process will verify	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
	that all records and segments received through the EIS interface are processed or are listed on error reports.	
40.2.2.3	Fiscal Agent shall reconcile specified State-entity DMH eligibility data with ASC X12N 834 transactions each State business day. This reconciliation process will verify that all records and segments received via the 834 transaction are processed or are listed on error reports.	X
40.2.2.4	Fiscal Agent shall coordinate with the applicable State entity to resolve Medicare enrollment problems.	
40.2.2.5	Fiscal Agent shall perform buy-in functions for the North Carolina Medicaid Program using automated and manual operating procedures.	
40.2.2.6	Fiscal Agent shall support training requirements for LMEs, local health departments, Developmental Evaluation Centers/Children's Developmental Services Agencies (DECs/CDSAs), DPH, and other State-approved local entities.	X
40.2.2.7	Fiscal Agent shall communicate with recipients and employers regarding COCCs verbally and in written correspondence.	
40.2.2.8	Fiscal Agent shall identify and assign the applicant's CNDS ID and associate/link it to the financial eligibility application in accordance with CNDS Governance Rules.	X

**40.2.3 Recipient Operational Performance Standards**

Requirement #	Requirement Description	Non-Medicaid Only
40.2.3.1	Fiscal Agent shall provide online access to State entities' eligibility edit/error reports by 7:00 A.M. Eastern Time each State business day.	
40.2.3.2	Fiscal Agent shall update the Replacement MMIS with batch eligibility data from each State entity by 7:00 A.M. Eastern Time each State business day.	
40.2.3.3	Fiscal Agent shall update each State entity's Eligibility Data from online processes for State EIS, CNDS, LMEs, and DPH in near-real time.	
40.2.3.4	Fiscal Agent shall generate COCC and log the mail date for each COCC mailed. Fiscal Agent shall provide a monthly report with the number of recipients/clients terminated from each health plan and the number of COCC mailed within one (1) month of the termination.	

**40.3 ELIGIBILITY VERIFICATION SYSTEM REQUIREMENTS**

**40.3.1 EVS System Requirements**

Requirement #	Requirement Description	Non-Medicaid Only
40.3.1.1	Provides capability to receive and process ASC X12N 270/271 eligibility inquiry and response transactions in real-time and batch transactions	
40.3.1.2	Provides capability for inquiry via ASC X12N 270 transactions by recipient identification number, recipient full name and DOB, recipient partial name and DOB, and recipient SSN and DOB	
40.3.1.3	Provides capability for ensuring safeguards in responses via ASC X12N 271 transactions, including: <ul style="list-style-type: none"> <li>▪ Limiting access to eligibility information to authorized medical providers, VANs, and authorized State personnel only; and</li> <li>▪ Protecting the confidentiality of all recipient information</li> </ul>	
40.3.1.4	Provides capability for access to eligibility verification inquiry to inquire for dates of service within the preceding twelve (12) months	
40.3.1.5	Provides capability for an online audit trail of all inquiries and verification responses made, the information conveyed, and to whom the information was conveyed	
40.3.1.6	Provides capability to report all EVS transactions online, segregating transaction data by provider and source of inquiry (Automated Voice Response System [AVRS], Web, EVS, etc.) at a minimum	
40.3.1.7	Provides capability to uniquely identify and track each EVS recipient eligibility verification inquiry and response	
40.3.1.8	Provides capability to issue a reference number to a provider for any Medicaid eligibility inquiry and response issued from the EVS	

**40.3.2 EVS Operational Requirements**

Requirement #	Requirement Description	Non-Medicaid Only
40.3.2.1	Fiscal Agent shall obtain State approval and demonstrate acceptable test results to the State prior to implementing each VAN.	

Requirement #	Requirement Description	Non-Medicaid Only
40.3.2.2	Fiscal Agent shall provide necessary file specifications and testing assistance to VANs on how to access EVS.	
40.3.2.3	Fiscal Agent shall provide the necessary instructions to State and VANs in how to use the EVS. <i>Note: The VANS are responsible for training the providers who contract with them.</i>	

**40.3.3 EVS Operational Performance Standards**

Requirement #	Requirement Description	Non-Medicaid Only
40.3.3.1	Fiscal Agent shall provide for a response from the EVS in three (3) seconds or less ninety-eight (98) percent of the time, twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year.	
40.3.3.2	Fiscal Agent shall provide applicable documentation and successful test data for State approval within ten (10) State business days prior to VAN Replacement MMIS implementation.	
40.3.3.3	Fiscal Agent shall ensure the EVS is available ninety-nine and nine tenths (99.9) percent of the time, twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year, except for scheduled downtimes.	

**40.4 AUTOMATED VOICE RESPONSE SYSTEM REQUIREMENTS**

**40.4.1 AVRS System Requirements**

Requirement #	Requirement Description	Non-Medicaid Only
40.4.1.1	Provides AVRS capability and toll-free telephone access for providers and Medicaid recipients to access information from the Replacement MMIS AVRS, twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year except for agreed-upon scheduled down-time for maintenance	
40.4.1.2	Provides capability for an online audit trail of all inquiries and verification responses made, the information conveyed, and to whom the	





**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
	information was conveyed	
40.4.1.3	Provides capability for eligibility verification inquiry by recipient identification number, or SSN and DOB, and date of service	
40.4.1.4	Provides capability for access to eligibility verification for dates of service within the preceding 365 days	
40.4.1.5	Provides capability for access to eligibility verification for dates of service not greater than the current date for Medicaid recipients	
40.4.1.6	Provides capability for access to eligibility verification for dates of service not greater than the current date plus 365 days for DPH recipients	X
40.4.1.7	Provides capability for system-generated monthly reporting of AVRS daily system availability checks	
40.4.1.8	Provides capability for an AVRS menu Help option, accessible at any time during the call, which allows callers a choice of being transferred to the Fiscal Agent call center or being directed to a specific Web site where detailed, written instructions are available	
40.4.1.9	Provides capability for menu options to distinguish between NC DHHS provider and Medicaid recipient callers; designs cascading options appropriate to these two (2) caller types	
40.4.1.10	Provides capability for AVRS to repeat to caller the recipient's full name and spelling of full name exactly as defined in the Recipient business area	
40.4.1.11	Provides capability to process inquiries made by enrolled providers entering either a National Provider Identifier (NPI) or a legacy provider ID number (for atypical providers)	
40.4.1.12	Provides capability to process inquiries made by Medicaid recipients entering the recipient's Medicaid ID number, DOB, and SSN	
40.4.1.13	Provides capability to report all AVRS transactions online, segregating transaction data by caller type (provider or recipient), inquiry type (eligibility, claim status, etc.), and inquiry source (AVRS, Web, EVS, etc.)	
40.4.1.14	Provides capability to allow access by providers, aides, potential employers, etc. via AVRS to the Division of Health Service Regulation (DHSR) Health Care Personnel Registry (HCPR) and the DHSR Nurse Aide Training & Registry (NATRA) for inquiry on DHSR registry information	X



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
40.4.1.15	Provides capability to allow callers to interact with the AVRS by interactive voice response (IVR) or by touch-tone telephone keypad	
40.4.1.16	Provides capability to retain and transfer all information entered and received when the caller chooses to be transferred to the Fiscal Agent call center	
40.4.1.17	Provides capability to switch from English to other languages for all Medicaid recipient inquiry options	
40.4.1.18	Provides capability to refer or transfer recipient calls for information about additional translator services	
40.4.1.19	Provides capability for providers to enter real-time requests for prior approval adjudication via AVRS	
40.4.1.20	Provides capability to interface with the communication solution that will execute a fax verification (and/or e-mail verification, if no protected health information is involved) of entry, approval, or denial of a prior approval request	
40.4.1.21	Provides capability for providers to request printed copies of their Remittance Advice (RA) statements	
40.4.1.22	Provides capability for call flows for the following provider inquiry types: <ul style="list-style-type: none"> <li>▪ Claim status</li> <li>▪ Checkwrite</li> <li>▪ Drug coverage</li> <li>▪ Procedure code pricing</li> <li>▪ Modifier verification</li> <li>▪ Procedure code and modifier combination</li> <li>▪ Procedure code pricing for Medicaid Community Alternatives Program services</li> <li>▪ Prior approval for procedure code</li> <li>▪ Medicaid dental benefit limitations</li> <li>▪ Medicaid refraction and eyeglass benefits</li> <li>▪ Medicaid prior approval for durable medical equipment (DME), orthotics, and prosthetics</li> <li>▪ Prior Approval for DPH benefits</li> <li>▪ Recipient eligibility, enrollment, and Medicaid service limits</li> <li>▪ Sterilization consent and hysterectomy statement inquiry</li> </ul>	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
	<ul style="list-style-type: none"> <li>▪ Referrals</li> <li>▪ Medicaid Carolina ACCESS Emergency Authorization Overrides</li> </ul>	
40.4.1.23	Provides capability to allow the Carolina ACCESS referring provider and the Carolina ACCESS referred-to provider to inquire on the primary care provider referral status	
40.4.1.24	Provides capability for call flows for responses for the following Medicaid recipient inquiry types: <ul style="list-style-type: none"> <li>▪ Medicaid eligibility</li> <li>▪ Managed care enrollment information, including the primary care provider name, address, and daytime and after-hours phone numbers</li> <li>▪ Third party liability</li> <li>▪ Medicare coverage</li> <li>▪ Well child checkup dates</li> <li>▪ Hospice eligibility</li> </ul>	
40.4.1.25	Provides capability to uniquely identify and track each AVRS recipient eligibility verification inquiry and response	
40.4.1.26	Provides capability to return a reference number to a provider for any DMA/Medicaid eligibility verification inquiry and response issued from the AVRS	
40.4.1.27	Provides capability for Web-accessible downloads of AVRS training documentation that will be synchronized with application system updates	
<b>Web Inquiry</b>		
40.4.1.28	Provides capability for an online, HIPAA-compliant inquiry of all information available via the AVRS	
40.4.1.29	Provides capability to return a reference number to a provider for any DMA/Medicaid eligibility verification inquiry and response issued from the Web	
40.4.1.30	Provides capability for Medicaid recipient access to recipient eligibility and enrollment information, including: <ul style="list-style-type: none"> <li>▪ Medicaid eligibility</li> <li>▪ Carolina ACCESS enrollment information to include the primary care provider name, address, and daytime and after-hours phone numbers</li> </ul>	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
	<ul style="list-style-type: none"> <li>▪ Third party liability</li> <li>▪ Medicare coverage</li> <li>▪ Well child checkup dates</li> <li>▪ Hospice eligibility</li> </ul>	
40.4.1.31	Provides capability for the option to switch from English to non-English (Spanish, Russian, Hmong, etc.) static content on each non-secure page that is targeted for consumers/recipients for all Medicaid recipient inquiry options	
40.4.1.32	Provides capability for the option to switch from English to non-English (Spanish, Russian, Hmong, etc.) static content on each secure page targeted for recipients for all Medicaid recipient inquiries and responses	
40.4.1.33	Provides capability for English and non-English (Spanish, Russian, Hmong, etc.) versions of all downloadable written materials targeted for recipients/consumers	
40.4.1.34	Provides capability to report all Web inquiry transactions online, segregating transaction data by provider and recipient inquiry, by inquiry type (eligibility, claim status, etc.), and inquiry source (AVRS, Web, EVS, etc.)	
40.4.1.35	Provides capability to uniquely identify and track each online recipient eligibility verification and nurse aide verification inquiry and response	
40.4.1.36	Provides capability to provide access to providers, nurse aides, potential employers of nurse aides, etc., via the Web query functionality to the DHSR Health Care Personnel Registry (HCPR) and the DHSR Nurse Aide Training & Registry (NATRA) for inquiry on DHSR registry information	X
40.4.1.37	Provides capability to report all Web Inquiry transactions online, segregating transaction data by caller type (provider or recipient), inquiry type (eligibility, claim status, etc.) and inquiry source (AVRS, Web, EVS, etc.)	

**40.4.2 AVRS Operational Requirements**

Requirement #	Requirement Description	Non-Medicaid Only
40.4.2.1	Fiscal Agent shall perform daily systems check to ensure that the AVRS electronic interface is working properly and report the findings monthly.	



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
40.4.2.2	Fiscal Agent shall perform transaction analysis by hour of the day, indicate the number of transactions processed, and report the findings monthly.	
40.4.2.3	Fiscal Agent shall perform telephone analysis by hour of the day, track the number of transactions, number of transactions with less than a ten-second (10-second) response time, and number of transactions with greater than a ten-second (10-second) response time, and report the findings monthly.	
40.4.2.4	Fiscal Agent shall operate and maintain a Web site for providers and recipients, nurse aides, potential employers of nurse aides, etc. twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year, with the exception of State-approved scheduled maintenance.	

### 40.4.3 AVRS Operational Performance Standards

Requirement #	Requirement Description	Non-Medicaid Only
40.4.3.1	Fiscal Agent shall provide for a response from the AVRS in three (3) seconds or less ninety-eight (98) percent of the time, twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year, with the exception of State-approved scheduled system maintenance.	
40.4.3.2	Fiscal Agent shall provide system checks to the AVRS daily and log the findings.	
40.4.3.3	Fiscal Agent shall provide monthly AVRS logs within five (5) State business days from the end of the previous month.	
40.4.3.4	Fiscal Agent shall ensure the Web inquiry functionality is available twenty-four (24) a day, seven (7) days a week, three hundred sixty-five (365) days a year, except during State-approved maintenance periods.	

## 40.5 PROVIDER REQUIREMENTS

Provider functionality provides the capability for document imaging/electronic copying and workflow functionality to support all Provider Relations functions, such as:



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



- Provider credentialing, verification, re-credentialing, enrollment, demographic information changes, and related activities,
- Provider communications,
- Provider on-site visits,
- Provider training, and
- Provider publications, letters, and notifications.

**40.5.1 Provider System Requirements**

Requirement #	Requirement Description	Non-Medicaid Only
	<b>Provider Enrollment</b>	
40.5.1.1	Provides capability to interactively enroll eligible providers in a multi-payer environment using a single enrollment strategy to eliminate process redundancy	
40.5.1.2	Provides capability to generate and accept electronic and hard copy supporting documentation for enrollment and re-enrollment or verification functions	
40.5.1.3	Provides capability for provider access to online and batch enrollment functionality	
40.5.1.4	Provides capability for secure log-on that allows providers to retrieve and update incomplete application or check status of a submitted application	
40.5.1.5	Provides capability for a provider to download application for paper submission	
40.5.1.6	Provides capability to edit against duplicate provider record during enrollment, addition, or change processes	
40.5.1.7	Provides capability to image, link, and reference all provider correspondence, enrollment applications, contracts, and supporting documentation to be retrieved by the Fiscal Agent or State-authorized staff	
40.5.1.8	Provides capability for a provider to select services that will be provided at a practice location or by the provider entity	
40.5.1.9	Provides capability to capture and maintain demographic information of the LME from which the provider is seeking and/or has received endorsement	



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
40.5.1.10	Provides capability to capture and maintain Medicare numbers and crossover information	
40.5.1.11	Provides capability for a provider to access enrollment functions, download enrollment package, recall a saved application, submit, and check the status of an application online	
40.5.1.12	Provides capability to receive, image, and link hard copy attachments, executed contracts, and signatory documentation to the provider application	
40.5.1.13	Provides capability to capture and maintain all provider data elements necessary to support the enrollment, credentialing, inquiry, and participation by program	
40.5.1.14	Provides capability to electronically store multiple historic provider identifiers	
40.5.1.15	Provides capability to accept and electronically store multiple occurrences of provider demographic information, including e-mail	
40.5.1.16	Provides capability to capture information on provider billing agents	
40.5.1.17	Provides capability to present customized enrollment application options	
40.5.1.18	Provides capability to edit data during the enrollment process to ensure that all required information is captured based on provider's participation and contractual requirements	
40.5.1.19	Provides capability to present enrollment instructions and guidelines for supporting functions by selected enrollment options	
40.5.1.20	Provides capability to system-generate application attachments based on required criteria and affirmative responses	
40.5.1.21	Provides capability to identify and enroll providers classified as special, atypical, State-funded, or funded by other assistance programs	
40.5.1.22	Provides capability to identify and assign unique identifiers to providers	
40.5.1.23	Provides capability to support a time-limited, abbreviated, or expedited enrollment process that collects a limited amount of information to enroll a provider for a limited period	
40.5.1.24	Provides capability to capture the requestor, sender, and status for all hard copy provider enrollment form requests	
40.5.1.25	Provides capability to capture all enrollment events	



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
40.5.1.26	Provides capability to accept and electronically store electronic funds transfer (EFT) information	
40.5.1.27	Provides capability to flag provider records to support operational activities	
40.5.1.28	Provides capability to capture and validate nine-digit (9-digit) zip code to geographic location	
40.5.1.29	Provides capability to store abandoned or incomplete applications for ninety (90) days	
40.5.1.30	Provides capability to capture provider eligibility, program eligibility, and participation status codes with associated affiliations, effective dates, and end dates	
40.5.1.31	Provides capability to capture the providers' preference to use electronic submittal of claims, remittance, and/or EFT	
40.5.1.32	Provides capability to capture, link, and reference multiple provider affiliations, specialties, and taxonomies, by program, with associated effective and end dates	
40.5.1.33	Provides capability to capture providers' legal business filing status, including Non-profit, Corporate, State-owned, Federally owned, For Profit, and Tribal-owned	
40.5.1.34	Provides capability to capture, verify, and cross-reference provider ownership information	
40.5.1.35	Provides capability to recognize predefined events requiring State determination or intervention	
40.5.1.36	Provides capability to accommodate NPI and multiple associated taxonomies	
40.5.1.37	Provides capability to validate all NPIs	
40.5.1.38	Provides capability for option selection for a provider to indicate preference to receive a paper RA	
40.5.1.39	Provides capability for the system to capture electronic signatures	
40.5.1.40	Provides capability to use workflow functionality to forward a completed application for credentialing/re-credentialing or verification	
40.5.1.41	Provides capability for batch and/or online real-time access between EIS, Mental Health Eligibility Inquiry, CSDW, Medicaid Quality Control, Online Verification, Automated Collection and Tracking System (ACTS),	





## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
	and Health Information System (HIS) and the Replacement MMIS using API and SOA concepts	
40.5.1.42	Provides capability to send, receive, and update data between DHSR and the Replacement MMIS in support of provider participation for enrollment functionality	
	<b>Provider Credentialing</b>	
40.5.1.43	Provides capability to conduct provider credentialing and source verification of provider participation criteria and requirements	
40.5.1.44	Provides capability for credentialing to include Office of Inspector General (OIG) participation "exclusion" data or capability to receive and employ OIG file interface	
40.5.1.45	Provides capability for credentialing process to include criminal background checks and query of the North Carolina State Provider Penalty Tracking "exclusions" data	
40.5.1.46	Provides capability to restrict or eliminate provider billable services if the service requirements are no longer supported (by endorsement, certification, or licensure) with associated begin and end date by service	
40.5.1.47	Provides capability to send and receive electronic communications to support credentialing data verifications	
40.5.1.48	Provides capability to exclude a provider from licensure requirements based on provider type or category	
40.5.1.49	Provides capability to generate notification to providers of status, changes, enrollment, termination, credentialing, re-verification, penalties, and termination	
40.5.1.50	Provides capability to capture and electronically store critical credentialing data missing from current Legacy MMIS+ to support licensure, credentialing, and verification processes	
40.5.1.51	Provides capability to share licensure, endorsement, and accreditation information with issuing agencies, authorized State entities, and users	
40.5.1.52	Provides capability to send notification to a provider of impending renewal	
40.5.1.53	Provides capability to send notification to providers who failed to respond to renewal information requests	
40.5.1.54	Provides capability to send, receive, and update data between DHSR and the Replacement MMIS in support of provider credentialing	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
	functionality	
	<b>Provider Maintenance</b>	
40.5.1.55	Provides capability to present to the provider selected data for verification and update	
40.5.1.56	Provides capability to support different business rule definitions by program and services to be provided	
40.5.1.57	Provides capability to make State-approved forms available online	
40.5.1.58	Provides capability to process online requests for generation and distribution of provider contracts	
40.5.1.59	Provides capability to accept and process online requests for additions and changes to the provider data	
40.5.1.60	Provides capability to capture, identify, and report suspected duplicate provider identification numbers and applicable expiration dates	
40.5.1.61	Provides capability to capture, update, and maintain Clinical Laboratory Improvement Amendments (CLIA) information for providers	
40.5.1.62	Provides capability to track, identify, and provide notification the status of licenses, certifications, endorsements, and State-defined participation requirements or criteria	
40.5.1.63	Provides capability to systematically suspend and notify providers who do not meet enrollment or participation criteria	
40.5.1.64	Provides capability to cross-reference all provider identifiers that correspond to the providers' tax identification/reporting number	
40.5.1.65	Provides capability for online access of providers to training materials, training registrations, and tracking, including audit history of all provider trainings	
40.5.1.66	Provides capability to generate on-demand reports with date span parameters for provider data	
40.5.1.67	Provides capability to enter and maintain tax and financial information, including budget codes for accessing State funds	
40.5.1.68	Provides capability to capture data regarding agency-specific provider incentives, sanctions, withholds, and review processes by issuing agency with beginning and end dates	
40.5.1.69	Provides capability to capture the providers who participate in the	



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
	Competitive Acquisition Program with begin and end dates by program	
40.5.1.70	Provides capability to suspend, sanction, or terminate providers	
40.5.1.71	Provides capability to identify and report on out-of-state provider claims denied for non-enrollment	
40.5.1.72	Provides capability to maintain 1099 and associated payment summary data	
40.5.1.73	Provides capability to identify and reference ownership across multiple occurrences and entities	
40.5.1.74	Provides capability to generate provider notifications of licensure, certification, accreditation, and endorsement renewals or expirations and monitor all response activity	
40.5.1.75	Provides capability for providers to enter requested updates to data and identify instances that require operational review	
40.5.1.76	Provides capability to identify to the State those providers with issues under review, giving the State equal access to work queue and documents to support the business decision process	
40.5.1.77	Provides capability to identify providers for whom mail has been returned and suppress all printing and claims activity	
40.5.1.78	Provides capability to place the provider on pre-payment, post-payment, payment review, compliance payment withholds, and denial as directed by the State	
40.5.1.79	Provides capability to leverage electronic listserv technology to allow providers to register for notifications and facilitate communications	
40.5.1.80	Provides capability for online access by State-authorized users to view and update information on sanctioned providers by LOB	
40.5.1.81	Provides capability to perform manual and automated updates to provider data	
40.5.1.82	Provides capability for online real-time access to Provider data using API and SOA concepts between EIS and the Replacement MMIS	
40.5.1.83	Provides capability for a daily provider table extract	
40.5.1.84	Provides capability for online, real-time responses to EIS and DIRM applications for all provider data processing transactions	
40.5.1.85	Provides capability to send, receive, and update data between DHHS	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
	and the Replacement MMIS in support of provider maintenance functionality	
	<b>Provider Training</b>	
40.5.1.86	Provides capability for online automated provider training and related documentation access	
40.5.1.87	Provides capability to capture and maintain provider-written, verbal, or electronic correspondence requesting an on-site visit or training	
40.5.1.88	Provides capability for automated workflow functionalities to process call center and provider training requests and educational monitoring activities	
40.5.1.89	Provides capability for an online provider training tutorial that can be tailored by selection to facilitate training in a variety of subject matters	
40.5.1.90	Provides capability to image, maintain, and make accessible all (current and historic) course instructional materials	
40.5.1.91	Provides capability to image instructional materials, training evaluations, and other correspondence linked to a site visit to the provider record	
40.5.1.92	Provides capability to track and report on provider requested visits	
40.5.1.93	Provides capability for online and on-site training evaluation questionnaires for providers to complete	
40.5.1.94	Provides capability to develop a State-approved training evaluation process	
40.5.1.95	Provides capability to maintain and submit to the State provider training sessions participants	
40.5.1.96	Provides capability to identify providers with a claims denial rates of twenty (20) percent or higher	
40.5.1.97	Provides capability to maintain State-approved instructional materials for viewing and retrieval	
40.5.1.98	Provides capability for initial and updated State-approved Provider Basic Training Tutorials to be available through Web access	
	<b>Secure, Browser-Based, Web-Enabled Capability To Record and Track All Verbal Communication between State/Fiscal Agent and Providers</b>	
40.5.1.99	Provides capability to record, track, and report on provider and recipient	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
	communication	
40.5.1.100	Provides capability to make provider contact data accessible and retrievable	
40.5.1.101	Provides capability to report on queries for call-related data	
40.5.1.102	Provides capability for communication tracking business area to interface with other MMIS functional areas	
40.5.1.103	Provides capability for individual access to query tools	
40.5.1.104	Provides capability to auto-populate Replacement MMIS provider data into the Web-based provider enrollment and maintenance functions	

**40.5.2 Provider Operational Requirements**

Requirement #	Requirement Description	Non-Medicaid Only
	<b>General</b>	
40.5.2.1	Fiscal Agent shall provide State-authorized access to the Provider database.	
40.5.2.2	Fiscal Agent shall receive and process provider complaints and summarize this activity in the Status Report.	
40.5.2.3	Fiscal Agent shall respond to and report on activities and outcomes of all inquiries referred by the State.	
40.5.2.4	Fiscal Agent shall perform imaging of all provider documents, contracts, agreements, attachments, training and publication material and forms, and on-site visitation documentation, linking them to the provider for viewing and retrieval by State and Fiscal Agent staff.	
40.5.2.5	Fiscal Agent shall provide the capability to link provider applications in PDF format for retrieval via a document management system.	
40.5.2.6	Fiscal Agent shall initiate and complete re-credentialing procedures on all providers who have not been previously credentialed and on providers whose data indicates expiration of any license, accreditation, certification, or other authorizing agencies. All re-credentialing and credentialing should be completed within twelve (12) months of contract start up.	



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
40.5.2.7	Fiscal Agent shall generate and distribute provider contract renewals to providers seventy-five (75) days before expiration.	
40.5.2.8	Fiscal agent shall accept, process, and maintain DMH attending-only provider records entered by the LME	X
<b>Provider Enrollment, Credentialing, and Verification</b>		
40.5.2.9	Fiscal Agent shall implement at the direction of the State suspension or termination action for providers whose licenses have been revoked or suspended by State licensing or accrediting bodies.	
40.5.2.10	Fiscal Agent shall conduct activities to suspend, terminate, or withhold payments, percentages, and incentives from providers under investigation by State or Federal agencies at the sole discretion of the State.	
40.5.2.11	Fiscal Agent shall implement provider sanctions, as directed by the State.	
40.5.2.12	Fiscal Agent shall initiate recoupment/collection of claims and non-claims payments made subsequent to the effective date of an action or sanction, as directed by the State.	
40.5.2.13	Fiscal Agent shall send enrollment information and instructions to a provider whose claims have denied for non-enrollment.	
40.5.2.14	Fiscal Agent shall retain all active and historical provider documents, contracts, participation agreements, and supporting documentation for control, balance, audit, and State retrieval.	
40.5.2.15	Fiscal Agent shall capture and maintain information on all billing agents, including information necessary to identify and contact billing agents and providers using each billing agent within a specified timeframe.	
40.5.2.16	Fiscal Agent shall test potential Trading Partners to be implemented into MMIS production and maintain signed and State-approved Trading Partner Agreements.	
40.5.2.17	Fiscal Agent shall obtain and maintain all executed EFT Agreements.	
40.5.2.18	Fiscal Agent shall create and distribute to each independent enrolled provider or provider site a New Provider Participation Packet.	
40.5.2.19	Fiscal Agent shall respond to provider requests for participation in a NC DHHS program.	
40.5.2.20	Fiscal Agent shall review applications and contracts for completeness,	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
	original signature, and required participation criteria.	
40.5.2.21	Fiscal Agent shall update provider data based on information received during the credentialing, re-credentialing, and subsequent enrollment of the provider.	
40.5.2.22	Fiscal Agent shall initiate communication to providers advising them of the potential for suspension of services.	
40.5.2.23	Fiscal Agent shall route any incomplete credentialing or re-credentialing requests to the State for final disposition as to the provider's initial or ongoing participation.	
	<b>Urgent Reviews</b>	
40.5.2.24	Fiscal Agent shall perform "Urgent Reviews" when the State or Fiscal Agent has become aware of negative provider information that may affect the provider's participation status.	
40.5.2.25	Fiscal Agent shall route imaged data regarding Urgent Review through Workflow to the Quality Review/Appeals Coordinator for assessment.	
40.5.2.26	Fiscal Agent shall send a system-generated letter to the provider advising disposition of the case and appeal process procedures.	
40.5.2.27	Fiscal Agent shall notify the State's Medical Board or other appropriate agencies of its intent to suspend/terminate a provider's participation.	
	<b>Appeals</b>	
40.5.2.28	Fiscal Agent shall receive, image, and link provider appeals correspondence to the provider record.	
40.5.2.29	Fiscal Agent shall system-generate appeal letters advising the provider of the date the appeal request is received and that a written response shall be sent within thirty (30) days.	
40.5.2.30	Fiscal Agent shall ensure the Review/Appeals Coordinator obtains any additional information to provide to the State Review Committee to support an informed decision.	
40.5.2.31	Fiscal Agent shall route appeals and all supporting documentation to the State Review Committee Work Queue for disposition.	
40.5.2.32	Fiscal Agent shall update Provider data with the completed dates and disposition of appeal information.	
	<b>Provider Communications</b>	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
40.5.2.33	Fiscal Agent shall staff a separate Provider communications business function area to include toll-free telephone lines that are staffed from 8 A.M. to 5:00 P.M. Eastern Time Monday through Friday, except for State-approved holidays.	
40.5.2.34	Fiscal Agent shall respond to all verbal provider inquiries immediately. If an immediate response is not possible, then a written or verbal response shall be provided within two (2) business days.	
40.5.2.35	Fiscal Agent shall track and report on all State-referred or provider-initiated calls and/or complaints.	
40.5.2.36	Fiscal Agent shall respond in writing to written provider inquiries within five (5) business days of the date of receipt.	
40.5.2.37	Fiscal Agent shall refer questions regarding eligibility and program benefits to the State.	
40.5.2.38	Fiscal Agent shall refer questions regarding rates and budgets to the State.	
40.5.2.39	Fiscal Agent shall respond to all other provider inquiries as referred by the State.	
40.5.2.40	Fiscal Agent shall track and trend the number and nature of inquiries or complaints and status of resolution, referring clarification of policy issues to the State.	
40.5.2.41	Fiscal Agent shall coordinate and conduct all training for new and ongoing State and Fiscal Agent employees on Fiscal Agent MMIS procedures.	
<b>Provider Publications</b>		
40.5.2.42	Fiscal Agent shall prepare and post provider publications and instructions online.	
40.5.2.43	Fiscal Agent shall publish approved bulletins via e-mail and Web.	
40.5.2.44	Fiscal Agent shall provide the State with current update of MMIS-related forms to be accessible via the State's Web site.	
40.5.2.45	Fiscal Agent shall use the workflow management tools to publish drafts and receive approvals of all provider publications, e.g., bulletins, training materials, standard letters, etc.	
<b>Provider Training</b>		





**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
40.5.2.46	Fiscal Agent shall present mock training sessions to the State for approval prior to conducting provider training workshops.	
40.5.2.47	Fiscal Agent shall determine topics for workshops by assessing and targeting provider types with special need.	
40.5.2.48	Fiscal Agent shall track and report on provider requested visits.	
40.5.2.49	Fiscal Agent shall implement annual marketing plans for electronic commerce options.	
40.5.2.50	Fiscal Agent shall conduct provider workshops at State-approved locations.	
40.5.2.51	Fiscal Agent shall assist the State with annual meetings of billing providers.	
40.5.2.52	Fiscal Agent shall assist the State with quarterly training conferences.	
40.5.2.53	Fiscal Agent shall distribute on-site training evaluation questionnaires for providers to complete.	
40.5.2.54	Fiscal Agent shall analyze completed evaluation questionnaires and provide the State with a compiled summary report within five (5) business days from the training seminar date.	
40.5.2.55	Fiscal Agent shall maintain and submit to the State lists of provider training session participants.	
40.5.2.56	Fiscal Agent shall prepare State-approved online provider enrollment and billing instructions, ensuring the inclusion of all revisions and policy-related communications, such as special bulletins and/or newsletters, in the format and number specified by the State.	
40.5.2.57	Fiscal Agent shall ensure the accuracy and consistency of initial and ongoing updated State-approved tutorials.	
40.5.2.58	Fiscal Agent shall ensure that whenever changes are made that affect the information available on the tutorials that State-approved changes are made as a part of the CSR change documentation, provider publication/ALERT, or as directed by the State.	
40.5.2.59	Fiscal Agent shall maintain State-approved instructional materials for viewing and retrieval.	
40.5.2.60	Fiscal Agent shall provide training workshop materials and evaluations imaged and electronically available with ninety-nine and nine tenths (99.9) percent accuracy.	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
	<b>Imaging Provider Communications</b>	
40.5.2.61	Fiscal Agent shall image all provider written communications.	
	<b>Imaging Provider On-Site Visit Materials and Evaluation</b>	
40.5.2.62	Fiscal Agent shall perform imaging of all materials and the provider on-site evaluation applicable to a provider site visit, linking to the provider identification number for complete profile data retrieval.	
	<b>Imaging Provider Training Workshop Materials and Provider Evaluation Forms</b>	
40.5.2.63	Fiscal Agent shall perform imaging of all Provider Training Workshop materials and Provider Training Evaluations, linking to the provider identification number for complete profile data retrieval.	
40.5.2.64	Fiscal Agent shall provide training to State staff in the use of the Customer Call Center System, initially and on an ongoing basis.	
40.5.2.65	Fiscal Agent shall provide all Customer Service Call Center reports according to State specification.	
40.5.2.66	Fiscal Agent shall maintain up-to-date complete system and user documentation.	
40.5.2.67	Fiscal Agent shall develop workflow processes for customer service support activities.	
	<b>E-mail Communications</b>	
40.5.2.68	Fiscal Agent shall produce listserv lists that are updated as appropriate to new enrollments, disenrollments, and provider change requests for individual or mass communications based on State protocols and approval for types of communications.	
	<b>Recording/Tracking Provider/Recipient Verbal Communications</b>	
40.5.2.69	Fiscal Agent shall ensure recording and tracking verbal communications with provider and recipients are available for use between the hours of 7:00 A.M. to 11:00 P.M. Eastern Time Monday through Friday and from 7:00 A.M. to 6:00 P.M. Saturday and Sunday.	
40.5.2.70	Fiscal Agent shall perform daily system checks to ensure that the recording/tracking business area is functioning as designed and provides system logging of check date, time, operator, comments, and reporting as directed by the State.	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
40.5.2.71	Fiscal Agent shall provide State-approved instructional materials and secure, browser-based, Web-enabled tutorial for use of the Recording/Tracking Provider/Recipient Communications function/query tool.	
40.5.2.72	Fiscal Agent shall provide appropriate staff to monitor and support the continuous availability of the recording/tracking query tool.	

**40.5.3 Provider Operational Performance Standards**

Requirement #	Requirement Description	Non-Medicaid Only
40.5.3.1	Fiscal Agent shall log and image all hard copy provider applications received within one (1) State business day of receipt.	
40.5.3.2	Fiscal Agent shall initiate credentialing and source verification to ensure participation guidelines are met on all completed applications within three (3) business days.	
40.5.3.3	Fiscal Agent shall complete and approve all providers for participation who have no negative responses to credentialing requirements within two (2) State business days of receipt of all data necessary to adjudicate the application.	
40.5.3.4	Fiscal Agent shall send approval letters and other State-required information within one (1) State business day of provider participation approval.	
40.5.3.5	Fiscal Agent shall send denial letters and other State-required information within one (1) State business day of provider participation denial.	
40.5.3.6	Fiscal Agent shall initiate Urgent Reviews within one (1) State business day of receipt of any adverse provider information.	
40.5.3.7	Fiscal Agent shall acknowledge receipt of provider appeal requests within one (1) State business day of receipt.	
40.5.3.8	Fiscal Agent shall ensure that all appeals are adjudicated within thirty (30) calendar days of receipt unless permission for delay is received from the State.	
40.5.3.9	Fiscal Agent shall provide the State with an extract of the MMIS Provider tables each business night.	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
40.5.3.10	Fiscal Agent shall support online real-time access between EIS, Mental Health Eligibility Inquiry, Medicaid Quality Control, Online Verification, ACTS, and HIS and the Replacement MMIS using API and SOA concepts, from 7:00 A.M. until 7:00 P.M. Eastern Time Monday through Friday, including non-State business days when EIS is available for online processing, and from 10:00 A.M. to 5:00 P.M. Eastern Time on weekends when EIS is available for online processing.	
40.5.3.11	Fiscal Agent shall provide online real-time access to provider data for State-designated staff using API and SOA concepts between EIS and the Replacement MMIS 7:00 A.M. until 8:00 p.m. Eastern Time Monday through Friday, including non-State business days when EIS is available for online processing, and from 10:00 A.M. to 5:00 P.M. Eastern Time on weekends and when EIS is available for online processing.	
40.5.3.12	Fiscal Agent shall provide batch access to provider data using API and SOA concepts between EIS and the Replacement MMIS from 5:30 P.M. Eastern Time Monday through Friday until batch processing is completed.	
40.5.3.13	Fiscal Agent shall provide online real-time access to Provider data for State-designated staff using API and SOA concepts between EIS and the Replacement MMIS.	
40.5.3.14	Fiscal Agent shall provide initial and ongoing updated e-mail listservs based on initial and ongoing provider enrollments, disenrollments, and change requests the same day the transaction occurs ninety-nine and nine tenths (99.9) percent of the time.	
40.5.3.15	Fiscal Agent shall provide initial and ongoing capability for recording and tracking communications with providers and recipients during State business days between the hours of 7:00 A.M. to 11:00 P.M. Eastern Time Monday through Friday and from 7:00 A.M. to 6:00 P.M. Saturday and Sunday ninety-nine and nine tenths (99.9) percent of the time.	
40.5.3.16	Fiscal Agent shall provide monthly system check logs in the content, frequency, format, and media as directed by the State.	
40.5.3.17	Fiscal Agent shall produce State-approved initial and ongoing updates to training materials and secure, browser-based, Web-enabled tutorials in the content, frequency, format, and all media as directed by the State.	

**40.6 REFERENCE REQUIREMENTS**

**40.6.1 Reference System Requirements**

Requirement #	Requirement Description	Non-Medicaid Only
40.6.1.1	Provides capability for necessary data to accommodate multiple population groups, their benefit packages, and payment methodologies	
40.6.1.2	Provides capability for online access to all Reference and pricing data	
40.6.1.3	Provides capability to accept online and batch updates, additions, and deletions to all Reference data with the capability to make changes to individual records or mass changes to groups or classes/records	
40.6.1.4	Provides capability to identify all covered and non-covered ICD-9/ICD-10 Diagnosis codes and any field value differences based upon a match of the Replacement MMIS Diagnosis Codes to the Diagnosis Update Tape/data	
40.6.1.5	Provides capability to produce a report that demonstrates the differences of all covered and non-covered ICD-9/ICD-10 Diagnosis codes and any field value differences based upon a match of the Legacy MMIS+ Diagnosis Codes to the Diagnosis Update Tape/Data for State use in determining appropriateness to update ICD-9/ICD-10 data	
40.6.1.6	Provides capability for diagnosis codes to be accessible from the National Council of Prescription Drug Programs (NCPDP) claims and physician drug program	
40.6.1.7	<p>Provides capability to configure maximum rates and algorithms that permit rates to be assigned based on one of the following for all providers:</p> <ul style="list-style-type: none"> <li>▪ Financial payer</li> <li>▪ Billing provider (i.e., single county or multi-county)</li> <li>▪ Population group</li> <li>▪ Procedure code</li> <li>▪ Begin and end date of service</li> <li>▪ Attending provider (i.e., single county or multi-county)</li> <li>▪ Recipient</li> </ul>	
40.6.1.8	Provides capability to allow reformatting of automated files to develop or update fee schedules and/or rate files	
40.6.1.9	Provides capability for system logging of receipt date of each Reference File Maintenance Request, file maintenance initiation completion date, operator completing request, and supervisor validation date	



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
40.6.1.10	Provides capability for parameter-driven, ad hoc activity logging reports	
40.6.1.11	Provides capability to ensure appropriate tracking, controls, and audit logs are associated with all file updates	
40.6.1.12	Provides capability to link Reference File updates to applicable edits/audits	
40.6.1.13	<p>Provides capability to maintain the diagnosis data set using State-approved number of characters of the ICD-9/ICD-10 coding system that supports relationship between diagnosis code and claim information, including:</p> <ul style="list-style-type: none"> <li>▪ Valid age</li> <li>▪ Valid gender</li> <li>▪ Family planning indicator</li> <li>▪ Health Check indicator</li> <li>▪ Prior approval requirements</li> <li>▪ Reference indicator</li> <li>▪ TPL, emergency, accident trauma diagnosis, and cause code/indicator</li> <li>▪ Inpatient length of stay criteria</li> <li>▪ Description of the diagnosis</li> <li>▪ Attachment required</li> <li>▪ Primary and secondary diagnosis code usage</li> <li>▪ Cross-reference to procedure codes</li> <li>▪ Drug by designated parameters</li> </ul>	
40.6.1.14	<p>Provides capability for online, updateable edit disposition tables and files that contain unlimited edit numbers with:</p> <ul style="list-style-type: none"> <li>▪ Description of edit</li> <li>▪ Description of edit for RA per RA media</li> <li>▪ RA print indicator, exception print detail, or list indicator</li> <li>▪ Disposition, force indicator, deny indicator, location code, prior approval override indicator, location override per claim type, per claim media, per program, per provider</li> <li>▪ Cross-referencing edits/audits</li> <li>▪ Information line</li> </ul>	
40.6.1.15	Provides capability to audit HCPCS codes and associated National Drug	



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
	Codes (NDCs) against pharmacy NDCs to prevent duplicative services	
40.6.1.16	Provides capability to maintain an online, updateable claims Edit Resolution Manual that reflects correct processes for adjudicating edits and audits	
40.6.1.17	Provides capability to cross-reference new CPT codes and ICD-9/ICD-10 codes to Replacement MMIS edits and audits that support the code's data set within the same or specified range	
40.6.1.18	Provides capability to generate a report of edits/audits associated with codes that will be end-dated	
40.6.1.19	Provides capability to categorize edits/audits	
40.6.1.20	Provides capability to link each procedure code, diagnosis code, revenue code, dental code, etc. to the associated current and reverse (historical) edit	
40.6.1.21	<p>Provides capability to create online Edit Manuals that enables access by edit or specific procedure code, revenue code, diagnosis code, dental code, etc. that displays:</p> <ul style="list-style-type: none"> <li>▪ Edit relationships</li> <li>▪ Other procedure, revenue, diagnosis, dental codes</li> <li>▪ Modifiers related</li> <li>▪ Sex, age indicators (by day, month, year)</li> <li>▪ State Memo effective date with a link to a separate promulgated policy file to obtain policy or related detail information</li> <li>▪ Any other parameters that drive the edit</li> </ul>	
40.6.1.22	Provides capability to upload State-approved HCPCS updates from CMS, including Resource-Based Relative Value Scale (RBRVS)	
40.6.1.23	<p>Provides capability for a procedure code data set that contains the current five-character (5-character) HCPCS/CPT code and can accommodate the future six-character (6-character) HCPCS codes, second-level HCPCS codes, State-specific local Level III codes, and ICD-9 procedure codes and can accommodate the future ICD-10 procedure codes, acceptance of a one-character (1-character) or a two-character (2-character) field for HCPCS pricing modifier(s); and at a minimum, the following elements:</p> <ul style="list-style-type: none"> <li>▪ Valid tooth surface codes and tooth number/quadrant designation</li> <li>▪ Date-specific pricing segments by program code, provider taxonomy, and/or provider type and or specialty</li> </ul>	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
	<ul style="list-style-type: none"> <li>▪ Five (5) date-specific pricing segments, including two (2) occurrences of pricing action</li> <li>▪ Five (5) status code segments with effective beginning and end dates for each segment</li> <li>▪ Indicator of covered/not-covered and effective and end dates by program code</li> <li>▪ Allowed amount for each pricing segment</li> <li>▪ Multiple modifiers and the percentage of the allowed price applicable to each modifier or procedure code/modifier combination</li> <li>▪ State-specified restrictions on conditions to be met for a claim to be paid, including, but not limited to:               <ul style="list-style-type: none"> <li>○ Recipient eligibility</li> <li>○ Pricing Action Code</li> <li>○ Category of service</li> <li>○ Specialty</li> <li>○ Lab certification</li> <li>○ Recipient age/sex restrictions</li> <li>○ Allowed diagnosis codes</li> <li>○ Prior approval required</li> <li>○ Medical review required</li> <li>○ Place of service</li> <li>○ Pre- and post-operative days</li> <li>○ Appropriate diagnosis</li> <li>○ Acceptable place of service</li> <li>○ Units of service</li> <li>○ Once-in-a-lifetime indicator</li> <li>○ Attachments required</li> <li>○ Valid provider type/specialty</li> <li>○ NDC codes and units</li> <li>○ Claim type</li> <li>○ Purge criteria</li> <li>○ Provider subspecialty</li> <li>○ Drug Coverage (effective/term dates)</li> <li>○ Health Check reporting indicator</li> </ul> </li> </ul>	





## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
	<ul style="list-style-type: none"> <li>○ Family Planning indicator</li> <li>○ Family Planning Waiver Indicator</li> <li>▪ Narrative language of procedure codes in both short and long description</li> <li>▪ Indication of when or whether claims for the procedure can be archived from online history (such as once-in-a-lifetime procedures)</li> <li>▪ Indication of TPL actions, such as cost avoidance, benefit recovery, or pay and chase by procedure code</li> <li>▪ Indication of third party payers, non-coverage by managed care organizations by managed care organization type</li> <li>▪ Other information, such as accident/trauma indicators for possible TPL, Federal cost-sharing indicators, and Medicare coverage indicator</li> </ul>	
40.6.1.24	<p>Provides capability to maintain Pharmacy Point-of-Sale (POS) reference files that include:</p> <ul style="list-style-type: none"> <li>▪ NDC number</li> <li>▪ Generic Code Number (GCN) or formulation ID</li> <li>▪ Generic Code Number-Sequence (GCN-Sequence) or clinical formulation ID</li> <li>▪ Therapeutic class-specific (TxCL) or Therapeutic class code (General Classification Code 3 [GC3])</li> <li>▪ Ingredient list ID (HICL-S, relational and non-relational)</li> <li>▪ HICL sequence number</li> <li>▪ Med ID</li> <li>▪ Routed DF Med ID</li> <li>▪ Routed MED ID</li> <li>▪ Med Name ID</li> <li>▪ HIC Sequence</li> <li>▪ Generic name (GNN)</li> <li>▪ Ingredient List ID (HICL)</li> <li>▪ Brand name</li> <li>▪ Label name</li> <li>▪ Manufacturer</li> <li>▪ Enhanced Therapeutic Classification (ETC) system</li> <li>▪ American Hospital Formulary (AHF) classification</li> </ul>	



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
	<ul style="list-style-type: none"> <li>▪ Universal Product Code (UPC)</li> </ul> Search criteria should also include edit description, claim exceptions, explanation of benefits (EOBs), and NCPDP rejects.	
40.6.1.25	Provides capability for the procedure code data set to contain a minimum of five (5) years of data to support claims online history	
40.6.1.26	Provides capability to upload annual Diagnosis Related Group (DRG) and Medicare Code Editors (MCE) software based on a Federal fiscal year no later than October 1 <sup>st</sup> each year and report all errors that occur in processing of the annual DRG code update	
40.6.1.27	Provides capability to receive all weekly, biweekly, or daily drug updates from the drug update service vendor and upload within one (1) business day, including all new modules developed by the Vendor	
40.6.1.28	Provides capability to process updates from the contracted or State-owned drug update service upon receipt without overwriting exact updates previously made by the State or at the request of the State	
40.6.1.29	Provides capability to produce a report that identifies contracted drug updates bypassed identifying the data on the database and the update received from the State-owned or contracted drug update service	
40.6.1.30	Provides capability for State-specified customized updates to the drug file from a contracted or State-owned drug update service	
40.6.1.31	Provides capability for specific “facility rate times DRG weight” as well as appropriate facility disproportionate share information for inpatient reimbursement annually	
40.6.1.32	Provides capability to maintain rate files for all services and institutional rates to support pricing that conforms to program requirements	
40.6.1.33	Provides capability to create NC Title XIX Tables Manual and Edit Resolution Manuals	
40.6.1.34	Provides capability to apply edit criteria across claim types, provider type, and specialty types of service, provider taxonomy, provider type and/or specialty by procedure code and therapeutic class, generic product indicator, generic code, and all other drug codes	
40.6.1.35	Provides capability to electronically store State-assigned EOB and ESC message descriptions	
40.6.1.36	Provides capability to store unlimited policy changes received via State/Fiscal Agent Memo regarding file changes for procedure codes, diagnosis codes, revenue codes, dental codes, etc.	



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
40.6.1.37	Provides capability to electronically store accommodation rate data	
40.6.1.38	Provides capability to maintain indefinitely procedure codes that have timeframe limitations	
40.6.1.39	Provides capability to electronically store modifier information with appropriate multiple modifier and payment calculations	
40.6.1.40	Provides capability to produce electronic copies of Reference Files	
40.6.1.41	Provides capability to electronically store an unlimited number of pricing files and methodologies by date range that support NC DHHS program requirements	
40.6.1.42	Provides capability to create crosswalk of all claim type/provider type/taxonomy combinations to State, Family Planning, and Federal Categories of Service for all Types of Service	
40.6.1.43	Provides capability to apply State-approved policy to: <ul style="list-style-type: none"> <li>▪ HCPCS, including CPT, American Dental Association (ADA) codes, HCPCS Level II codes, NDCs, State local codes, International Classification of Diseases diagnosis and procedure codes (ICD-9) and future ICD codes</li> <li>▪ Drug codes</li> <li>▪ Edits</li> <li>▪ Rate methodology and calculations</li> <li>▪ Professional services fees</li> </ul>	
40.6.1.44	Provides capability for the Replacement MMIS Reference diagnosis file to interface with pharmacy claims processing to ensure that the diagnosis data is the same in both systems	
40.6.1.45	Provides capability to maintain a Reference Modifier File that contains procedure code and modifier information, including sub-database/matrix that supports State/Fiscal Agent staff-authorized access by procedure code and modifier that displays: <ul style="list-style-type: none"> <li>▪ Narrative of procedure code</li> <li>▪ Narrative of modifier, including effective end dates by either date of service, date of processing, or date of receipt</li> <li>▪ Modifier and narrative applicable to the use of the procedure code/modifier combination</li> <li>▪ Modifier pricing information, including effective end dates by either date of service, date of processing, or date of receipt</li> </ul>	



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
	<ul style="list-style-type: none"> <li>▪ Applicable modifier combinations</li> <li>▪ Applicable procedure/modifier combinations</li> <li>▪ Applicable providers for each modifier, including effective and end dates</li> </ul>	
40.6.1.46	<p>Provides capability to maintain Reference data with all procedure codes and pricing action codes (PAC) that indicate where pricing occurs based on:</p> <ul style="list-style-type: none"> <li>▪ Procedure code, type of service, and/or modifier</li> <li>▪ Provider type, provider specialty, taxonomy, and procedure code</li> <li>▪ Type of service</li> <li>▪ Place of service</li> <li>▪ Provider and per diem rate</li> <li>▪ Provider, DRG rate, and financial payer</li> <li>▪ Provider accommodation code</li> <li>▪ Provider number, percentage of charges, and financial payer</li> <li>▪ Pharmacy dispensing fee</li> <li>▪ Enhanced pharmacist professional services fee for performing cognitive services and State-approved interventions</li> <li>▪ Revenue code</li> <li>▪ Accommodation code on the Accommodation Rate File</li> <li>▪ Capitation payments and management fees</li> </ul>	
40.6.1.47	Provides capability to indicate whether pricing is performed on the revenue code or the CPT code when a combination of the two is billed	
40.6.1.48	Provides capability to determine if auditing/editing occurs on procedure code or revenue code when a combination of revenue code and procedure code is used	
40.6.1.49	<p>Provides capability to search for drugs using the following search criteria:</p> <ul style="list-style-type: none"> <li>▪ NDC number</li> <li>▪ Generic code number or formulation ID</li> <li>▪ Generic sequence number or clinical formulation ID</li> <li>▪ Therapeutic class specific or Therapeutic class code</li> <li>▪ Ingredient list ID (HICL-S, relational and non-relational)</li> <li>▪ HICL sequence number</li> </ul>	



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
	<ul style="list-style-type: none"> <li>▪ Med ID</li> <li>▪ Routed DF Med ID</li> <li>▪ Routed Med ID</li> <li>▪ Med Name ID</li> <li>▪ HIC Sequence</li> <li>▪ Generic name (GNN)</li> <li>▪ Ingredient List ID (HICL)</li> <li>▪ Brand name</li> <li>▪ Label name</li> <li>▪ Manufacturer</li> <li>▪ Enhanced Therapeutic Classification (ETC)</li> <li>▪ AHF classification</li> <li>▪ UPC</li> </ul>	
40.6.1.50	Provides capability to search for Drug Utilization Review (DUR) parameter data, drug name, NDC, TxCL, GCN, GCN-Sequence, or State-defined data elements	
40.6.1.51	Provides capability for an online, updateable GCN data set to maintain references and associations of drugs with similar indications/therapeutic benefits	
40.6.1.52	Provides capability for an online, updateable GCN data set to identify acute level and duration of a drug before prior approval is required	
40.6.1.53	Provides capability to electronically store and maintain all State-approved pharmacy pricing methodologies	
40.6.1.54	Provides capability to create a crosswalk of HCPCS Level I and Level II codes in the Physician Drug Program (PDP) to NDC/GC3 codes	
40.6.1.55	Provides capability to create a crosswalk of HCPCS Level I and Level II codes to rebateable NDCs	
40.6.1.56	Provides capability to identify Drug Efficacy Study Implementation (DESI) drugs	
40.6.1.57	Provides capability for State-approved provider maximum reimbursement rates for claims processing to ensure the ability to modify, add, or delete any rates on an individual provider basis or mass provider basis	
40.6.1.58	Provides capability to electronically store maximum reimbursement rates	



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
	for DME by procedure code priced for rental or purchase (new or used)	
40.6.1.59	Provides capability to electronically store laboratory maximum reimbursement rates for individual and "panel" laboratory procedures	
40.6.1.60	Provides capability to maintain an online audit trail of all updates to Reference data, including PRO-DUR data, identifying source of the change, CSR number, memo number, before and after images, and change dates to assure State and Federal auditing requirements are met	
40.6.1.61	Provides capability to receive memos from the State online and send memos to the State online for approval	
40.6.1.62	Provides capability to electronically store and track State Memos with online status updates	
40.6.1.63	Provides capability to generate an online status report of State Memos	
40.6.1.64	Provides capability for note entry	
40.6.1.65	Provides capability for electronic storage of unlimited policy changes received via State/Fiscal Agent Memos and link to all the memo contents for all record changes	
40.6.1.66	Provides capability to link a State/Fiscal Agent Memo with associated procedure codes	
40.6.1.67	Provides capability to maintain budget criteria information	X
40.6.1.68	Provides capability to replicate rates from one (1) type of provider and service to another like type of provider when the service and rate are equal	
40.6.1.69	Provides capability to supply claims pricing information to the Division of Vocational Rehabilitation and the Division of Services for the Blind	
40.6.1.70	Provides capability to retain MMIS Reference data change requests received from the State in the format received for control, balance, and audit purposes for the life of the Fiscal Agent Contract	
40.6.1.71	Provides capability for a user-controlled method to maintain edit criteria online	
40.6.1.72	Provides capability to access or link with State online policies to facilitate search of policies for changes in CPT and ICD-9/ICD-10 codes	
40.6.1.73	Provides capability for inquiry, entry, and updates to group-level pricing parameters for the determination of pharmacy reimbursement	



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
	calculations	
40.6.1.74	Provides capability to maintain and electronically store pharmacy pricing methodologies to appropriately price claims according to the appropriate financial payer or population according to State policy and business rules	
40.6.1.75	Provides capability to maintain and electronically store new pricing methodologies, criteria, and/or parameters	
40.6.1.76	Provides capability to search for drug data using as primary search criteria: <ul style="list-style-type: none"> <li>▪ NDC</li> <li>▪ Generic code number</li> <li>▪ Generic sequence number</li> <li>▪ Therapeutic class</li> <li>▪ Drug name</li> <li>▪ Any State-identified First DataBank (FDB) data element</li> </ul>	
40.6.1.77	Provides capability for inquiry, entry, and updates of existing and new drug data for a specific drug	
40.6.1.78	Provides capability to search for claim exception parameter data using primary and/or secondary search criteria	
40.6.1.79	Provides capability to search by phonetic and partial description or user-defined selection criteria	
40.6.1.80	Provides capability to electronically store and update drug rates on a schedule determined by the State that allows drug price indicator to be turned on or off for coverage	
40.6.1.81	Provides capability to restrict pharmacy services according to State policy and business rules	
40.6.1.82	Provides capability to handle recipient opt-in to specified lock-in pharmacies according to State policy and business rules	
40.6.1.83	Provides capability to electronically store and maintain the Prescription Advantage List (PAL) tiers	
40.6.1.84	Provides capability to maintain and use list of Medicare Part D drugs for dual-eligible recipients according to State policy and business rules	
40.6.1.85	Provides capability to search inquiry, entry, and updates for step care data	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
40.6.1.86	Provides capability for inquiry, entry, and updates to a list of preferred agents for a specific step care plan	
40.6.1.87	Provides capability to ensure that all prior approval requirements and associated edits and audits are linked	
40.6.1.88	Provides an online separate file in the Prior Approval business area that includes all services that require prior approval with a minimum of code, definition, initial date the prior approval was required, and end date when prior approval is no longer required	
40.6.1.89	<p>Provides capability to create Fee Schedule reports detailed in the bullets below:</p> <ul style="list-style-type: none"> <li>▪ Adult Care Home Personal Care</li> <li>▪ Ambulance</li> <li>▪ Ambulatory Surgical Centers/Birthing Centers</li> <li>▪ Behavioral Health (separate schedules)</li> <li>▪ Certified Clinical Supervisor and Addictions Specialist</li> <li>▪ Children’s Developmental Service Agencies</li> <li>▪ Licensed Clinical Social Worker and Licensed Professional Counselor and Licensed Marriage and Family Therapist</li> <li>▪ Licensed Psychological Associate</li> <li>▪ Mental Health Enhanced Services</li> <li>▪ Mental Health (LME)</li> <li>▪ Mental Health Non-Licensed Clinical Fee Schedule</li> <li>▪ Nurse Practitioner</li> <li>▪ Nurse Specialist</li> <li>▪ Prospective Rates</li> <li>▪ Psychologist</li> <li>▪ Residential Treatment Level III and IV</li> <li>▪ Community Alternatives Program (CAP) Rates (separate rates)</li> <li>▪ CAP/AIDS</li> <li>▪ CAP/Children</li> <li>▪ CAP/DA</li> <li>▪ CAP/Mentally Retarded-Development Disability (MR-DD)</li> <li>▪ DRG Weight Table</li> <li>▪ Dental Services</li> </ul>	





**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
	<ul style="list-style-type: none"> <li>▪ Durable Medical Equipment</li> <li>▪ Federally Qualified Health Center</li> <li>▪ Home Health Agency Services</li> <li>▪ Home Infusion Therapy</li> <li>▪ Hospice</li> <li>▪ Local Education Agency Practitioners</li> <li>▪ Local Health Department</li> <li>▪ Multi-specialty Independent Practitioner</li> <li>▪ Nursing Facility Rates</li> <li>▪ Occupational Therapy</li> <li>▪ Orthotics and Prosthetics</li> <li>▪ Physical Therapy</li> <li>▪ Physician Drug Program</li> <li>▪ Respiratory Therapy</li> <li>▪ Rural Health Center</li> <li>▪ Speech and Audiology Services</li> </ul>	
40.6.1.90	Provides capability to create fee schedules and related rate reports for State users and division Web site, including: <ul style="list-style-type: none"> <li>▪ Dialysis Centers</li> <li>▪ Nurse Midwife</li> <li>▪ Portable X-ray</li> <li>▪ Optical and Visual Aids</li> <li>▪ Private Duty Nursing</li> <li>▪ Targeted Case Management</li> </ul>	
40.6.1.91	Provides capability to create rate reports for internal State use only, including: <ul style="list-style-type: none"> <li>▪ Lower Level NF Rates</li> <li>▪ Outpatient Hospital Pricing, Ratio-Cost-to-Charge</li> <li>▪ Nursing Facility Rates</li> </ul>	
40.6.1.92	Provides capability to electronically store a daily file of county DSS mailing addresses	
<b>New Requirement</b>	Provides capability to calculate selected physician fee schedule records based on periodic Resource-Based Relative Value Scale (RBRVS)	



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
40.6.1.93	updates	

### 40.6.2 Reference Operational Requirements

Requirement #	Requirement Description	Non-Medicaid Only
40.6.2.1	Fiscal Agent shall log receipt date of each Reference File maintenance request, file maintenance initiation completion date, operator completing request, and supervisor validation date.	
40.6.2.2	Fiscal Agent shall notify the State in writing when a file maintenance request has not been made in accordance with the State Memo and/or as applicable to the contractual performance criteria.	
40.6.2.3	Fiscal Agent shall maintain procedure code updates and applicable editing data as directed by the State or upon receipt of all pertinent information requested from the State; produce before and after images; and return them to the originator of the State request.	
40.6.2.4	Fiscal Agent shall retain MMIS Reference data change requests received from the State in the format received for control, balance, and audit purposes for the life of the Fiscal Agent Contract.	
40.6.2.5	Fiscal Agent shall verify the accuracy of all file maintenance activities; produce weekly reports that summarize, by operator, file maintenance activities, including timeliness of updates and operator accuracy; reports shall be made available to the Contract Monitoring Unit by 7:00 A.M. Eastern Time each Monday following the update activity.	
40.6.2.6	Fiscal Agent shall perform research and analysis for adjudication and policy issues.	
40.6.2.7	Fiscal Agent shall analyze the appropriateness of the cross-reference of new CPT codes and ICD-9/ICD-10 codes to MMIS edits and audits and make recommendations to the State for incorporation of the codes into the established edit criteria or for additional edits/audits as appropriate.	
40.6.2.8	Fiscal Agent shall update edit criteria and all applicable documentation and notify the State when updates occur.	
40.6.2.9	Fiscal Agent shall provide PAL tiers information for provider inquiries.	
40.6.2.10	Fiscal Agent shall notify providers of DESI drug denials of payment through the Pharmacy Newsletter or other State-approved medium for communication.	

**40.6.3 Reference Operational Performance Standards**

Requirement #	Requirement Description	Non-Medicaid Only
40.6.3.1	Fiscal Agent shall initiate all Reference File maintenance requests within one (1) State business day of receipt of a request and complete such maintenance according to State-defined timeframe: <ul style="list-style-type: none"> <li>▪ Online updates within two (2) State business days of receipt</li> <li>▪ Mass adjustments within two (2) claims cycles</li> <li>▪ Other within timeframe, as directed by the State.</li> </ul>	
40.6.3.2	Fiscal Agent shall apply Reference File updates (mass updates and subscription service updates) to the Replacement MMIS according to State-defined schedule.	
40.6.3.3	Fiscal Agent shall notify the State in writing when a file maintenance request has not been completed, as directed by the State.	
40.6.3.4	Fiscal Agent shall produce before and after images and return them to the originator of the State Memo the same day the change is made.	
40.6.3.5	Fiscal Agent shall verify the accuracy of all file maintenance activities, producing weekly reports for the Contract Monitoring Unit by 7:00 A.M. Eastern Time each State business Monday.	

**40.7 PRIOR APPROVAL REQUIREMENTS**

**40.7.1 Prior Approval System Requirements**

Requirement #	Requirement Description	Non-Medicaid Only
40.7.1.1	Provides capability to receive and adjudicate prior approval requests and adjustments	
40.7.1.2	Provides capability to integrate prior approval functionality for all applicable claims and benefit plans (services and drugs)	
40.7.1.3	Provides capability for secure electronic submissions of adjudicated Prior Approval data from State-contracted Prior Approval vendors	
40.7.1.4	Provides capability for receipt and response of prior approval and referral requests and adjustments via a secure electronic transmission medium, such as AVRS/IVR, Web, ASC X12 278 transactions, and/or NCPDP	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
40.7.1.5	Provides capability to receive and manage prior approval, override, and referral requests via telephone, mail, and fax	
40.7.1.6	Provides capability to create and maintain electronic copies of all prior approval, override, and referral requests and all supporting documentation, including medical photographs	
40.7.1.7	Provides capability to electronically link supporting documentation to prior approval, override, and referral request for on-demand online retrieval by staff	
40.7.1.8	Provides capability for real-time, online prior approval and referral adjudication and notification of response via secure electronic transmission medium, such as AVRS/IVR, Web, ASC X12 278 transactions, and/or NCPDP	
40.7.1.9	Provides capability to review online claims and stored electronic health information	
40.7.1.10	Provides capability for automated screening of drug claims to ensure that evidenced-based, drug-specific criteria are met for pharmacy claims, medical claims data (ICD-9/ICD-10, revenue, and CPT codes), laboratory data, and eligibility data	
40.7.1.11	Provides capability for entry, inquiry, updates, and reporting for prior approvals, overrides, and referrals	
40.7.1.12	Provides capability to manage and adjudicate prior approval requests for individuals who are not currently on the Recipient File	X
40.7.1.13	Provides capability for entry and adjudication of prior approval request by LOB	
40.7.1.14	Provides capability for online, real-time update and adjudication of prior approval requests by State and State Prior Approval contractors	
40.7.1.15	Provides capability for interface with State-contracted Prior Approval vendors to accept adjudicated prior approvals	
40.7.1.16	Provides capability for interface with the contracted Pre-Admission, Screening, and Annual Resident Review (PASARR) Vendor and retain PASARR number and associated start/end dates	
40.7.1.17	Provides capability to retain the relationship of recipient-based hospice information (recipient, diagnosis, provider, and coverage dates)	
40.7.1.18	Provides capability for a secure online entry of overrides and referrals	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
40.7.1.19	Provides capability to enter comments (free-form text) within a prior approval, referral, or override	
40.7.1.20	Provides capability for online inquiry, data entry, and update access for prior approval, referral, and override requests 6:00 A.M. until 11:00 P.M. Eastern Time Monday through Friday and 7:00 A.M. to 7:00 P.M. on Saturday and Sunday	
40.7.1.21	Provides capability for tracking prior approval date of receipt, date of decision, denial/reduction in service reason, and decision notification date	
40.7.1.22	Provides capability for tracking override date and time of receipt and date decision was rendered	
40.7.1.23	Provides capability to generate Prior Approval statistical processing report detailing contracted Prior Approval vendors' submissions that indicates the date and time file received, date and time processed, number of transactions received, number of transactions processed, number of transactions updated, and number of transaction errors, listing each error transaction and error reason	
40.7.1.24	Provides capability to ensure each keyed prior approval, referral, and override by Fiscal Agent, State agency, or vendor has complete audit trail	
40.7.1.25	Provides capability to enter prior approval, referral, and override services and limitations	
40.7.1.26	Provides capability to retain prior approvals for each State program's recipients for five (5) years from last occurrence online and an additional five (5) years near-line; provides capability to maintain all usage by recipient for those benefits that are considered to be periodical or lifetime	
40.7.1.27	Provides capability to retain overrides and referrals for each recipient for five (5) years from last occurrence online and an additional five (5) years near-line	
40.7.1.28	Provides capability to assign system-generated unique prior approval, referral, and override numbers to approved, pending, and denied requests	
40.7.1.29	Provides capability to encumber funds associated with approved prior approval/authorizations	X
40.7.1.30	Provides capability to establish variable recipient co-pay percentages on a prior approval	X



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
40.7.1.31	Provides capability for incrementing approved units, Prior Approval pricing amounts, and frequencies of authorizations resulting from adjusted claims and voided claims or fully refunded claims back to the Prior Approval data	
40.7.1.32	Provides capability for decrementing approved units, Prior Approval pricing amounts, and frequencies of authorizations of services reimbursed from paid claims, adjusted claims, and fully refunded claims to Prior Approval data until all services are used up or zero units remaining within approved timeframe in which time closure of prior approval should occur	
40.7.1.33	Provides capability to generate letters of notification for approved, denied, reduced, or pending prior approval requests	
40.7.1.34	Provides capability for automated denial of prior approval and referral requests for providers who are determined to be on suspension or under review	
40.7.1.35	Provides capability to request prior approval recipient profiles by name, recipient ID number, specific or range of time from five-year (5-year) Prior Approval history online; near-line five (5) years and lifetime procedures in State-approved format	
40.7.1.36	Provides capability to apply Prior Approval logic by LOB, benefit, and recipient eligibility category	
40.7.1.37	Provides capability for online, updateable letter templates to all prior approval letters with the ability to add free-form text specific to a provider or recipient	
<b>Prior Approval Customer Service Center</b>		
40.7.1.38	Provides capability to support inquiries regarding prior approval, referrals and overrides from physicians, pharmacists, recipients, and other health care professionals	
40.7.1.39	Provides capability to generate a prior approval to limit drug claims for a specific NDC, GCN, GCN-Sequence, GC3 therapeutic class, American Hospital Formulary Service (AHFS) therapeutic class, or any other State-determined FDB-selected data element	
40.7.1.40	Provides capability to change services authorized and to extend or limit the effective dates of the authorization while maintaining the original and the change data on the prior approval, referral, or override	
40.7.1.41	Provides capability to search prior approval and overrides by service type, name of provider (issuing and authorized), provider number, name of recipient, recipient number, prior approval and override number,	



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
	category of service, clerk identification, effective dates, prior approval type, diagnosis, HCPCS, or revenue code and any combinations thereof	
40.7.1.42	Provides capability to search referrals by recipient ID, referring provider ID, referred provider ID, and referral number	
40.7.1.43	Provides capability to validate the need for prior approvals based upon NDC, GCN, GCN-Sequence, GC3 therapeutic class, AHFS therapeutic class, or any other State-determined FDB-selected data element	
40.7.1.44	Provides capability to dispense a seventy-two-hour (72-hour) supply of drugs without prior approval in emergency situations	
40.7.1.45	Provides capability to tie in the date of delivery to the Prior Approval logic for Medicaid for Pregnant Women (MPW) (actually requiring prior approval for anything but postpartum care after the date of delivery)	
40.7.1.46	Provides capability for inquiry and update of prior approval, overrides, and referrals reason/exception codes and descriptions	
40.7.1.47	Provides capability to edit DME prior approvals online to include: <ul style="list-style-type: none"> <li>▪ Valid provider identification and eligibility, including other payers and place of residence</li> <li>▪ Valid recipient age for service</li> <li>▪ Duplicate approval check for previously authorized or previously adjudicated services, including the same service over the same timeframe by different providers</li> </ul>	
40.7.1.48	Provides capability to maintain multiple referral types	
40.7.1.49	Provides capability for data validation and duplicate prior approval, referral, and override editing	
40.7.1.50	Provides capability for authorized users to search for a provider number for purposes of authorizing a referral	
40.7.1.51	Provides capability to make available to a provider, his/her last twenty-five (25) unique referred-to provider IDs and provider names used during the submission of referrals via Web entry	
40.7.1.52	Provides capability to return to the provider, upon successful submission of a referral, a confirmation page in a readable PDF format	
40.7.1.53	Provides capability to allow the referring provider and the referred-to provider to inquire on referrals	
40.7.1.54	Provides capability to produce a report that lists all open referrals not	



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
	used within a specified period of time	
40.7.1.55	Provides capability for a monthly report that lists the total number of referrals processed within a given month, broken out by referral media type and referral type	
40.7.1.56	Provides capability for workflow imaging application, to enable automated processing and work queue functionality for prior approvals and overrides	
	<b>Searching and Tracking of Therapeutic Leave</b>	
40.7.1.57	Provides capability for online searchable tracking of therapeutic leave in child care facilities, nursing facilities, and intermediate care facilities for the mentally retarded (ICF-MR) by patient identification number and number of days used per calendar year to State staff	
	<b>Pharmacy Benefits Management</b>	
40.7.1.58	Provides capability for workflow imaging and work queue functionality to ensure that prior approval requests are listed in each work queue based on first in, first out	
40.7.1.59	Provides capability to generate adjudicated prior approval appeal letters to recipients and providers when prior approval was denied or reduced	
40.7.1.60	Provides capability to identify and capture recipient drug information where aberrant drug patterns have been identified	
40.7.1.61	Provides capability for providers to link to the DHHS Web site to obtain the current Prescription Advantage List (PAL) and other pharmacy-related information	
40.7.1.62	Provides capability to ensure verification of recipient eligibility, provider program participation, and third party coverage during adjudication of prior approvals	
40.7.1.63	Provides a prior approval Web site (prior approval-enhanced pharmacy program Web site to include: Home page/Welcome page, What's New section, prior approval list/criteria, prior approval forms, authorization via e-mail, provider information, FAQs, Contact Us page, link to NC Medicaid Home page), and PAL, including upgrades to drug list, updates to criteria, EBM prescriber updates to clinical pearls, and updates to information for providers and recipients	
40.7.1.64	Provides for search capability of covered drugs by: <ul style="list-style-type: none"> <li>• Effective, termination, or a range of dates</li> <li>• NDC. Generic name, brand name</li> </ul>	





## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
	<ul style="list-style-type: none"> <li>HICL, HICL-Sequence, HICL code, GCN, GCN-Sequence, GNN, label name manufacturer, UPC, GC3, TxCL, AHF</li> </ul>	

### 40.7.2 Prior Approval Operational Requirements

Requirement #	Requirement Description	Non-Medicaid Only
40.7.2.1	Fiscal Agent shall record telephone pharmacy prior approval requests in the same format as the pharmacy paper/facsimile hard copy version.	
40.7.2.2	Fiscal Agent shall enter each prior approval request online to include the following: receipt date of each prior approval request made to the Fiscal Agent, denial code, decision date, and mailing date of decision.	
40.7.2.3	Fiscal Agent shall adjudicate prior approvals and mail system-generated disposition letters.	
40.7.2.4	Fiscal Agent shall receive and determine resolution (e.g. approval, denial, or pending) of prior approval and override requests, including retroactive requests based on State-approved medical criteria and medical judgment.	
40.7.2.5	Fiscal Agent shall notify the State via a quarterly report of the number of prior approval requests received, number entered into the system within one (1) State business day, and the number entered into the system after more than one (1) State business day.	
40.7.2.6	Fiscal Agent shall provide a weekly batch processing report that indicates the date and time the file was received, date and time processed, number of transactions received, number of transactions processed, number of transactions updated, and number of transactions errored, listing each error transaction and error reason.	
40.7.2.7	Fiscal Agent shall notify the State monthly when it takes more than one (1) business day from receipt to process and render a decision on a non-emergency prior approval and override request that does not require additional research or additional information.	
40.7.2.8	Fiscal Agent shall notify the State monthly when it takes more than one (1) business day from receipt of all required information to process and render a decision on a non-emergency prior approval and override request that required additional information or research.	
40.7.2.9	Fiscal Agent shall notify the State when it takes more than five (5) business days to process, render a decision, and mail a status report on a prior approval request for retrospective and therapeutic days.	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
40.7.2.10	Fiscal Agent shall provide the capability for authorized services to be flagged for pre-payment review.	
40.7.2.11	Fiscal Agent shall represent the State throughout the hearing/appeals process for all prior approval decisions made by the Fiscal Agent. Fiscal Agent shall attend Office of Administrative Hearings Representation and must include the Fiscal Agent staff that rendered the final decision of denial.	
40.7.2.12	Fiscal Agent shall perform long-term care facility on-site visits with or without State staff as requested for specific provider problems.	
40.7.2.13	<p>Fiscal Agent shall evaluate and determine prior approval adjudication for:</p> <ul style="list-style-type: none"> <li>▪ Eye exams or refraction</li> <li>▪ Visual aids</li> <li>▪ Hearing aids, accessories, ear molds, FM systems, repairs</li> <li>▪ Dental and orthodontics</li> <li>▪ Hyperbaric oxygenation therapy</li> <li>▪ Blepharoplasty/blepharoptosis eyelid repair</li> <li>▪ Panniculectomy</li> <li>▪ Breast surgery</li> <li>▪ Clinical severe obesity surgery</li> <li>▪ Lingual frenulum surgery</li> <li>▪ Stereotactic pallidotomy</li> <li>▪ Electrical osteogenic stimulators</li> <li>▪ Keloids</li> <li>▪ Craniofacial/facial surgeries</li> <li>▪ Out-of-state ambulance</li> <li>▪ Rhinoplasty</li> <li>▪ Chiropractic and podiatry</li> <li>▪ Durable medical equipment</li> <li>▪ Orthotics and prosthetics</li> <li>▪ Pharmacy</li> <li>▪ All services for DPH payment programs</li> </ul>	
40.7.2.14	Fiscal Agent shall present prior approval, referral, and override information and provide education at provider workshops.	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
40.7.2.15	Fiscal Agent shall respond to and resolve all phone inquiries/questions from recipients, providers, Office of Citizen Services, and manufacturers pertaining to pharmacy drug-related issues and concerns.	
40.7.2.16	Fiscal Agent shall ensure that the Pharmacy Prior Approval Customer Service Center is available from 7:00 A.M. until 11:00 P.M. Eastern Time on State business days Monday through Friday, and from 7:00 A.M. until 6:00 P.M. Eastern Time on Saturday and Sunday.	
40.7.2.17	Fiscal Agent shall ensure that the non-pharmacy Customer Service Center is available for prior approval, referral and override requests from 7:00 A.M. until 7:00 P.M. Eastern Time Monday through Friday and from 8:00 A.M. until 5:00 P.M. Eastern Time on Saturday	
40.7.2.18	Fiscal Agent shall ensure that adequate prior approval staff, including a clinical pharmacist, is on-site during all hours of call center operation (including evenings and weekends).	
40.7.2.19	Fiscal Agent shall locate a Prior Approval Customer Service Center within the State-approved Fiscal Agent's local facility unless otherwise approved by the State.	
40.7.2.20	Fiscal Agent shall provide capability to receive prior approval requests for stem cell and bone marrow transplants. If all clinical information is included in the request, then the Fiscal Agent forwards the request to the DMA Hospital Consultant for review. If all clinical information is not included in the request, the Fiscal Agent must contact the requesting provider for additional clinical information before forwarding the request to the DMA Hospital Consultant for review.	
40.7.2.21	Fiscal Agent shall provide training for Prior Approval Vendors and State staff.	
40.7.2.22	Fiscal Agent shall ensure verification of recipient eligibility, provider program participation, and third party coverage during adjudication of prior approvals.	
40.7.2.23	Fiscal Agent shall ensure automated prior approval adjudication is not available when TPL coverage exists for recipient. Manual review and verification of coverage must be conducted to determine prior approval authorization.	
40.7.2.24	Fiscal Agent shall provide for toll-free telephone and fax number access for providers to request prior approvals, referrals, and overrides	
	<b>Pharmacy Benefits Management</b>	
40.7.2.25	Fiscal Agent shall prepare the CMS Annual Report that includes all information, charts, and statistics relating/pertaining to the Prospective	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
	and Retrospective DUR Programs in the format and media as directed by the State.	
40.7.2.26	Fiscal Agent shall coordinate with the DUR Contractor to assure functionality of the Pharmacy Point-of-Sale Business Area, including adding edits, PRO-DUR informational alerts and intervention, conflict, and outcome codes (NCPDP 5.1 standards) and shall assist DUR Vendor with the Retrospective DUR Program.	
40.7.2.27	Fiscal Agent shall provide for updating clinical data, dosing limits to DUR alerts, changes in GCN, GCN-Sequence, weekly DUR file updates, and State-selected FDB data elements.	
40.7.2.28	Fiscal Agent shall prepare monthly Pharmacy Newsletter for State approval and distribute as directed by the State.	
40.7.2.29	Fiscal Agent shall ensure daily supervisor signoffs of each Pharmacy Prior Approval Service Representative work queue transferring any prior approvals to the next shift's work queue to ensure performance standards are met.	
40.7.2.30	Fiscal Agent shall coordinate with the State's Drug Utilization Review Vendor or the State to ensure appropriate Pharmacy POS alerts for potential drug therapy problems are identified; shall meet each month; and shall prepare meeting minutes.	
40.7.2.31	Fiscal Agent shall post on the Web site the EBM updates to PAL clinical pearls.	
40.7.2.32	Fiscal Agent shall maintain the Prior Approval Web site that will contain the State Maximum Allowable Cost (SMAC) list and linkage to the Drug Effective Review Process (DERP) reports.	
40.7.2.33	Fiscal Agent shall notify DMA weekly of new drugs with recommended criteria/protocol that become available in the marketplace that are in the same classes as those drugs included in the Prior Approval drug list and PAL.	
40.7.2.34	Fiscal Agent shall develop criteria-driven recommendations for each new drug within an existing Prior Approval therapeutic class category.	
40.7.2.35	Fiscal Agent shall coordinate with the State's Retrospective DUR Vendor or the State to capture claim data specific to aberrant drug patterns; shall meet each month; and shall prepare meeting minutes.	
40.7.2.36	Fiscal Agent shall coordinate with the State's Community Care Program to prevent duplication or fragmentation of effort related to pharmacy benefit coverage; shall meet each month; and shall prepare meeting minutes.	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
40.7.2.37	Fiscal Agent shall adjudicate provider appeals.	
40.7.2.38	Fiscal Agent shall prepare monthly Pharmacy Bulletin/Newsletter information for State approval in format, content, and media as directed by the State, including the production, updating of preferred drug lists, prior approvals and lists, and other informational materials for prescribers.	
40.7.2.39	Fiscal Agent shall provide for dispensing and reimbursement of a seventy-two-hour (72-hour) supply of prior approval drug in emergency situations.	
40.7.2.40	Fiscal Agent shall identify pharmacy provider training issues related to prior approvals and shall address at workshops	
40.7.2.41	Fiscal Agent shall make recommendations to the State on drugs for a preferred drug list and drugs for which prior approval and/or step therapy protocols would be appropriate. The list shall be based on utilization patterns and shall take into consideration clinical value, recipient and provider disruption, and cost savings.	
40.7.2.42	Fiscal Agent shall add the new drug(s) to their respective therapeutic Prior Approval categories and to add new Prior Approval categories after final approval and notification from DMA; updates must be included on Web site within forty-eight (48) hours of notification.	

**40.7.3 Prior Approval Operational Performance Standards**

Requirement #	Requirement Description	Non-Medicaid Only
40.7.3.1	Fiscal Agent shall update the Prior Approval business area with all prior approval results received from other entities within twenty-four (24) hours of receipt from each entity, except Fridays, when the updates shall be available by 7:00 A.M. Eastern Time on the following Monday.	
40.7.3.2	Fiscal Agent shall render a decision for non-pharmacy prior approval within one (1) State business days of the receipt of all of the required information or research for non-emergency prior approval requests.	
40.7.3.3	Fiscal Agent shall generate and mail prior approval decisions to appropriate designees within two (2) State business days of rendering a decision.	
40.7.3.4	Fiscal Agent shall apply the State Prior Approval Policy with ninety-nine and nine-tenths (99.9) percent accuracy rate based on the information	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
	available when rendering a prior approval decision.	
40.7.3.5	Fiscal Agent shall provide online inquiry and data entry to the Prior Approval data to providers, Fiscal Agent staff, and State-designated staff from 6:00 A.M. until 11:00 P.M. Eastern Time Monday through Friday and 7:00 A.M. to 7:00 P.M. on Saturday and Sunday ninety-nine and nine-tenths (99.9) percent of the time.	
40.7.3.6	Fiscal Agent shall provide online inquiry and data entry to the Prior Approval data to AP/LME staff and State-designated staff from 7:00 A.M. until 7:00 P.M. Eastern Time Monday through Friday ninety-nine and nine-tenths (99.9) percent of the time.	X
40.7.3.7	Fiscal Agent shall provide online Prior Approval for Pharmacy Prior Approval from 7:00 A.M. to 11:00 P.M. Eastern Time Monday through Friday and 7:00 A.M. to 6:00 P.M. Eastern Time Saturday and Sunday ninety-nine and nine-tenths (99.9) percent of the time.	
40.7.3.8	Fiscal Agent shall produce system-generated letters to recipients and providers of the status of prior approval requests within twenty-four (24) hours from the time of receipt.	
40.7.3.9	Fiscal Agent shall produce weekly Pharmacy Alerts.	
40.7.3.10	Fiscal Agent shall adjudicate each complete pharmacy prior approval request within one (1) State business day of receipt.	
40.7.3.11	Fiscal Agent shall meet monthly with DUR, the State and/or Retrospective DUR vendors and Community Care Program and include minutes in bi-weekly Project Status Report.	
40.7.3.12	Fiscal Agent shall adjudicate provider pharmacy prior approval request appeals within one (1) State business days of receipt.	
40.7.3.13	Fiscal Agent shall respond to a requesting provider within one (1) hour for a telephone request for an emergency override.	

**40.8 CLAIMS PROCESSING REQUIREMENTS**

**40.8.1 Claims Processing System Requirements**

Requirement #	Requirement Description	Non-Medicaid Only
	<b>Mailroom</b>	
40.8.1.1	Provides capability for mechanized date stamping of all mail	



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
40.8.1.2	Provides capability to access system for logging receipt of packages and envelopes received from couriers	
40.8.1.3	Provides capability to access system log for entering checks received	
40.8.1.4	Provides capability for system-generated logging of regular mail costs	
40.8.1.5	Provides capability for automated Return to Provider (RTP) letter	
40.8.1.6	Provides capability for automated system log/accounting for mailroom	
<b>Claim Acquisition</b>		
40.8.1.7	Provides capability to assign a unique number for each claim, adjustment, and financial transaction that contains date of receipt, batch number, and sequence of document within the batch, upon receipt of each claim and adjustment	
40.8.1.8	Provides capability for tracking of all claims, adjustments, and financial transactions from receipt to final disposition	
40.8.1.9	Provides capability for mechanized images of all claims, attachments, adjustment requests, and other claims-related documents and ability to link these documents to the unique claim number they are associated with	
40.8.1.10	Provides capability to maintain batch and online entry controls for all claims, batch audit trails, and all other transactions entered into the system	
40.8.1.11	Provides capability to identify any activated claim batches that fail to balance to control counts	
40.8.1.12	Provides capability for editing to prevent duplicate entry of electronic media claims	
40.8.1.13	Provides capability to perform CLIA editing based on the provider CLIA number and the CLIA number for the service	
40.8.1.14	Provides capability to perform diagnosis editing by line item	
40.8.1.15	Provides capability to adjudicate a claim to the fullest extent possible in order to report all errors	
40.8.1.16	Provides capability to adjudicate claims for Medicare Part D dual-eligible recipients according to State business rules and policies	
40.8.1.17	Provides capability for key re-verification of critical fields, data entry	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
	software editing, and supervisor audit verification of keyed claims	
40.8.1.18	Provides capability to maintain extract tables that contain key elements to verify the validity of entered claim information	
40.8.1.19	Provides capability to perform presence and format editing on all entered claims	
40.8.1.20	Provides capability to perform validity editing on all entered claims using current information on Provider, Recipient, Claims History, Prior Approval, and Reference Files or business area/interfaces	
40.8.1.21	Provides capability to support the Medicare Correct Coding Initiative (CCI)	
40.8.1.22	Provides capability for front-end claim, adjustment, or crossover denials when required attachments are not present	
40.8.1.23	Provides capability to generate RTP letters with entry available to denote front-end claim error conditions	
40.8.1.24	Provides capability for individual paper and electronic claim overrides on edits such as presumptive eligibility, Medicare A, B, and C, HMO coverage, TPL, and timely filing limit	
40.8.1.25	Provides capability to override service limitations for Early Periodic Screening, Diagnosis, and Treatment (EPSDT) -eligible recipients	
40.8.1.26	Provides capability to identify and allow online correction to claims suspended as a result of data entry errors	
40.8.1.27	Provides capability to return to submitters an acknowledgement of all electronic submissions and claim status within twenty-four (24) hours of original receipt	
40.8.1.28	Provides capability to pre-screen batch electronic media claims to identify global error conditions and prevent entry of such claims into the system	
40.8.1.29	Provides capability to reject electronic claims at the claim level	
40.8.1.30	Provides capability to process claims and financial transaction adjustments	
40.8.1.31	Provides capability to perform duplicate editing of drugs billed by physicians and pharmacy	
40.8.1.32	Provides capability to use transfer of assets data on the Medicaid recipient record in claims processing	





## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
40.8.1.33	Provides capability to populate each claim detail with appropriate header level EOB	
40.8.1.34	Provides capability to use Medicaid/Medicare coverage data from EIS to adjudicate claims	
40.8.1.35	Provides capability to update the Claims History tables with paid and denied claims from the previous audit run	
40.8.1.36	Provides capability for inquiry on suspended claims, accessible for online inquiry	
40.8.1.37	Provides capability to accept the indicator denoting whether a third party was billed for TPL claims	
40.8.1.38	Provides capability to use EDB and BENDEX information to detect Medicare and Medicare HMO entitlement for use in claims processing	
40.8.1.39	Provides capability to define parameters and create a file for the negative and positive eligibility quality control sampling for DMH	X
40.8.1.40	Provides capability to produce reports regarding the results of the DMH negative and positive sampling	X
40.8.1.41	Provides capability to accept an MEQC positive sample file from DMA via DIRM	
40.8.1.42	Provides capability to produce claim history reports using the MEQC positive sample file from DMA via DIRM	
40.8.1.43	Provides capability to reflect all premium payments and adjustments on the online paid Claims History files	
40.8.1.44	Provides capability to maintain a complete history of all claims: paid, adjusted, and denied	
40.8.1.45	Provides capability to accrue all appropriate EOBs messages for relevant claim adjudication for each detail line and report on RA	
40.8.1.46	Provides capability to maintain a minimum five-year (5-year) history of previously paid or denied claims to support duplicate checking and utilization review	
40.8.1.47	Provides capability to assign the status of claims in the system to determine course of each action to be taken in the claims adjudication process and completion of appropriate financial processing tasks	
40.8.1.48	Provides capability to adjust paid claims history for State-specified TPL	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
	recoveries at the detail level to include duplicate check	
40.8.1.49	Provides capability to allow DME claims to span across calendar months in order to be consistent with Medicare and thus allow appropriate claims payment for Medicaid-covered items	
40.8.1.50	Provides capability for providers to bill ambulance services using multiple claim types	
40.8.1.51	Provides capability for an extract of DMH claims denied due to insufficient budget	X
	<b>Pharmacy Point-of-Sale</b>	
40.8.1.52	Provides capability for an interactive session that accepts submitted pharmacy claims and processes to identify and alert the provider of problems associated with inappropriate drug use prior to dispensing	
40.8.1.53	Provides capability to allow for the submitting provider to respond to alerts by overriding alerts or reversing the claim submitted based on State-determined hierarchy	
40.8.1.54	Provides capability to identify informational alerts for warning on claim denials	
40.8.1.55	Provides capability for an audit trail of all inquiries (event logging), including who made the inquiry, information input, and response provided	
40.8.1.56	Provides capability for alerts for drugs requiring prior approval; provides capability to allow providers to immediately apply for prior approval; provides capability to receive approval if appropriate and complete claim adjudication online	
40.8.1.57	Provides capability to price all pharmacy claims using lesser of logic incorporating all State-approved pricing methodologies	
40.8.1.58	Provides capability for online prospective drug utilization review (POS/PRO-DUR) for all pharmacy claims using 5.1 formats or newer, more recent NCPDP format updates	
40.8.1.59	Provides capability for submittal of decimal units on claims up to the maximum allowed by NCPDP standards and calculate payment based on the actual decimal versus rounding to a whole unit	
40.8.1.60	Provides capability to interface with Comprehensive Neuroscience (CNS) Program-Behavioral Pharmacy Management System (BPMS); provides capability to interface with BPMS quality indicator algorithms developed by an outside vendor (CNS)	



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
40.8.1.61	Provides capability for PRO-DUR and Retroactive DUR	
40.8.1.62	Provides capability to process all pharmacy claims in POS/PRO-DUR inclusive with edits/audits/overrides consistent with current State policy	
40.8.1.63	Provides capability to allow for online pharmacy claim reversal/adjustment within one (1) year of date of service	
40.8.1.64	Provides capability to allow for duplicate editing across lines of business, claim types, including pharmacy against HCPCS (e.g., J codes) or NDC codes to ensure both are not billing for nursing home and inpatient stays or pharmacy claims against DME, physician, or Competitive Acquisition Program (CAP) B claims	
40.8.1.65	Provides capability for an online audit trail of all POS/PRO-DUR transactions	
40.8.1.66	Provides capability for submissions and responses for all Replacement MMIS POS/PRO DUR via the Web Portal	
40.8.1.67	Provides capability to accept multiple NDCs and associated prices to calculate total allowed for compound drugs to price and pay compound drugs that include multiple NDCs, rebateable legend drugs, and selected covered over-the-counter products	
40.8.1.68	Provides capability for flexible State-determined dispensing fees	
40.8.1.69	Provides capability to set edits that cannot be overridden when the potential drug conflict reaches certain State-approved severity or significance levels	
40.8.1.70	Provides capability to exempt a drug or a recipient from the State-specific prescription limit according to policy	
40.8.1.71	Provides capability to maintain an online audit trail of all updates to Reference and POS/PRO-DUR data, identifying the source of the change, before and after, and change dates	
40.8.1.72	Provides capability to allow for the submitting provider to respond to alerts by overriding alerts or reversing the claim submitted	
40.8.1.73	Provides capability to edit for and deny FDA DESI-identified drugs	
40.8.1.74	Provides capability to pay or deny (but not suspend) all pharmacy claims entered through POS devices	
40.8.1.75	Provides capability to edit against lock-in/lock-out recipient data for pharmacy, primary care provider, and/or prescriber	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
40.8.1.76	Provides capability to process claims for pharmacist’s professional services and to price according to the cognitive service provided	
40.8.1.77	Provides capability for State-specified customized updates from a contracted drug update service and provides the State all clinical and editorial highlights, newsletter, product information, and modules	
40.8.1.78	Provides capability to edit all claims entered into the system to ensure claims for drugs mandated by Federal regulations, the Federal upper limit (FUL) drugs, and the SMAC drugs are processed correctly; provides capability to edit claims entered into the system to ensure claims are not paid for the drugs listed on the Federal DESI list	
40.8.1.79	Provides capability to edit against all State-determined DUR alerts	
40.8.1.80	Provides capability for e-prescribing services, e.g., Rx HUB , and access to formulary and benefit information to enrolled providers using NCPDP Version 1.0 ( or more recent) Formulary and benefit standard	
40.8.1.81	Provides capability to apply edits for coverage of non-legend drugs within compound drugs	
40.8.1.82	Provides capability to ensure use of the appropriate package size in calculating the maximum allowable unit cost for reimbursement	
40.8.1.83	Provides capability to edit for Part D eligibility or suspect and deny appropriately	
40.8.1.84	Provides capability to ensure drugs have not been previously issued within the Physician Drug Program and Pharmacy POS	
<b>Determination of Financial Payer and Population Group</b>		
40.8.1.85	Provides capability to ensure that financial payer and population group determination is based on the recipient’s program, enrollment, and related benefit packages, the enrollment of the provider, the inclusion of services in eligible benefit packages, and the dates services were rendered	
40.8.1.86	Provides capability to determine the most appropriate LOB and benefit plan for each claim (by line detail)	
40.8.1.87	Provides capability to perform Payer Determination process daily after input conversion process to accurately route the claim according to financial payer	
40.8.1.88	Provides capability to re-perform Payer Determination process before the claims processing cycle to incorporate any data corrections made	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
	subsequent to the initial Payer Determination process	
40.8.1.89	Provides capability to determine financial payer hierarchy	
40.8.1.90	Provides capability to determine population group hierarchy within a specified financial payer	
40.8.1.91	Provides capability to maintain, report, and view the original claim and associated actions that changed the original makeup of claim details	
40.8.1.92	Provides capability to identify any claim details and track back to the original claim	
40.8.1.93	Provides capability to identify a claim detail line that has been processed independent of the original claim and tie it to the original claim	
40.8.1.94	Provides capability to apply appropriate Replacement MMIS edits to any claim detail that is processed independent of the original claim	
40.8.1.95	Provides capability to require prior approval for recipients covered in the Medicaid for Pregnant Women (MPW) program for services (other than postpartum care) that are provided after date of delivery	
40.8.1.96	Provides capability to format key-entered POS, batch, and electronic claims submission/electronic data interchange (ECS/EDI) claims into common processing formats for each claim type	
40.8.1.97	Provides capability to perform claims processing based on recipient's enrollment and eligibility information	
40.8.1.98	Provides capability to edit claim detail identifying all error codes for claims that fail daily edit processing at initial processing of the claim to minimize the need for multiple re-submissions of claims	
40.8.1.99	Provides capability to identify the processing outcome of claims (suspend, deny, or pay and report) that fail edits, based on the edit disposition	
40.8.1.100	Provides capability for online claims correction and resolution of suspended claims	
40.8.1.101	Provides capability to receive paper/electronic claims for Medicare and Medicare HMO cost sharing	
40.8.1.102	Provides capability for the identification of potential TPL (including Medicare) and suspend, deny, or pay and report the claim	
40.8.1.103	Provides capability to distinguish between a Medicare denial versus	



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
	private insurance denials	
40.8.1.104	Provides capability for editing to assure that TPL has been satisfied or that a TPL denial attachment is present if required	
40.8.1.105	Provides capability for editing and suspending of claims for pre-payment review based on provider, recipient, procedure code, diagnosis code, third party insurance, and authorized services	
40.8.1.106	Provides capability for editing to assure that the services for which payment is requested are covered by the appropriate State Medical Assistance program	
40.8.1.107	Provides capability for editing to ensure that all required attachments are present	
40.8.1.108	Provides capability to edit for cost-sharing requirements on applicable claims	
40.8.1.109	Provides capability to edit any suspended claims requiring provider or recipient prepayment review	
40.8.1.110	Provides capability to process all claims against the edit criteria	
40.8.1.111	Provides capability for editing to assure that reported diagnosis, procedures, revenue codes, and denial codes are present on Medicare primary claims and all other appropriate claim types	
40.8.1.112	Provides capability to edit for recipient eligibility on date(s) of service	
40.8.1.113	Provides capability to edit for valid recipient identification, using DOB and a minimum of the first two (2) characters of last name and the first character of first name	
40.8.1.114	Provides capability to edit for special eligibility records, indicating recipient participation in special programs where program service limitations or restrictions may vary	
40.8.1.115	Provides capability to edit for recipient living arrangement within the dates of service	
40.8.1.116	Provides capability to edit for Provider program eligibility to perform procedure rendered on date of service	
40.8.1.117	Provides capability to edit for provider participation as a member of the billing group	
40.8.1.118	Provides capability to edit claims for recipients in nursing facilities against recipient approval data, level of care, patient liability, patient	



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
	deductible, Medicare denial, reserve bed and leave days, and admit/discharge information	
40.8.1.119	Provides capability to edit for prior approval and ensure an active prior approval number is on file	
40.8.1.120	Provides capability to edit for prior approval claims and cut back billed units or dollars	
40.8.1.121	Provides capability to edit for step therapy criteria and protocol for selected drugs	
40.8.1.122	Provides capability to override the thirty-four-day (34-day) supply limit edit for drugs	
40.8.1.123	Provides capability to maintain edit disposition to deny claims for services that require prior approval if no prior approval is identified or active	
40.8.1.124	Provides capability to update the Prior Approval record(s) to reflect the services paid on the claim, including units, amount paid, and the number of services still remaining to be used	
40.8.1.125	Provides capability for automated cross-checks and relationship edits on all claims	
40.8.1.126	Provides capability for automated audit processing against history, suspended, and same cycle claims	
40.8.1.127	Provides capability to apply Medical Procedure Audit Policy (MPAP) to determine audits on a specific claim detail	
40.8.1.128	Provides capability to ensure that auditing supports claim denials, automatic recoupments or cutbacks, suspended for review, or specific pricing	
40.8.1.129	Provides capability for automatic system recoupment and denial of hospital claim when prior approval for surgery was not granted	
40.8.1.130	Provides capability to apply clinical and pricing business rules in claims processing	
40.8.1.131	Provides capability to identify paid and denied claims in Claims History	
40.8.1.132	Provides capability for editing an unlimited number of claim lines	
40.8.1.133	Provides capability to process multiple units of service for a span of dates of service	



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
40.8.1.134	Provides capability to edit for potential duplicate claims based on a cross-reference of group and rendering provider, multiple provider locations, and across provider and claim types	
40.8.1.135	Provides capability to identify potential and/or exact duplicate claims in the MMIS and POS within and across financial payers	
40.8.1.136	Provides capability to edit using duplicate audit and suspect-duplicate criteria to validate against history, suspended claims, and same-cycle claims	
40.8.1.137	Provides capability for audit trail of all claims that identify timing and suspense status, error codes, and occurrences per claim header and claim detail as processed to final adjudication status	
40.8.1.138	Provides capability for an unlimited number of edits per claim	
40.8.1.139	Provides capability to identify and track all edits and audits posted to the claim from suspense through adjudication	
40.8.1.140	Provides capability for each error code to have a resolution code, an override, force or deny indicator, and the date that the error was resolved, forced, or denied	
40.8.1.141	Provides capability for the acceptance of overrides of claim edits and audits	
40.8.1.142	Provides capability to turn off and on edits/audits for program types as specified by State Memo	
40.8.1.143	Provides capability to identify the claim disposition, based on the edit status or force code with the highest severity specific to each LOB	
40.8.1.144	Provides capability to maintain a record of service codes required for audit processing where the audit criteria covers a period longer than five (5) years (such as once-in-a-lifetime procedures)	
40.8.1.145	Provides capability to modify the disposition of edits by LOB to: <ul style="list-style-type: none"> <li>▪ Suspend for special handling</li> <li>▪ Deny and print an explanatory message on the provider RA</li> <li>▪ Suspend to a specific location unit</li> <li>▪ Pay and report to a specific location/unit</li> <li>▪ Pay</li> </ul>	
40.8.1.146	Provides capability to set claim edits to allow dispositions and exceptions to edits based on claim type submission media, provider	





## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
	type and specialty and subspecialty or taxonomy, recipient Medical Assistance program, or individual provider number	
40.8.1.147	Provides capability to perform edits against claims for limits on dollars, units, and percentages	
40.8.1.148	Provides capability to override the Prior Approval edit to allow for emergency seventy-two-hour (72-hour) supply of a drug and does not count toward service limitations for prescriptions	
40.8.1.149	Provides capability for variable limitations of pharmacy prescription benefits, such as number of prescriptions, quantity of drugs, specific drugs, and upper limits	
40.8.1.150	Provides capability to allow for exceptions to pharmacy lock-ins	
40.8.1.151	Provides capability to edit claims with billed amounts that vary by a specified degree above or below allowable amounts	
40.8.1.152	Provides capability to validate provider IDs for billing, attending, referring, and prescribing providers	
40.8.1.153	Provides capability to edit for valid CLIA certification for laboratory procedures	
40.8.1.154	Provides capability to edit claim for tooth numbers for procedures requiring tooth number, surface, or quadrant	
40.8.1.155	Provides capability to edit for procedure to procedure on same date of service	
40.8.1.156	Provides capability to edit for service limitations	
40.8.1.157	Provides capability to edit for the identification of the quadrant based on tooth number for editing	
40.8.1.158	Provides capability to track service limitations online	
40.8.1.159	Provides capability to edit and suspend with procedure codes set to manually price unless there is a prior approval for the procedure code for the recipient with the servicing provider	
40.8.1.160	Provides capability to edit for program and allow for services to ICF-MR adults for procedures limited to those individuals under twenty-one (21) years of age	
40.8.1.161	Provides capability to edit for timely filing	
40.8.1.162	Provides capability to cut back units on claims, retaining the original	



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
	units billed and units paid	
40.8.1.163	Provides capability to process Medicare cost-sharing charges using the full claim input information and system edit capability	
40.8.1.164	Provides capability to edit across claim types, including the ability to process with a minimum of four (4) modifiers and edit for modifier appropriateness	
40.8.1.165	Provides capability to edit for disproportionate share hospitals	
40.8.1.166	Provides capability for all edits as listed by the State	
40.8.1.167	Provides capability for encounter-specific editing and auditing	
40.8.1.168	Provides capability to edit billed charges for high and low variances	
	<b>Suspended Claims</b>	
40.8.1.169	Provides capability to suspend claims for review, as required by the State	
40.8.1.170	Provides capability for manual review of claims for specific services, such as hysterectomies, abortions, sterilizations, DME claims for external insulin pumps, equipment repairs, miscellaneous pediatric items, miscellaneous drugs, off-labeled drugs, and all PAC "1" codes	
40.8.1.171	Provides capability to process Medicare cost-sharing charges	
40.8.1.172	Provides capability to electronically store and report comparable codes used to price unlisted procedure codes	
40.8.1.173	Provides capability to subject all pharmacy claims to the automated POS PRO-DUR consistently	
40.8.1.174	Provides capability to provide adjudication of the pharmacy POS claim as paid or denied when it passed all edits and audits, sending a response back to the provider via a VAN	
	<b>General Claims Resolution</b>	
40.8.1.175	Provides capability for online claims resolution, edit override capabilities for all claim types, and online adjudication	
40.8.1.176	Provides capability to ensure that all corrected claims are completely re-edited	
40.8.1.177	Provides capability for claims correction process that allows inquiry and update by transaction control number, provider ID, recipient ID, location	



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
	code, adjustment initiator ID, clerk ID, claim type, date of service, ranges of dates, and prior approval number	
40.8.1.178	Provides capability to sort suspended claims into applicable work queues	
40.8.1.179	Provides capability to forward suspended claims to multiple locations	
40.8.1.180	Provides capability to accept mass adjustments to suspended claims	
40.8.1.181	Provides capability to link free-form notes from all review outcomes and directions to the imaged claim	
40.8.1.182	Provides capability to maintain error codes and messages that clearly identify the reason(s) for the suspension	
40.8.1.183	Provides capability for the methodology to process the adjustment offset in the same payment cycle as the adjusting claim	
40.8.1.184	Provides capability to adjust Claims History only	
40.8.1.185	Provides capability to re-edit, re-price, and re-audit each adjustment, including checking for duplication against other regular and adjustment claims, in history, and in process	
40.8.1.186	Provides capability to allow online changes to the adjustment claim record to reflect corrections or changes to information during the claim correction (suspense resolution) process	
40.8.1.187	Provides capability to maintain primary and secondary adjustment reason codes that indicate who initiated the adjustment, the reason for the adjustment, and the disposition of the claim for use in reporting the adjustment	
40.8.1.188	Provides capability for the methodology to allow online changes to the adjustment claim record to reflect corrections or changes to information during the claim correction (suspense resolution) process	
40.8.1.190	Provides capability to capture and maintain the medical reviewer ID and claims resolution worker ID by date and by error/edit for each suspended claim	
40.8.1.191	Provides capability to identify and access the status of any related limitations for which the recipient has had services	
40.8.1.192	Provides capability to enter multiple error codes for a claim to appear on the RA	
40.8.1.193	Provides capability to assign a unique status to corrected claims	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
40.8.1.194	Provides capability of entering multiple error codes for a claim to appear on the RA	
40.8.1.195	Provides capability to maintain all claims on the suspense file until corrected, automatically recycled, or automatically denied	
40.8.1.196	Provides capability to adjudicate special batches of claims	
40.8.1.197	Provides capability to force release of claims	
40.8.1.198	Provides capability to adjudicate and track non-covered service claims for EPSDT recipients	
40.8.1.199	Provides capability to capture rebateable NDCs for all administered drugs in the Physician Drug Program, including drugs administered with HCPCS codes	
<b>Retrospective Drug Utilization Review</b>		
40.8.1.200	Provides capability to generate a file of paid drug claims to the Retrospective DUR Vendor	
40.8.1.201	Provides capability to generate a file of physician, clinic, hospital, and pharmacy Provider data to the Retrospective DUR Vendor	
40.8.1.202	Provides capability to generate a file of the recipient data to the Retrospective DUR Vendor	
40.8.1.203	Provides capability to produce the CMS Annual Drug Utilization Review Report	
<b>Adjustment Processing</b>		
40.8.1.204	Provides capability for online search inquiry for pharmacy claims via any available FDB data element/module, including, but not limited to: <ul style="list-style-type: none"> <li>▪ Recipient identifier</li> <li>▪ Provider identifier</li> <li>▪ Pharmacy number</li> <li>▪ Internal control number (ICN)</li> <li>▪ Prescription number</li> <li>▪ Therapeutic class</li> <li>▪ Drug codes</li> <li>▪ GCN</li> <li>▪ GCN-Sequence</li> </ul>	



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
	<ul style="list-style-type: none"> <li>▪ NDC</li> </ul>	
40.8.1.205	Provides capability to update provider payment history and recipient claims history with all appropriate financial records and reflect adjustments in subsequent reporting, including claim-specific and non-claim-specific recoveries	
40.8.1.206	Provides capability to link an original claim with all adjustment transactions	
40.8.1.207	Provides capability for an online mass-adjustment function to re-price claims, within the same adjudication cycle, for retroactive pricing changes	
40.8.1.208	Provides capability to correct the tooth surface on dental claims and process as an adjustment	
40.8.1.209	Provides capability to process unit dose credits	
40.8.1.210	Provides capability to input transactions to Drug Rebate and TPL of all collected dollars	
40.8.1.211	Provides capability to capture pharmacy/drug rebates on professional and institutional claims	
40.8.1.212	Provides capability to capture and electronically store the clerk ID of the individual who initially entered the adjustment and the clerk ID who worked the suspended adjustment	
	<b>General Payment Processing</b>	
40.8.1.213	Provides capability to process all claims and adjustments in accordance with Replacement MMIS policy and procedure	
40.8.1.214	Provides capability to assign the status of claims in the system to determine the course of each action to be taken in the claims adjudication process and completion of appropriate financial processing tasks	
40.8.1.215	Provides capability to apply payments to open accounts receivables when the provider has a positive balance, apply third party collections, create Adjudication Claims File for checkwrite period, and update Provider Earnings file	
40.8.1.216	Provides capability to generate Health Insurance Premium Payments (HIPP)	
40.8.1.217	Provides capability for claims exceptions to process automatically when prior authorized by the lock-in primary care provider or prescriber in	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
	accordance with State policy	
	<b>Financial and Related Processing</b>	
40.8.1.218	Provides capability to maintain complete audit trails of adjustment processing activities	
40.8.1.219	Provides capability to assign the status of claims in the system to determine course of each action to be taken in the claims adjudication process and completion of appropriate financial processing tasks	
40.8.1.220	Provides capability to calculate claims payments by payer source, balancing payments due from adjudicated claims with any increase/decrease for adjustments or other financial transactions	
40.8.1.221	Provides capability to apply payments to open accounts receivables when the provider has a positive balance, apply third party collections, create Adjudication Claims File for checkwrite period, and update Provider Earnings file	
40.8.1.222	Provides capability to produce system-generated check registers, provider checks, and RAs and update control totals by LOB	
40.8.1.223	Provides capability to print provider voucher statements and checks by LOB	
40.8.1.224	Provides capability to validate a provider's status prior to issuing payments or processing refund checks and voided checks	
40.8.1.225	Provides capability to produce a monthly file of all adjudicated claims and other financial transactions by LOB	
40.8.1.226	Provides capability to track the status of all financial transactions by payer source	
40.8.1.227	Provides capability to run separate payment cycles by each LOB	
40.8.1.228	Provides capability to override the system date used for the payment cycle through a system parameter	
40.8.1.229	Provide the capability to use the same system date for all outputs of a claims payment cycle	
40.8.1.230	Provides capability to create a single check or EFT per payment cycle for each provider by LOB	
40.8.1.231	Provides capability to generate beneficiary Recipient Explanation of Medicaid Benefits (REOMBs)	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
40.8.1.232	Provides capability to generate beneficiary Recipient Explanation of Benefits (REOBs) by LOB	X
40.8.1.233	Provides capability to produce and distribute paper RAs formatted separately for individual provider types	
40.8.1.234	Provides capability to produce ANSI 835 and 820 transactions	
40.8.1.235	Provides capability for EFT by LOB	
40.8.1.236	Provides capability to update historical files with information from RAs/835s and checks	
40.8.1.237	Provides capability to ensure RAs contain State-approved EOB messages by LOB	
40.8.1.238	Provides capability for producing statistically valid sampling reports for use in provider audits by LOB	
40.8.1.239	Provides capability to rerun a payment cycle by LOB before the next regularly scheduled cycle and within eight (8) clock hours of State notification, when the original cycle is considered unacceptable	
40.8.1.240	Provides capability to produce EFT register and ANSI 835	
40.8.1.241	Provides capability for balancing process associated with financial month-end reporting	
40.8.1.242	Provides capability to modify payment cycle schedule	
40.8.1.243	Provides capabilities to provide independent and separate banking	
40.8.1.244	Provides capability to combine claims from MMIS and POS for payment processing	
40.8.1.245	Provides capability to withhold adjudicated claims from the payment cycle by payer source	
40.8.1.246	Provides capability to retrieve budget and available balance data from North Carolina Accounting System (NCAS)	
40.8.1.247	Provides capability to accept and process budget data from a DMH file	X
40.8.1.248	Provides capability to use approved budget data for expenditure allotment and control	
40.8.1.249	Provides capability to process and pay claims, based on the applicable budget hierarchy, from the first eligible benefit plan where money is	X



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
	available and the service is covered, within the same payment cycle	
40.8.1.250	Provides capability to deny claims for services for lack of available funds	X
40.8.1.251	Provides capability to hold payment of a claim for a specified period of time	
40.8.1.252	Provides capability to exclude “to be paid” claims for payment processing when the provider is in hold status	
40.8.1.253	Provides capability to accumulate by LOB the reimbursement amounts of all original claims, voids, adjustments, and financial transactions in a “to-be-paid” status to determine an initial net payment amount for a provider	
40.8.1.254	Provides capability to create a receipt for individual claims that were overpaid or paid in error and produce a void or adjustment claim showing the transaction	
40.8.1.255	Provides capability to create a financial transaction to correct overpayments, link to original transaction, and apply to offset future payments	
40.8.1.256	Provides capability to apply all or a portion of the provider’s initial payment amount, if it is positive, to recoup monies against any outstanding accounts receivable balances present for the provider	
40.8.1.257	Provides capability to use the Thursday following the processing date as the last payment cycle of the month	
40.8.1.258	Provides capability to process adjustment claims and credit the appropriate budgets before processing any new day claims	
40.8.1.259	Provides capability to apply Patient Monthly Liability (PML) to specific types of claims and post liability amounts used	
40.8.1.260	Provides capability to apply recipient deductible balance to specified types of claims	
40.8.1.261	Provides the capability for positive pay processing	
40.8.1.262	Provides the capability for provider payment data	
40.8.1.263	Provides capability to apply withholds to capitation payments	
40.8.1.264	Provides capability to release withholds to capitation payments	
40.8.1.265	Provides capability to apply provider sanctions by rate or percentage	





**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
40.8.1.266	Provides capability to apply provider incentives to management fee claims	
40.8.1.267	Provides all payments, adjustments, and other financial transactions to enrolled providers for approved services	
40.8.1.268	Provides the capability to associate all drug rebates to the claim detail	
<b>Financial Management and Accounting Business Area</b>		
40.8.1.269	Provides capability to establish accounts receivable in the format of withholds, liens, levy data, and advance payment/recovery of advance payment	
40.8.1.270	Provides capability for claims that have passed all edit and pricing processing or that have been denied to be documented on the RA by LOB	
40.8.1.271	Provides capability to create financial transactions	
40.8.1.272	Provides capability to create receivables generated from other MMIS functions	
40.8.1.273	Provides capability to create provider, recipient, reference, and account receivable/payout data	
40.8.1.274	Provides capability to make retroactive changes to deductibles	
40.8.1.275	Provides capability to create transactions for corrections to receivables entered into the Replacement MMIS	
40.8.1.276	Provides capability to create transactions for manual checks	
40.8.1.277	Provides capability to create transactions for paper checks	
40.8.1.278	Provides capability to validate new and updated EFT provider information	
40.8.1.279	Provides capability to requests an override EFT and create paper checks for a date range and check pulls for void and replacement	
40.8.1.280	Provides capability to create transactions of check voucher status from the State Controller's Office	
40.8.1.281	Provides capability for notes tracking to accommodate tracking of calls	
40.8.1.282	Provides capability for online access to all recipient, provider, encounter (shadow claims), and reference data related to Financial Management	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
	and Accounting by LOB	
40.8.1.283	Provides capability for Financial Management and Accounting functions with system update capability	
40.8.1.284	Provides capability to maintain a consolidated accounting function, by program, type, and provider	
40.8.1.285	Provides capability to process capitation payments	
40.8.1.286	Provides capability to withhold a percentage of capitation payments	
40.8.1.287	Provides capability to process Managed Care management fees	
40.8.1.288	Provides capability to process management fees for Health Check	
40.8.1.289	Provides capability to process capitation and/or management fee adjustments	
40.8.1.290	Provides capability to process management fees for APs/LMEs	
40.8.1.291	Provides capability to process encounter claims through the payment cycle, updating the final status of the claims to "paid" or "denied" but not producing an associated payment	
40.8.1.292	Provides capability to produce an output extract of encounters (an Encounter RA)	
40.8.1.293	Provides capability to produce an output extract of enhanced Pharmacist Professional fee (on a Pharmacy RA)	
40.8.1.294	Provides capability for system-generated log and tracking of receipt date of request for changes	
40.8.1.295	Provides capability to ensure that provider payments are generated by the processing of claims for eligible recipients and provides capability for adjustments	
40.8.1.296	Provides capability to carry the provider's selection of receiving checks or EFT form of payment	
40.8.1.297	Provides capability to carry the provider's selection of receiving hard copy, electronic RAs, or both	
40.8.1.298	Provides capability to accept pended and adjudicated claims against Provider Earnings file	
40.8.1.299	Provides capability to generate or reproduce provider RAs, to include:	



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
	<ul style="list-style-type: none"> <li>▪ An itemization of submitted claims that were paid, denied, or adjusted, and any financial transactions that were processed for that provider, including subtotals and totals by LOB</li> <li>▪ An itemization of suspended claims, including dates of receipt and suspense and dollar amount billed by LOB</li> <li>▪ Adjusted claim information showing the original claim information and the adjusted information, with an explanation of the adjustment reason code and credits pending by LOB</li> <li>▪ Reason for recoupment or adjustment by LOB</li> <li>▪ Indication that a claim has been rejected due to TPL coverage on file for the recipient; include available relevant TPL data on the RA by LOB</li> <li>▪ Tooth number and surface</li> <li>▪ Explanatory messages relating to the claim payment cutback, denial, or suspension</li> <li>▪ Summary section containing earnings information, by program, regarding the number of claims paid, denied, suspended, adjusted, in process, and financial transactions for the current payment period, month-to-date, and year-to-date</li> <li>▪ Listing of all relevant error messages per claim header and claim detail that would cause a claim to be denied by LOB</li> </ul>	
40.8.1.300	Provides capability to print global informational messages on RAs by LOB; provides capability to make multiple messages available on an online, updateable, user-maintainable message text table; provides capability for unlimited free-form text messages; provides capability for parameters such as provider category of service, provider type, provider specialty, program enrollment, claim type, individual provider number, or pay cycle to control the printing of RA messages	
40.8.1.301	Provides capability to suppress the generation of (both zero-pay and pay) check requests for any provider or provider type but generates associated RAs	
40.8.1.302	Provides capability to update provider payment data	
40.8.1.303	Provides capability to maintain a process of fiscal pends	
40.8.1.304	Provides capability to not accumulate claims in a “to be paid” status that have been excluded from payment	
40.8.1.305	Provides capability to suppress the print of a RA when the only thing that is being printed is related to a credit balance	
40.8.1.306	Provides capability to maintain all data items received on all incoming	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
	claims, including the tooth number and tooth surface(s)	
40.8.1.307	Provides capability to update Claims History and online financial files with the date of payment and amount paid	
40.8.1.308	Provides capability for summary-level provider accounts receivable and payable data and pending recoupment amounts that are automatically updated after each claims processing payment cycle	
40.8.1.309	Provides capability to adjust claim money fields to net out	
40.8.1.310	Provides capability to automatically establish new accounts receivables	
40.8.1.311	Provides identification of providers with credit balances and no claim activity, by program, during a State-specified number of months	
40.8.1.312	Provides capability for the issuance of provider checks and/or EFTs for all claims in the current checkwrite cycle	
40.8.1.313	Provides capability to ensure accurate balances for each checkwrite in accordance with State-approved policy and procedures	
40.8.1.314	Provides capability to process transactions for manually written checks generating a Claims History record	
40.8.1.315	Provides capability to process EFT provider information, updating provider records to reflect their status with EFT	
40.8.1.316	Provides capability to accept requests to override EFT payment to a provider	
40.8.1.317	Provides capability to process check voucher information from the State Controller's Office	
40.8.1.318	Provides capability to update Claims History with RA number and RA issued date from the State Controller's Register file	
40.8.1.319	Provides capability to ensure that the weekly budget reporting is consistent with the costs allocated during the checkwrite by LOB	
40.8.1.320	Provides capability to produce reports and RAs within the financial processing function of the checkwrite cycle by LOB	
40.8.1.321	Provides capability to process and/or set up a recoupment against a provider without specifying a credit balance by LOB	
40.8.1.322	Provides capability to use a hierarchy table when a provider has multiple recoupment accounts	



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
40.8.1.323	Provides capability to identify and recoup payments from the provider made for services after a recipient's date of death	
40.8.1.324	Provides capability to apply claims payments recouplements to more than one (1) account receivable at a time	
40.8.1.325	Provides capability to support a methodology that allows the portion of payments made against each account receivable to be controlled by State staff	
40.8.1.326	Provides capability to validate provider tax identification numbers and associated tax names	
40.8.1.327	Provides capability to process any change transactions received for corrections to checks by LOB	
40.8.1.328	Provides capability to ensure that all financial reports can be tied into the basic financial activity recorded in Provider histories by LOB	
40.8.1.329	Provides capability to generate weekly, monthly, quarterly, and annual financial reports after checkwrites	
40.8.1.330	Provides capability for Advance Provider payments by LOB	
40.8.1.331	Provides capability to receive online requests from authorized users to retrieve paid claims data to produce Recipient Profiles by LOB and return the data in a printable electronic format	
40.8.1.332	Provides capability to include all buy-in premium payments and adjustments in the online paid Claims History files and in Recipient Profile Reports	
40.8.1.333	Provides the capability to obtain approval from NC DHHS for the amount to be applied for payment prior to each checkwrite	
40.8.1.334	Provides the capability to check remaining balance as each payment amount is calculated to verify that the budgeted amount is not exceeded	
40.8.1.335	Provides capability to identify and calculate pricing amounts according to the fee schedules, per diems, rates, and business rules	
40.8.1.336	Provides capability to apply pricing and reimbursement methodologies to appropriately price claims according to NC DHHS pricing standards	
40.8.1.337	Provides capability to price using any combination of procedure code, population group, billing provider, attending provider, and client	
40.8.1.338	Provides capability to establish fee schedules based on procedures, procedure/modifier, or procedure/type of service, including provider	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
	specific rates, DRGs, anesthesia base units, and global surgery days	
40.8.1.339	Provides capability to apply percentages for dual-eligible recipients	
40.8.1.340	Provides capability for pricing of pharmacy claims and reimbursement methodologies to appropriately price claims according to the appropriate financial payer or population group in accordance with State policy, including a dispensing fee and pricing actions	
40.8.1.341	Provides capability to determine calculations for the PAL tiers	
40.8.1.342	Provides capability to process and reimburse pharmacy-enhanced professional service fees as defined by State policy and business rules	
40.8.1.343	Provides capability to price pharmacy claims using lesser of logic incorporating all State-approved pricing methodologies	
40.8.1.344	Provides capability to price using State-specific services from the Prior Approval File	
40.8.1.345	Provides capability to apply recipient liability and co-pay rules, including varying co-pay amounts	
40.8.1.346	Provides capability to identify and calculate payment amounts for Health Check procedures when higher rate applies	
40.8.1.347	Provides capability to deduct either the provider reported or recipient database deductible amount	
40.8.1.348	Provides capability to use non-Medicaid charges first and apply the remainder to allowed charges based on first bill received for processing for the deductible for recipients classed as medically needy	
40.8.1.349	Provides capability to allow the deductible amount to be assigned to specific providers for recipients classed as medically needy	
40.8.1.350	Provides capability to invoke State-approved "Medicare Suspect" procedures	
40.8.1.351	Provides capability to deduct or otherwise apply TPL amounts when pricing claims	
40.8.1.352	Provides capability to price procedure codes, allowing for multiple modifiers that enable reimbursement by program at varying percentages of allowable amounts	
40.8.1.353	Provides capability to price units for procedures based on the cutback units	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
40.8.1.354	Provides capability to price encounter claims at equivalent fee for service payment less deductions, such as TPL or co-payments	
40.8.1.355	Provides capability to maintain multiple date-specific prices for each applicable provider, procedure code, revenue code, and DRG	
40.8.1.356	Provides capability to maintain multiple date-specific rates for each procedure code, population group, billing provider, attending provider, and/or client specific combination	
40.8.1.357	Provides capability to ensure that NC DHHS programs are payers of last resort with respect to private insurance	
40.8.1.358	Provides capability to ensure that claims with known TPL are reduced by the liability in accordance with NC DHHS standards	
40.8.1.359	Provides capability to support application of State-specific services for claims processing	
40.8.1.360	Provides capability to pay only out-of-plan services for capitated program enrollees as fee-for-service and deny in-plan services	
40.8.1.361	Provides capability to automate the calculation for Ambulatory Surgical Centers	
40.8.1.362	Provides capability to apply Graduate Medical Education (GME), both direct and indirect, to inpatient claims	
40.8.1.363	Provides capability to price NDC codes	
40.8.1.364	Provides capability to price or deny claims with Medicare participation, including Medicare HMOs Part C, according to program pricing rules	
40.8.1.365	Provides capability to calculate a DRG per diem for undocumented alien's claims	
40.8.1.366	Provides capability to apply a percentage of an existing fee schedule rate for a different provider specialty	
40.8.1.367	Provides capability to apply variable recipient co-pay percentages to a claim from a prior approval	
40.8.1.368	Provides capability to prorate monthly rate for days billed according to State business rules	
40.8.1.369	Provides capability to calculate provider reimbursement according to business rules	



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
40.8.1.370	Provides capability to price pharmacy claims up to a maximum level allowed by current NCPDP and FDB	
40.8.1.371	Provides capability to price a claim at the lower of the maximum applicable rate, the provider's billed amount, applicable manual pricing, or invoice pricing	
40.8.1.372	Provides capability to accommodate and provide for claims sampling specific to Payment Error Rate Measurement (PERM) Program requirements mandated by CMS and/or their Federal contract agent within designated timeframes  Refer to <i>2007 PERM Data Submission Instructions–Jan 2007[1].pdf</i> for current PERM data submission requirements.	
40.8.1.373	Provides capability to process HIPP payments	
40.8.1.374	Provides capability to produce and send correspondence related to recipient premiums in the recipient's preferred language, including invoices, notices of non-payment, cancellation notices, receipts, and refunds	
40.8.1.375	Provides capability to collect recipient premium payments	
40.8.1.376	Provides capability to produce refunds of recipient premiums	
40.8.1.377	Provides capability to process financial accounting records for premium payments and refunds	
40.8.1.378	Provides capability to produce reports for recipient premium payment and cost-sharing (e.g., recipient co-insurance, deductibles, co-payments, etc.) processes	
40.8.1.379	Provides capability to apply cost-sharing, e.g., recipient co-insurance, deductibles, co-payments	
40.8.1.380	Provides capability to ensure cost-sharing does not exceed threshold for the family group	
40.8.1.381	Provides capability to produce and send recipient letters/notices and Explanations of Benefits (EOB) in the recipient's preferred language	





**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



**40.8.2 Claims Processing Operational Requirements**

Requirement #	Requirement Description	Non-Medicaid Only
<b>General Responsibilities</b>		
40.8.2.1	Fiscal Agent shall perform all claims processing operations functions to support Claims Processing Business Area requirements specified in the Replacement MMIS and user documentation and operating procedures, including, but not limited to: <ul style="list-style-type: none"> <li>▪ Pickup and delivery of mail</li> <li>▪ Sorting and screening of documents</li> <li>▪ Scanning and batching of documents</li> <li>▪ Batch control</li> <li>▪ Data entry</li> <li>▪ Pharmacy Point-of-Sale</li> <li>▪ Payer determination processing</li> <li>▪ Edit processing</li> <li>▪ Suspense resolution</li> <li>▪ Medical review</li> <li>▪ Claims pricing</li> <li>▪ Adjudication processing</li> <li>▪ Adjustment processing</li> <li>▪ Payment processing</li> <li>▪ Financial processing</li> <li>▪ Encounter processing</li> </ul>	
40.8.2.2	Fiscal Agent shall maintain and update the current State-approved Medical Procedure Audit Policy (MPAP).	
40.8.2.3	Fiscal Agent shall create test, process, and review claims in a duplicate region (test region) to assure that State-requested changes to the system adjudicate as anticipated and make changes or receive approval according to contractual agreements.	
<b>Mailroom</b>		
40.8.2.4	Fiscal Agent shall prepare and process all incoming and outgoing mail.	
40.8.2.5	Fiscal Agent shall pick up and deliver mail to the State once in the morning, once in the afternoon of each State business day, and at the request of the State.	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
40.8.2.6	Fiscal Agent shall control hand-delivered mail at the Fiscal Agent’s main entrance for security and management of routing to appropriate personnel or functional unit.	
40.8.2.7	Fiscal Agent shall ensure no mail, claims, tapes, diskettes, cash, or checks are misplaced after receipt by the Fiscal Agent.	
40.8.2.8	Fiscal Agent shall ensure all mail is date-stamped with date of receipt and within one (1) business day of receipt.	
40.8.2.9	Fiscal Agent shall maintain system logging for packages/envelopes mailed via USPS or any other mailing service.	
40.8.2.10	Fiscal Agent shall prepare RTP letters, REOMBs, notice of service approval or denial, and appeal rights TPL letters, drug recovery invoices, estate letters, COCC, and small packages for First Class Mail delivery.	
40.8.2.11	Fiscal Agent shall print and mail/deliver electronically Replacement MMIS State-approved forms.	
40.8.2.12	Fiscal Agent shall log postage costs daily and report to the State a reconciliation of all postage costs to types of articles mailed and distributed	
40.8.2.13	Fiscal Agent shall prepare RAs for mailing and/or transmitting, EFTs for transmitting, and checks for release and mailing.	
<b>Claims Acquisition</b>		
40.8.2.14	Fiscal Agent shall scan hard copy claims and accompanying documentation.	
40.8.2.15	Fiscal Agent shall pre-screen hard copy claims before entering claims into the system and return those not meeting certain criteria to providers under the RTP letter, indicating missing or incorrect information and log returned claims daily.	
<b>Adjustments</b>		
40.8.2.16	Fiscal Agent shall sort, log, and batch adjustment requests and supporting documentation.	
40.8.2.17	Fiscal Agent shall assign adjustment internal control numbers that can associate back with the original claim or previous adjustment.	
40.8.2.18	Fiscal Agent shall return adjustment requests with RTP letter to provider, indicating missing or other required information needs.	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
40.8.2.19	Fiscal Agent shall scan adjustments and supporting documentation.	
40.8.2.20	Fiscal Agent shall verify the quality and readability of scanned adjustment documents.	
40.8.2.21	Fiscal Agent shall reconcile all adjustments (hard copy) entered into the system to batch processing cycle input and output figures.	
	<b>Claims Entry</b>	
40.8.2.22	Fiscal Agent shall perform data entry of all hard copy claims.	
40.8.2.23	Fiscal Agent shall determine if front-end denials are required (such as claims that do not have required sterilization forms or Medicare voucher attached for Medicaid Claims).	
40.8.2.24	Fiscal Agent shall perform individual paper and electronic claim overrides on edits, such as presumptive eligibility, Medicare A, B, and C, HMO coverage, TPL, and timely filing limit	
	<b>Specific to Adjustments</b>	
40.8.2.25	Fiscal Agent shall perform data entry of adjustments.	
	<b>Specific to Electronic Claims Submission/Electronic Data Interchange</b>	
40.8.2.26	Fiscal Agent shall distribute provider claim submission software.	
40.8.2.27	Fiscal Agent shall develop and implement procedures to ensure the integrity of claims submitted by providers via ECS/EDI.	
40.8.2.28	Fiscal Agent shall ensure that all providers submitting via ECS/EDI have signed and returned State-approved ECS/EDI agreements prior to accepting any "production" claim data.	
40.8.2.29	Fiscal Agent shall maintain the original imaged provider-signed ECS/EDI agreements linked to the provider's file data.	
40.8.2.30	Fiscal Agent shall accept tape-to-tape billing from defined sources.	
40.8.2.31	Fiscal Agent shall staff ECS/EDI Help Desk to respond to provider support requirements from 8:00 A.M. to 5:00 P.M. Eastern Time on State business days.	
40.8.2.32	Fiscal Agent shall perform ECS/EDI Trading Partner acceptance testing and send memo to the State for signoff and approval of Trading Partner claims submission once testing is successful.	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
40.8.2.33	Fiscal Agent shall perform provider ECS/EDI acceptance testing.	
40.8.2.34	Fiscal Agent shall assign provider ECS/EDI security identification number during testing and add to the production security file when provider is ECS/EDI-approved.	
40.8.2.35	Fiscal Agent shall log tapes and diskettes upon receipt and assigns batch number.	
40.8.2.36	Fiscal Agent shall perform acceptance testing of VANs for Pharmacy POS claim submission.	
40.8.2.37	Fiscal Agent shall obtain and maintain signed Pharmacy POS Trading Partner Agreements prior to accepting any "production" POS claim data.	
40.8.2.38	Fiscal Agent shall perform pharmacy worksheet resolutions to resolve pending front-end edits for pharmacy claims and submits resolved worksheets to data entry for processing.	
<b>Drug Utilization Review</b>		
40.8.2.39	Fiscal Agent shall produce information to support the State in completing the CMS Annual Drug Utilization Review Report.	
40.8.2.40	Fiscal Agent shall attend the DUR board meetings, supply copies of the annual DUR Report, and apply all board recommendations to POS once approved by the State.	
<b>Retrospective Drug Utilization Review</b>		
40.8.2.41	Fiscal Agent shall submit quarterly extract files to the DUR Vendor within five (5) State business days of the month following the quarter's end.	
<b>Manual Review</b>		
40.8.2.42	Fiscal Agent shall conduct manual reviews of claims for specific services.	
40.8.2.43	Fiscal Agent shall perform manual review on claims according to the manual review procedure manual that identifies claim error information and State-approval criteria.	
40.8.2.44	Fiscal Agent shall refer claims requiring policy decisions to the State.	
40.8.2.45	Fiscal Agent shall perform manual review when claim for EPSDT eligible recipient is denied for "non-covered" services.	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
<b>Adjustments</b>		
40.8.2.46	Fiscal Agent shall return adjustment requests not acceptable due to individual invalid information.	
40.8.2.47	Fiscal Agent shall review adjustment requests.	
40.8.2.48	Fiscal Agent shall process claim-specific retroactive rate adjustments as specified by the State.	
<b>State-Authorized Claim Overrides</b>		
40.8.2.49	Fiscal Agent shall refer denied claims to the State for review when special circumstances require override designation.	
40.8.2.50	Fiscal Agent shall provide a method to process payments for any specific claim and maintain an audit trail.	
<b>General Claims Resolution</b>		
40.8.2.51	Fiscal Agent shall add functionality to management fee payments to allow for enhanced/reduced fees for individual providers and shall provide interactive updates when entering the revisions into the system.	
40.8.2.52	Fiscal Agent shall complete a report of identified claims with the potential for TPL, including Medicare, based on the previous mentioned elements.	
40.8.2.53	<p>Fiscal Agent shall use claims consultants to serve as technical supervisors to staff performing claims processing. These individuals shall:</p> <ul style="list-style-type: none"> <li>▪ Research and analyze problem areas at the request of the State</li> <li>▪ Provide consultation on complex cases and advise when to refer to the Fiscal Agent’s medical consultant and/or the State</li> <li>▪ Review, analyze, and recommend suggestions affecting State operations.</li> </ul>	
40.8.2.54	Fiscal Agent shall obtain approval from NC DHHS for the amount to be applied for payment.	
40.8.2.55	Fiscal Agent shall check remaining balance as each payment amount is calculated to verify that the budgeted amount is not exceeded.	
40.8.2.56	Fiscal Agent shall manually price claims as designated by State policy.	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



**40.8.3 Claims Processing Operational Performance Standards**

Requirement #	Requirement Description	Non-Medicaid Only
40.8.3.1	Fiscal Agent shall date-stamp all mail with actual date of receipt within one (1) business day of receipt at Fiscal Agent site.	
40.8.3.2	Fiscal Agent shall print and mail Replacement MMIS State-approved forms to providers within two (2) business days of receipt of the provider request (at no cost to the provider).	
40.8.3.3	Fiscal Agent shall provide ECS/EDI Help Desk staff from 8:00 A.M. to 5:00 P.M. Eastern Time on State business days.	
40.8.3.4	Fiscal Agent shall electronically acknowledge back to the submitter, within twenty-four (24) hours of processing, a notice of all teleprocessed electronic claims files received as either accepted or rejected, along with the number of claims.	
40.8.3.5	Fiscal Agent shall assign an ICN to every claim, attachment, and adjustment within twenty-four (24) hours of receipt.	
40.8.3.6	Fiscal Agent shall maintain data entry-field accuracy rates above ninety-eight (98) percent.	
40.8.3.7	Fiscal Agent shall scan every claim and attachment within one (1) State business day.	
40.8.3.8	Fiscal Agent shall return hard copy claims missing State-specified required data within two (2) State business days of receipt.	
40.8.3.9	Fiscal Agent shall process all provider-initiated adjustments within forty-five (45) calendar days of receipt; however, if the claim requires a review by the State, the forty-five (45) calendar days shall suspend until the claim is returned to the Fiscal Agent.	
40.8.3.10	Fiscal Agent shall adjudicate: <ul style="list-style-type: none"> <li>▪ Ninety (90) percent of all clean claims for payment or denial within thirty (30) calendar days of receipt</li> <li>▪ Ninety-nine (99) percent of all clean claims for payment or denial within ninety (90) calendar days of receipt</li> <li>▪ All non-clean claims within thirty (30) calendar days of the date of correction of the condition that caused the claim to be unclean.</li> </ul>	
40.8.3.11	Fiscal Agent shall provide correct claims disposition and post to the appropriate account or when appropriate, request additional information within one (1) State business day of receipt.	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
40.8.3.12	Fiscal Agent shall notify the State of any delays in the checkwrite process by 8:00 A.M. Eastern Time the next State business day following the checkwrite cycle.	
40.8.3.13	Fiscal Agent shall notify the State immediately upon discovery of any erroneous payments, irrespective of cause, and prior to initiating appropriate recovery action. Fiscal Agent shall use the change request process to notify the State of any system errors that result in a potential provider erroneous payment.	
40.8.3.14	Fiscal Agent shall provide financial month-end reporting to the State within three (3) days from the last checkwrite of each month.	
40.8.3.15	Fiscal Agent shall provide specified quarterly extract files to the DUR Vendor within five (5) State business days of the start of the month following the quarter's end.	
40.8.3.16	Fiscal Agent shall adjudicate for payment all claims with date of service in previous fiscal year July through April claims by the last checkwrite in May for payment, and shall adjudicate all claims for May and June by the last checkwrite in October of the current fiscal year August for payment due to State fiscal year processing of the State monies.	X
40.8.3.17	Fiscal Agent shall ensure that all payments, adjustments, and other financial transactions made through the Replacement MMIS shall be made on behalf of eligible clients to enrolled providers for approved services in accordance with the payment rules and other policies of the State.	
40.8.3.18	Fiscal Agent shall timely process all claims to assure that the average time from receipt to payment is within the schedule of allowable times. In addition, payments shall be made in compliance with Federal regulations, and the Fiscal Agent shall pay any penalties, interest, and/or court cost and attorney's fees arising from any claim made by a provider against the Fiscal Agent or the State where the Fiscal Agent's actions resulted in a claim payment that was late.	
40.8.3.19	Fiscal Agent shall successfully complete each checkwrite by the date on the State-approved Checkwrite Schedule.	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



**40.9 MANAGED CARE REQUIREMENTS**

**40.9.1 Managed Care System Requirements**

Requirement #	Requirement Description	Non-Medicaid Only
40.9.1.1	Provides capability for notes tracking for managed care provider complaints	
40.9.1.2	Provides capability for online access to all recipient, provider, claims, and reference data related to Managed Care	
40.9.1.3	Provides capability to support multiple Managed Care programs, including those currently in existence: <ul style="list-style-type: none"> <li>▪ Primary Care Case Management (PCCM)</li> <li>▪ Pre-Paid Inpatient Mental Health Plan (PIHP)</li> </ul>	
40.9.1.4	Provides capability to maintain Managed Care capitation rates for specific groups of recipients	
40.9.1.5	Provides capability to apply edits/audits that prevent claims from being paid when Managed Care program recipients receive program-covered services from sources other than the capitated plans in which they are enrolled	
40.9.1.6	Provides capability to apply edits/audits that prevent claims from being paid when a recipient has not received a referral or override approval when required by the Managed Care program or primary care provider with whom they are enrolled	
40.9.1.7	Provides capability to track the utilization rates and costs for program enrollees and to compare such utilization rates and costs to comparable groups of non-Managed Care recipients and across different Managed Care plans to assure sufficient savings are achieved	
40.9.1.8	Provides capability to auto-assign recipients into a Managed Care program(s) See Auto Assignment Business Rules in the Managed Care DSD Exhibits in the Procurement Library.	
40.9.1.9	Provides capability to automatically and on demand produce notices and letters to recipients about their eligibility, enrollment/disenrollment, unavailability of chosen plan, and Managed Care program changes	
40.9.1.10	Provides capability to calculate member months per Managed Care program by age groups and/or by aid categories	
40.9.1.11	Provides capability to maintain an online audit trail of all updates to Managed Care data	





## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
40.9.1.12	Provides capability for online, updateable letter templates for Managed Care recipient and provider letters with the ability to add free-form text and allow for online template changes	
40.9.1.13	Provides capability to apply primary care provider sanctions by entering a provider-specific dollar amount or percentage that results in withholding, or repaying, suppressing, and releasing of all or part of the provider's monthly management/coordination fee up to one hundred (100) percent and notify the State of completed transaction	
40.9.1.14	Provides capability for online logging and tracking of changes to capitation fees or administrative entity provider numbers, file maintenance initiation date, receipt date, file maintenance completion date, operator completing respective changes, name of supervisor, validation, and date	
40.9.1.15	Provides capability to support encounter processing data and costing for the following functions for generation of reports: <ul style="list-style-type: none"> <li>▪ State History File</li> <li>▪ Finalized Claim Activity File</li> <li>▪ Storage of encounter fee for service equivalent cost</li> </ul>	
40.9.1.16	Provides capability to produce monthly Managed Care enrollment reports	
40.9.1.17	Provides capability to produce a file to DIRM/EIS on a weekly basis to report auto-assignment results	
40.9.1.18	Provides capability to produce county-specific Managed Care Provider Directory and transmit electronically to DIRM nightly	
40.9.1.19	Provides capability to produce a county-specific Provider Availability Report and transmit electronically to DIRM nightly	
40.9.1.20	Provides capability to create an extract file containing North Carolina Health Choice recipients linked with a provider/administrative entity and send to the North Carolina State Health Plan by the third business day of each month	
40.9.1.21	Provides capability to generate management fees monthly	
40.9.1.22	Provides capability to generate capitation payments monthly and retroactively for one (1) year	
40.9.1.23	Provides capability to generate prorated capitation payments for a partial month of eligibility	



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
40.9.1.24	Provides capability to access Managed Care data by recipient identification number, recipient name, provider identification number, provider name, procedure code, procedure description, prior approval number, clerk identification, and any combinations thereof	
40.9.1.25	Provides capability to generate a monthly Federal report of auto-assigned Medicaid recipients	
40.9.1.26	Provides capability to produce PAL scorecard for Managed Care providers	
40.9.1.27	Provides capability to adjust base management fees by percentage resulting in enhanced/reduced fees for all individual providers or administrative entities	
40.9.1.28	Provides capability to create notification letters to the provider/administrative entity regarding the adjustment to management fee rates and the reason for the adjustment	
40.9.1.29	Provides capability to produce a monthly report of all adjusted management fees	
40.9.1.30	<p>Provides capability to produce quarterly utilization reports based on paid claims for all Community Care of North Carolina (CCNC) providers, comparing each provider's service rates and per member per month (PMPM) costs to other primary care provider types within their peer group(s)</p> <p>This will include the ability to automate these reports and to produce the report(s) with varying parameters, including, but not limited to, date spans, provider, provider specialties, provider network, service categories, diagnosis codes, CPT codes, and DRG diagnostic-related groupings. This report shall also include the average total enrollment, adult enrollment, and child enrollment for each CCNC provider.</p>	
40.9.1.31	<p>Provides capability to calculate utilization outlier data for the purpose of provider education, utilization management, and quality improvement</p> <p>This data shall be produced in conjunction with the Utilization Review Report.</p>	
40.9.1.32	Provides capability to revise the Quarterly Utilization Report format to allow for more flexibility to revise the report parameters and data and to include, but not be limited to, disease management and system of care groupings, drug utilization, and other group comparisons, as well as the current peer group comparisons	
40.9.1.33	Provides capability to produce recipient letters based on age, sex, and/or clinical data/medical services based on claim data	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
40.9.1.34	Provides capability to generate a report of mailed letters	

**40.9.2 Managed Care Operational Requirements**

Requirement #	Requirement Description	Non-Medicaid Only
40.9.2.1	Fiscal Agent shall resolve all errors, discrepancies, and/or issues related to capitated payments or management fees.	
40.9.2.2	Fiscal Agent shall monitor encounter processing to ensure no payments are generated as a result of encounter processing.	
40.9.2.3	Fiscal Agent shall compile, update, and distribute the Data Submission Manual for encounter data processing.	
40.9.2.4	Fiscal Agent shall serve as first point of contact for questions regarding encounter-related issues.	
40.9.2.5	Fiscal Agent shall conduct training seminars with providers and State staff regarding the encounter claim submission process.	
40.9.2.6	Fiscal Agent shall serve as point of contact for Medicaid providers requesting Managed Care override approvals, make a determination regarding issuance of override, and enter the override approval into the system.	
40.9.2.7	Fiscal Agent shall support toll-free telephone access and be the point of contact for Managed Care providers between 8:00 A.M. and 5:00 P.M. Eastern Time each State business day.	
40.9.2.8	Fiscal Agent shall log receipt of Managed Care provider telephone messages, including brief description of reason for the call, date received, date and who responded to the call, action taken, and any necessary follow-up actions, and ensure follow-up actions are completed.	



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



### 40.9.3 Managed Care Operational Performance Standards

Requirement #	Requirement Description	Non-Medicaid Only
40.9.3.1	Fiscal Agent shall provide the Withhold and Penalty Log within five (5) State business days of the end of the previous month.	
40.9.3.2	Fiscal Agent shall provide the file maintenance log for Managed Care-related transactions within five (5) State business days of the end of the previous month.	
40.9.3.3	Fiscal Agent shall complete requests for changes to capitation payments/management fees within two (2) State business days from date of request.	
40.9.3.4	Fiscal Agent shall enter all written override approval requests into the system within two (2) State business days from receipt of the request and provide a decision to the requesting providers within five (5) State business days from receipt of request.	
40.9.3.5	Fiscal Agent shall respond to a requesting provider within one (1) hour for a telephone request for an emergency override.	
40.9.3.6	Fiscal Agent shall compile, update, and distribute the Data Submission Manual for encounter data processing to providers within five (5) State business days from State date of approval of change.	
40.9.3.7	Fiscal Agent shall provide toll-free access and a point of contact for Managed Care providers between 8:00 A.M. and 5:00 P.M. Eastern Time each State business day.	
40.9.3.8	Fiscal Agent shall respond to Managed Care provider telephone messages within one (1) State business day of receipt of the message.	
40.9.3.9	Fiscal Agent shall produce Managed Care provider enrollment reports and make them available to providers no later than the first day of each month.	
40.9.3.10	Fiscal Agent shall conduct weekly searches for all “exempt” numbers that are linked to the mandatory program category for a system-generated letter advising the eligible of the potential of primary care provider selection from five (5) providers within a thirty-mile (30-mile) range.	
40.9.3.11	Fiscal Agent shall send the Health Choice file to the North Carolina State Health Plan by the third business day of each month.	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



**40.10 HEALTH CHECK REQUIREMENTS**

**40.10.1 Health Check System Requirements**

Requirement #	Requirement Description	Non-Medicaid Only
40.10.1.1	Provides capability to maintain the Health Check periodicity schedule	
40.10.1.2	Provides capability for online inquiry to all Health Check data with access by recipient ID and provider number	
40.10.1.3	Provides capability to maintain each Health Check-eligible recipient, the current and historical screening results, referral, diagnosis and treatment, and immunizations, including the provider numbers and dates	
40.10.1.4	Provides capability to identify paid and denied screening claims	
40.10.1.5	Provides capability to identify abnormal conditions by screening date and whether the condition was treated or referred for treatment	
40.10.1.6	Provides capability to update recipient Health Check data with screening results and dates and referral information	
40.10.1.7	Provides capability for online, updateable letter templates for Health Check monthly notifications, standardized letters, and inserts	
40.10.1.8	Provides capability for automatic generation of monthly notifications to case heads for next screenings, screenings missed, and abnormal conditions not treated based on State criteria	
40.10.1.9	Provides capability to maintain all notices sent, identifying case and recipient and date the notice was sent	
40.10.1.10	Provides capability to maintain an online audit trail of all updates to Health Check data	
40.10.1.11	Provides capability for Web-based Health Check functionality that allows for the creation, update, and management of: <ul style="list-style-type: none"> <li>▪ Health Check Information Notifications</li> <li>▪ Monthly Accounting of Activities Report (MAAR) Information</li> <li>▪ County Options Change Request (COCR) Information</li> <li>▪ Full-Time Equivalency (FTE) Information</li> <li>▪ Health Check Recipient Data</li> </ul>	
40.10.1.12	Provides capability for the following Web-based functionality: <ul style="list-style-type: none"> <li>▪ Search recipient data</li> <li>▪ Enter comments</li> <li>▪ Update notification suppression</li> <li>▪ Send standardized notifications</li> </ul>	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
40.10.1.13	Provides capability to calculate and system-generate Health Check Coordinator management fees	
40.10.1.14	Provides capability to generate a monthly FTE report based on information received on the MAAR and COCR	
40.10.1.15	Provides capability to capture and electronically store all Health Check county staff information	
40.10.1.16	Provides Web-based access to current Health Check data to include new eligibles, new health check screenings, referral, etc.; provides access to each Health Check Coordinator (HCC) to their specific county information and provides ad hoc query capability for extraction of data to the desktop	
40.10.1.17	Provides capability to produce the Health Check Activity Report	
40.10.1.18	Provides capability to convert HCC comments from legacy FoxPro Data Shell application into the Replacement MMIS	
40.10.1.19	Provides capability to generate EPSDT report for primary care providers and administrative entities monthly no later than the fifth day of the month for the preceding month's data  This information should be available on the Web for providers to download for their practice only.	
40.10.1.20	Provides capability to produce monthly MAAR Summary reports	
40.10.1.21	Provides capability to generate reports of recipients who have been in a particular practice for defined time periods, which includes the county and Statewide participation rates	

**40.10.2 Health Check Operational Requirements**

Requirement #	Requirement Description	Non-Medicaid Only
40.10.2.1	Fiscal Agent shall produce and update Health Check User Manual(s).	
40.10.2.2	Fiscal Agent shall provide telephone and on-site technical support and training for Health Check Coordinators.	
40.10.2.3	Fiscal Agent shall participate in Health Check Coordinator Training Sessions in Raleigh, NC.	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
40.10.2.4	Fiscal Agent shall update Health Check Billing Guide.	
40.10.2.5	Fiscal Agent shall conduct agenda planning meetings with State Health Check staff prior to Provider Training Workshops and conduct mock workshops for State approval.	
40.10.2.6	Fiscal Agent shall conduct annual regional Health Check workshops for participating providers in six (6) separate sites throughout the State.	
40.10.2.7	Fiscal Agent shall monitor the Denied Claims Report for Health Check denials and contact providers by telephone to educate and schedule provider visits if denial rate is above ten (10) percent.	
40.10.2.8	Fiscal Agent shall review the Health Check County Option File Master Report monthly to ensure that all participating counties received Automated Information Notification System (AINS) (or Fiscal Agent equivalent) data and all Health Check reports.	
40.10.2.9	Fiscal Agent shall review the Health Check Management Fee Option File Master Report monthly to ensure that Health Check management fee claims were generated correctly.	
40.10.2.10	Fiscal Agent shall submit the monthly FTE Report to the State for approval.	
40.10.2.11	Fiscal Agent shall respond to questions from Health Check County staff related to Health Check management fees and provides written responses to the State.	
40.10.2.12	Fiscal Agent shall provide telephone support and on-site provider visits to educate providers on the Health Check program, policies, and billing requirements.	
40.10.2.13	Fiscal Agent shall coordinate rewrite of the Health Check Billing Guide.	

**40.10.3 Health Check Operational Performance Standards**

Requirement #	Requirement Description	Non-Medicaid Only
40.10.3.1	Fiscal Agent shall maintain and update Health Check User Manual(s) within thirty (30) days of a change in policy/procedures and shall notify HCCS within two (2) days after posting.	
40.10.3.2	Fiscal Agent shall produce CMS Statistical Database updates and required reports one (1) month prior to CMS deadline and shall make all	



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
	appropriate corrections to reports within forty-eight (48) hours of notification of problem.	
40.10.3.3	Fiscal Agent shall produce a monthly FTE Report by the second Friday from the end of each month.	
40.10.3.4	Fiscal Agent shall provide training for use of the Health Check functionality to HCCS, in their respective counties, within three (3) weeks of notification by the State.	
40.10.3.5	Fiscal Agent shall review claim denials and contact providers with denial rate greater than ten (10) percent within fourteen (14) days of claim denial.	
40.10.3.6	Fiscal Agent shall respond to questions from Health Check county staff related to Health Check management fees within twenty-four (24) hours of receipt and shall notify State Health Check staff in writing of inquiry and resolution within forty-eight (48) hours of receipt.	
40.10.3.7	Fiscal Agent shall update addresses in the Health Check County Option File within twenty-four (24) hours of receipt.	
40.10.3.8	Fiscal Agent shall coordinate with the State for the annual revisions to the Health Check Billing Guide.	

### 40.11 THIRD PARTY LIABILITY REQUIREMENTS

#### 40.11.1 TPL System Requirements

Requirement #	Requirement Description	Non-Medicaid Only
40.11.1.1	Provides capability to search TPL database by recipient name, recipient number, policy number, policy holder name, policy holder ID number, SSN of the policy holder, by either the whole name or number or any part of the last name or number, or combination thereof	
40.11.1.2	Provides capability to ensure that claims for preventive pediatric services and prenatal care for pregnant women are paid to providers and not cost-avoided if TPL is available	
40.11.1.3	Provides capability to ensure that claims for inpatient hospital stays for pregnant women are cost avoided	
40.11.1.4	Provides capability for updating of insurance carrier information	





## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
40.11.1.5	Provides capability to retrieve/search third party resource information by the following: <ul style="list-style-type: none"> <li>▪ Name (by any part of last name), ID number (by any part of ID number), date of birth, SSN (by any part of number) of eligible recipient, and relationship of covered individual to policy holder, or combination thereof</li> <li>▪ Insurance carrier</li> <li>▪ Policy number (by any part of number), Medicare Health Insurance Claim (HIC) number (by any part of number), or railroad number</li> <li>▪ Group name and number</li> <li>▪ Source code indicating source of suspect TPL information</li> <li>▪ Name, SSN, and/or ID number of policy holder (by any part of number)</li> <li>▪ Prescription number, whole number, or any part of number</li> <li>▪ Therapeutic code</li> <li>▪ Therapeutic class</li> <li>▪ User ID of individual entering or updating TPL record</li> </ul>	
40.11.1.6	Provides capability to electronically store multiple, date-specific TPL resources for each recipient	
40.11.1.8	Provides capability to electronically store all third party resource information by recipient	
40.11.1.9	Provides capability to electronically store third party carrier information	
40.11.1.10	Provides capability to identify all cost-avoided payments due to established TPL	
40.11.1.11	Provides capability to bill carriers for “pay and chase” claims and automatically create a “case” once claims have accumulated to defined threshold amount	X
40.11.1.12	Provides capability to automatically identify previously paid claims for recovery when TPL resources are identified or verified retroactively and automatically creates a recovery “case” to initiate recovery within a period specified by the State	X
40.11.1.13	Provides capability to identify claims and support recovery actions on paid claims when Medicare coverage is identified or verified after claims have been paid.	
40.11.1.14	Provides capability to track and post recoveries to individual claim histories	X



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
40.11.1.15	Provides capability for archival and retrieval of closed TPL recovery cases	X
40.11.1.16	Provides capability to identify accident/trauma claims and automatically generate questionnaire/reports	
40.11.1.17	Provides capability to approve or cancel trauma questionnaires	
40.11.1.18	Provides capability to retrieve paid claims from history to assist in TPL recovery	
40.11.1.19	Provides capability to maintain an online audit trail of all updates to TPL data	
40.11.1.20	Provides capability to generate carrier update transactions to the State	
40.11.1.21	Provides capability to provide online inquiry, add, and update to TPL data	
40.11.1.22	Provides capability to enter or update recovery cases from recoveries received	X
40.11.1.23	Provides capability to ensure that if the recipient has a pharmacy policy on the date of service that the pharmacy policy is billed or displayed at point of sale rather than any medical policy	
40.11.1.24	Provides capability to identify previously paid claims from the past three (3) years of claims history when TPL resources are identified or verified retroactively	
40.11.1.25	Provides capability to identify previously paid claims from Claims History for the allowed Medicare time limit for filing when Medicare resources are identified or verified after Medicaid payment has occurred	
40.11.1.26	Provides capability to produce and bill drug invoices for insurance carriers	
40.11.1.27	Provides capability to produce accident inquiry letters for identified recipients	
40.11.1.28	Provides capability to maintain recipient health insurance data for TPL through updates from EIS and ACTS to assist in claims processing	
40.11.1.29	Provides capability to capture and maintain Estate Recovery Data, including claims, invoice data, and recovery data on each individual that meets defined criteria	
40.11.1.30	Provides capability to flag and maintain Estate Recovery claims for a	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
	lifetime	
40.11.1.31	Provides capability to produce claims/invoices in order to bill for Estate Recovery	
40.11.1.32	Provides capability to track and report on invoices	
40.11.1.33	Provides capability to route specific DME claims to Medicaid after Children's Special Health Services (CSHS) has paid	X
40.11.1.34	Provides capability for online updating and reporting function for cases to track open cases, type of case, amount of liens, amount of recoveries	X
40.11.1.35	Provides capability to view the invoices for prescription drugs generated by Fiscal Agent, by carrier, or by recipient	
40.11.1.36	Provides capability for online updating, payment, and reporting for the HIPPP Program	
40.11.1.37	Provides capability to systematically build recovery cases, allowing users to inquire, add, and update recovery case records	X
40.11.1.38	Provides capability to search recovery case records by unique recovery case identification number, case type, policy number, policy holder name, policy holder SSN, claim number, recipient name or number, carrier name, carrier number, provider name or number, attorney name, accident number, or a combination of these data elements	X
40.11.1.39	Provides capability to include attorney name, attention line, address, and telephone number in a recovery case record	X
40.11.1.40	Provides capability to view all TPL receivables online in determining which claim details have not be completed and the total amount not posted	X
40.11.1.41	Provides capability to add or delete claims that are included in any recovery case	X
40.11.1.42	Provides capability to add and update the TPL threshold amount online	X
40.11.1.43	Provides capability to enter free-form text in a recovery case	X
40.11.1.44	Provides capability to maintain all open recovery cases online until closed by authorized user	X
40.11.1.45	Provides capability to maintain and flag claims that are part of a TPL recovery/cost avoidance case online for three (3) years after the case is closed before archiving	X



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
40.11.1.46	Provides capability to flag a recipient for which a TPL recovery case has been created	X
40.11.1.47	Provides capability to generate unique Case Identification Numbers	X
40.11.1.48	Provides capability to close a case without full recovery	X
40.11.1.49	Provides capability to reproduce a claim and send either by fax, mail or electronically	
40.11.1.50	Provides the capability to flag claims for recipients who have reached a defined threshold	X
40.11.1.51	Provides capability for online access and update to TPL data by State-designated staff	
40.11.1.52	Provides capability for batch and/or online real-time access to TPL data between EIS, Mental Health Eligibility Inquiry, CSDW, Medicaid Quality Control, Online Verification, ACTS, and HIS and the Replacement MMIS using API and SOA concepts	
40.11.1.53	Provides capability for daily (next business day) transmission logs showing successful transmission of TPL data to DIRM for CSDW, ACTS, and EIS	
40.11.1.54	Provides capability to exclude third party insurance from claims processing on a per-person/per-policy basis, for a set period; provides capability to support multiple exclusions per person/per policy	
40.11.1.55	Provides capability to process and pay claims when policy limits are exhausted for individuals related to a specific service either annual or lifetime benefits	
40.11.1.56	Provides capability to associate and track Non-Custodial Parent (NCP) policy holder information to covered individuals	
40.11.1.57	Provides capability to pend updates to TPL resource data received from Child Support for Medicaid recipients	
40.11.1.58	Provides the capability to pend TPL updates for recipients who are covered by Breast and Cervical Cancer Medicaid (BCCM) or Health Choice programs and display a notification message that the recipient has BCCM or Health Choice	
40.11.1.59	Provides capability to produce a report of TPL segments that have been updated more than once in thirty (30) days	
40.11.1.60	Provides capability to produce a Health Choice Recipient Activity Report	



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
	in addition to the reports listed in the Design documentation	
40.11.1.61	Provides capability to provide TPL edit/error report(s) for ACTS for State staff access	
40.11.1.62	Provides capability to extract and process TPL data transmitted by ACTS from the DIRM electronic File Cabinet	
40.11.1.63	Provides capability to produce a daily extract of TPL carrier and recipient resource data for ACTS, CSDW, and EIS	
40.11.1.64	Provides capability to produce an extract of updates to TPL recipient resource data for ACTS for Medicaid recipients referred to Child Support	
40.11.1.65	Provides capability for batch access to TPL data using API and SOA concepts between EIS, ACTS, and the Replacement MMIS	
40.11.1.66	Provides capability to produce system-generated letters to providers, recipients, and county offices	X

### 40.11.2 TPL Operational Requirements

Requirement #	Requirement Description	Non-Medicaid Only
40.11.2.1	Fiscal Agent shall identify claims and support recovery actions when Medicare resources are identified or verified after claims have been paid.	
40.11.2.2	Fiscal Agent shall process and track recoveries and collections	X
40.11.2.3	Fiscal Agent shall track and post recoveries to individual claim histories.	X
40.11.2.4	Fiscal Agent shall enter or update recovery cases from recoveries received	X
40.11.2.5	Fiscal Agent shall generate carrier update transactions to the State	
40.11.2.6	Fiscal Agent shall extract and process TPL data transmitted by ACTS from the DIRM electronic File Cabinet	
40.11.2.7	Fiscal Agent shall produce a daily extract of TPL carrier and recipient resource data for ACTS, CSDW, and EIS	
40.11.2.8	Fiscal Agent shall produce an extract of updates to TPL recipient resource data for ACTS for Medicaid recipients referred to Child Support	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



**40.11.3 TPL Operational Performance Standards**

Requirement #	Requirement Description	Non-Medicaid Only
40.11.3.2	Fiscal Agent shall adjust paid Claims History for State-specified TPL recoveries and provider/recipient collections within five (5) State business days from end of the previous month.	
40.11.3.3	Fiscal Agent shall disposition the recoveries/collections accurately and consistently ninety-nine and eight tenths (99.8) percent of the time.	X
40.11.3.4	Fiscal Agent shall produce and bill drug invoices for insurance carriers within five (5) State business days of TPL entry.	
40.11.3.5	Fiscal Agent shall mail the accident inquiry letters to the identified recipients within five (5) State business days from end of the previous month.	
40.11.3.6	Fiscal Agent shall generate an Estate Recovery invoice within 2 business days after a recipient meets the defined criteria.	
40.11.3.7	Fiscal Agent shall provide TPL edit/error report(s) for ACTS for State staff access each State business day.	
40.11.3.8	Fiscal Agent shall provide daily (next business day) transmission logs showing successful transmission of TPL data to CSDW and to and from ACTS available for State staff access each State business day.	
40.11.3.9	The Fiscal Agent shall extract and process recipient TPL data transmitted by ACTS from the electronic DIRM File Cabinet by 7:00 A.M.	
40.11.3.10	The Fiscal Agent shall produce a daily extract of TPL carrier and recipient resource data to DIRM for ACTS, CSDW, and EIS	
40.11.3.11	The Fiscal Agent shall produce a daily extract of updates to TPL recipient resource data to DIRM for ACTS for Medicaid recipients referred to Child Support.	

**40.12 DRUG REBATE REQUIREMENTS**

**40.12.1 Drug Rebate System Requirements**

Requirement #	Requirement Description	Non-Medicaid Only
40.12.1.1	Provides capability to maintain and update data on manufacturers with whom rebate agreements exist, including:	



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
	<ul style="list-style-type: none"> <li>▪ Manufacturer ID numbers and labeler codes</li> <li>▪ Indication of collection media</li> <li>▪ Indication of invoicing media</li> <li>▪ Contact name, mailing and e-mail address, phone and fax numbers</li> <li>▪ Manufacturer (labeler) enrollment, termination and reinstatement dates</li> <li>▪ Manufacturer Unit Rebate Amount (URA)</li> <li>▪ Manufacturer units of measure</li> </ul>	
40.12.1.2	Provides capability to capture CMS drug unit rebate amount and units of measure and provides capability to capture T-bill rates for interest calculation	
40.12.1.3	Provides capability to validate units of measure from CMS file to Replacement MMIS drug file for consistency and reporting on exceptions	
40.12.1.4	Provides capability to calculate and generate rebate adjustments by program and/or labeler based on retroactively corrected CMS and North Carolina rebate data	
40.12.1.5	Provides capability to determine the amount of rebates due by NDC and UPC, using paid claim data and eligible data from both the pharmacy program and NDCs from the physician drug program procedure codes	
40.12.1.6	Provides capability to generate invoices and regenerate invoices that separately identify rebate amounts and interest amounts by program, labeler, and rebate quarter	
40.12.1.7	Provides capability to maintain identification of the original drug rebate quarter for the claim throughout any adjustments made to the claim	
40.12.1.8	Provides capability for system determination of the rebate amounts and adjustments overdue, calculates interest, and generates new invoices, separately identifying rebate amounts and interest by program, labeler, and rebate quarter	
40.12.1.9	Provides capability for system generation of invoice details and post-payment details that are consistent with the State's reconciliation of invoices and prior quarter adjustment statement	
40.12.1.10	Provides capability to generate invoice cover letters, collection letters, and follow-up collection letters	
40.12.1.11	Provides capability for online, updateable letter templates, including	



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
	templates for invoice letters, collection letters, follow-up collection letters, allowing for a free-form comments section	
40.12.1.12	Provides capability to maintain and retrieve history of letters sent to manufacturers	
40.12.1.13	Provides capability to update payment details and adjustments to the Replacement MMIS accounting system	
40.12.1.14	Provides capability to maintain and retrieve drug rebate invoice and payment data indefinitely, including CMS drug data, claim data, and operational comments	
40.12.1.15	Provides capability for system identification and exclusion of claims for drugs not eligible for drug rebate program	
40.12.1.16	Provides capability for system identification and exclusion of claims from dispensing pharmacies that are not eligible for drug rebate program (340B providers)	
40.12.1.17	Provides capability for online access by the State to quarterly manufacturer drug rebate invoice detail and balances	
40.12.1.18	Provides capability for online access to five (5) years of historical drug rebate invoices, including supporting claims-level detail with selection criteria by labeler, quarter, NDC, or any combination of criteria	
40.12.1.19	Provides capability for online posting of accounts receivables labeler, NDC for each quarter, rebates receivable, and interest receivable	
40.12.1.20	Provides capability for unit conversion of units paid per claim to CMS units billed and CMS units billed to units paid per claim	
40.12.1.21	Provides capability to maintain units paid (as used to calculate claims pricing) and CMS units billed for drug rebate on Claims History	
40.12.1.22	Provides capability for online access to accounts receivable data, invoice history, payment history, adjustment history, and the audit trail at the labeler, quarter, and NDC level	
40.12.1.23	Provides capability to adjust accounts receivable balances for: <ul style="list-style-type: none"> <li>▪ Rebates only at labeler/quarter level</li> <li>▪ Interest only at labeler/quarter level</li> <li>▪ Rebates and units at NDC level, which would also update labeler/quarter balances</li> <li>▪ Adjustments and State approved write-offs</li> </ul>	





## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
	<ul style="list-style-type: none"> <li>▪ Interest only at the drug detail level</li> </ul>	
40.12.1.24	Provides capability for online maintenance of comprehensive dispute tracking, including an automated tickler file to flag, track, and/or report quarterly on responding and non-responding manufacturers and disputes	
40.12.1.25	Provides capability for logging and tracking all telephone conversations, letters, inquiries, and other correspondence and actions taken by manufacturers, the State, and others related to drug rebate processing	
40.12.1.26	Provides capability for generation of manufacturer mailing labels on request	
40.12.1.27	Provides capability for an online audit trail of all activities and updates to drug rebate data	
40.12.1.28	Provides capability for online update for Drug Rebate accounts receivable via the NDC with data such as labeler check number and check receipt date to monitor all Drug Rebate accounts receivable activity	
40.12.1.29	Provides capability to make available to the State the total Medicaid expenditures for multiple source drugs (annually) as well as other drugs (every three [3] years); provides capability to include mathematical or statistical computations, comparisons, and any other pertinent records to support pricing changes as they occur	
40.12.1.30	Provides capability for adjustment and State-approved write-off records	
40.12.1.31	Provides capability for system interest calculation on outstanding Drug Rebate balances and applies results to DRS Accounts Receivable File	
40.12.1.32	Provides capability to perform end-of-month balancing process	
40.12.1.33	Provides capability to load all pharmacy claims to the Drug Rebate business area weekly, regardless of where they are paid	
40.12.1.34	Provides capability to maintain the Drug Rebate Labeler Data, facilitating automatic updating with information from CMS and the State	
40.12.1.35	Provides capability to maintain online Drug Rebate Claims Detail generated from the Drug Rebate History File of paid claims and adjustment activity that balances to each Labeler invoice by State entity	
40.12.1.36	Provides capability for audits that ensure consistency of data from detail level to summary level	
40.12.1.37	Provides capability to ensure automated electronic transfer of invoice	



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
	data and detail history to CMS and the State in their respectively approved formats	
40.12.1.38	Provides capability to freeze invoices so they can no longer be recalculated	
40.12.1.39	Provides capability to create a report showing a list of all invoices for a specified rebate program and quarter; provides capability to allow users to view invoices before or after being frozen and allow user determination of whether to include under-threshold invoices	
40.12.1.40	Provides capability to create a report showing quarterly changes to amounts due in the format required for inclusion in the CMS 64 Report	
40.12.1.41	Provides capability to produce Payment Summary Report to display payments received during a specified date range and balances due by quarter within manufacturer	
40.12.1.42	Provides capability to produce Rebate Summary Report to display payments received, invoiced amounts, and disputed amounts by quarter or by year	
40.12.1.43	Provides capability to produce Quarterly Payment Report to give summary of payments received versus the original and current invoiced amounts per manufacturer	
40.12.1.44	Provides capability to produce the NDC Detail Report to give summary data by quarter for selected NDCs	
40.12.1.45	Provides capability to produce the NDC History Report to display all the activities that have occurred for a selected drug by quarter	
40.12.1.46	Provides capability to produce the Manufacturer Summary Report to display information by quarter, including amounts invoiced, paid, and disputed	
40.12.1.47	Provides capability to produce the Reconciliation of State Invoice (ROSI)/Prior Quarter Adjustment Report to display the amounts allocated for a selected manufacturer or NDC	
40.12.1.48	Provides capability to produce the Unallocated Balance Report to display unallocated balances selected according to user-supplied criteria	
40.12.1.49	Provides capability to produce the Adjusted Claims Report to display claims where the number of units considered for invoicing differed from those originally supplied by the claims processing system	
40.12.1.50	Provides capability to produce a Drug Rebate Distribution Report, listing	



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
	Drug Rebate Collections by county, with Federal, State, and county share specified	
40.12.1.51	Provides capability to produce an Excluded Provider Report, listing those providers whose claims will not be included in Drug Rebate invoices	
40.12.1.52	Provides capability to produce Excluded Provider Listing, displaying the claims paid for providers not subject to rebate	
40.12.1.53	Provides capability to produce a XIX-CMS Utilization Mismatch Report, showing drugs where the Unit Type from CMS does not match that on the Drug File	
40.12.1.54	Provides capability to produce an Invoice Billing for Quarter Report, showing a summary of drug utilization billed to manufacturers for the quarter	
40.12.1.55	Provides capability to produce a Balance Due Report listing the top ten (10) credit balances at run time	
40.12.1.56	Provides capability to produce a Balance Due Report listing the top twenty (20) debit balances at run time	
40.12.1.57	Provides capability to produce a Check/Deposit Comparison Report for reconciliation with deposit slips	
40.12.1.58	Provides capability to produce a Check/Voucher Comparison Report, comparing the Check Voucher Total and the Interest Voucher Total and the Interest Voucher Total with the Check Table Total	
40.12.1.59	Provides capability to produce a Disputes Activity Report to display disputes by Unassigned, Assigned, and Resolved dispute types	
40.12.1.60	Provides capability to produce an Interest Activity Report to display all interest overrides	
40.12.1.61	Provides capability to produce an Interest Detail Report to display all interest for a labeler and quarter	
40.12.1.62	Provides capability to produce a report of invoiced amounts greater than the sum of claim reimbursement amounts	
40.12.1.63	Provides capability to produce an Invoice not Paid Report, showing all invoices for which no payment has been received	
40.12.1.64	Provides capability to produce a report that will list all codes (HCPCS) from medical claims, including J codes, M codes, Q codes, and others that have been converted to NDCs	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
40.12.1.65	Provides capability to produce a Monthly Balance Report to summarize the balance due per labeler per quarter and across all labelers	
40.12.1.66	Provides capability to produce a report of payments received for drugs with CMS URA of zero	
40.12.1.67	Provides capability to produce a Recapitulation Report that notifies manufacturers of corrected balances after dispute resolution procedures have been completed for one (1) or more quarters.	
40.12.1.68	Provides capability to produce a Generic/Non-Generic Report that lists drug rebate amounts invoiced by brand, generic, and multi-source, further divided into brand and generic, plus total for a selected period, and percentages	
40.12.1.69	Provides capability to produce ad hoc reports, including, but not limited to, ad hoc reporting on utilization detail by GCN, GC3 (therapeutic class), and GCN-Sequence	
40.12.1.70	Provides capability to access current and historical URA amounts for all rebateable drugs	

**40.12.2 Drug Rebate Operational Requirements**

Requirement #	Requirement Description	Non-Medicaid Only
40.12.2.1	Fiscal Agent shall update online Drug Rebate accounts receivable via the NDC with data such as labeler check number and check receipt date to monitor all Drug Rebate accounts receivable activity.	
40.12.2.2	Fiscal Agent shall make available to the State the total Medicaid expenditures for multiple source drugs (annually) as well as other drugs (every three [3] years); the record keeping for this requirement should include data such as mathematical or statistical computations, comparisons, and any other pertinent records to support pricing changes as they occur.	
40.12.2.3	Fiscal Agent shall receive and process rebate checks from labelers.	
40.12.2.4	Fiscal Agent shall deposit labeler checks.	
40.12.2.5	Fiscal Agent shall allow for adjustment and write-off records.	
40.12.2.6	Fiscal Agent shall perform interest calculation on outstanding Drug Rebate balances and apply results to Drug Rebate accounts receivable	



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
	file.	
40.12.2.7	Fiscal Agent shall perform end-of-month balancing process.	
40.12.2.8	Fiscal Agent shall maintain Drug Rebate history data with online accessibility by extracting claims data monthly from Claims History and moving the data to the Drug Rebate history on a quarterly basis.	
40.12.2.9	Fiscal Agent shall perform check and voucher entry for update to the accounts receivable records.	
40.12.2.10	Fiscal Agent shall receive, log, and process labeler disputes.	
40.12.2.11	Fiscal Agent shall maintain data for each quarter that a labeler disputes a particular NDC.	
40.12.2.12	Fiscal Agent shall research and resolve discrepancies, including calling providers about questionable claims.	
40.12.2.13	Fiscal Agent shall initiate any necessary adjustments to change units of NDC.	
40.12.2.14	Fiscal Agent shall produce a Recapitulation Report.	
40.12.2.15	Fiscal Agent shall send Recapitulation Report to NC DHHS Auditor(s) for review and approval.	
40.12.2.16	Fiscal Agent shall send Recapitulation Report to labeler with copy of current summary balance once report is approved.	
40.12.2.17	Fiscal Agent shall create and send quarterly invoices for each labeler that has a rebate agreement signed with CMS or the State as division-appropriate.	
40.12.2.18	Fiscal Agent shall update DRS Labeler Data with information from CMS and the State.	
40.12.2.19	Fiscal Agent shall ensure automated electronic transfer process to deliver invoice data and detail history to CMS and the State.	
40.12.2.20	Fiscal Agent shall attend CMS-sponsored Drug Rebate Labeler Dispute meetings as required by the State and based on relevance of agenda.	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



**40.12.3 Drug Rebate Operational Performance Standards**

Requirement #	Requirement Description	Non-Medicaid Only
40.12.3.1	Fiscal Agent shall maintain an outstanding rebate balance percentage (i.e., over forty-five [45] days) of less than ten (10) percent of total rebates due for each quarter excluding the outstanding balance of Manufacturers' Disputes Accounts Receivable.	
40.12.3.2	Fiscal Agent shall make available to the State the total Medicaid expenditure for multiple source drugs (annually) as well as other drugs (every three years) accurately and consistently ninety-nine and nine tenths (99.9) percent of the time.	
40.12.3.3	Fiscal Agent shall log all labeler checks received by labeler, check number, amount, date received, date entered into DRS Accounts Receivable file, and date of deposit. Fiscal Agent shall forward the logs to the State within five (5) business days from the end of the previous month.	
40.12.3.4	Fiscal Agent shall update the Drug Rebate accounts receivable within two (2) State business days of receipt.	
40.12.3.5	Fiscal Agent shall deposit all labeler checks within one (1) State business day of receipt.	
40.12.3.6	Fiscal Agent shall perform interest calculation on outstanding Drug Rebate balances and apply results to Drug Rebate accounts receivable ninety-nine and nine tenths (99.9) percent of the time, as directed by the State.	
40.12.3.7	Fiscal Agent shall perform end-of-month Drug Rebate balancing processes and forward to the State for review within five (5) State business days of the end of the previous month.	
40.12.3.8	Fiscal Agent shall extract Drug Rebate history data monthly, moving it to the quarterly file within two (2) State business days from the end of the previous month.	
40.12.3.9	Fiscal Agent shall receive and log all labeler disputes on the date of receipt, including data such as labeler, date of call, caller name/telephone number, issue, processor of call, resolution, follow-up requirements, and a tickler to ensure any follow-up requirements are completed. Fiscal Agent shall forward the log to the State within five (5) business days from the end of the previous month.	
40.12.3.10	Fiscal Agent shall process all labeler disputes within ten (10) State business days from the date of receipt.	
40.12.3.11	Fiscal Agent shall produce a Recapitulation Report, which is a revised invoice, for the labeler one (1) State business day after the completion	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
	of the dispute resolution.	
40.12.3.12	Fiscal Agent shall send the Recapitulation Report to NC DHHS Auditor(s) for review and approval by close of business the same day the Recapitulation Report is produced.	
40.12.3.13	Fiscal Agent shall send the Recapitulation Report to the labeler with a copy of the current summary balance the same day the Fiscal Agent has received the NC DHHS Auditor's approval.	
40.12.3.14	Fiscal Agent shall create and forward quarterly invoices for each labeler that has a rebate agreement signed with CMS or the State, as division appropriate, within five (5) State business days from receipt of CMS tape.	
40.12.3.15	Fiscal Agent shall maintain an outstanding rebate balance percentage (i.e., forty-five [45] days or more) of less than ten (10) percent of total rebates due for each quarter excluding the Labeler Disputes Outstanding Accounts Receivable balance accurately and ninety-nine and nine tenths (99.9) percent of the time.	
40.12.3.16	Fiscal Agent shall electronically transfer required data to CMS and the State as applicable to the Drug Rebate requirements within five (5) State business days from invoicing.	
40.12.3.17	Fiscal Agent shall attend CMS-sponsored Drug Rebate Labeler Dispute meetings, as directed by the State.	
40.12.3.18	Fiscal Agent shall provide online access to five (5) years of historical drug rebate invoices based on criteria provided by the State accurately and consistently ninety-nine and nine tenths (99.9) percent of the time.	

**40.13 MANAGEMENT ADMINISTRATIVE AND REPORTING SYSTEM REQUIREMENTS**

**40.13.1 MARS Requirements**

Requirement #	Requirement Description	Non-Medicaid Only
40.13.1.1	Provides capability to maintain source data from all other functions of the Replacement MMIS to create State and Federal reports at frequencies defined by the State	
40.13.1.2	Provides capability for compiling subtotals, totals, averages, variances, and percents of items and dollars on all reports, as appropriate	



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
40.13.1.3	Provides capability to generate user-identified reports on a State-specified schedule	
40.13.1.4	Provides capability to generate reports to include the results of all State-initiated financial transactions, by State-specified categories, whether claim-specific or non-claim-specific	
40.13.1.5	Provides capability to identify, separately or in combination as requested by the State, the various types of recoupsments and collections	
40.13.1.7	Provides capability for uniformity, comparability, and balancing of data through the MARS reports and between these and other functions' reports, including reconciliation of all financial reports with claims processing reports	
40.13.1.8	Provides capability for detailed and summary-level counts of services by service, program, and eligibility category, based on State-specified units (days, visits, prescriptions, or other); provides capability for counts of claims, counts of unduplicated paid participating and eligible recipients, and counts of providers by State-specified categories	
40.13.1.9	Provides capability for a statistically valid trend methodology approved by the State for generating MARS reports	
40.13.1.10	<p>Provides capability for charge, expenditure, program, recipient eligibility, and utilization data to support State and Federal budget forecasts, tracking, and modeling, to include:</p> <ul style="list-style-type: none"> <li>▪ Participating and non-participating eligible recipient counts and trends by program and category of eligibility</li> <li>▪ Utilization patterns by program, recipient medical coverage groups, provider type, and summary and detailed category of service</li> <li>▪ Charges, expenditures, and trends by program and summary and detailed category of service</li> <li>▪ Lag factors between date of service and date of payment to determine billing and cash flow trends</li> <li>▪ Any combination of the above</li> </ul>	
40.13.1.11	Provides capability to describe codes and values to be included on reports	
40.13.1.12	Provides capability for users to specify selection, summarization, and un-duplication criteria when requesting claim detail reports from Claims History	
40.13.1.13	Provides capability to capture and maintain online at least four (4) years of MARS reports and five (5) years of annual reports, with reports over	





## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
	four (4) years archived and available to NC DHHS within twenty-four (24) hours of the request	
40.13.1.14	Provides capability to generate all MARS reports that will be sent to CMS in the format specified by Federal requirements	
40.13.1.15	Provides capability for the maintenance of the integrity of data element sources used by the MARS reporting function and integrates the necessary data elements to produce MARS reports and analysis	
40.13.1.16	Provides capability for system checkpoints that ensure changes made to programs, category of service, etc. are accurately reflected in MARS reports	
40.13.1.17	Provides capability for consistent transaction processing cutoff points to ensure the consistency and comparability of all reports	
40.13.1.18	Provides capability to ensure all MARS report data supports accurate balancing, uniformity, and comparability of data to ensure internal validity and to non-MARS reports to ensure external validity (including reconciliation between comparable reports and all financial reports)	
40.13.1.19	Provides capability for an audit trail for balanced reporting	
40.13.1.20	Provides capability for a standard date of service/date of procedure cutoff for cost audit data with the capability to report prior year data separately from current year data, as well as summary data for all claims	
40.13.1.21	Provides capability for the MARS database to include the following types of data: <ul style="list-style-type: none"> <li>▪ Adjudicated claims data</li> <li>▪ Adjustment/void data</li> <li>▪ Financial transactions for the reporting period</li> <li>▪ Reference data for the reporting period</li> <li>▪ Provider data for the reporting period</li> <li>▪ Recipient data (including LTC, EPSDT, cost of care, co-pays, benefits used, and insurance information) for the reporting period</li> <li>▪ Budget data from the NCAS</li> <li>▪ Financial data, for the reporting period</li> <li>▪ Other, such as Medco and Health Check, inputs not available from or through the Replacement MMIS claims financial function</li> </ul>	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
40.13.1.22	Provides capability to capture and maintain the necessary data to meet all Federal and State requirements for MARS, with the Vendor identifying and providing all Federal MARS reports required to meet and maintain CMS certification	
40.13.1.23	Provides capability to generate reports at monthly, quarterly, semiannual, annual, and bi-annual intervals, as specified by the State and Federal requirements	
40.13.1.24	Provides capability to create all required MMA file and MMA State Response File reports	
40.13.1.25	Provides capability to produce MARS reports by program, plan, county, and population group; reports for other State programs in addition to the standard MARS reports will need to be developed	

**40.13.2 MARS Operational Requirements**

Requirement #	Requirement Description	Non-Medicaid Only
40.13.2.1	Fiscal Agent shall review the system audit trail for balanced reporting and deliver the balanced report to the State with each MARS production run.	
40.13.2.2	Fiscal Agent shall respond to State requests for information concerning the reports.	

**40.13.3 MARS Operational Performance Standards**

Not applicable

**40.14 FINANCIAL MANAGEMENT AND ACCOUNTING REQUIREMENTS**

**40.14.1 Financial Management and Accounting System Requirements**

Requirement #	Requirement Description	Non-Medicaid Only
40.14.1.1	Provides capability to create and update Financial Participation Rate Tables	



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
40.14.1.2	Provides capability to create withholds, advance payments, and recovery of advance payments	
40.14.1.3	Provides capability to record liens and levy data	
40.14.1.4	Provides capability to process retroactive changes to deductible, TPL retroactive changes, and retroactive changes to program codes (from State-funded to Title XIX)	
40.14.1.5	Provides capability to process transactions containing total amount of dollars, per check, received by the State for TPL recoveries, drug rebates, medical refunds, Fraud and Abuse Detection System (FADS) recoveries, and any cash receipts that should be applied to the Replacement MMIS	
40.14.1.6	Provides capability to accept and process Fiscal Agent bank transactions of check and EFT statuses, such as paid, void, and stop payment transactions	
40.14.1.7	Provides capability for fully integrated financial operations, including general ledger, accounts receivable, claims payment/accounts payable, cash receiving, receipts dispositioning, and apportionment functions	
40.14.1.8	Provides capability to automatically compute financial participation (State, Federal, county, and other)	
40.14.1.9	Provides capability for the accounting of all program financial transactions in a manner that provides timely and accurate production of State and CMS reporting requirements	
40.14.1.10	Provides capability to deduct or add appropriate amounts and/or percentages from processed payments, regardless of origin of the transaction in accordance with GAAP via system financial management and accounting functions with online update and inquiry capability	
40.14.1.11	Provides capability for transactions that use existing State accounting and financial reason codes and descriptions (including division, LOB, benefit plan, NCAS Cost Accounting Code [CAC], Period code, Reason Code, Category of Service Code (COS) Code, County Code, type, and provider) that supports production of required financial reports without the need for maintenance of conversion tables	
40.14.1.12	Provides capability to meet CMS requirement to reduce program expenditures for provider accounts receivable that are not collected within sixty (60) days of the date they are discovered	
40.14.1.13	Provides capability to produce NCAS interface file weekly to support checkwrite activity	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
40.14.1.14	Provides capability to apply special "timely filing" edits at the end of the State fiscal year	
40.14.1.15	Provides capability for tracking calls regarding Fiscal Agent-related issues, claims, and complaints; provides capability for easy access to the call information by all users	
40.14.1.16	Provides capability to identify and update payment data with each payment cycle	
40.14.1.17	Provides capability to interface with NCAS for accounts receivable and accounts payable functions	
40.14.1.18	Provides capability for a Client Data Warehouse extract of DMH data	X
<b>MMIS Accounts Payable Processes</b>		
40.14.1.19	Provides capability for accounts payable functionality for all programs	
40.14.1.20	Provides capability to identify providers with credit balances and no claim activity, by program, during a State-specified number of months	
40.14.1.21	Provides capability to process transactions for checks from outside systems, generating a Claims History record	
40.14.1.22	Provides capability for online access to check voucher reconciliation information by provider number or check voucher number and/or issue date, displaying the following information: <ul style="list-style-type: none"> <li>▪ Provider number</li> <li>▪ Issue date</li> <li>▪ Check voucher number</li> <li>▪ Amount</li> <li>▪ Disposition</li> <li>▪ Disposition date</li> </ul>	
40.14.1.23	Provides capability for online inquiry access and update ability on selected individual fields	
40.14.1.24	Provides capability to generate a stop payment or cancel transaction	
40.14.1.25	Provides capability to process the check voucher returned file for failed EFTs	
40.14.1.26	Provides capability to update funding sources and criteria lists based on financial participation rate information received from the State	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
40.14.1.27	Provides capability to ensure that weekly budget reporting is consistent with the costs allocated during the checkwrite	
40.14.1.28	Provides capability to produce a provider voucher account payable upon receipt of a State Payout Authorization Form signed by an authorized State Official; provides capability to schedule payment of the voucher by the system in a future checkwrite cycle	
40.14.1.29	Provides capability to support Cost Settlement transaction, which includes disburse payments upon request, recoup receivables, deposit receipts, set up and post the associated accounts receivable/accounts payable transactions, and produce MMIS reports by provider that are required by the DMA Audit Section to support the cost settlement process	
40.14.1.31	Provides capability to set up an accounts payable for non-provider-specific payments, issue payment, and adjust the financial reporting	
<b>MMIS Accounts Receivable Process</b>		
40.14.1.32	Provides capability to ensure accurate collection and management of account receivables	
40.14.1.33	Provides capability for summary-level provider accounts receivable and payable data and pending recoupment amounts that are automatically updated after each claims processing payment cycle, with summary-level data consisting of calendar week-to-date, month-to-date, year-to-date, State, and Federal fiscal year-to-date totals	
40.14.1.34	Provides capability to maintain an accounts receivable detail and summary section for each account	
40.14.1.35	Provides capability for automated and manual establishment of accounts receivable for a provider and to alert the other Financial Processing portion of this function if the net transaction of claims and financial transactions results in a negative amount (balance due)	
40.14.1.36	Provides capability to monitor the status of each account receivable and report weekly and monthly to the State in aggregate and/or individual accounts, on paper and online	
40.14.1.37	Provides capability to produce collection letters within the financial processing function of the checkwrite cycle	
40.14.1.38	Provides capability to establish systematic payment plans or recoupments for provider receivable balances, as directed by the State	
40.14.1.39	Provides capability to "write off" outstanding account receivables when	



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
	approved by the State	
40.14.1.40	Provides capability to set up multiple open accounts receivable items for recoupment against provider claims payable in the financial system, subject to a hierarchy table; provides capability for the system to withhold the money from provider claims payable for all receivable items meeting recoupment criteria until the provider payable balance for all receivables have been fully recouped or the payable balance is equal zero	
40.14.1.41	Provides capability to perform the cash control processing cycle, updating master files for bank reconciliation, cash receipts, and accounts receivables and producing applicable cash control reports, including the cash receipts and accounts receivable detail from the checkwrite cycle	
40.14.1.42	Provides capability to accept claim-specific and gross recoveries, regardless of submitter (provider, carrier, recipient, drug manufacturer); provides capability to apply gross recoveries to providers and/or recipients as identifiable	
40.14.1.43	Provides capability to set up receivables and recoup payments to the provider for services after a recipient's date of death	
40.14.1.44	Provides capability for an online hierarchy table by fund code or recoupment type for the recovery of monies from claims payable to a provider, such as: <ul style="list-style-type: none"> <li>▪ Claims paid in error</li> <li>▪ Cost settlements receivables</li> <li>▪ Program integrity receivables</li> <li>▪ Provider advances tax withholding</li> <li>▪ Tax levies</li> </ul>	
40.14.1.45	Provides capability for an online accounts receivable process with the ability to request recoupments by the following portions of the receivable amount during one (1) payment cycle: <ul style="list-style-type: none"> <li>▪ Percent</li> <li>▪ Dollar amount</li> <li>▪ Total amount</li> </ul>	
40.14.1.46	Provides capability to automatically recoup accounts receivables by either deductions from claims payments or through direct payment by the provider or combinations of both	
40.14.1.47	Provides capability to apply cash received and recoupments to the accounts receivable, including a history of the RA date, number, and	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
	amount and have related information available online	
40.14.1.48	Provides capability to apply claims payments recoupments to more than one (1) account receivable at a time	
40.14.1.49	Provides capability to allow the portion of payments made against each account receivable to be controlled by State staff	
40.14.1.50	Provides capability to remove accounts and produce reports on a monthly basis when a provider record has been inactive for one (1) year	
40.14.1.51	Provides capability to generate transactions to the system for each accounts receivable item created and invoiced, accounts receivable adjustments, payments received and, recouped and write-offs	
40.14.1.52	Provides capability for online daily receipts and recoupment information to the unit responsible for dispositioning the detail, for example TPL, drug rebate, medical refund, FADS recoveries, and any other cash receipts received by the State	
40.14.1.53	Provides capability to produce and send correspondence related to recipient premiums in the recipient's preferred language, including invoices, notices of non-payment, cancellation notices, receipts, and refunds	
40.14.1.54	Provides capability to collect recipient premium payments	
40.14.1.55	Provides capability to produce refunds of recipient premiums	
40.14.1.56	Provides capability to process financial accounting records for premium payments and refunds	
40.14.1.57	Provides capability to produce reports for recipient premium payment and cost-sharing (e.g., recipient co-insurance, deductibles, co-payments, etc.) processes	
40.14.1.58	Provides capability to apply cost-sharing, e.g., recipient co-insurance, deductibles, co-payments	
40.14.1.59	Provides capability to ensure cost-sharing does not exceed threshold for the family group	
40.14.1.60	Provides capability to produce and send recipient letters/notices and Explanations of Benefits (EOB) in the recipient's preferred language	
	<b>Financial Accounting and Reporting Processes</b>	
40.14.1.61	Provides capability to perform financial cycles upon completion of each checkwrite and at month-end, summarize paid claims and financial	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
	transactions, update account balances and transaction files, and produce interface files and reports	
40.14.1.62	Provides capability to account for and report to the State all program funds paid out and recovered in accordance with State-accounting codes and report specifications	
40.14.1.63	Provides capability for a process to designate which Federal fiscal year claim adjustments and other financial transactions are to be reported	
40.14.1.64	Provides capability to prepare fiduciary statements in accordance with GAAP to account for all program funds received and disbursed under the Fiscal Agent contract	
40.14.1.65	Provides capability to produce general ledger to correspond to the checkwrites over the State's fiscal year; adjusts the general ledger account balances on June 30 <sup>th</sup> to reflect activity between the last June checkwrite and June 30 <sup>th</sup>	
40.14.1.66	Provides capability to summarize checkwrite activity in the Financial Participation Report and general expenditure reports on a year-to-date basis and within ten (10) days of the State's fiscal year's end on June 30 <sup>th</sup> ; provides capability to generate these reports in accordance with State-approved format, media, distribution, and frequency	
40.14.1.67	Provides capability to summarize financial data to meet reporting requirements on a State and Federal fiscal-year basis	
40.14.1.68	Provides capability to ensure all reporting cross-checks and balances to other reports using the same data	
40.14.1.69	Provides capability to produce reporting on providers required by the Federal False Claims Act	
40.14.1.70	Provides capability to maintain all records and reports of administrative expenses permitting the State to verify that the Fiscal Agent bills are accurate and appropriate to enable the State to claim Federal financial participation (FFP) on the Fiscal Agent fees at the appropriate rate	
40.14.1.71	Provides capability to ensure that all financial reports can be tied into the basic financial activity recorded in Provider History	
40.14.1.72	Provides capability to generate weekly, monthly, quarterly, and annual Medicaid and other EOB financial reports after checkwrites in accordance with State approved specifications, basis of accounting, and reporting deadlines	
40.14.1.73	Provides capability to balance details posted to each receivable transaction and update Claims History and Provider paid claims	





## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



Requirement #	Requirement Description	Non-Medicaid Only
	summary information	
40.14.1.74	Provides capability to incorporate data from State-approved automated systems to satisfy accounting and record keeping objectives	
40.14.1.75	Provides capability for system-generated letters to providers requesting updated W-9s or a special IRS form depending on whether they are a first or second B-Notice	
40.14.1.76	Provides capability for system logging and tracking of receipt date of each withholding and penalty request and completion date of withholding or penalty	
40.14.1.77	Provides capability to provide the State with confirmation and validation for each completed date of withholding or penalty	
40.14.1.78	Provides capability to implement backup withholding from all providers who do not respond to the notices within the required timeframes	
40.14.1.79	Provides capability for mechanized copies of documentation to support compliance with IRS procedures and efforts to obtain information from providers in order to abate penalties assessed	
40.14.1.80	Provides capability to report year-to-date provider 1099 earnings	
40.14.1.81	Provides capability to create end-of-year 1099 for providers whose earnings exceed \$600 on a calendar year basis and meet IRS criteria for issuance	
40.14.1.82	Provides capability to generate provider 1099 file and reports annually that indicate LOB, the total paid claims, plus or minus any appropriate adjustments and financial transactions	
40.14.1.83	Provides capability to issue corrected 1099s to providers prior to March 31 <sup>st</sup> each year; provides capability to ensure that corrections are incorporated into the IRS file to report earnings for the prior year	
	<b>Cash Control and Bank Accounts</b>	
40.14.1.84	Provides capability to automate and apply NC DHHS Cash Management Plan business rules and procedures to receive all program receipts in a State Treasurer designated bank  Refer to <i>DHHS Cash Management Plan</i> in the Procurement Library.	
40.14.1.85	Provides capability for automated application of cash receipts and provide for online posting of the detail of receipts received to the system with simultaneous notice to for TPL recovery, Drug Rebates, FADS recoveries business areas	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
40.14.1.86	Provides capability for indexed images of checks and all written correspondence from or to the provider for audit purposes throughout the life of the Contract	
40.14.1.87	Provides capability to process and post transactions for all program cash receipts received in Fiscal Agent/bank managed lock-boxes	
40.14.1.88	Provides capability to assign and retain a unique transaction control number, the date of receipt, the remitter's name, the remitter's bank name, purpose or reason code, the check/money order number, the transaction amount, and the unit to which the receipt is directed for dispositioning when there is no matching account receivable	
40.14.1.89	Provides capability to account for disposition of all program cash receipts and adjustments within the month of receipt	
40.14.1.90	Provides capability for an audit trail of corrections to posted transactions	
<b>Budget Checking Prior To Payment of Claims</b>		
40.14.1.91	Provides capability to link the detail financial transaction to the claim detail level activity	
40.14.1.92	Provides capability to produce balancing reports available online at detail and summary levels on budget availability	X
40.14.1.93	Provides capability to produce exception reports on un-reconciled balances or undefined chart of accounts shall be available online	
<b>Accounting Processes</b>		
40.14.1.94	<p>Provides capability for integration of all Medicaid Accounting System (MAS) legacy system functionality, processes, data, reports and interfaces</p> <p>Refer to <i>Approved MAS Requirements &amp; Business Rules—Updated 12-06-06</i> and attachments in the Procurement Library.</p>	
<b>General Account Receivable/Accounts Payable Requirements</b>		
40.14.1.95	<p>Provides capability for accounts receivable and accounts payable functionality that is integrated with case management and billing using the open item method to support collection of program overpayments from providers and amounts determined to be due from third parties</p> <p>Refer to <i>Approved AR-AP Requirements &amp; Business Rules—Updated 12-19-06</i> in the Procurement Library.</p>	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



**40.14.2 Financial Management and Accounting Operational Requirements**

Requirement #	Requirement Description	Non-Medicaid Only
<b>General Financial Management and Accounting</b>		
40.14.2.1	Fiscal Agent shall maintain the Replacement MMIS consolidated accounting function by program, type, and provider. Fiscal Agent shall deduct/add appropriate amounts from provider payments for past due receivables and other required withholding.	
40.14.2.2	Fiscal Agent shall provide the State with confirmation and validation for each completed file maintenance request (receipt date of file maintenance request, file maintenance initiation date, file maintenance completion date, and supervisor validation date) related to Financial Management and Accounting.	
40.14.2.3	Fiscal Agent shall ensure provider payments are generated by the processing of claims for eligible recipients, adjustments, or by State authorizations, such as payouts for court orders, open/shut cases, dropped eligibility, and policy changes.	
40.14.2.4	Fiscal Agent shall provide nightly interface to NCAS to validate availability of funds for claim-specific reimbursement.	X
40.14.2.5	Fiscal Agent shall establish systematic payment plans or recoupments for provider receivable balances, collect the payments, apply the payments, monitor the process, and report on the payment activity at a provider and summary level on a weekly basis. Once a provider becomes delinquent in the payment schedule, the recoupment process shall be implemented until the debt is resolved.	
40.14.2.6	Fiscal Agent shall ensure that correct Federal Medical Assistance Percentage (FMAP) is applied to receivables and payables within the monthly financial processing cycles. (Certain receivables and payables may be subject to prior period FMAP.)	
40.14.2.7	Fiscal Agent shall issue provider checks in the number of cycles required by the State each year on State-designated business days, dating the checks and reports for the checkwrite date except for the final checkwrite of the month, which is dated, as directed by the State.	
40.14.2.8	Fiscal Agent shall balance each checkwrite in accordance with State-approved policy and procedures to ensure report accuracy and the completion of a final audit for that checkwrite.	
40.14.2.9	Fiscal Agent shall accept requests to override EFT payment to a provider and create the check voucher as a paper check request.	
40.14.2.10	Fiscal Agent shall accept and process all check voucher reconciliation.	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
40.14.2.11	Fiscal Agent shall execute Positive Pay processing.	
40.14.2.12	Fiscal Agent shall ensure weekly budget reporting is consistent with the costs allocated during the checkwrite.	
40.14.2.13	Fiscal Agent shall submit a draft annual checkwrite schedule by the last State business day in September each year.	
40.14.2.14	Fiscal Agent shall perform checkwrites per the State-approved checkwrite schedules.	
40.14.2.15	Fiscal Agent shall notify the State of the total checkwrite expenditure on the first day following the cycle.	
40.14.2.16	Fiscal Agent shall notify the State by close of business of notification from the State Controller's Office that funds are in place each day following any delays in check mailings and EFTs.	
40.14.2.17	Fiscal Agent shall notify the State the next State business day following the checkwrite cycle of any delays in the checkwrite process.	
40.14.2.18	Fiscal Agent shall respond to State Memos as appropriate for canceling or delaying checkwrites or release of system-generated checks or EFTs.	
40.14.2.19	Fiscal Agent shall balance each checkwrite in accordance with State-approved policy and procedures to ensure report accuracy and the completion of a final audit for that checkwrite.	
40.14.2.20	Fiscal Agent shall process check voucher information from the State Controller's Office, updating payment information.	
40.14.2.21	Fiscal Agent shall ensure that the weekly budget reporting is consistent with the costs allocated during the checkwrite.	
40.14.2.22	Fiscal Agent shall produce third party letters within the financial processing function of the checkwrite cycle.	
40.14.2.24	Fiscal Agent shall process State Payout Authorization Forms in accordance with State-approved guidelines to adjudicate claims that fail to process through the Replacement MMIS under normal circumstances.	
40.14.2.25	Fiscal Agent shall execute, manage, maintain, and update financial operations, including claims payment, accounts receivable, accounts payable, cash management, transaction data entry, and financial participation calculations while maintaining detail accounting records in accordance with GAAP for all program financial transactions.	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
40.14.2.26	Fiscal Agent shall enter and summarize all Replacement MMIS financial accounting transactions in accordance with GAAP prior to month-end closing deadlines specified by the NC DHHS Controller.	
40.14.2.27	Fiscal Agent shall maintain the MMIS Financial System operations in compliance with applicable State and Federal laws, regulations, reporting requirements, policies, business rules, and procedures as published and referenced in the Contract and the Procurement Library.	
40.14.2.28	Fiscal Agent shall implement and maintain effective internal controls over financial operations, accounting, physical access, system backup and recovery, and security for all Replacement MMIS financial operations, data, records, and assets.	
40.14.2.29	Fiscal Agent shall complete the Office of State Controller Internal Control Self Assessment upon request by the NC DHHS Controller and provide a signed original to the NC DHHS Controller.	
<b>MMIS Program Account Payable</b>		
40.14.2.30	Fiscal Agent shall record provider claims payable less any overpayment recoupments and required withholding and produce all program cash disbursements in accordance with procedures and a schedule approved by the State for each checkwrite cycle, including State-authorized payments.	
40.14.2.31	Fiscal Agent shall determine daily cash requirements and draw program cash from a special State disbursing account as needed.	
40.14.2.32	Fiscal Agent shall collect recipient premium payments.	
40.14.2.33	Fiscal Agent shall produce refunds of recipient premiums.	
<b>Replacement MMIS Accounts Receivable Process</b>		
40.14.2.34	Fiscal Agent shall monitor the status of each accounts receivable and reports weekly and monthly to the State in aggregate and/or individual accounts, both on paper and online.	
40.14.2.35	Fiscal Agent shall monitor compliance with written procedures to meet State and Federal guidelines for collecting outstanding provider and recipient account receivables in accordance with State-approved policy and procedures to ensure report accuracy and the completion of a final audit for that checkwrite.	
40.14.2.36	Fiscal Agent shall monitor compliance with written procedures to meet State and Federal guidelines for collecting outstanding provider accounts receivable.	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
40.14.2.37	Fiscal Agent shall “write off” outstanding accounts receivable, when directed by the State.	
40.14.2.38	Fiscal Agent shall ensure accurate collection and management of accounts receivables.	
40.14.2.39	Fiscal Agent shall ensure that correct FMAP is applied to receivables and payables within the monthly financial processing cycles. (Certain receivables and payables may be subject to prior period FMAP.)	
40.14.2.40	Fiscal Agent shall maintain claim specific and gross level accounts receivable records for amounts due the program, recoup past due items based on a hierarchy table approved by the State, apply all payments, and produce and distribute invoices, collection letters and accounts receivable reports.	
<b>Financial Accounting and Reporting Process</b>		
40.14.2.41	Fiscal Agent shall produce general ledger to correspond to the checkwrite over the State’s fiscal year and adjust the general ledger account balances on June 30 <sup>th</sup> to reflect activity between the last June checkwrite and June 30 <sup>th</sup> .	
40.14.2.42	Fiscal Agent shall make details of the general ledger, including all entries and balances, available to authorized State staff.	X
40.14.2.43	Fiscal Agent shall summarize checkwrite activity in the Checkwrite Financial Summary, Financial Participation Report, and general expenditure reports on a year-to-date basis and within ten (10) days of the State’s fiscal year end on June 30 <sup>th</sup> and provide these reports in accordance with State-approved format, media, distribution, and frequency.	
40.14.2.44	Fiscal Agent shall change financial participation rates in the Replacement MMIS to correspond with the Federal fiscal year.	
40.14.2.45	Fiscal Agent shall ensure cross-checks and balances to other reporting is using the same data and is categorized in such a manner as to facilitate informed program administration and supporting the State’s receipt of maximum.	
40.14.2.46	Fiscal Agent shall refer questions regarding rates and budgets to the State.	X
40.14.2.47	Fiscal Agent shall ensure adherence to NC DHHS Cash Management Plan and Procedures.	
40.14.2.48	Fiscal Agent shall incorporate State-approved automated and manual	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
	systems to satisfy accounting and record-keeping objectives.	
40.14.2.49	Fiscal Agent shall notify the State immediately upon discovery of any erroneous payments, irrespective of cause, and prior to initiating appropriate recovery action.	
40.14.2.50	Fiscal Agent shall produce an extract of DMH claims data for the Client Data Warehouse (CDW) with each checkwrite.	X
	<b>IRS Reporting and Compliance</b>	
40.14.2.51	Fiscal Agent shall summarize each provider's NC DHHS earnings by LOB for the previous calendar year no later than January 15 <sup>th</sup> of the succeeding year, providing the summary to the Internal Revenue Service and North Carolina Department of Revenue (NC DOR) by sending a file using File Transfer Protocol (FTP) media. Fiscal Agent shall provide this same information on each provider's last RA for the calendar year.	
40.14.2.52	Fiscal Agent shall send system-generated letters to providers requesting updated W-9s or a special IRS form depending on whether they are a first or second B-Notice.	
40.14.2.53	Fiscal Agent shall record receipt date of each withholding and penalty request and completion date of withholding or penalty.	
40.14.2.54	Fiscal Agent shall provide the State with confirmation and validation for each completed date of withholding or penalty.	
40.14.2.55	Fiscal Agent shall comply with all IRS regulations.	
40.14.2.56	Fiscal Agent shall issue corrected 1099s to providers prior to March 31 <sup>st</sup> each year and shall ensure that corrections are incorporated into the IRS file to report earnings for the prior year.	
40.14.2.57	Fiscal Agent shall ensure accuracy of tax identification numbers and tax names reported.	
	<b>Cash Control and Bank Accounts</b>	
40.14.2.58	Fiscal Agent shall ensure returned or refund receipts are received at the Fiscal Agent lock box for security and are accessed only by designated Fiscal Agent or bank personnel; receipts received are to be logged each State business day with disposition denoted, date, time, and individual processing the check.	
40.14.2.59	Fiscal Agent shall deposit program cash receipts into the State-designated State Treasurer's Account on a daily basis; checks received that are missing information are photocopied and deposited into the	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
	State's designated account daily regardless of whether they are missing information. Checks received that are missing information result in a system-generated form letter denoting the required corrective action. (Letters are to be maintained in an online report for follow-up actions.)	
40.14.2.60	Fiscal Agent shall retain copies of checks and all written correspondence from or to the provider for audit purposes throughout the life of the Contract.	
40.14.2.61	Fiscal Agent shall process other non-provider checks received, such as TPL and Drug Rebate receipts, in accordance with State-approved policies and procedures; deposits these funds daily into the designated State Treasurer's Account.	
40.14.2.62	Fiscal Agent shall contract and maintain State-approved banking services for, remittance lock box operations, and Fiscal Agent Disbursing Accounts.	
40.14.2.63	Fiscal Agent shall perform daily transfer of funds out of the State's Disbursing Account as appropriate to cover "presentments" on the Fiscal Agent Disbursing Account.	
40.14.2.64	Fiscal Agent shall provide the bank with instructions to transfer funds from the State Disbursing Account to the Fiscal Agent Disbursing Account to cover the "presentments."	
40.14.2.65	Fiscal Agent shall accept responsibility for and bear the cost of any overdraft penalties on Fiscal Agent-controlled checking accounts.	
40.14.2.66	Fiscal Agent shall monitor security of checks during matching, stuffing, and mailing process.	
40.14.2.67	Fiscal Agent shall perform monthly account reconciliation and submit State-approved reports within ten (10) business days of each calendar month, unless the Fiscal Agent notifies the State the reports have not been received from the banking institution in a timely manner.	
	<b>MMIS Program Cash Receiving</b>	
40.14.2.68	Fiscal Agent shall receive all program receipts in State-approved Fiscal Agent lock boxes established for each payer source, log each deposit item, scan or copy all deposit items and information received with the remittance, deposit all receipts daily, accurately record cash, and correctly apply receipts to the correct accounts in accounts receivable.	
40.14.2.69	Fiscal Agent shall report the daily deposit totals to the NC DHHS Controller by 1:30 P.M. for all program cash receipts, including TPL, Drug Rebates, FADS, audit recoveries, cost settlements, refunds, and any other program receipts in accounts receivable while maintaining	





**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
	complete, accurate and detailed accounting records for all program funds received.	
	<b>Production and Distribution of Management and Financial Reports</b>	
40.14.2.70	Fiscal Agent shall produce and distribute all financial reports and interface files accurately and in the media, format, basis of accounting, and according to a schedule approved by the State.	
40.14.2.71	Fiscal Agent shall ensure that all financial reports and files meet State cutoff dates and can be balanced with underlying transactions for the applicable accounting period.	

**40.14.3 Financial Management and Accounting Operational Performance Standards**

Requirement #	Requirement Description	Non-Medicaid Only
40.14.3.1	Fiscal Agent shall provide the State with confirmation and validation of accurate file maintenance request transactions ninety-nine and nine tenths (99.9) percent of the time.	
40.14.3.2	Fiscal Agent shall process accurate capitation and/or management fee adjustments ninety-nine and nine tenths (99.9) percent of the time.	
40.14.3.3	Fiscal Agent shall provide deposit of returned monies the same State business day of receipt.	
40.14.3.4	Fiscal Agent shall provide for processing of accurate capitation payments and management fees in the month-end claims cycle and payment in the first checkwrite of the next month.	
40.14.3.5	Fiscal Agent shall accurately complete processing of all HMO withholds and penalties and primary care provider penalties in the next claim cycle after receipt of withholding and penalty requests ninety-nine and nine tenths (99.9) percent of the time.	
40.14.3.6	Fiscal Agent shall publish the planned annual checkwrite schedule sixty (60) days prior to the start of the next calendar year.	
40.14.3.7	Fiscal Agent shall notify the State by 9:30 A.M. Eastern Time on the first State business day following checkwrite of funds required.	
40.14.3.8	Fiscal Agent shall notify the State by close of the business day of notification from the Controller's Office that funds are in place each day	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
	following any delays in check mailings and EFTs.	
40.14.3.9	Fiscal Agent shall notify the State of any delays and reasons in the checkwrite process by 8:00 A.M. Eastern Time the next business day following the checkwrite cycle and estimated timeframe for completion.	
40.14.3.10	Fiscal Agent shall balance each checkwrite accurately ninety-nine and nine tenths (99.9) percent of the time. Any discrepancies shall be reported to the State immediately via Operations Incident Reporting procedures.	
40.14.3.11	Fiscal Agent shall process check voucher information from the State Controller's Office accurately ninety-nine and nine tenths (99.9) percent of the time and within one (1) State business day of receipt.	
40.14.3.12	Fiscal Agent shall ensure that weekly budget reporting is accurate and consistent ninety-nine and nine tenths (99.9) percent of the time with the costs allocated during the checkwrite.	
40.14.3.13	Fiscal Agent shall accurately complete processing of all HMO withholds and penalties and primary care provider penalties in the next claim cycle after receipt of withholding and penalty requests.	
40.14.3.14	Fiscal Agent shall perform cost settlement activities accurately and consistently ninety-nine and nine tenths (99.9) percent of the time, as directed by the State.	
40.14.3.15	Fiscal Agent shall ensure that correct FMAP is applied to receivables and payables accurately and consistently ninety-nine and nine tenths (99.9) percent of the time within the monthly financial processing cycles (certain receivables and payables may be subject to prior period FMAP).	
40.14.3.16	Fiscal Agent shall ensure accurate collection and management of accounts receivable/payable ninety-nine and nine tenths (99.9) percent of the time.	
40.14.3.17	Fiscal Agent shall produce and mail out 1099/W9 earnings reports no later than January 31 <sup>st</sup> each year and report to the IRS no later than March 1 <sup>st</sup> .	
40.14.3.18	Fiscal Agent shall maintain the capability to remove accounts receivable on a monthly basis when a provider record has been terminated for one (1) year. Fiscal Agent shall generate a report of remove accounts receivables on a monthly basis.	
40.14.3.19	Fiscal Agent shall account for and report accurately and consistently ninety-nine and nine tenths (99.9) percent of the time to the State all program funds paid out and recovered in accordance with State-approved guidelines.	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
40.14.3.20	Fiscal Agent shall summarize each provider's NC DHHS for the previous calendar year no later than January 15 <sup>th</sup> of the succeeding year, providing the summary to the Internal Revenue Service and NC DOR by sending a file using FTP media. Fiscal Agent shall provide this same information on each provider's last RA for the calendar year accurately ninety-nine and nine tenths (99.9) percent of the time.	
40.14.3.21	Fiscal Agent shall log receipt date of each withholding and penalty request and completion date of withholding or penalty within one (1) State business day of receipt accurately ninety-nine and nine tenths (99.9) percent of the time.	
40.14.3.22	Fiscal Agent shall provide the State with confirmation and validation for each completed date of withholding or penalty on the State business day that the transaction is completed.	
40.14.3.23	Fiscal Agent shall comply with all IRS regulations ninety-nine and nine tenths (99.9) percent of the time.	
40.14.3.24	Fiscal Agent shall issue corrected 1099s to providers prior to March 31 <sup>st</sup> each year. Fiscal Agent shall ensure that corrections are incorporated into the IRS file to report earnings for the prior year accurately ninety-nine and nine tenths (99.9) percent of the time.	
40.14.3.25	Fiscal Agent shall ensure accuracy of tax identification numbers and tax names reported ninety-nine and nine tenths (99.9) percent of the time.	
40.14.3.26	Fiscal Agent shall ensure that returned or refund checks are received at the Fiscal Agent lock box for security and are accessed only by designated Fiscal Agent personnel. Checks received shall be logged each State business day with disposition denoted, date, time, and individual processing the check accurately ninety-nine and nine tenths (99.9) percent of the time.	
40.14.3.27	Fiscal Agent shall deposit all program cash receipts received into the State-designated State Treasurer's Account each State business day by 1:00 P.M. and certify the amount deposited to the NC DHHS Controller by 1:30 P.M.	
40.14.3.28	Fiscal Agent shall process other non-provider checks received, such as TPL and Drug Rebate receipts, in accordance with State-approved policies and procedures. Fiscal Agent shall deposit these funds daily into the State-designated State Treasurer's Account ninety-nine and nine tenths (99.9) percent of the time.	
40.14.3.29	Fiscal Agent shall perform monthly bank account reconciliation and submit State-approved reports within ten (10) State business days of each calendar month unless the Fiscal Agent notifies the State the reports have not been received from the banking institution in a timely	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
	manner.	
40.14.3.30	Fiscal Agent shall receive NCAS account data weekly to support checkwrite activity accurately and consistently ninety-nine and nine tenths (99.9) percent of the time.	
40.14.3.31	Fiscal Agent shall apply special “timely filing” edits at the end of the State fiscal year: <ul style="list-style-type: none"> <li>▪ AP/LMEs shall file all services rendered prior to May 1<sup>st</sup> no later than the cutoff for the last payment cycle in June.</li> <li>▪ May and June services shall be presented to the Fiscal Agent by a date established by the State. Timely filing allows budgeted services to be allocated to the appropriate fiscal year accurately and consistently ninety-nine and nine tenths (99.9) percent of the time.</li> </ul>	X
40.14.3.33	Fiscal Agent shall summarize checkwrite activity in the Checkwrite Financial Summary, Financial Participation Report, and general expenditure reports on a year-to-date basis and within ten (10) days of the State’s fiscal year end on June 30 <sup>th</sup>	
40.14.3.34	Fiscal Agent shall assure that Checkwrite Financial Summary and FPR Reports are completed the day after each checkwrite.	
40.14.3.35	Fiscal Agent shall ensure month-end processing and financial reports are completed, balanced and distributed no later than the fifth business day of the following month.	
40.14.3.36	Fiscal Agent shall produce and maintain accounts receivable reports.	
40.14.3.37	Fiscal Agent shall produce and maintain MMIS Medicaid Accounting System Reporting.	
40.14.3.38	Fiscal Agent shall produce and maintain Maximum Allowable Cost (MAC) Transactions and Reporting.	
40.14.3.39	Fiscal Agent shall produce and maintain Medicaid Adjustments Register Reporting.	
40.14.3.40	Fiscal Agent shall produce and maintain listing of paid claims for Indians on reservations.	
40.14.3.41	Fiscal Agent shall produce and maintain the listing of buy-in premiums paid for Indians on reservations.	
40.14.3.42	Fiscal Agent shall produce and maintain the listing and file containing Indian financial adjustment transactions.	



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



Requirement #	Requirement Description	Non-Medicaid Only
40.14.3.43	Fiscal Agent shall produce and maintain the Medicaid Cost Calculation Reporting.	
40.14.3.44	Fiscal Agent shall produce and maintain NCAS Program Cost Interface.	
40.14.3.45	Fiscal Agent shall produce and maintain the Monthly County Bank Draft File.	
40.14.3.46	Fiscal Agent shall produce and maintain MMIS Summary of Paid Claims.	
40.14.3.47	Fiscal Agent shall provide system logging for all program cash receipts received each State business day in Fiscal Agent/bank-managed lock boxes designated by the State with disposition denoted, date, time, and individual processing the receipt.	
40.14.3.48	Fiscal Agent shall index images of checks and all written correspondence from or to the provider for audit purposes throughout the life of the Contract.	
40.14.3.49	Fiscal Agent shall provide verification of daily deposit total to receipt logs by an employee who is independent of the lock box remittance and bank deposit process.	
40.14.3.50	Fiscal Agent shall process and post transactions for all program cash receipts received in Fiscal Agent/bank-managed lock boxes designated by the State.	
40.14.3.51	Fiscal Agent shall disposition all program cash receipts and adjustments within the month of receipt to the applicable program division, benefit plan, NCAS CAC code and period code, reason code, service, and county code.	
40.14.3.52	The Fiscal Agent shall produce an extract of DMH claims data for CDW with each checkwrite.	
40.14.3.53	Fiscal Agent shall successfully complete each checkwrite by the date on the State-approved Checkwrite Schedule.	

**40.15 CONTRACT DATA REQUIREMENTS LIST**

The Contract Data Requirements List (CDRL) describes data deliverables identified by both the State and the Vendor. The State has intentionally identified only a subset of the required data for the project in order to allow the Vendor to propose documents and formats that meet the Contract requirements in the most efficient and effective manner. Because of this, the Vendor must identify data deliverables that it intends to provide to



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



the State and describe them in the CDRL. To avoid duplication, operations reports in the CDRL should be limited to management-oriented reports and not duplicate the business reports identified in Section 40, Appendix G of this RFP.

Vendors may add to the State-identified data requirements for a particular item, if desired, but may not reduce these requirements.

The fields are defined as follows:

**Title:** This is the title of the document; it should be a recognizable title that allows for easy identification of the purpose of the data.

**Vendor:** This is the name of the Vendor.

**Type of Data:** This describes the type of data in the requirement chosen from the following list:

**Planning/Execution:** Data used for project or operations planning and execution

**Software:** Data that includes items such as source code, object code, build/make files, and other items required to create an operational system

**Reporting:** Data consisting of reports, metrics, and other outcomes-based items

**Technical:** Data supporting requirements analysis, design, construction, test, and other engineering-type data (other than software)

**Other:** Any data not fitting into another category

**Data Rights:** This describes the State's rights in the data using the categories defined in Section 30 of this RFP. If additional explanation is required for a given category, this explanation should be provided in the Description field. The categories are:

**State Material**

**Proprietary Contractor Material**

**Third Party Materials**

**State-Provided Materials**

**Public Material**

**Frequency Due:** This describes how often the document will be updated.

**1<sup>st</sup> Submission Date:** This is the date (which can be relative to Contract award or an IMP event or accomplishment; e.g., "One month after Detailed Design Completed") when the data are first provided to the State. For those State-identified data requirements that have "Vendor Proposed" in this field, the Vendor shall replace this entry with the actual first submission date that it proposes.

**Method of Delivery:** This should identify the format in which the data will be provided. Additional details (such as the format for electronic data) should be provided, as necessary.

**Description:** This defines the content of the data in enough detail so that the State can understand its purpose, relevance, and completeness.

Data Items listed:

- Integrated Master Plan
- Integrated Master Schedule
- Risk and Issue Management Plan
- Change Management Plan
- Software Development and Systems Engineering Plan
- Master Test and Quality Assurance Plan
- Data Accession List
- Data Conversion and Migration Plan
- Security Plan
- Business Continuity/Disaster Recovery Plan
- Turnover Plan
- Training Plan
- Communications Plan
- Project Management Plan
- Operations Management Plan
- Deployment/Rollout Plan
- Earned Value Management System Reports



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



TITLE	Integrated Master Plan (IMP)		
VENDOR			
TYPE OF DATA	Planning/Execution	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1 <sup>ST</sup> SUBMISSION DATE	With Proposal
METHOD OF DELIVERY	Electronic and paper with Proposal; electronic thereafter		
DESCRIPTION	<p>This document is an event-based plan consisting of a hierarchy of project events (milestones), with each event being supported by specific accomplishments and each accomplishment associated with specific criteria to be satisfied for its completion.</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> An event is a project assessment point that occurs at the culmination of significant project activities: accomplishments and criteria.</li> <li><input type="checkbox"/> An accomplishment is the desired result(s) prior to or at completion of an event that indicates a level of the project's progress.</li> <li><input type="checkbox"/> Criteria provide definitive evidence that a specific accomplishment has been completed. Entry criteria reflect what must be done to be ready to initiate a review, demonstration, or test. Exit criteria reflect what must be done to clearly ascertain the event has been successfully completed.</li> </ul> <p>If there are any important processes supporting events that are not described in other plans or Proposal approaches, a brief narrative should be written to provide greater understanding. Additionally, any support the Vendor requires from the State must be identified for each item in the IMP in enough detail for the State to understand the quantity and types of resources it needs to make available.</p> <p>There are overlaps in the content of IMP and the SOW. The SOW should be comprehensive, thus allowing some reduction in the content and descriptions in the IMP where it duplicates SOW material. Additionally, as identified above, there are overlaps in the content of the IMP and many of the stand-alone plans. In these cases, the narrative details should reside in the stand-alone plans.</p> <p>Changes to the IMP, other than minor clarifications, usually require a Contract change.</p>		





## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



TITLE	Integrated Master Schedule (IMS)		
VENDOR			
TYPE OF DATA	Planning/Execution	DATA RIGHTS	State Material
FREQUENCY DUE	At least monthly	1 <sup>ST</sup> SUBMISSION DATE	With Proposal
METHOD OF DELIVERY	Electronic and paper with Proposal; electronic thereafter (MS Project)		
DESCRIPTION	<p>This document establishes dates and dependencies for items from the Integrated Master Plan (IMP), along with the detailed tasks needed to complete the activities.</p> <p>For the Proposal, the IMS should be at a level of detail needed to demonstrate support of the IMP and convey a realistic approach. Additionally, at least the first three (3) months of the project need to be in detail at the time of the Proposal submission (with dates relative to Contract award).</p> <p>During Contract execution, detailed portions of the IMS shall be maintained three (3) or more months in the future at all times.</p>		

TITLE	Risk and Issue Management Plan (RIMP)		
VENDOR			
TYPE OF DATA	Planning/Execution	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1 <sup>ST</sup> SUBMISSION DATE	With Proposal
METHOD OF DELIVERY	Electronic and paper with Proposal; electronic thereafter		
DESCRIPTION	<p>The RIMP documents the general process for risk and issue management to include activities such as identification, evaluation, mitigation, and reporting, along with process cycle times. While the activities may differ in urgency and reporting to a certain extent, this plan shall integrate management of risks and issues to allow the earliest practical identification and mitigation in order to minimize impacts.</p> <p>The plan shall also cover the application of the general process to this specific project in terms of major activities and roles and responsibilities.</p> <p>This plan shall include processes for corrective action plans used when significant deviations from the IMP, IMS, requirements, or the Contract occur that would require greater explanation and documentation than a typical issue would need.</p> <p><i>Note: Specific risks and issues are not part of the plan. For the Proposals, they will be identified in the Initial Risk Assessment section. Vendors shall identify data item descriptions for the risks and issues being managed during Contract execution and add them to the CDRL.</i></p>		



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



TITLE	Change Management Plan (CMP)		
VENDOR			
TYPE OF DATA	Planning/Execution	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1 <sup>ST</sup> SUBMISSION DATE	Vendor Proposed
METHOD OF DELIVERY	Electronic		
DESCRIPTION	<p>This document describes the process, roles, responsibilities, and documentation required to manage change within the project and subsequent operations. The plan should describe the operation of the Change Control Board both during the DDI and Operations Phases. Changes managed via this process include both those that result in Contract changes and those that do not require Contract changes.</p> <p>The process described in this plan should manage changes to any baselined artifact. A baselined artifact is one that has been completed or signed off in its current version (i.e., it is complete for its current use even if the Vendor or State plans to change it again in the future for a different purpose). Artifacts can include plans, software, data, or any other items over which management control is necessary.</p> <p>The Change Management Plan shall also contain information describing configuration management information necessary for the Vendor's day-to-day artifact control that is at a level of detail lower than needs to be managed by the joint State/Vendor team (e.g., source code management during construction). The Vendor's entire configuration management process is not required in this document.</p>		

TITLE	Software Development and Systems Engineering Methodology		
VENDOR			
TYPE OF DATA	Planning/Execution	DATA RIGHTS:	State Material
FREQUENCY DUE	When changed	1 <sup>ST</sup> SUBMISSION DATE	With Proposal
METHOD OF DELIVERY	Electronic		
DESCRIPTION	<p>This document describes the Vendor's processes used for requirements analysis, design, construction, testing, deployment, documentation, quality assurance, and integration of the software and hardware for the system. It should also include the relationships of the methodology to risk and issue management as well as overall quality management.</p> <p>The document should discuss development and deployment strategies as well as any tools that are used for development or to improve efficiency and effectiveness.</p> <p>Software development and systems engineering planning and execution methods must be discussed in this document, along with how technical and quality metrics are used to control and improve the process and products.</p> <p>The IMP shall identify key events, accomplishments, and criteria for project-specific activities that are supported by this methodology.</p>		



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



TITLE	Master Test and Quality Assurance Plan (MTQAP)		
VENDOR			
TYPE OF DATA	Planning/Execution	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1 <sup>ST</sup> SUBMISSION DATE	Vendor Proposed
METHOD OF DELIVERY	Electronic		
DESCRIPTION	<p>This plan applies the processes for testing and quality assurance from the Software Development and Systems Engineering Methodology to this project to include specific test and quality assurance activities and results required for success.</p> <p>The plan should identify key events and their objectives, along with roles, responsibilities, and resources needed for these events to be successful.</p> <p>The MTQAP adds detail to items in the IMP related to testing and quality assurance.</p>		

TITLE	Data Accession List (DAL)		
VENDOR			
TYPE OF DATA	Other	DATA RIGHTS	State Material
FREQUENCY DUE	Monthly	1 <sup>ST</sup> SUBMISSION DATE	One (1) month after Contract award
METHOD OF DELIVERY	Electronic		
DESCRIPTION	<p>This document shall list all data (to include software) and documents that are not part of the CDR that are created under this Contract. The DAL shall include the data or document title, a reasonable description, the in-house release date, and the data rights associated with the item.</p> <p><i>Note: Any data required for proper operation and maintenance of the system and for proper conduct of the Fiscal Agent operations shall be identified in the CDRL rather than the DAL.</i></p>		



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



TITLE	Data Conversion and Migration Plan		
VENDOR			
TYPE OF DATA	Planning/Execution	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1 <sup>ST</sup> SUBMISSION DATE	Vendor Proposed
METHOD OF DELIVERY	Electronic		
DESCRIPTION	<p>This document describes a comprehensive plan to convert and migrate all required data from the Legacy MMIS+ to the Replacement MMIS. It must include strategies and activities required to support development, testing, certification, and long-term operations.</p> <p>The plan must document processes and activities to include analysis of the conversion and migration requirements; design and construction of solutions; testing of these solutions; identification of documentation required to support conversion and migration activities; and the processes that will actually be used to convert and migrate the data.</p> <p>The plan must clearly identify the data to be converted, the specific methods to be applied to these data (both automatic and manual), data cleansing and validation, data security, and the strategy to ensure that the data are converted and migrated in a timely fashion to support testing and implementation. Additionally, the plan shall describe the roles and responsibilities of the parties involved in these activities.</p> <p>The IMP shall identify key events, accomplishments, and criteria for data conversion and migration that are supported by this plan.</p>		

TITLE	Security Plan		
VENDOR			
TYPE OF DATA	Planning/Execution	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1 <sup>ST</sup> SUBMISSION DATE	Vendor Proposed
METHOD OF DELIVERY	Electronic		
DESCRIPTION	<p>This document describes the DDI and operations processes and the system features that will ensure that the Vendor meets the Contract requirements for security.</p> <p>The plan shall describe how the Fiscal Agent intends to use current industry, State, and Federal standards during the DDI Phase and within the Operations Phase to address:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Security features inherent in the system design and operation</li> <li><input type="checkbox"/> Entity-wide security program planning and management, including risk management, data protection assurance, staff responsibilities, performance assessment and audit, and reporting</li> <li><input type="checkbox"/> Access controls for the system and the facility and assurance of system availability and performance</li> </ul>		



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



	<ul style="list-style-type: none"> <li><input type="checkbox"/> Management of application development and change controls (with respect to security)</li> <li><input type="checkbox"/> Controls for protecting, managing, and monitoring the technical environment</li> <li><input type="checkbox"/> Controls for continuing services and access to information during and after minor to disastrous interruptions (by reference to the Business Continuity/Disaster Recover Plan)</li> <li><input type="checkbox"/> Responses to attacks on security and actual breaches of security</li> </ul>
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TITLE	Business Continuity/Disaster Recovery Plan		
VENDOR			
TYPE OF DATA	Planning/Execution	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1 <sup>ST</sup> SUBMISSION DATE	Vendor Proposed
METHOD OF DELIVERY	Electronic		
DESCRIPTION	<p>This document describes the processes required to ensure the continuation of critical business processes and the information systems and services supporting them in the event of a disruption of the system itself, the loss of key personnel, and/or the loss of facilities housing the Fiscal Agent's operations.</p> <p>Plans and processes documented in this plan shall be consistent with the those identified in the requirements and its referenced documents:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Roles and responsibilities of participants</li> <li><input type="checkbox"/> Processes that address preparation and planning</li> <li><input type="checkbox"/> Awareness and recognition training</li> <li><input type="checkbox"/> Business service and process relocation</li> <li><input type="checkbox"/> Notification and communication</li> <li><input type="checkbox"/> Testing and auditing processes for ensuring the currency of the plan</li> <li><input type="checkbox"/> Response plans for epidemiological disasters that may result in prolonged workforce absence from the Fiscal Agency location</li> </ul> <p>This document shall also describe additional processes associated with disaster recovery to include:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Recovery priority for critical resources (including the RPO and RTO)</li> <li><input type="checkbox"/> Processes for data relocation and recovery</li> </ul>		



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



TITLE	Turnover Plan		
VENDOR			
TYPE OF DATA	Planning/Execution	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1 <sup>ST</sup> SUBMISSION DATE	Vendor Proposed
METHOD OF DELIVERY	Electronic		
DESCRIPTION	<p>This document describes the activities needed to ensure an uninterrupted and transparent turnover to a new Fiscal Agent at the completion of the Vendor's Contract.</p> <p>This plan shall describe the activities that will be performed to ensure that required system and operational knowledge will be transferred to the new Fiscal Agent. This includes the conversion and migration of all pertinent information and work in progress, leases, etc. Additionally, the plan shall discuss roles and responsibilities of the organizations and the workflow between the Vendor and new Fiscal Agent. High-level timelines and contingency plans should be included.</p>		

TITLE	Training Plan		
VENDOR			
TYPE OF DATA	Planning/Execution	DATA RIGHTS:	State Material
FREQUENCY DUE	Annually or more frequently	1 <sup>ST</sup> SUBMISSION DATE	Vendor Proposed
METHOD OF DELIVERY	Electronic		
DESCRIPTION	<p>This document describes the Vendor's cohesive and responsive training program to ensure that all users can be efficient and effective while using the system, including the Vendor's staff, State staff, and external users—such as the providers. It should reflect the relative lead-time for the development of training materials prior to conducting training classes (including the training of testing participants and all training before implementation); how users' skills will remain current throughout the operations phase; and how the Vendor will build and maintain the training environment. Additionally, it must specify the planned duration of the implementation training rollout, including the development of Desk Procedures for use in the Operations Phase.</p> <p>The document shall specify the delivery media to be used for each training activity and the accessibility of training materials and/or training news before, during, and after training. It should describe the process to identify and track training needs and to evaluate trainee feedback to improve course materials and methods.</p> <p>The Training Plan shall be updated annually to address specific training activities for the upcoming year and shall be completed at least ninety (90) days prior to the beginning of the Contract year.</p>		



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



TITLE	Joint DDI Communications Plan		
VENDOR			
TYPE OF DATA	Planning/Execution	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1 <sup>ST</sup> SUBMISSION DATE	One (1) month after Contract award
METHOD OF DELIVERY	Electronic		
DESCRIPTION	<p>This document will define the methodology for sharing project-specific communications among all project stakeholders during the DDI Phase. It will describe the processes to ensure timely and appropriate generation, collection, dissemination, storage, and ultimate disposition of project information. It must include, but is not limited to:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Information communications</li> <li><input type="checkbox"/> Information communication requirements/needs</li> <li><input type="checkbox"/> How, where, and when communications will occur</li> <li><input type="checkbox"/> Who will provide/receive the communication</li> <li><input type="checkbox"/> Meeting protocol procedures—noting when minutes are taken, etc.</li> <li><input type="checkbox"/> Provider communications approach—to include interactions among the State, Vendor, and providers; the Vendor's approach to provider awareness following Contract award; and the facilitation of ongoing project status communications</li> <li><input type="checkbox"/> Incident reporting and escalation—to include reporting of security incidents</li> </ul> <p>The State and Vendor will develop a mutually acceptable Joint DDI Communications Plan after Contract award. Updates/modifications to the Joint DDI Communication Plan, as mutually agreed, will occur as needed.</p>		



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



TITLE	Project Management Plan		
VENDOR			
TYPE OF DATA	Planning/Execution	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1 <sup>ST</sup> SUBMISSION DATE	With Proposal
METHOD OF DELIVERY	Electronic and paper with proposal. Electronic thereafter		
DESCRIPTION	<p>This document will define how all project activities are executed, monitored, and controlled. It will reflect how and when a project's objectives are to be achieved by showing the major products, milestones, activities, and resources required on the project. This document describes the processes for ensuring adherence to State, NC DHHS, and Offeror-established policies, standards, guidelines, and procedures.</p> <p>Significant portions of the Project Management Plan are contained in other data items described in the CDRL: Integrated Master Plan, Integrated Master Schedule, Master Test and Quality Assurance Plan, Joint DDI Communications Plan, Risk and Issue Management Plan, and Change Management Plan. The Project Management Plan can reference these documents rather than duplicating the information. In addition to these items, the minimum requirements for the Project Management Plan are:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Project management overview</li> <li><input type="checkbox"/> Objectives and priorities</li> <li><input type="checkbox"/> Project planning process</li> <li><input type="checkbox"/> Planning assumptions, constraints, and decisions</li> <li><input type="checkbox"/> Project Organization and Staffing Plan with roles and responsibilities</li> <li><input type="checkbox"/> Project deliverables and approval process</li> <li><input type="checkbox"/> Standards, tools, and techniques to be used</li> <li><input type="checkbox"/> Monitoring and control procedures for cost, schedule, scope, and staffing</li> <li><input type="checkbox"/> Performance metrics reporting process</li> <li><input type="checkbox"/> Metrics data quality process</li> <li><input type="checkbox"/> Financial reporting processes via an Earned Value Management System</li> <li><input type="checkbox"/> Electronic data-sharing system and process</li> <li><input type="checkbox"/> Project status reporting process</li> <li><input type="checkbox"/> Project management review process</li> </ul> <p>This document must describe the processes for evolution/updates to the PMP, along with version control.</p>		





## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



TITLE	Operations Management Plan (OMP)		
VENDOR			
TYPE OF DATA	Planning/Execution	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1 <sup>ST</sup> SUBMISSION DATE	Vendor Proposed
METHOD OF DELIVERY	Electronic		
DESCRIPTION	<p>The Operations Management Plan strategically describes how the Fiscal Agent will successfully deliver and support all operational services. The plan should clearly document the Vendor's approach to operations and communicate an understanding of how it operates a Medicaid Fiscal Agent Contract. Roles and responsibilities of the Fiscal Agent and the State should be clearly delineated.</p> <p>The following areas should be included in an Operations Management Plan, either by incorporating the topic in the document or referring to other stand-alone documents (duplication of information is not necessary):</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Strategic plan for operations</li> <li><input type="checkbox"/> Process improvement</li> <li><input type="checkbox"/> Quality management</li> <li><input type="checkbox"/> Performance metrics</li> <li><input type="checkbox"/> Operations management reviews</li> <li><input type="checkbox"/> Change and configuration management</li> <li><input type="checkbox"/> Risk and Issue Management Plan</li> <li><input type="checkbox"/> Resource management</li> <li><input type="checkbox"/> Security Plan</li> <li><input type="checkbox"/> Disaster Recover/Continuity of Operations Plan</li> <li><input type="checkbox"/> Training Plan</li> <li><input type="checkbox"/> Communications process/procedure (between Fiscal Agent and the State, providers, and citizens)</li> </ul>		



## SECTION 40: REPLACEMENT MMIS REQUIREMENTS



TITLE	Deployment/Rollout Plan		
VENDOR			
TYPE OF DATA	Planning/Execution	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1 <sup>ST</sup> SUBMISSION DATE	Vendor Proposed
METHOD OF DELIVERY	Electronic		
DESCRIPTION	<p>This document will describe the detailed plan for implementing the Replacement MMIS (including any future integration with Reporting &amp; Analytics or DHSR) It will include the processes and planning activities, roles and responsibilities, and schedule for all activities related to cut-over from the Legacy MMIS+ to the Replacement MMIS without impacting system processing. It will establish success criteria and provide for a Post-Implementation Evaluation, including metrics for measurement of successful implementation. Other considerations for inclusion are:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Communication of the plan</li> <li><input type="checkbox"/> Disaster recovery and backup procedures</li> <li><input type="checkbox"/> Training manuals</li> <li><input type="checkbox"/> System documentation</li> <li><input type="checkbox"/> Back-out plan</li> <li><input type="checkbox"/> Software support (help desk and break fix)</li> <li><input type="checkbox"/> Monitoring system performance</li> </ul>		

TITLE	Earned Value Management System (EVMS) Reports		
VENDOR			
TYPE OF DATA	Planning/Execution	DATA RIGHTS	State Material
FREQUENCY DUE	Monthly	1 <sup>ST</sup> SUBMISSION DATE	One (1) month after contract award
DELIVERY	Electronic		
DESCRIPTION	<p>This report shall describe the project status based on the Vendor's EVMS using the Vendor's format. At a minimum, this report shall provide earned value data for the current period (month), cumulative information to date for the project, estimates at complete, and explanations and projections for both the current period and cumulative to date variances.</p>		



**SECTION 40: REPLACEMENT MMIS REQUIREMENTS**



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## **SECTION 50: PROPOSAL SUBMISSION REQUIREMENTS**

This section presents the requirements for submission of Proposals in response to this RFP. The State will use a two-step (2-step) bid submission process (discussed in Section 60 of this RFP) for this procurement. Offerors shall submit a Technical Proposal to this RFP as Step One (1). After evaluation and scoring of the Step One (1) responses, the State will solicit a Cost Proposal from qualified vendors as Step Two (2). Cost Proposals submitted prior to the State's request shall be destroyed or returned to the vendor.

Proposals shall be prepared in a straightforward and brief manner to ensure the most effective and equitable evaluation of all materials received. In their Proposals, Offerors may refer to their pre-existing solutions by their proprietary, marketplace names for purposes such as describing how other states have used their solutions and for identifying the systems to be featured in the Offerors' demonstrations. However, Offerors shall consistently refer to the solution they propose to develop, implement and operate for the State of North Carolina as the "Replacement MMIS."

Offerors shall not repeat information in their Proposal. If information is appropriate for more than one (1) section, the Offeror shall include it in one (1) section and refer to it in the other sections. Evaluators shall have access to the full Technical Proposal to facilitate referral to the section(s) as directed.

### **50.1 GENERAL PROPOSAL REQUIREMENTS**

The Technical Proposal shall be submitted in the order and format described below, shall include a table of contents, and shall contain the content required for each section as specified in Section 50.2 of this RFP.

Technical Proposals shall be submitted no later than the date and time specified on the RFP Cover Page and shall be submitted in the manner specified on the RFP Cover Page. The number of originals and copies of the Technical Proposal, including the number of CDs, specified on the RFP Cover Page shall be submitted. The packages containing the Technical Proposal shall be labeled on the outside as specified on the RFP Cover Page. The original Proposal shall be clearly marked as such. Offerors shall comply with Section 30.28 of this RFP for any materials contained in their Proposal that are confidential.

Submission of a Proposal shall constitute recognition, understanding, acceptance, and consent by the Offeror to adhere (without any reservation or limitation whatsoever) to the requirements, terms, and conditions of this RFP, including any RFP addenda. This consent to adhere to requirements shall also apply to the use of all forms and tables of this RFP.

The Technical Proposal shall adhere to the page limitations specified for each section. Pages in the Proposal in excess of the specified limits shall be removed and not considered for evaluation purposes. This includes but is not limited to any additional attachments and/or additional sections added to the Proposal.



## SECTION 50: PROPOSAL SUBMISSION REQUIREMENTS



The following RFP appendices shall not be submitted by the Offerors in .PDF format but shall be submitted in their native form (MS Word). The MS Word versions of these appendices, for completion by the Offerors, are located in the Replacement MMIS Procurement Library Update, Volume 3. These appendices are:

1. Appendix 50, Attachment A, Replacement MMIS Proposal Submission Requirements Checklist
2. Appendix 50, Attachment B, High-Level System Functionality Matrix
3. Appendix 50, Attachment C, Exhibit 1: State Requirements Matrix
4. Appendix 50, Attachment C, Exhibit 2: Adjusted Function Point (FP) Count
5. Appendix 50, Attachment D, Statement of Work Format
6. Appendix 50, Attachment E, Listing of Offeror's Corporate Relevant Experience

The Integrated Master Schedule (IMS) shall be submitted in MS Project and shall be submitted in its native format.

Brochures or other presentations beyond those sufficient to present a complete and effective Proposal in conformance with the specified page limitations shall not be submitted. Audio and/or videotapes are not allowed and shall not be considered in the evaluation. Elaborate artwork or expensive paper is not necessary. The Proposal shall be printed on 8-1/2" x 11" paper, shall use 12-point font, and shall be single spaced using 6-point spacing between paragraphs. The Proposal shall be printed double-sided and submitted in a loose-leaf notebook(s). Additional requirements regarding the procurement process are contained in Section 10 of this RFP.

### 50.2 TECHNICAL PROPOSAL REQUIREMENTS

The Technical Proposal shall include only the specified eleven (11) separate sections (with named tabs separating each section) presented in the following order:

1. Section A Transmittal Letter and Execution Page
2. Section B Proposal Submission Requirements Checklist
3. Section C Executive Summary
4. Section D Proposed Solution Details
5. Section E Project Management Plan
6. Section F Operations Management Approach
7. Section G Contract Data Requirements List
8. Section H Security Approach
9. Section I Turnover Approach
10. Section J Corporate Capabilities
11. Section K Oral Presentations and Demonstrations

Descriptions for the mandatory format and content for the material to be included under each of these headings follows. Each section within the Proposal shall include all items listed under its heading. All products submitted by the Vendor subsequent to the Contract award shall reflect the substance indicated in this RFP and Technical Proposal (unless otherwise mutually agreed). For example, detailed plans/schedules submitted during the life of the Contract shall reflect what is stated within the associated approach and/or methodology, etc.

The Offeror's proposed solution shall satisfy all requirements documented within the RFP, except items that are identified as State goals. Offerors shall propose solutions to goals that represent reasonable cost/schedule/performance/risk tradeoffs. The Offeror shall address how it will meet the requirements contained in Section 40 of this RFP, to the extent practicable, in the correlated sections within its Proposal. For all RFP Requirement Subsections (e.g., Provider, Recipient, etc.) from Section 40 of this RFP addressed in each section of the Offeror's Technical Proposal, the Offeror shall indicate the Subsection Number preceding its response explaining its fulfillment.

Offerors shall provide sample formats for proposed metrics that will be used for the DDI Phase. These samples must be attached to the specific section of the Proposal that they support. These samples shall not count towards any page limit. Offerors shall provide descriptions or samples of any reports or other deliverables being proposed (e.g., requirements artifacts, design artifacts, etc.). These documents shall provide sufficient information for the State to understand the content and intent of the report. These samples shall not count towards any page limit

#### **50.2.1 Section A—Transmittal Letter and Execution Page**

This section describes the information the Offeror shall include in Section A of its Technical Proposal. The Transmittal Letter shall be limited to a maximum of three (3) pages, excluding the required certifications and representations from the appendices (as identified below) and excluding the signed cover pages of RFP addenda issued by the State and any requests for consideration of non-substantive changes to the Contract language.

The Transmittal Letter shall be submitted on official business letterhead by the prime Vendor and shall be signed by an individual authorized to legally bind the company to the terms and conditions, scope of work proposed, and costs proposed.

The Transmittal Letter shall include the following in the order given:

1. An itemization of all materials and enclosures being forwarded in response to the RFP;
2. A listing of all RFP addenda reviewed by the Offeror (by addendum number and listing issue date) to warrant that the Offeror is aware of all such addenda, in the event that any addenda are issued;
3. A statement confirming that the Offeror has read, understands, and agrees to all the provisions of the RFP without qualification, including the addenda;
4. A signed *Certification Regarding Lobbying* (Appendix 30, Attachment A of this RFP);



## SECTION 50: PROPOSAL SUBMISSION REQUIREMENTS



5. A signed *Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion of Lower-Tier Covered Transactions* (Appendix 30, Attachment B of this RFP);
6. A signed *Certification Regarding Drug-Free Workplace Requirements* (Appendix 30, Attachment C of this RFP);
7. A signed *Certification Regarding Environmental Tobacco Smoke* (Appendix 30, Attachment D of this RFP);
8. A signed representation that the solution presented for the demonstrations complies in all respects with the description of a "baseline" solution below (Appendix 50, Attachment H of this RFP);
9. A statement that identifies the corporate entity that is the prime Vendor;
10. A statement identifying any and all subcontractors;
11. A statement that the prime Vendor shall assume sole and exclusive responsibility for all of the Fiscal Agent responsibilities and work indicated in this RFP (including any and all RFP addenda) without regard to whether the work is assigned to the prime Vendor or a subcontractor;
12. A statement reflecting the prime Offeror's interest in assuming the role of *system integrator* for the addition of other functional groups;
13. The name, address, telephone number, and e-mail address of a contact person regarding the Proposal;
14. Completed and signed Execution Page (Page 1 of 3 of RFP Cover Page); and
15. A statement that the offer is valid for a minimum of 330 days from the Proposal's submission date.

Offerors shall not place any conditions, reservations, limitations, or substitutions in their Proposal with regard to the Contract language found in Section 30 of this RFP. In its Transmittal Letter, the Offeror may request that the State consider non-substantive changes to the Contract language, but the State reserves the sole right to accept or reject any requested changes.

### 50.2.2 Section B—Proposal Submission Requirements Checklist

This section describes the information the Offeror shall include in Section B of the Proposal. Appendix 50, Attachment A of this RFP contains the Proposal Submission Requirements Checklist that each Offeror shall submit as part of the Technical Proposal. The completed Proposal Submission Requirements Checklist shall be included in this section of the Technical Proposal. Agreement or acknowledgement of a submission requirement shall be shown by writing "yes" or "no" next to the requirement on the checklist. **Failure to adequately meet any submission requirement may cause the entire Proposal to be deemed non-responsive and be rejected from further consideration.**

### 50.2.3 Section C—Executive Summary

This section describes the information the Offeror shall include in Section C of the Proposal. The Executive Summary shall be limited to fifteen (15) pages, including all

attachments, except Appendix 50, Attachment B (i.e., each page of each attachment except Appendix 50, Attachment B, counts toward the limit).

The Executive Summary shall include a clear and concise summary of the Offeror's understanding of the project and the State's needs for a Replacement MMIS and Fiscal Agent services as defined in this RFP. This section shall also include a summary of the contents of the Technical Proposal. At a minimum, this shall include the Offeror's:

Understanding that this procurement is for the implementation of a multi-payer Replacement MMIS and that the Legacy MMIS+, as of the publication date of this RFP, is a multi-payer system for the NC DMA and DMH;

Understanding that the Offeror shall be required to expand the Replacement MMIS to include functionality and processing for additional NC DHHS divisions;

Understanding that the Offeror received Procurement Library information and is aware that updates will continue to be made available;

Commitments that are offered to the State in this Proposal;

Overall approach for this implementation (indicating whether it includes COTS, etc.) and the plans for the operation of the proposed system through the balance of the Contract; and

Proposed system's high-level functionality.

### **High-Level System Functionality Matrix**

The Offeror shall complete the table in Appendix 50, Attachment B of this RFP. Based on the Offeror's review of the business areas addressed in Section 40 of this RFP, the Offeror shall provide high-level information relating its proposed system/product to each area's key functionality and the applicable requirement(s) met by the system/product. The Offeror shall enter the name of the product or system being proposed and list all systems/products related to the business area sequentially in alphabetical order. The Offeror shall enter a brief description of the functionality that the system or product addresses (e.g., enrollment, call tracking, etc.) If, in addition to meeting the State's requirements, this system/product offers additional benefit to the State, the Offeror may so designate in the Benefits column.

## **50.2.4 Section D—Proposed Solution Details**

### **50.2.4.1 *Proposed System Solution and Solution for Design, Development, and Installation***

#### **50.2.4.1.1 Overview of System Solution and Solution for Design, Development, and Installation**

The Offeror shall describe the overall systems solution and design, development, and installation (DDI) strategy that includes:

- A brief description of the approach for any customization/modifications required with the proposed approach;



- A description of enhancements to the functional requirements stated herein that the proposed Replacement MMIS offers and why it is beneficial to the State;
- A description of multi-payer issues that are critical to the success of the Replacement MMIS and how the Offeror shall manage such issues;
- A description of all early implementations proposed and how they will be implemented to ensure continuity of current business operations;
- A description of the work site(s) proposed to use for the work during the DDI Phase;
- A description of the proposed technical architecture, including platforms and hardware, operating system(s), systems software, and development software, including the specifications that reflect alignment with the Statewide Technical Architecture (STA);
- A description of any licensing and/or software/hardware support relationships with a third party and the general terms involved with any agreements, including limitations and constraints; and
- A description of how the Offeror's solution minimizes the total cost of ownership for the proposed capability by explaining how the specific features of its approach will affect TCO. Offerors shall not provide specific estimates of TCO.
- A description of the baseline solution and how it addresses the system requirements.

The Vendor shall provide a warranty after final delivery of the system. The scope and duration of this warranty shall be identified in this Section of the Technical Proposal, and it shall include the repair of defects in system and non-system deliverables. A defect is defined as any aspect of deliverable's performance that does not meet its requirements.

This Section is limited to five hundred (500) pages.

#### **50.2.4.1.2 Software Development and Systems Engineering Methodology**

The Offeror shall describe its software development and systems engineering methodology, including the State's role in its systems engineering processes. Reference the Software Development and Systems Engineering Methodology Contract Data Requirements List (CDRL) for additional information.

This Section is limited to fifty (50) pages.

#### **50.2.4.1.3 Data Conversion and Migration Approach**

The Offeror shall describe its Data Conversion and Migration Approach. While a Data Conversion and Migration Plan will contain details which may be unknown at the time of Proposal submission, the proposed Data Conversion and Migration Approach shall demonstrate that the Offeror's strategy will enable the fulfillment of all Business Data Conversion and Migration requirements and will be reflective of the content of the subsequent Data Conversion and Migration Plan to the extent practicable. Reference the Data Conversion and Migration Plan CDRL (Section 40.15 of this RFP) for additional information.

The Offeror shall designate the proposed first submission date for the Business Data Conversion and Migration Plan.

This Section is limited to twenty (20) pages.

**50.2.4.1.4 Deployment/Rollout Approach**

The Offeror shall describe its Deployment/Rollout Approach. While a Deployment/Rollout Plan contains details which may be unknown at the time of Technical Proposal submission, the Deployment/Rollout Approach must demonstrate that the Offeror’s Deployment/Rollout strategy will enable the fulfillment of all Deployment/Rollout requirements.

The Offeror shall specify the proposed first submission date for the Deployment/Rollout Plan. Reference the Deployment/Rollout Plan CDRL (Section 40.15 of this RFP) for additional information.

This Section is limited to twenty (20) pages.

**50.2.4.1.5 State Requirements Matrix**

Appendix 50, Attachment C, Exhibit I of this RFP contains all the requirements for the system’s business areas as well as the operational requirements. The State is interested in knowing any requirements that are not in the baseline and requirements that exist in the baseline and require configuration and/or modification.

The Offeror shall complete the table following the instructions below and submit the completed table in this section of its Proposal.

The Offeror shall identify in the columns provided each individual requirement that is not in the baseline or exists in the baseline and requires configuration and/or modification.

The Offeror shall complete Columns A–E for requirements that result in system capabilities (even if they are operational requirements). Valid values for columns A, B, C, and E are Y=Yes or N=No. Complete only Columns D and E for operational requirements for which there are no associated system capabilities.

Note that a system capability that is in the Baseline System and does not require either manual configuration or software modification to meet the requirements would be marked with an “N” in Columns A, B, and C, and a “Y” in Column E.

**Table Legend**

- (A) System capability is in the Baseline System or COTS and configuration is required via manual table updates to meet proposed solution (Y/N)\*
- (B) System capability is in the Baseline System or COTS and software modification is required to meet proposed solution (Y/N)\*
- (C) System capability is not in the Baseline System and requires new functionality via software modification to meet proposed solution (Y/N)
- (D) Enter the Proposal Section (A–L) that reflects the fulfillment of the Section 40 of this RFP requirement and page number(s).

(E) Will meet requirement (Y/N)

\* If both A and B above apply, indicate Yes (Y) in each column.

**50.2.4.1.6 Adjusted Function Point Count**

Where a function point assessment can be made, the Offeror shall enter it in the table in Appendix 50, Attachment C, Part II of this RFP.

This table must be filled out with the Offeror's estimated adjusted function point counts for the baseline system (application function point count), enhanced capabilities (enhancement function point count), and new capabilities (development function point count).

For system requirements that do not translate well into function points (e.g., architectural standards, etc.) Offerors shall identify those requirements in the "Notes" field of the table. For third party COTS software Offerors do not need to count application adjusted function points but must be able to trace which requirements are satisfied by the COTS software.

**50.2.4.2 Operations**

**50.2.4.2.1 Proposed Solution for Operations**

The Offeror shall describe how it plans to meet the Operations Requirements outlined in Section 40 of this RFP. Information supplied in Section 50.2.6 of this RFP (Operations Management Approach) shall not be duplicated in this Section.

This Section is limited to one hundred fifty (150) pages.

**50.2.4.3 Statement of Work**

This section provides the format for and information required in the Offeror's SOW. The SOW shall cover all work required to satisfy the State's requirements throughout this RFP and external documents specifically referenced as requirements in this RFP. Offerors may propose work items that are not directly traceable to requirements in this RFP, and those shall be clearly marked as such. The SOW has no page limitation, but it shall not include information extraneous to the requirements for this Section.

The SOW shall be all-inclusive of the work necessary to achieve the State's requirements. Other documents, particularly the Integrated Master Plan (IMP), also contain descriptions of the work being done, and the SOW may point to those documents, as appropriate, rather than duplicating information in multiple elements of the Technical Proposal. SOW sections associated with operations-based activities, (e.g., Operations, operations portions of Early Implementation, etc.) should be written as Performance Work Statements (PWS).

The Offeror may divide the work in the SOW in any reasonable manner; however, work being done for DDI, Operations, Turnover, and Early Implementation Phases shall be separate. If the same type of work needs to be accomplished during each of these efforts, the Offeror shall list those work statements in each appropriate section.



Appendix 50, Attachment D of this RFP reflects the format for the SOW to be submitted in this Section of the Proposal.

**50.2.4.4 Training Approach**

The Offeror shall describe its Training Approach. While a Training Plan contains details which may be unknown at the time of Proposal submission, the Training Approach must demonstrate that the Vendor’s training strategy will enable the fulfillment of all training requirements and reflect Training Plan contents to the extent possible. The Training Approach and subsequent Training Plan shall be inclusive of DDI and Operations for the Fiscal Agent, State, and Providers.

The Offeror shall specify the first submission date for the Training Plan. Reference the Training Plan CDRL (Section 40.15 of this RFP) for additional instructions.

This Section is limited to twenty (20) pages.

**50.2.5 Section E—Project Management Plan**

Offerors shall describe how they perform planning and how they control execution via the use of cost, schedule, performance (scope and quality), staffing, risk, and issue metrics and reporting, as well as the methods they use to ensure the quality of these data.

Offerors shall propose a plan for Project Management Reviews to include their planned content and frequency.

Offerors shall identify those artifacts for which approval is important to the success of the project.

This Section is limited to fifty (50) pages, excluding the IMP and the Integrated Master Schedule (IMS), which are unlimited; and other elements of this Plan with page limitations assigned (e.g., Master Test Process and Quality Assurance Approach [MTQAP] is limited to 20 pages above the 50 pages identified for the Project Management Plan).

**50.2.5.1 Integrated Master Plan**

The Offeror shall submit its IMP. Reference the IMP CDRL (Section 40.15 of this RFP) for additional information. There is no page limitation on the IMP.

**50.2.5.2 Integrated Master Schedule**

The Offeror shall submit its IMS. Reference the IMS CDRL (Section 40.15 of this RFP) for additional information. There is no page limitation on the IMS.

**50.2.5.3 Master Test Process and Quality Assurance Approach**

The Offeror shall describe its Master Test and Quality Assurance Approach. While a Master Test and Quality Assurance Plan (MTQAP) will contain details that may be unknown at the time of Proposal submission, the proposed Master Test and Quality Assurance Approach shall demonstrate that the Offeror’s strategy will enable the fulfillment of all Master Test and Quality Assurance requirements.

Reference the MTQAP CDRL (Section 40.15 of this RFP) for additional information.

This Section is limited to twenty (20) pages.

**50.2.5.4 Staffing Approach**

**50.2.5.4.1 Staffing Approach—DDI**

The Offeror shall provide its comprehensive Organizational Chart for DDI and a description of its organization.

The Offeror shall propose the positions and staff to be designated as key personnel for DDI. Offeror shall provide its Corporately Certified Position descriptions for the key personnel and résumé and references for any key personnel currently identified.

The Offeror's Organization Chart for DDI is limited to two (2) pages. Position descriptions and résumés/references are limited as follows: one (1) page for each job description and three (3) pages for each résumé, including references for key personnel being identified.

Appendix 50, Attachment I of this RFP is attached for information. With the exception of the positions the State has mandated as being key, these qualifications are being provided as guidelines.

**50.2.5.4.2 Staffing Approach—Operations**

The Offeror shall provide its proposed comprehensive Organization Chart for operations. The Offeror shall propose the positions to be designated as key personnel for operations and provide its Corporately Certified Position descriptions. The Operations Manager shall be identified in the proposal and his/her résumé and references submitted.

For continuity, the State requires that the Operations Manager also serve in a key personnel position (to be proposed by the Offeror) upon the onset of DDI.

The Offeror's Organization Chart for Operations is limited to two (2) pages. Job descriptions and résumés/references are limited as follows: one (1) page for each job description and three (3) pages for each resume, including references for key personnel being identified.

Appendix 50, Attachment I of this RFP is attached for information. With the exception of the positions the State has mandated as being key, these qualifications are being provided as guidelines.

**50.2.5.5 Communications Approach**

The Offeror shall describe its Communications Approach. While a Communications Plan will contain details which may be unknown at the time of Proposal submission, the proposed Communications Approach shall demonstrate that the Offeror's communications strategy will enable the fulfillment of all communications requirements and shall reflect its commitment to the development of a Joint Communications Plan (which involves the Vendor's preparation of a Communications Plan and then a collaboration with the State to prepare the Joint Communications Plan).



Reference the Communications Plan CDRL (Section 40.15 of this RFP) for additional information. The Communications Plan shall cover only DDI.

This Section is limited to fifteen (15) pages.

**50.2.5.6 Risk and Issue Management Plan**

The Offeror shall submit its Risk and Issue Management Plan (RIMP). Reference the RIMP CDRL (Section 40.15 of this RFP) for additional information.

The RIMP is also referenced on the Operations Management Section. Only one Plan, which encompasses DDI and operations, shall be submitted.

This Plan is limited to thirty (30) pages.

**50.2.5.7 Initial Risk Assessment (Risk Profile)**

The Offeror shall submit an Initial Risk Assessment. This shall include risks identified by the Offeror affecting the Replacement, Operations, and Turnover Phases of the project. Reference the RIMP CDRL (Section 40.15 of this RFP) for additional information.

This Section is limited to no more than one (1) page per identified risk.

**50.2.5.8 Change Management Approach**

The Offeror shall describe its Change Management Approach. While a Change Management Plan (CMP) will contain details which may be unknown at the time of proposal submission, the proposed Change Management Approach shall demonstrate that the Offeror's change management strategy will enable the fulfillment of all change management requirements and will be reflective of the content of any subsequent CMP to the extent practicable. Reference the CMP CDRL (Section 40.15 of this RFP) for additional information.

Offerors shall propose a process that efficiently and effectively manages technical, programmatic, and operational changes within the overall program. The CMP is also referenced in Operations Management; however, only one CMP covering DDI and operations shall be submitted.

This Section is limited to twenty (20) pages.

**50.2.6 Section F—Operations Management Approach**

The Offeror shall describe its Operations Management Approach and how it will succeed. While an Operations Management Plan will contain details which may be unknown at the time of Proposal submission, the proposed Operations Management Approach shall demonstrate that the Offeror's strategy will enable the fulfillment of all operations management requirements and will be reflective of the content of the subsequent Operations Management Plan to the extent practicable.

The Offeror shall include a plan for operations management reviews, including frequency and general content. The Offeror shall designate the proposed first submission date for the Operations Management Plan. This Plan shall include the Communications Plan/Processes during operations.

The Offeror shall describe how it will fulfill the primary requirements of Operations described in Section 40 of this RFP, including the provision of business continuity.

This Section is limited to thirty (30) pages, excluding those subsections with assigned page number limitations.

**50.2.6.1 *Change and Configuration Management***

The Offeror shall describe its Change and Configuration Management Approach for Operations. This area in the Proposal shall not be duplicated. See Section 50.2.5.8 of this RFP.

**50.2.6.2 *Risk and Issue Management***

The Offeror's RIMP shall include operations as well as systems and DDI. This area in the Proposal shall not be duplicated. See Section 50.2.5.6 of this RFP.

**50.2.6.3 *Business Continuity/Disaster Recovery Approach***

While a Business Continuity/Disaster Recovery Plan will contain details which may be unknown at the time of Proposal submission, the proposed Business Continuity/Disaster Recovery Approach shall demonstrate that the Offeror's strategy will enable the fulfillment of all Business Continuity/Disaster Recovery requirements and will be reflective of the content of the subsequent Business Continuity/Disaster Recovery Plan to the extent practicable.

Reference the CDRL and the Business Continuity/Disaster Recovery Plan CDRL (Section 40.15 of this RFP) for additional information.

This Section is limited to fifteen (15) pages.

**50.2.6.4 *Ongoing Training***

The Offeror shall describe its approach to Ongoing Training. See Section 50.2.4.4 of this RFP.

**50.2.6.5 *Communications Process/Procedures***

The Offeror shall describe its Communications Approach for operations. See Section 50.2.5.5 of this RFP.

Reference the Communications Plan CDRL (Section 40.15 of this RFP) for additional information.

**50.2.7 *Section G—Contract Data Requirements List***

The CDRL is a list of contract data requirements for the Replacement MMIS and is part of the contract. Reference the CDRL in Section 40.15 of this RFP. It contains specific requirements as identified by the State. The Offeror shall complete the CDRL with the additional data requirements it proposes.

The State-identified CDRL referenced in other subsections within this Section 50 shall be addressed in their entirety within their respective Technical Proposal subsections. All other CDRLs identified by the State as well as those identified by the Offeror shall be addressed to the extent possible within this Section.

There is no page limitation on the CDRL.

**50.2.8 Section H—Security Approach**

The Offeror shall describe its Security Approach. While the Offeror’s Security Plan will contain details which may be unknown at the time of Proposal submission, the proposed Security Approach shall demonstrate that the Offeror’s security strategy will enable the fulfillment of all security requirements and will be reflective of the content of the subsequent Security Plan.

The Offeror shall designate the proposed first submission date for the Security Plan.

This Section is limited to thirty (30) pages.

**50.2.9 Section I—Turnover Approach**

The Offeror shall describe the Turnover Approach. While the Turnover Plan may contain details that are unknown at the time of Technical Proposal submission, the Turnover Approach must demonstrate that the Offeror’s Turnover strategy will enable the fulfillment of all turnover requirements and reflect the future Turnover Plan contents to the extent practicable. Reference the CDRL (Section 40.15 of this RFP) for the Turnover Plan.

Offerors shall provide a warranty under which they will provide continuing system operational support to the incoming entity after expiration or termination of the Contract. Offerors shall propose the duration of this warranty, as well as terms that ensure that its expert staff will be on call for a sufficient amount of time to respond to questions or address any issues that arise during the warranty period. The successful Offeror will be responsible for communications to all stakeholders, interface agents, and the user community to present its plans to ensure the continuity of services.

This Section is limited to twenty (20) pages.

**50.2.10 Section J—Corporate Capabilities**

This section describes the information the Offeror shall include in Section J of the Proposal. Section J is limited to forty (40) pages, excluding all related attachments.

**50.2.10.1 Relevant Experience**

The Offeror shall describe its overall corporate experience related to the objectives and requirements of this proposed Contract. This includes relevant MMIS experience; other health care claims processing experience; implementation and system maintenance of health care transaction replacement systems; Fiscal Agent operations experience; MMIS and other health care system experience; and multi-payer claims processing experience. Additionally, the Offeror shall specifically describe any other relevant projects that it believes establishes its ability to successfully complete the RFP requirements. Offerors shall specifically describe their experience with their replacement system; their experience, both implementation and operations, with the proposed replacement system and/or business areas; the success of the implementation and operations; and lessons learned from the experience.



**50.2.10.2 Summary Information Listing the Offeror's Corporate Relevant Experience**

The Offeror shall provide a summary listing in a table format of all its contracts for MMIS and/or other health care claims processing for the last five (5) years. Appendix 50, Attachment E of this RFP contains the prescribed table format to use for Listing of Offeror's Corporate Relevant Experience. The table pages shall not be counted in the page limitation.

The listing shall contain the following items for each referenced contract:

- The name of the customer;
- The name of the project;
- An indication of whether the referenced contract involved claims processing specifically for either or all of the following:
  - Medicaid,
  - Medicare,
  - Mental health,
  - Public health, and/or
  - Other health care entity;
- An indication of whether the Offeror performed any of the following tasks on the referenced Contract:
  - Claims processing (include whether fee-for-service, capitation, and/or encounters),
  - Provider relations services,
  - Prior approval services,
  - Drug rebate services,
  - Point-of-sale processing and support services,
  - Electronic eligibility verification system processing and services,
  - Provider payment issuance and financial management, or
  - Other tasks that demonstrate experience similar to the objectives and requirements of this RFP;
- An indication of whether the role the Offeror had on the referenced Contract was as a prime or a subcontractor;
- The time period of the referenced contract during which the Offeror participated;
- The contract size (number of beneficiaries and dollar amount of claims paid per year);
- An indication of whether the Offeror's overall responsibilities on the referenced contract included:
  - Design, development, and installation of a system—indicating whether the design, development, and installation product/approach was a COTS, COTS with modifications, in-house development, transferred system, transferred and modified system, any

- combination of products or a combination of approaches, and applicability to CMS certification requirements;
- Operations of a system;
  - Maintenance and modification of a system;
  - Serving as the systems integrator; and
  - Any responsibilities for system turnover at the end of the contract;
- An indication of whether the referenced contract involved health care claims processing in a multi-payer environment;
  - The platform on which the system of the referenced contract operates;
  - Key technologies used in the implementation and/or operation of the system in the referenced contract;
  - Whether damages or penalties have been assessed during the last five (5) years of the referenced contract; and
  - A customer reference (including name, address, and current telephone number of the responsible project administrator or manager who is familiar with the Offeror's performance).

The State shall conduct reference checks to verify the accuracy of submitted materials and to ascertain the quality of past performance. The State reserves the right to pursue any references that may assist in completing the Proposal Evaluation process. Submission of the Technical Proposal establishes the Offeror's agreement for the State to make any contacts it deems necessary to confirm the Offeror's experience and performance.

#### **50.2.10.3      *Financial Stability***

The Offeror shall attach a copy of the entity's most recent two (2) years of independently audited financial reports and financial statements. The financial reports and financial statements pages from the auditing firm shall not be counted in the page limitation for this Section. The Offeror shall provide the name, address, and telephone number of a responsible representative of the Offeror's principal financial or banking organization.

In addition, the Offeror shall include a disclosure of all judgments, pending or expected litigation, or other real or potential financial reversals that might materially affect the viability or stability of the proposing organization or any majority-owned subsidiary. Filings with the Securities Exchange Commission may be provided. If there are none, the Offeror shall represent that no such condition is known to exist.

#### **50.2.10.4      *Replacement MMIS Account's Place in the Corporate Structure***

The Offeror shall describe how North Carolina's Replacement MMIS account shall fit into its business organizational structure during said account's DDI Phase and then during its Operations Phase. A business organizational chart(s) that details this shall be provided. The Offeror shall describe who in the organization has ownership and/or

oversight of the performance criteria for the DDI Phase and how this oversight is managed and monitored.

**50.2.10.5 Damages and Penalties Asserted**

The Offeror shall describe any damages, penalties or credits issued, individually in excess of one hundred thousand dollars (\$100,000.00), that it or its majority-owned subsidiaries have paid, or which have been asserted against it or such subsidiaries, in the last five (5) years, including the date of each underlying claim and cross-referencing, as appropriate, to the contracts listed in response to Section 50.2.10.2 of this RFP. The Offeror shall describe the circumstances of the claim and how it rectified the situation that caused the claim of the damages and/or penalties. When disclosing information pursuant to this Section 50.2.10.5, the Vendor may designate certain of its information as "Confidential" in accordance with Section 30.27.

**50.2.11 Section K—Oral Presentations and Demonstrations**

The Offerors shall acknowledge in Section K of their Technical Proposal that they understand and agree to perform the requirements of the Oral Presentations and System Demonstrations as represented in this section.

**50.2.11.1 Oral Presentations**

All Offerors shall make oral presentations of key sections of their Technical Proposals. These presentations will occur during two (2) days, with approximately eight (8) hours available each day for presentation. Presentations shall begin at 8:00 A.M. and complete at 4:50 P.M. Eastern Time each day. There shall be ten-minute (10-minute) breaks each hour from fifty (50) minutes past the hour until the top of the hour. There shall be a lunch break of one (1) hour from 12:00–1:00 P.M. Discussions concerning the Technical Proposal shall not continue during breaks or outside of the presentation room.

Offerors need not use the entire allotted time if it is not necessary to convey the required information. Unneeded time shall not be filled with marketing information. The State shall make no judgment on the Offeror's Technical Proposal merely because the Offeror did not use all of the allotted time.

Oral presentations shall focus on the areas identified below:

- An overview of the Technical Proposal (equivalent to the Executive Summary in the written Technical Proposal);
- Presentation on key aspects of the proposed technical solution;
- Project Management Approach during the DDI Phase;
- Discussion of how the Offeror plans to work with the State during the DDI Phase;
- Presentation on key aspects of the Offeror's IMP and IMS to include a discussion on the development strategy;
- Presentation on key aspects of the proposed operations solution;
- Operations Management Approach;



- Discussion of how the Offeror plans to work with the State during the Operations Phase;
- Training Approach;
- Deployment/Rollout Approach;
- Change Management Approach;
- Presentation of the Initial Risk Assessment;
- Technical and architectural aspects of the system design; and
- Software development and systems engineering methodologies.

The Offeror shall present a maximum of one hundred sixty (160) total printed/displayed slides for the presentation.

The Offeror may allocate the time between the subjects and select the order of presentation at its discretion, with the exception that the overview of the Technical Proposal shall be the first subject presented on Day 1.

**50.2.11.2 System Demonstrations**

Each Offeror shall have three (3) days to present a demonstration of its baseline system. The demonstrations shall begin at 8:00 A.M. and continue until 4:50 P.M. Eastern Time each day. There shall be a ten-minute (10-minute) break each hour (from fifty [50] minutes past the hour until to the top of the hour) during which there shall be no discussions between the Offeror and State personnel during the breaks or outside of the demonstration room. Lunch shall be from 12:00–1:00 P.M. Eastern Time. The afternoon session shall begin at 1:00 P.M. Eastern Time, again with ten-minute (10-minute) breaks each hour. The demonstration shall end at 4:50 P.M. Eastern Time.

**Purpose:** To provide information on the Offeror’s baseline system in order to:

- Gain a better understanding of the baseline systems to supplement the Offerors’ written proposals;
- Evaluate the compatibility of the Offerors’ baseline systems to the State’s requirements and objectives in order to gain a feel for the level of effort and risk required for the Offerors to transform their baseline systems into the required system; and
- Gain an understanding of different solutions to the common MMIS requirements across states in order to widen the pool of potential solutions that could meet the State’s requirements and objectives.

**What the System Demonstrations Are Not:**

- An evaluation of the Offerors’ proposed systems;
- An evaluation of the Offerors’ baseline systems against the requirements
- A direct competition or “bake off” between Offerors;
- An evaluation of non-production software;

- A quantifiable evaluation of the Offerors' baseline systems; or
- A comprehensive evaluation of the Offerors' baseline systems.

**A "baseline system" is:**

- An MMIS that is currently deployed in one (1) or more states that may be modified by:
  - New capability that is a requirement of an executed contract with a state that has not yet been deployed but is planned to be deployed prior to Contract award for the Replacement MMIS;
  - New capability funded by the Offeror that is in a production-ready state (having completed the Offeror's entire systems engineering process through system testing) by the date the Replacement MMIS RFP is released;
- Or, an MMIS that is not currently deployed in a state but that is under development via an executed contract with one (1) or more states and is planned to be deployed prior to Contract award for the Replacement MMIS. This may be modified by:
  - New capability funded by the Offeror that is in a production-ready state (having completed the Offeror's entire systems engineering process through system testing) by the date the Replacement MMIS RFP is released;
- Or, a non-MMIS claims system that is deployed in a production environment as of the date the Replacement MMIS RFP is released. (No additional capability is allowed to be demonstrated beyond the production system in this case.)

Prior to demonstrating a pre-existing MMIS software solution to the State, each Offeror shall identify the solution and the state(s) where it is installed and represent to the State that the solution complies in all respects with the foregoing description of a "baseline" solution. Offerors shall make this representation by signing the statement in Appendix 50, Attachment H of this RFP and delivering it to the State as part of their Technical Proposal.

In Section K, the Offerors shall specify state(s) where its baseline system is installed and shall advise the desktop solution to be used, including the version of the operating system.

Offerors have significant flexibility in how to best present the material; however, at a minimum, the Offeror shall cover 1) key elements of the business areas; 2) the claim "life cycle"; and 3) how providers and recipients access the system.

During the demonstrations, State personnel may ask clarifying questions but will not provide feedback on the quality or capability of the system being demonstrated or on any other system. The Offeror shall not solicit such feedback.

Offerors need not use all of the allotted time if it is not necessary. They shall not "fill" the time with marketing information. The State shall make no judgment on the Offeror's Technical Proposal merely because the Offeror did not use all of the allotted time. While a smooth presentation will assist the State in understanding the Offeror's baseline system, the State shall not evaluate the Offeror on presentation style or personal attributes of the presenter(s).

**50.2.11.3 Resources**

Offerors shall provide a room large enough to handle thirty (30) State personnel plus the Offeror's team along with tables and chairs for the same. The presentation / demonstration location shall be within 15 miles of the OMMISS (at 3101 Industrial Drive, Raleigh, NC). Additionally, the Offeror shall supply all hardware, software, and presentation equipment, as needed. Offerors shall provide 30 printed copies of the presentation used for the Oral Presentations and shall have no additional handouts for the System Demonstrations.

**50.3 COST PROPOSAL REQUIREMENTS**

After evaluation of Step One (Step 1), Technical Proposals, the State will request Cost Proposals from those Offerors deemed technically acceptable. It shall be understood that all pricing proposed by the Offeror in response to this RFP shall remain firm and constant during the entire Contract and any extensions.

**Note**

Further instructions regarding the Cost Proposal will be provided as a part of Step Two (Step 2). Cost Proposals shall not be submitted as a part of Step One (Step 1). Cost Proposals submitted prior to the State's request shall be destroyed or returned to the vendor.

Proposal pricing for the Replacement MMIS will be divided into three (3) sections: Replacement Phase, Operations Phase, and Turnover Phase. When submitting the Cost Proposal, the Offeror shall be required to submit its prices on Price Tables which will be included in the State's request for Cost Proposals in Step 2. Offerors will be required to provide the basis of estimates presented on the Price Tables as an attachment to each table.

**Failure to use the Price Tables and/or to submit all of the requested information and basis of estimates attachments shall result in the Cost Proposal being deemed non-responsive.** Typographical or transposition errors may not be corrected following Proposal acceptance.



**SECTION 50: PROPOSAL SUBMISSION REQUIREMENTS**



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## **SECTION 60: EVALUATION METHODOLOGY**

The State of North Carolina shall conduct a comprehensive, fair, and impartial evaluation of Proposals received in response to this RFP using a two-step, “Best-Value” procurement process. Proposals shall be evaluated using “Best-Value” procurement methods consistent with N.C.G.S. §143-135.9. The award will be based on multiple factors, as described in this Section.

A two-step bid process using a tradeoff/ranking method of source selection will be used in this procurement. By using this method, the overall ranking may be adjusted up or down when considered with, or traded off against, other non-price factors.

The Selection Committee may engage in communications, negotiations, or request clarifications from any or all Offerors. Offerors are cautioned that the Evaluators are not required to request clarifications; therefore, all offers should be complete and reflect the most favorable terms. Offerors should be prepared to send qualified personnel to Raleigh, NC, to make oral presentations, perform system demonstrations (per Section 50 of this RFP), and discuss technical and contractual aspects of the Proposal.

Offerors shall submit a Technical Proposal as Step 1. After evaluation and scoring of the Step 1 responses, the State will solicit Cost Proposals from qualified Offerors in Step 2. Step 2 Cost Proposals will be solicited only from those Offerors within a competitive range as determined by the State after reviewing the Step 1 Technical Proposals. Cost Proposals submitted prior to the State’s request will be destroyed or returned to the Offeror.

- All Proposals will be initially classified as being responsive or non-responsive. If a Proposal is found to be non-responsive, it may not be considered further.
- To be eligible for consideration, an Offeror shall meet the intent of all requirements and objectives. Compliance with the intent of all requirements and objectives shall be determined by the State. Responses that do not meet the full intent of all requirements and objectives listed in this RFP may be subject to reductions in score during the evaluation process or may be deemed non-responsive. Further, a serious deficiency impacting any evaluation criterion may be grounds for rejection, regardless of the overall score.

The State shall determine competitive range by evaluating whether or not the Offeror appears reasonably able to meet the requirements of this RFP. Minor deficiencies that could be easily remedied via negotiations will not be grounds for elimination from the competitive range. However, significant deficiencies or large numbers of smaller deficiencies that demonstrate the Offeror’s lack of understanding or inability to meet the scope and intent of the project shall be grounds for elimination from the competitive range.

The State has also developed a Proposal Evaluation Plan (PEP) and guidelines to conduct the evaluation as required by CMS per Section 11275 of the State Medicaid Manual. Throughout all steps of the Proposal Evaluations, the confidentiality and security of all Proposals and the scoring process shall be maintained. To ensure





## SECTION 60: EVALUATION METHODOLOGY



confidentiality and security, evaluation and selection sessions shall be closed to the public in accordance with 9 NCAC 06B.0309.

### 60.1 EVALUATION OF PROPOSAL REQUIREMENTS

Each Proposal shall comply with the requirements listed in the Replacement MMIS Proposal Submission Requirements Checklist (Appendix 50, Attachment A of this RFP) as per the instructions in Section 50 of this RFP.

Those Proposals that have been correctly completed according to the Replacement MMIS Proposal Submission Requirements Checklist shall be deemed responsive to the requirements of the Replacement MMIS RFP.

Those Proposals that have not been correctly completed according to the Replacement MMIS Proposal Submission Requirements Checklist may be deemed non-responsive to the RFP. Non-responsive Proposals may be rejected from further consideration. The rejection and final disposition of Proposals are discussed in Section 20 of this RFP.

The Offerors shall adhere to the formats and page limitations prescribed in Section 50 of this RFP. Any pages (including attachments, brochures, etc.) exceeding the limitations shall be removed from the Proposals before they are given to the Evaluators. No deviations, qualifications, or counteroffers to requirements and requested formats shall be accepted. The State shall reserve the right to waive minor irregularities or seek clarification from the Offerors.

Those Proposals that meet all requirements and are deemed responsive shall proceed to the Evaluation of Technical Proposals and Cost Proposals (Two-Step Process).

### 60.2 COMPUTATION OF SCORES AND RANKING OF PROPOSALS

Each of the evaluation criteria for this solicitation, along with weighting of each, is listed in Exhibit 1.

#### EXHIBIT 1: RANKING OF EVALUATION CRITERIA

Category of Proposal Evaluation Criteria	Value
<b>Technical and Operations Solution:</b> The extent to which the solution improves the State’s current operations and has the capability to continue to foster future improvements in operations. The technical and operations solution includes the satisfaction of requirements and goals, the system's architectural quality, and the Offeror's approach and staff skills in performing the needed Fiscal Agent operations in accordance with statutes as well as CMS and State regulations and policies.	20 points
<b>Program Risk:</b> This includes risks affecting cost, schedule, and system and operational performance. Schedule realism will be evaluated as part of Program Risk.	20 points



SECTION 60: EVALUATION METHODOLOGY



Category of Proposal Evaluation Criteria	Value
<b>Total Price:</b> This includes all proposed prices and rates for the Replacement, Operations, and Turnover Phases, including the Provider early implementation initiative, but excluding the Additional Functionality Pool and other early implementation initiatives. The Total Price will also include the estimated costs of all licenses procured by the State under the Enterprise License Agreements as directed in Section 10.5. Rates and prices for the Additional Functionality Pool and other early implementation initiatives will be evaluated as part of the best value tradeoff process.	20 points
<b>DDI Schedule:</b> The proposed schedule for Replacement Phase.	15 points
<b>Past Performance and Experience:</b> The Offeror’s performance on previous projects of similar scope (e.g., health care and Medicaid-specific services).	15 points
<b>Corporate Capabilities and Financial Stability:</b> This includes an Offeror’s strengths, capabilities, and overall experience, including corporate background and structure and financial soundness.	10 points

The State shall evaluate and score the Technical Proposals by awarding points for each of the criteria in Exhibit 1 except for Total Price. After completion of a competitive range determination, the State shall solicit Cost Proposals from those Offerors in the competitive range. After receipt of the Cost Proposals, the State will evaluate the Total Price criterion. The State shall then determine the overall ranking using price and non-price factors based on the State’s evaluation of the tradeoffs between the evaluation factors. These tradeoffs may include quantitative and qualitative evaluations and judgments. The State intends to award the Contract to the Offeror who has the highest overall ranking after consideration of these tradeoffs and after completion of negotiations, should it choose to negotiate with Offerors.

In addition, the State may rate any Offeror’s Proposal as unacceptable, regardless of total score, if any element of that Proposal is deemed unacceptable. Examples of this include, but are not limited to:

- Unreasonable proposed costs and schedule, to include “buying in” by intentionally reducing the DDI Prices and/or DDI Schedule below that which could be reasonably achieved;
- Unacceptable intellectual property rights terms;
- High-risk items for which no reasonable mitigation is proposed;
- Proposing unproven technologies as key elements of the Offeror’s solution;

- Substantiated feedback from references indicating a history of failure to achieve promised results; inability or unwillingness to comply with contract terms; or significant post-award reduction in productivity for modifications that result in increased costs; and
- Proposed prices that are inadequately supported by bases of estimates.

### **60.3 RECOMMENDATION OF THE SELECTED OFFEROR**

The State shall reserve the right to conduct negotiations according to Title 9 NCAC 06B.0403. When technical negotiations or subsequent technical offers are solicited, the Offerors shall provide the subsequent offers in response. When cost negotiations are performed, the Offerors shall provide final pricing or Best and Final Offers (BAFOs), as specified by the State, in response. Failure to deliver a subsequent offer or BAFO when requested may disqualify the non-responsive Offeror from further consideration. The State may establish a competitive range based upon evaluations of Proposals and request BAFOs from the Offerors within this range, e.g., "Finalist Offerors." During the BAFO process, the State reserves the right to remove selected functionality from those listed in Section 40 of this RFP and request a BAFO without the specified functionality.

The Selection Committee shall review the final ranking and the pertinent evaluation materials in making their recommendation for selection. The Selection Committee shall prepare a narrative report summarizing the evaluation results for the selected Offeror.

### **60.4 CONTRACT AWARD**

Upon approval of the Selection Committee's recommendation by all required State and Federal authorities, the State shall notify the successful Offeror of award of the Contract. Section 20 of this RFP contains additional information about Contract award.



**RFP APPENDICES INDEX**

Appendix 10, Attachment A	Anticipated Replacement MMIS Procurement Schedule
Appendix 10, Attachment B	Replacement MMIS Procurement Library Listing
Appendix 30, Attachment A	Certification Regarding Lobbying
Appendix 30, Attachment B	Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion—Lower-Tier Covered Transactions
Appendix 30, Attachment C	Certification Regarding Drug-Free Workplace Requirements
Appendix 30, Attachment D	Certification Regarding Environmental Tobacco Smoke
Appendix 40, Attachment A	Document Imaging of Claims Documents and Claims History
Appendix 40, Attachment B	DMA Network
Appendix 40, Attachment C	DMH Network
Appendix 40, Attachment D	SAS 70 Audit Requirements—North Carolina Replacement Medicaid Management Information System (Replacement MMIS)
Appendix 40, Attachment E	North Carolina Department of Health and Human Services Business Associate Addendum to Replacement MMIS Contract
Appendix 40, Attachment F	Replacement MMIS Sample Operations Invoice Supporting Documentation
Appendix 40, Attachment G	Consolidated List of Reports
Appendix 40, Attachment H	Replacement MMIS External Interfaces
Appendix 40, Attachment I	System Availability
Appendix 40, Attachment J	Desktop Standards



## RFP APPENDICES INDEX

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Appendix 50, Attachment A	Replacement MMIS Proposal Submission Requirements Checklist
Appendix 50, Attachment B	High-Level System Functionality Matrix
Appendix 50, Attachment C, Exhibit 1	State Requirements Matrix
Appendix 50, Attachment C, Exhibit 2	Adjusted Function Point Count
Appendix 50, Attachment D	Statement of Work Format
Appendix 50, Attachment E	Listing of Offeror's Corporate Relevant Experience
Appendix 50, Attachment F	***DELETED***
Appendix 50, Attachment G	Description of Account Codes for Replacement MMIS Procurement
Appendix 50, Attachment H	Baseline Representation
Appendix 50, Attachment I	Personnel Staffing Qualification Matrix
Glossary and Acronym List	



**ANTICIPATED REPLACEMENT MMIS PROCUREMENT SCHEDULE**

<b>Event</b>	<b>Date</b>
RFP for the Replacement MMIS Issued	July 27, 2007
Deadline for Submission of Offerors' Questions	December 4, 2007
Replacement MMIS Technical Proposals due to NC DHHS	December 20, 2007
Oral Presentations and System Demonstrations Begin	February 11, 2008
Oral Presentations and System Demonstrations End	March 14, 2008
Cost Proposals Requested	June 20, 2008
Cost Proposals Due to NC DHHS	July 7, 2008
Selection Committee Recommendation	August 11, 2008
Final Approval of Selected Proposal for the Replacement MMIS	September 2, 2008
Contract Award and Signing	September 9, 2008
Start Date for Replacement MMIS Activities	September 16, 2008

## REPLACEMENT MMIS PROCUREMENT LIBRARY LISTING

### DETAILED SYSTEM DESIGN DOCUMENTATION

The documentation for Detailed System Design (DSD) is an artifact set of documents from the previous Design, Development, and Implementation (DDI) Phase and is to be used as reference material. DSD includes the detailed design of all subsystems and includes background, project management oversight and testing documents.

Item	Description	Media
v1.003	Detailed System Design documentation from DDI	CD/DVD

### FINAL RFP DOCUMENTATION

Final Request for Proposal (RFP) documentation includes the complete RFP documents from November 2003 and is an artifact to be used as reference material.

Item	Description	Media
110503 RFP 30-DHHS-736-04.doc	112003 RFP documentation	CD/DVD

### GSD DOCUMENTATION

The documentation for General System Design (GSD) is an artifact from the design phase of the previous DDI and is to be used as reference material.

Item	Description	Media
v1.0	General System Design documentation from DDI	CD/DVD

### IPRS DOCUMENTATION

The list of system technical documentation for the Integrated Payment and Reporting System (IPRS) includes reports, job descriptions, workflows, Internet browser screens, operations manuals, and desk procedures required to process, track, pay, and report on all claims submitted by providers for services rendered to its constituent population.

Item	Description	Media
Adjustments	System files, reports, jobs, programs and training	CD/DVD



APPENDIX 10, ATTACHMENT B



Item	Description	Media
	documentation for Adjustments subsystem	
Claims Processing	System files, reports, jobs, programs and training documentation for Claims processing	CD/DVD
Claims Receipt	System files, reports, jobs, programs and training documentation for Claims receipt	CD/DVD
Claims Eligibility	System files, reports, jobs, programs and training documentation for Claims eligibility	CD/DVD
DMH Desktop Procedures Monthly Deltas	Financial, accounting, refunds, security administration, and file maintenance desktop procedures for the Division of Mental Health	CD/DVD
Edits_Audits	Edit and audit system files, reports, jobs, programs and training documentation	CD/DVD
Financial	System files, reports, jobs, programs and training documentation for the Financial subsystem	CD/DVD
General Archive	Obsolete general system files, reports, jobs, programs and training documentation	CD/DVD
HIPAA	Health Insurance Portability and Accountability Act (HIPAA) system files	CD/DVD
Interfaces	System files, reports, jobs, programs and training documentation for system interfaces	CD/DVD
MAPS	Maps used to create or translate various transactions	CD/DVD
Payer Control	System files, reports, jobs, programs and training documentation for Payer Control subsystem	CD/DVD
Pcode	System files, reports, jobs, programs and training documentation for Procedure Code subsystem	CD/DVD
Prior Approval	Prior Approval subsystem files, reports, jobs, programs and training documentation	CD/DVD
Provider Eligibility	System files, reports, jobs, programs and training documentation for Provider eligibility	CD/DVD





## APPENDIX 10, ATTACHMENT B



Item	Description	Media
Rate Pricing	Rate/Pricing subsystem files, reports, jobs, programs and training documentation	CD/DVD
Retro Medicaid	System files, reports, jobs, programs and training documentation for Retro Medicaid subsystem	CD/DVD
Retro Rate	System files, reports, jobs, programs and training documentation for Retro Rate subsystem	CD/DVD

### MMIS DOCUMENTATION

The list of system technical documentation in the Medicaid Management Information System (MMIS) folder in Procurement Library II is for the Division of Medical Assistance (DMA) and includes reports, job descriptions, workflows, Internet browser screens, operations manuals, and desk procedures

Item	Description	Media
AR&AP	Requirements and business rules documentation for Accounts Receivable and Accounts Payable	CD/DVD
MAS	Medicaid Accounting System requirements and business rules	CD/DVD
MMIS Business Documents	Information used by the business units during Medicaid claims processing	CD/DVD
MMIS System Documents	MMIS subsystem files, reports, job, programs and training specification documents	CD/DVD
MMIS Technical Documents	Legacy source code, data models and standards manuals	CD/DVD

### MMIS MEDICAL POLICY MANUALS

The items contained in this subfolder are imaged Clinical Manuals policies, training documents, articles, and special bulletins.

Item	Description	Media
AddendumToChiropracticServices	Chiropractic addendum	CD/DVD



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Item	Description	Media
General Info BK1	General information	CD/DVD
Medicaid Covered Service BK2	Articles, policy and training information	CD/DVD
Medicaid Covered Service BK3	Articles, policy and training information	CD/DVD
Medicaid Covered Service BK4	Articles, policy and training information	CD/DVD
Medicaid Covered Service BK5	Articles, policy and training information	CD/DVD
Medicaid Covered Service BK6	Articles, policy and training information	CD/DVD
Medicaid Covered Service BK7	Articles, policy and training information	CD/DVD
Medicaid Covered Service BK8	Articles, policy and training information	CD/DVD
Medicaid Covered Service BK9	Articles, policy and training information	CD/DVD
Medicaid Covered Service BK10	Articles, policy and training information	CD/DVD
Medicaid Covered Service Update BK1	Updated articles, policy and training information	CD/DVD
Medicaid Covered Service Update BK2	Updated articles, policy and training information	CD/DVD

**POMCS DOCUMENTATION**

System documentation for Purchase of Medical Care Services (POMCS) provided is for the POMCS and includes tables, layouts, and reports.



## APPENDIX 10, ATTACHMENT B



Item	Description	Media
POMCS	System documentation	CD/DVD

### RAD DOCUMENTATION

The documentation for Requirements Analysis Document (RAD) and is an artifact from the previous DDI.

Item	Description	Media
v1.03	Requirements Analysis documentation from previous DDI	CD/DVD

### DHSR DOCUMENTATION

The list of system technical documentation for the Division of Health Service Regulation (DHSR) includes license application and processing cost information.

Item	Description	Media
Applications	Initial and renewal licenses information	CD/DVD
Processing Costs	Licensing expenditure information	CD/DVD

### DRIVE & FADS DOCUMENTATION

The list of documentation for DRIVE and FADS include manuals, contract, and system input and output information.

Item	Description	Media
Contract Amendments	Amendments to contract	CD/DVD
DRIVE&FADS Invoices	Customer Invoices	CD/DVD
DSSRFP97	Sections from the 1997 RFP	CD/DVD
Inputs&outputs	Input / output file information	CD/DVD
Lvl2	Drive Level 2 user manual	CD/DVD
Lvl3	Drive Level 3 user manual	CD/DVD
Online Help	Drive online help manual	CD/DVD



Contract #  
(Contractor)

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
**DIVISION OF (FILL IN DIVISION NAME)**

**CERTIFICATION REGARDING LOBBYING**

Certification for Contracts, Grants, Loans and Cooperative Agreements

The undersigned certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any Federal, State, or local government agency, a member of Congress, a member of the General Assembly, an officer or employee of Congress, an officer or employee of the General Assembly, an employee of a member of Congress, or an employee of a member of the General Assembly in connection with the awarding of any Federal or State contract, the making of any Federal or State grant, the making of any Federal or State loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal or State contract, grant, loan, or cooperative agreement.
2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any Federal, State, or local government agency, a member of Congress, a member of the General Assembly, an officer or employee of Congress, an officer or employee of the General Assembly, an employee of a member of Congress, or an employee of a member of the General Assembly in connection with the awarding of any Federal or State contract, the making of any Federal or State grant, the making of any Federal or State loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal or State contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.
3. The undersigned shall require that the language of this certification be included in the award documents for all sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.
4. This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

Notwithstanding other provisions of Federal OMB Circulars A-122 and A-87, costs associated with the following activities are unallowable.

**PARAGRAPH A**

1. Attempts to influence the outcomes of any Federal, State, or local election, referendum, initiative, or similar procedure, through in kind or cash contributions, endorsements, publicity, or similar activity;

2. Establishing, administering, contributing to, or paying the expenses of a political party, campaign, political action committee, or other organization established for the purpose of influencing the outcomes of elections;
3. Any attempt to influence: (i) The introduction of Federal or State legislation; or (ii) the enactment or modification of any pending Federal or State legislation through communication with any member or employee of the Congress or State legislature (including efforts to influence State or local officials to engage in similar lobbying activity), or with any government official or employee in connection with a decision to sign or veto enrolled legislation;
4. Any attempt to influence: (i) The introduction of Federal or State legislation; or (ii) the enactment or modification of any pending Federal or State legislation by preparing, distributing, or using publicity or propaganda, or by urging members of the general public or any segment thereof to contribute to or participate in any mass demonstration, march, rally, fundraising drive, lobbying campaign, or letter writing or telephone campaign; or
5. Legislative liaison activities, including attendance at legislative sessions or committee hearings, gathering information regarding legislation, and analyzing the effect of legislation, when such activities are carried on in support of or in knowing preparation for an effort to engage in unallowable lobbying.

The following activities as enumerated in Paragraph B are excepted from the coverage of Paragraph A.

## **PARAGRAPH B**

1. Providing a technical and factual presentation of information on a topic directly related to the performance of a grant, contract, or other agreement through hearing testimony, statements, or letters to the Congress or a State legislature, or subdivision, member, or cognizant staff member thereof, in response to a documented request (including a Congressional Record notice requesting testimony or statements for the record at a regularly scheduled hearing) made by the recipient member, legislative body or subdivision, or a cognizant staff member thereof, provided such information is readily obtainable and can be readily put in deliverable form, and further provided that costs under this section for travel, lodging, or meals are unallowable unless incurred to offer testimony at a regularly scheduled Congressional hearing pursuant to a written request for such presentation made by the chairman or ranking minority member of the committee or subcommittee conducting such hearing
2. Any lobbying made unallowable by subparagraph A (3) to influence State legislation in order to directly reduce the cost or to avoid material impairment of the organization's authority to perform the grant, contract, or other agreement
3. Any activity specifically authorized by statute to be undertaken with funds from the grant, contract, or other agreement

## **PARAGRAPH C**

1. When an organization seeks reimbursement for indirect costs, total lobbying costs shall be separately identified in the indirect cost rate proposal and thereafter treated as other unallowable activity costs in accordance with the procedures of subparagraph B (3).
2. Organizations shall submit, as part of the annual indirect cost rate proposal, a certification that the requirements and standards of this paragraph have been complied with.
3. Organizations shall maintain adequate records to demonstrate that the determination of costs as being allowable or unallowable pursuant to this section complies with the requirements of this circular.
4. Time logs, calendars, or similar records shall not be required to be created for purposes of complying with this paragraph during any particular calendar month when: (1) the employee engages in lobbying (as defined in subparagraphs (a) and (b)) 25 percent or less of the employee's compensated hours of employment during that calendar month, and (2) within the preceding five-year period, the



## APPENDIX 30, ATTACHMENT A



organization has not materially misstated allowable or unallowable costs of any nature, including legislative lobbying costs. When conditions (1) and (2) are met, organizations are not required to establish records to support the allowability of claimed costs in addition to records already required or maintained. Also, when conditions (1) and (2) are met, the absence of time logs, calendars, or similar records will not serve as a basis for disallowing costs by contesting estimates of lobbying time spent by employees during a calendar month.

- 5. Agencies shall establish procedures for resolving in advance, in consultation with OMB, any significant questions or disagreements concerning the interpretation or application of this section. Any such advance resolution shall be binding in any subsequent settlements, audits or investigations with respect to that grant or contract for purposes of interpretation of this circular, provided, however, that this shall not be construed to prevent a contractor or grantee from contesting the lawfulness of such a determination.

### PARAGRAPH D

Costs incurred in attempting to improperly influence either directly or indirectly, an employee or officer of the Executive Branch of the Federal Government to give consideration or to act regarding a sponsored agreement or a regulatory matter are unallowable. Improper influence means any influence that induces or tends to induce a Federal employee or officer to give consideration or to act regarding a federally sponsored agreement or regulatory matter on any basis other than the merits of the matter.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Agency/Organization

\_\_\_\_\_  
Date

**Note**  
Certification signature should be same as Contract signature.



Contract #  
(Contractor)

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
**DIVISION OF (FILL IN DIVISION NAME)**

**CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY, AND  
VOLUNTARY EXCLUSION—LOWER-TIER COVERED TRANSACTIONS**

Certification for Contracts, Grants, Loans and Cooperative Agreements

1. By signing and submitting this proposal, the prospective lower-tier participant is providing the certification set out below.
2. The certification in this clause is a material representation of the fact upon which reliance was placed when this transaction was entered into. If it is later determined that the prospective lower-tier participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.
3. The prospective lower-tier participant will provide immediate written notice to the person to which the proposal is submitted if at any time the prospective lower-tier participant learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.
4. The terms "covered transaction," "debarred," "suspended," "ineligible," "lower-tier covered transaction," "participant," "person," "primary-covered transaction," "principal," "proposal," and "voluntarily excluded," as used in this clause, have the meanings set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. You may contact the person to which this proposal is submitted for assistance in obtaining a copy of those regulations.
5. The prospective lower-tier participant agrees by submitting this proposal that, should the proposed covered transaction be entered into, it shall not knowingly enter any lower-tier covered transaction with a person who is debarred, suspended, determined ineligible, or voluntarily excluded from participation in this covered transaction unless authorized by the department or agency with which this transaction originated.
6. The prospective lower-tier participant further agrees by submitting this proposal that it will include this clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion—Lower-Tier Covered Transaction," without modification, in all lower-tier covered transactions and in all solicitations for lower-tier covered transactions.
7. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not debarred, suspended, ineligible, or voluntarily excluded from covered transaction, unless it knows that the certification is erroneous. A participant may decide the method and frequency of which it determines the eligibility of its principals. Each participant may, but is not required to, check the Non-procurement List.
8. Nothing contained in the foregoing shall be construed to required establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.



## APPENDIX 30, ATTACHMENT B



9. Except for transactions authorized in paragraph 5 of these instructions, if a participant in a covered transaction knowingly enters into a lower-tier covered transaction with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension, and/or debarment.
- a) The prospective lower-tier participant certifies, by submission of this proposal, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency.
  - b) Where the prospective lower-tier participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Agency/Organization

\_\_\_\_\_  
Date

**Note**

Certification signature should be same as Contract signature.





Contract #  
(Contractor)

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
**DIVISION OF (FILL IN DIVISION NAME)**

**CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS**

Certification for Contracts, Grants, Loans and Cooperative Agreements

- I. By execution of this Agreement the Contractor certifies that it will provide a drug-free workplace by:
  - A. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the Contractor's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
  - B. Establishing a drug-free awareness program to inform employees about:
    - (1) The dangers of drug abuse in the workplace;
    - (2) The Contractor's policy of maintaining a drug-free workplace;
    - (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
    - (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
  - C. Making it a requirement that each employee engaged in the performance of the agreement be given a copy of the statement required by Paragraph A;
  - D. Notifying the employee in the statement required by Paragraph A that, as a condition of employment under the agreement, the employee will:
    - (1) Abide by the terms of the statement; and
    - (2) Notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five (5) days after such conviction;
  - E. Notifying the Department within ten (10) days after receiving notice under subparagraph D(2) from an employee or otherwise receiving actual notice of such conviction;
  - F. Taking one of the following actions, within thirty (30) days of receiving notice under subparagraph D(2), with respect to any employee who is so convicted:
    - (1) Taking appropriate personnel action against such an employee, up to and including termination; or



APPENDIX 30, ATTACHMENT C



- (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency; and
- G. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs A, B, C, D, E, and F.
- II. The site(s) for the performance of work done in connection with the specific agreement are listed below:

1. \_\_\_\_\_  
 (Street address)

\_\_\_\_\_  
 (City, county, state, zip code)

2. \_\_\_\_\_  
 (Street address)

\_\_\_\_\_  
 (City, county, state, zip code)

The Contractor will inform DHHS of any additional sites for performance of work under this agreement.

False certification or violation of the certification shall be grounds for suspension of payment, suspension or termination of grants, or government-wide Federal suspension or debarment (Section 4 CFR Part 85, Section 85.615 and 86.620).

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Agency/Organization

\_\_\_\_\_  
Date

**Note**  
 (Certification signature should be same as Contract signature.)



Contract #  
(Contractor)

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
**DIVISION OF (FILL IN DIVISION NAME)**

**CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE**

Certification for Contracts, Grants, Loans and Cooperative Agreements

Public Law 103-227, Part C-Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, education, or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee. The law does not apply to children’s services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for inpatient drug or alcohol treatment. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 per day and/or the imposition of an administrative compliance order on the responsible entity.

By signing and submitting this application, the Contractor certifies that it will comply with the requirements of the Act. The Contractor further agrees that it will require the language of this certification be included in any sub-awards which contain provisions for children’s services and that all subgrantees shall certify accordingly.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Agency/Organization

\_\_\_\_\_  
Date

**Note**  
Certification signature should be same as Contract signature.

## DOCUMENT IMAGING OF CLAIMS DOCUMENTS AND CLAIMS HISTORY

Document images are retained as described below:

- six (6) months of image data that is immediately accessible online;
- eighteen (18) months of image data “near line” that resides in a storage media that meets or exceeds the functionality of a CD Jukebox; and
- data available within five (5) minutes of the interactive search request by user via online request through application.

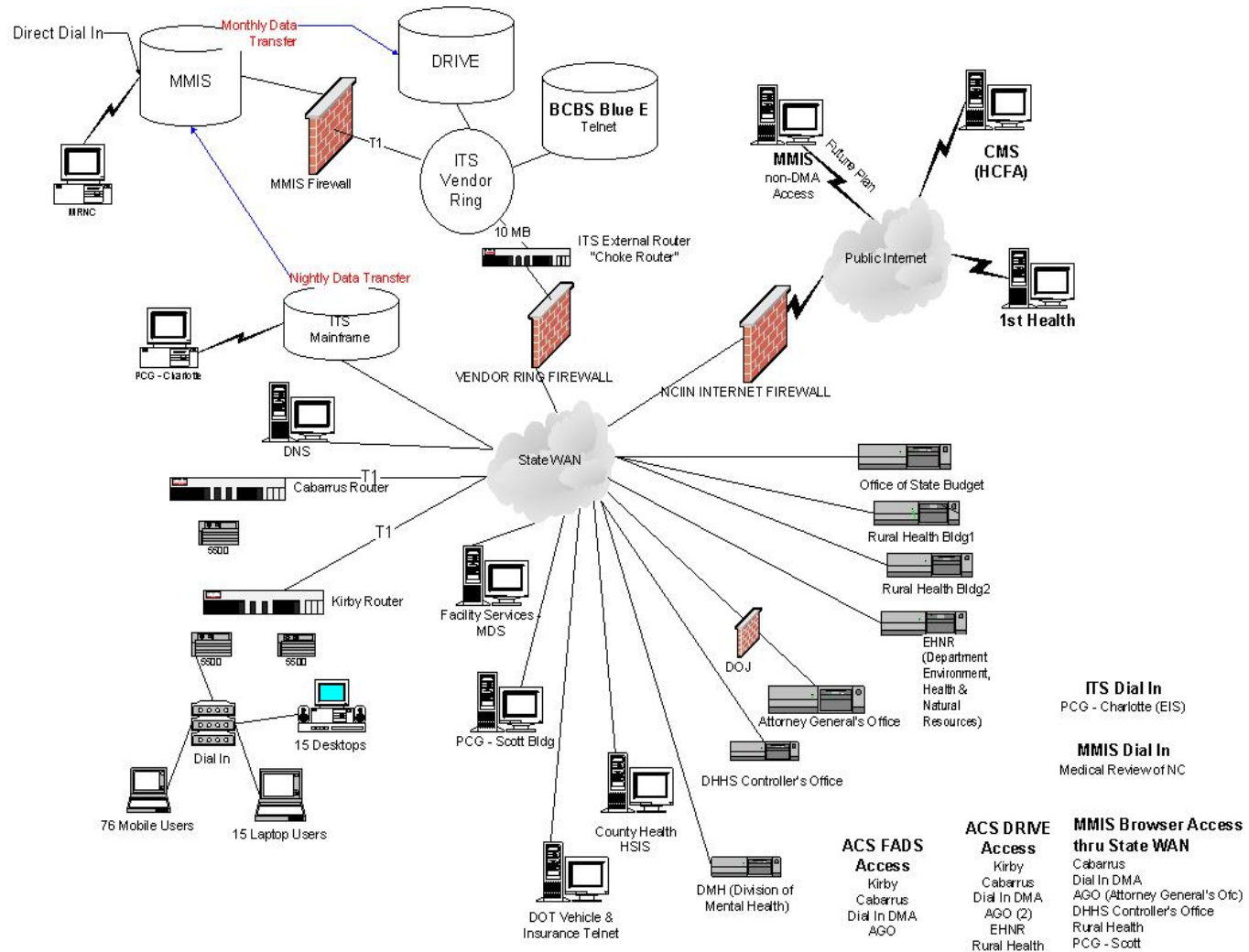
Document images must be archived for a period of five (5) years beyond contract end in a non-proprietary electronic medium and in a standard, non-proprietary format, such as multi-page TIFF format.

All other document images are retained for five (5) years beyond the contract end, in either CD or microfilm format.

### CLAIMS HISTORY

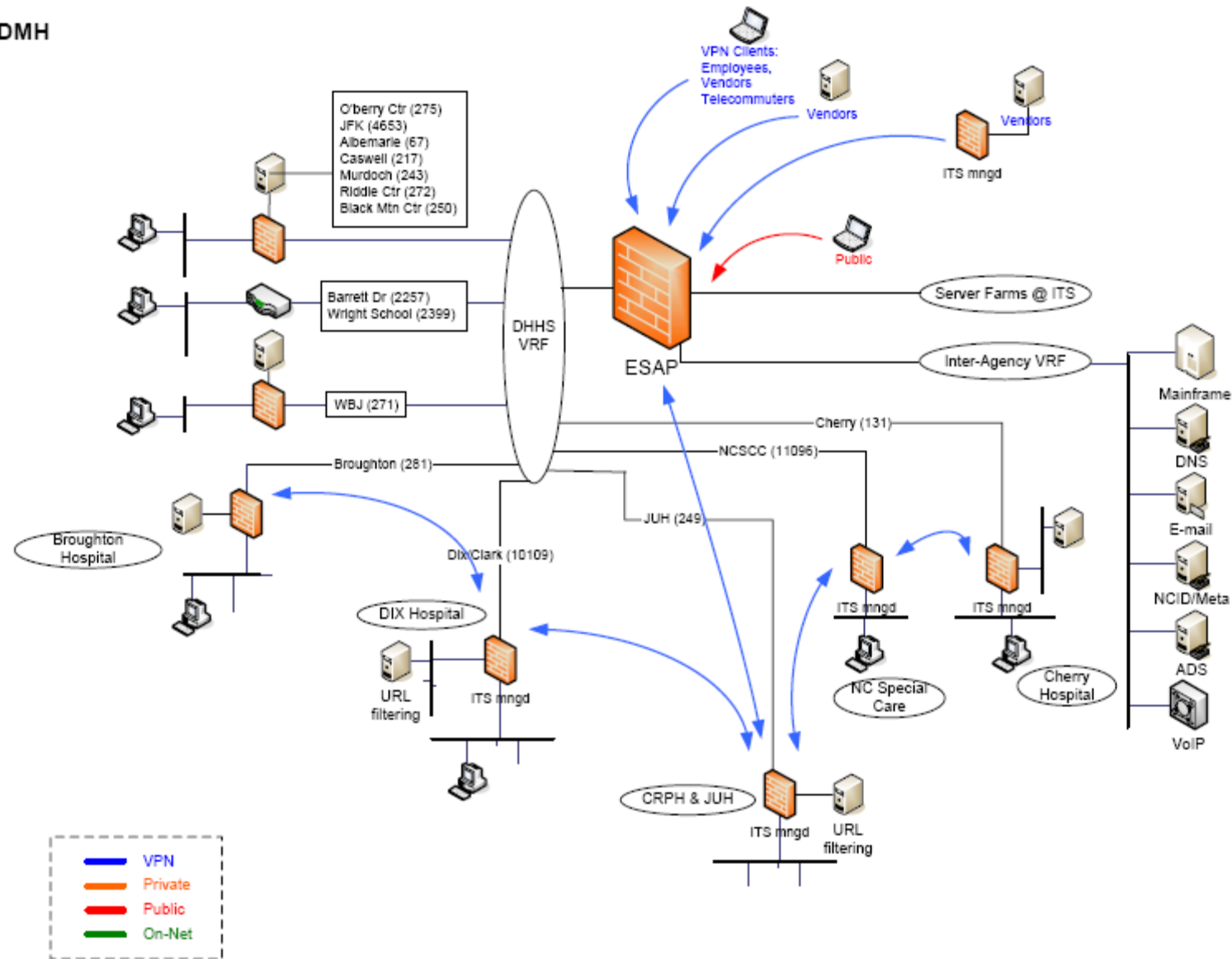
- The State History File, Monthly Paid Claims History file is archived to tape; no retention period is specified.
- Paper claims are shredded after sixty (60) days after they have been scanned. The images of the paper claims are retained for the life of the contract, plus five (5) years.
- Online claims data, in current Medical Policy claim format, is retained for five (5) years.

## DMA Network



## DMH Network

DMH





## **SAS 70 AUDIT REQUIREMENTS—NORTH CAROLINA REPLACEMENT MEDICAID MANAGEMENT INFORMATION SYSTEM (REPLACEMENT MMIS)**

### **Type Report Required**

The Report will address the controls placed in operation and tests of operating effectiveness performed by the independent auditor, a SAS 70 type II report. A SAS 70 type II report includes a description by the service organization’s management of control objectives and related controls as they relate to the services provided, a description by the service organization’s auditor of their tests of operating effectiveness and the results of those tests, and the independent auditor’s report

### **Guidance**

American Institute of Certified Public Accountants, AICPA Audit Guide for Service Organizations: Applying SAS 70 as Amended May 1, 2006

Statements on Auditing Standards issued by the AICPA including No. 53, *The Auditor’s Responsibility to Detect and Report Errors and Irregularities*, No. 54, *Illegal Acts by Clients* and No. 55, *Consideration of the Internal Control Structure in a Financial Statement Audit*

### **Nature and Scope of Work**

The audit must be performed in accordance with standards established by the AICPA. The application to be reviewed is the North Carolina Medicaid Management Information System (Replacement NCMMIS). The audit and report must address all locations where transactions of the Replacement NCMMIS are processed. This includes all transactions, including manual transactions, related to the Replacement NCMMIS as well as any related systems run by the fiscal intermediary’s subcontractors

The engagement involves reviewing the operations of the Replacement MMIS contractor providing electronic benefit services for the state of North Carolina. The auditor should review the processing of the Replacement NCMMIS system’s operations and transactions. The engagement should be performed in accordance with the AICPA’s SAS 70, Reports on the Processing of Transactions by Service Organizations. The service organization auditor should obtain an understanding of the system’s internal control structure, including the policies and procedures placed into operation by the Medicaid contractor. The auditor should perform tests and report on the operating effectiveness of the controls. The auditor should plan the engagement to ensure the review will adequately meet these guidelines

The report must cover (1) suitability of control design; (2) controls placed in operation; and (3) whether controls tested were sufficiently effective to provide reasonable assurance that control objectives were achieved during the period specified. The shorter the



period covered by a test of effectiveness and the longer the time elapsed since the performance of the test, the less support is provided for control risk reduction.

The following are illustrative of the control objectives that the auditor must test:

- General Computer Controls
- Operating System and Software Installation and Deployment
  - Control Objective 1: Control policies and procedures should provide reasonable assurance that the installation and implementation of the MMIS+ operating system and third-party software are authorized, tested, approved, properly implemented, and documented.
- Operating Systems Maintenance
  - Control Objective 2: Control policies and procedures should provide reasonable assurance that changes to existing operating system and third-party software are authorized, tested, approved, properly implemented, and documented.
- Physical Access
  - Control Objective 3: Control policies and procedures should provide reasonable assurance that physical access to the computer equipment, storage media, and operation system documentation is limited to authorized personnel.
- Logical Access
  - Control Objective 4: Control policies and procedures should provide reasonable assurance that logical access to operating system and third-party software is limited to properly authorized personnel.
- Computer Operations
  - Control Objective 5: Control policies and procedures should provide reasonable assurance that processing is scheduled appropriately and deviations are identified and resolved.
- Communication Networks
  - Control Objective 6: Control policies and procedures should provide reasonable assurance that data transmission over internal communication networks are complete and accurate.
- Physical Environment
  - Control Objective 7: Administrative and operational procedures should be established to provide reasonable assurance of the protection of physical assets.



Contingency Planning

- Control Objective 8: Administrative and operational procedures should be established to provide reasonable assurance of continuity of operations.

In addition, outside parties such as regulatory authorities or a user group(s) may specify selected applications and control objectives that should be covered by the tests of operating effectiveness.

In the absence of control objectives established by such outside parties, the service auditor should be satisfied that the control objectives, as set forth by the service organization, are reasonable in the circumstances and consistent with the service organization's contractual obligation.

## Report Requirements

The audit report must contain:

- specific reference to the applications, services, products, or aspects of the service organization covered;
- a description of the scope and nature of the service auditor's procedures and identification of the party who specifies the control objectives;
- indication that the purpose of the service auditor's engagement was to determine whether:
  - the service organization's description presents fairly, in all material respects, those aspects of the service organization's policies and procedures that may be relevant to a user organization's internal control structure;
  - those policies and procedures had been placed in operation as of a specific date; and
  - those policies and procedures were suitably designed to meet specified control objectives;
- the service auditor's opinion on whether the description presents fairly, in all material respects, the relevant aspects of the service organization's policies and procedures as of a specific date and whether, in the service auditor's opinion, the policies and procedures were suitably designed to provide reasonable assurance that the control objectives specified by the service organization would be achieved if those policies and procedures were complied with satisfactorily;
- the service auditor's opinion on whether the internal control structure policies and procedures that were tested were operating with sufficient effectiveness to provide

reasonable, but not absolute, assurance that the related control objectives were achieved during the period specified;

- a reference to a description of tests of specified service organization policies and procedures designed to obtain evidence about their effectiveness in meeting specified control objectives. The description should include the policies and procedures that were tested, the control objectives that the policies and procedures were intended to achieve, the tests applied, and the results of the tests. The description should include an indication of the nature, timing, and extent of the tests, as well as sufficient detail to enable user auditors to determine the effect of such tests on user auditors' assessments of control risk;
- when all of the control objectives listed in the description of controls placed in operation are not covered by tests of operating effectiveness, a statement that the service auditor does not express an opinion on control objectives not listed in the description of tests performed at the service organizations;
- to the extent that the service auditor is able to identify causative factors for exceptions, to determine the status of corrective actions, or to provide other relevant qualitative information about exceptions noted;
- a statement of the period covered by the service auditor's report on operating effectiveness of specified control policies and procedures;
- a statement that the relative effectiveness and significance of specific service organization policies and procedures and their effect on assessments of control risk at user organizations are dependent on their interaction with the policies, procedures, and other factors present at individual user organizations;
- a statement that the service auditor has performed no procedures to evaluate the effectiveness of policies and procedures at individual user organizations;
- a statement of the inherent limitations of the potential effectiveness of policies and procedures at the service organization and of the risk of projecting to the future any evaluation of the description or any conclusions about the effectiveness of policies and procedures in achieving control objectives; and
- identification of the parties for whom the report is intended.

## Service Organization

The State Replacement MMIS Contractor

## User Auditors

North Carolina Office of the State Auditor and the DHHS Office of Internal Audit



## Period for Review

State Fiscal Year (SFY) ending June 30<sup>th</sup>

## Frequency of Report

Every State Fiscal Year (SFY) runs from July 1<sup>st</sup> of the calendar year through June 30<sup>th</sup> of the following calendar year.

## Due Date for Report

The SAS 70 audit report shall be due ninety (90) days after the end of the SFY, or September 30.

## Audit Documentation Requirements

Engagement letters, audit program(s), internal control questionnaires, representation letters, technical manuals, narratives, NCMMS+ operations flowcharts (with subsystems identified), audit test work papers, confirmation statements, and findings and recommendations

## Availability of Audit Work Papers

Audit work papers must be made available to Department of Health and Human Services, the Office of the State Auditor, or any other entity approved by the State. Work papers must be available upon request and within a two-week period.

## Deliverables

A Report on Controls Placed in Operation and Tests of Operating Effectiveness must be prepared, and the SAS 70 management letter that accompanies the audit report must be delivered with the audit report.

The report will be produced electronically and the original hard copy of the report will be delivered to the DHHS Assistant Secretary for Health Policy. In addition, a soft copy of the report will be delivered to the following individuals:

- Director of the Division of Medical Assistance,
- Director of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services,
- Director of the Division of Public Health,
- Office of the State Auditor, and
- DHHS Office of Internal Audit.



## NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES BUSINESS ASSOCIATE ADDENDUM TO REPLACEMENT MMIS CONTRACT

This Business Associate Agreement is ancillary to the Replacement MMIS Contract to which it is attached. This Agreement shall become effective upon the State's fully executed acceptance of the Contractor's bid with respect to the Replacement MMIS Contract. For purposes of this Addendum, the term "Business Associate" refers to the Contractor; the term "Covered Entity" refers to the healthcare component of the NC DHHS on whose behalf the Contractor is performing covered functions.

### 1. Background

Covered Entity and Business Associate are parties to a contract entitled "Replacement MMIS Contract" (the Contract), whereby Business Associate agrees to perform certain services for or on behalf of Covered Entity.

Covered Entity is an organizational unit of the North Carolina Department of Health and Human Services (the Department) that has been designated in whole or in part by the Department as a health care component for purposes of the HIPAA Privacy and Security Rules.

The relationship between Covered Entity and Business Associate is such that the Parties believe Business Associate is or may be a Business Associate within the meaning of the HIPAA Privacy and Security Rules.

The Parties enter into this Business Associate Addendum to the Contract with the intention of complying with the HIPAA Privacy and Security Rules provision that a Covered Entity may disclose electronic protected health information or other protected health information to a Business Associate and may allow a Business Associate to create or receive electronic protected health information or other protected health information on its behalf if the covered entity obtains satisfactory assurances that the business associate will appropriately safeguard the information.

### 2. Definitions

Unless some other meaning is clearly indicated by the context, the terms below shall have the following meaning in this Agreement.

- A. "Electronic Protected Health Information" shall have the same meaning as the term "electronic protected health information" in 45 CFR 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.
- B. "HIPAA" means the Administrative Simplification Provisions, Sections 261 through 264, of the Federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.
- C. "Individual" shall have the same meaning as the term "individual" in 45 CFR 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR 164.502(g).
- D. "Privacy and Security Rules" shall mean the Standards for Privacy of Individually Identifiable Health Information and the Security Standards for the Protection of Electronic Protected Health Information set out in 45 CFR part 160 and part 164, subparts A and E.
- E. "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.



## APPENDIX 40, ATTACHMENT E



- F. "Required By Law" shall have the same meaning as the term "required by law" in 45 CFR 164.103.
- G. "Secretary" shall mean the Secretary of the United States Department of Health and Human Services or designee.
- H. "Security Incident" shall have the same meaning as the term "security incident" in 45 CFR 164.304.
- I. Unless otherwise defined in this Agreement, terms used herein shall have the same meaning as those terms have in the Privacy and Security Rules.

### 3. Obligations of Business Associate

- A. Business Associate agrees to not use or disclose electronic protected health information or other protected health information other than as permitted or required by this Agreement or as required by law.
- B. Business Associate agrees to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information and other protected health information that it creates, receives, maintains, or transmits on behalf of Covered Entity, as required by the Privacy and Security Rules.
- C. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of electronic protected health information or other protected health information by Business Associate in violation of the requirements of this Agreement.
- D. Business Associate agrees to report to Covered Entity: (i) any use or disclosure of electronic protected health information or other protected health information not provided for by this Agreement of which it becomes aware; and (ii) any security incident of which it becomes aware.
- E. Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides electronic protected health information and/or other protected health information received from, or created or received by Business Associate on behalf of Covered Entity: (i) agrees to be bound by the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information; and (ii) agrees to implement reasonable and appropriate safeguards to protect such information.
- F. Business Associate agrees to provide access, at the request of Covered Entity, to electronic protected health information and other protected health information in a Designated Record Set to Covered Entity or, as directed by Covered Entity, to an individual in order to meet the requirements under 45 CFR 164.524.
- G. Business Associate agrees, at the request of Covered Entity, to make any amendment(s) to electronic protected health information and other protected health information in a Designated Record Set that Covered Entity directs or agrees to pursuant to 45 CFR 164.526.
- H. Unless otherwise prohibited by law, Business Associate agrees to make internal practices, books, and records, including policies and procedures concerning electronic protected health information and other protected health information, relating to the use and disclosure of electronic protected health information and other protected health information received from, or created or received by Business Associate on behalf of Covered Entity, available to the Covered Entity, or to the Secretary, in a time and manner designated by the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy and Security Rules.



## APPENDIX 40, ATTACHMENT E



- I. Business Associate agrees to document such disclosures of electronic protected health information and other protected health information related to such disclosures as would be required for Covered Entity to respond to a request by an individual for an accounting of disclosures of electronic-protected health information and other protected health information in accordance with 45 CFR 164.528, and to provide this information to Covered Entity or an individual to permit such a response.

#### 4. Permitted Uses and Disclosures

Except as otherwise limited in this Agreement or by other applicable law or agreement, if the Contract permits, Business Associate may use or disclose electronic protected health information and other protected health information to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Contract, provided that such use or disclosure:

- A. would not violate the Privacy and Security Rules if done by Covered Entity; or
- B. would not violate the minimum necessary policies and procedures of the Covered Entity.

Except as otherwise limited in this Agreement or by other applicable law or agreements, if the Contract permits, Business Associate may use electronic protected health information and other protected health information as necessary for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

Except as otherwise limited in this Agreement or by other applicable law or agreements, if the Contract permits, Business Associate may disclose electronic protected health information and other protected health information for the proper management and administration of the Business Associate, provided that:

- disclosures are required by law; or
- Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and will be used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

Except as otherwise limited in this Agreement or by other applicable law or agreements, if the Contract permits, Business Associate may use electronic protected health information and other protected health information to provide data aggregation services to Covered Entity as permitted by 45 CFR 164.504(e)(2)(i)(B).

Notwithstanding the foregoing provisions, Business Associate may not use or disclose electronic protected health information or other protected health information if the use or disclosure would violate any term of the Contract or other applicable law or agreements.

#### 5. Term and Termination

**Term:** This Agreement shall be effective as of the effective date stated above and shall terminate when the Contract terminates.

**Termination for Cause:** Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity may, at its option:

- provide an opportunity for Business Associate to cure the breach or end the violation, and terminate this Agreement and services provided by Business Associate, to the extent permissible by law, if



## APPENDIX 40, ATTACHMENT E



Business Associate does not cure the breach or end the violation within the time specified by Covered Entity;

- immediately terminate this Agreement and services provided by Business Associate, to the extent permissible by law; or
- if neither termination nor cure is feasible, report the violation to the Secretary as provided in the Privacy and Security Rules.

**Effect of Termination:** Except as provided in paragraph (2) of this section or in the Contract or by other applicable law or agreements, upon termination of this Agreement and services provided by Business Associate, for any reason, Business Associate shall return or destroy all electronic protected health information and other protected health information received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to electronic protected health information and other protected health information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the electronic protected health information or other protected health information.

In the event that Business Associate determines that returning or destroying the electronic protected health information or other protected health information is not feasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction not feasible. Business Associate shall extend the protections of this Agreement to such electronic protected health information and other protected health information and limit further uses and disclosures of such electronic protected health information and other protected health information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such electronic protected health information and other protected health information.

### 6. General Terms and Conditions

This Agreement amends and is part of the Contract.

Except as provided in this Agreement, all terms and conditions of the Contract shall remain in force and shall apply to this Agreement as if set forth fully herein.

In the event of a conflict in terms between this Agreement and the Contract, the interpretation that is in accordance with the Privacy and Security Rules shall prevail. In the event that a conflict then remains, the Contract terms shall prevail so long as they are in accordance with the Privacy and Security Rules.

A breach of this Agreement by Business Associate shall be considered sufficient basis for Covered Entity to terminate the Contract for cause.

### 7. Signatures

\_\_\_\_\_  
Covered Entity

\_\_\_\_\_  
Business Associate



REPLACEMENT MMIS
SAMPLE OPERATIONS INVOICE SUPPORTING DOCUMENTATION

SECTION 1: PHARMACY FCBU

Table with 5 columns: Claims Paid Data by Payer, Total, DMA, DMH, DPH. Rows include Medicaid: All Other, DD Adult: SSBG, DD Adult: MR/MI, DD Adult: State, MH Adult: PATH, MH Adult: CMHBG, MH Adult: SSBG, MH Adult: State, SA Adult: IV Drug, SA Adult: HIV, SA Adult: Women State, SA Adult: Women SAPTBG, SA Adult: SSBG, SA Adult: SAPTBG, SA Adult: State, SA Adult: Core, SA Adult: Prevention, DD Child: State (0-5 only), DD Child: EHA (0-3 only).





**APPENDIX 40, ATTACHMENT F**



<b>Claims Paid Data by Payer</b>	<b>Total</b>	<b>DMA</b>	<b>DMH</b>	<b>DPH</b>
DD Child: State	51,909	0	51,909	0
DD Child: SSBG	14,525	0	14,525	0
MH Child: SSBG	27,133	0	27,133	0
MH Child: PATH	25	0	25	0
MH Child: CMHBG	14,210	0	14,210	0
MH Child: ARC	201,238	0	201,238	0
MH Child: State	55,352	0	55,352	0
SA Child: Drug-Free	764	0	764	0
SA Child: Prevention	439	0	439	0
SA Child: Women State	0	0	0	0
SA Child: SAPTBG	4,779	0	4,779	0
SA Child: Core	173	0	173	0
SA Child: State	12,237	0	12,237	0
POMCS: HIV Meds.	27,042	0	0	27,042
POMCS: All Other	36,502	0	0	36,502
<b>Total</b>	<b>91,555,132</b>	<b>89,784,255</b>	<b>1,707,333</b>	<b>63,544</b>

**SECTION 2: NON-PHARMACY FCBU**

<b>Claims Paid Data by Payer</b>	<b>Total</b>	<b>DMA</b>	<b>DMH</b>	<b>DPH</b>
Medicaid: All Other	89,784,255	89,784,255	0	0
DD Adult: SSBG	162,585	0	162,585	0
DD Adult: MR/MI	170,821	0	170,821	0



**APPENDIX 40, ATTACHMENT F**



<b>Claims Paid Data by Payer</b>	<b>Total</b>	<b>DMA</b>	<b>DMH</b>	<b>DPH</b>
DD Adult: State	337,668	0	337,668	0
MH Adult: PATH	2,102	0	2,102	0
MH Adult: CMHBG	115,466	0	115,466	0
MH Adult: SSBG	1,291	0	1,291	0
MH Adult: State	248,266	0	248,266	0
SA Adult: IV Drug	24,012	0	24,012	0
SA Adult: HIV	8,033	0	8,033	0
SA Adult: Women State	9,221	0	9,221	0
SA Adult: Women SAPTBG	9,821	0	9,821	0
SA Adult: SSBG	843	0	843	0
SA Adult: SAPTBG	15,740	0	15,740	0
SA Adult: State	98,961	0	98,961	0
SA Adult: Core	1,061	0	1,061	0
SA Adult: Prevention	26	0	26	0
DD Child: State (0-5 only)	97,522	0	97,522	0
DD Child: EHA (0-3 only)	21,110	0	21,110	0
DD Child: State	51,909	0	51,909	0
DD Child: SSBG	14,525	0	14,525	0
MH Child: SSBG	27,133	0	27,133	0
MH Child: PATH	25	0	25	0
MH Child: CMHBG	14,210	0	14,210	0
MH Child: ARC	201,238	0	201,238	0
MH Child: State	55,352	0	55,352	0



**APPENDIX 40, ATTACHMENT F**



<b>Claims Paid Data by Payer</b>	<b>Total</b>	<b>DMA</b>	<b>DMH</b>	<b>DPH</b>
SA Child: Drug-Free	764	0	764	0
SA Child: Prevention	439	0	439	0
SA Child: Women State	0	0	0	0
SA Child: SAPTBG	4,779	0	4,779	0
SA Child: Core	173	0	173	0
SA Child: State	12,237	0	12,237	0
POMCS: HIV Meds.	27,042	0	0	27,042
POMCS: All Other	36,502	0	0	36,502
<b>Total</b>	<b>91,555,132</b>	<b>89,784,255</b>	<b>1,707,333</b>	<b>63,544</b>

**SECTION 3: NON-PHARMACY SCBU**

<b>Claims Paid Data by Payer</b>	<b>Total</b>	<b>DMA</b>	<b>DMH</b>	<b>DPH</b>
Medicaid: All Other	89,784,255	89,784,255	0	0
DD Adult: SSBG	162,585	0	162,585	0
DD Adult: MR/MI	170,821	0	170,821	0
DD Adult: State	337,668	0	337,668	0
MH Adult: PATH	2,102	0	2,102	0
MH Adult: CMHBG	115,466	0	115,466	0
MH Adult: SSBG	1,291	0	1,291	0
MH Adult: State	248,266	0	248,266	0
SA Adult: IV Drug	24,012	0	24,012	0
SA Adult: HIV	8,033	0	8,033	0



**APPENDIX 40, ATTACHMENT F**



<b>Claims Paid Data by Payer</b>	<b>Total</b>	<b>DMA</b>	<b>DMH</b>	<b>DPH</b>
SA Adult: Women State	9,221	0	9,221	0
SA Adult: Women SAPTBG	9,821	0	9,821	0
SA Adult: SSBG	843	0	843	0
SA Adult: SAPTBG	15,740	0	15,740	0
SA Adult: State	98,961	0	98,961	0
SA Adult: Core	1,061	0	1,061	0
SA Adult: Prevention	26	0	26	0
DD Child: State (0-5 only)	97,522	0	97,522	0
DD Child: EHA (0-3 only)	21,110	0	21,110	0
DD Child: State	51,909	0	51,909	0
DD Child: SSBG	14,525	0	14,525	0
MH Child: SSBG	27,133	0	27,133	0
MH Child: PATH	25	0	25	0
MH Child: CMHBG	14,210	0	14,210	0
MH Child: ARC	201,238	0	201,238	0
MH Child: State	55,352	0	55,352	0
SA Child: Drug-Free	764	0	764	0
SA Child: Prevention	439	0	439	0
SA Child: Women State	0	0	0	0
SA Child: SAPTBG	4,779	0	4,779	0
SA Child: Core	173	0	173	0
SA Child: State	12,237	0	12,237	0
POMCS: HIV Meds.	27,042	0	0	27,042



**APPENDIX 40, ATTACHMENT F**



Claims Paid Data by Payer	Total	DMA	DMH	DPH
POMCS: All Other	36,502	0	0	36,502
<b>Total</b>	<b>91,555,132</b>	<b>89,784,255</b>	<b>1,707,333</b>	<b>63,544</b>

**SECTION 4: NON-PHARMACY ECBU**

Claims Paid Data by Payer	Total	DMA	DMH	DPH
Medicaid: All Other	89,784,255	89,784,255	0	0
DD Adult: SSBG	162,585	0	162,585	0
DD Adult: MR/MI	170,821	0	170,821	0
DD Adult: State	337,668	0	337,668	0
MH Adult: PATH	2,102	0	2,102	0
MH Adult: CMHBG	115,466	0	115,466	0
MH Adult: SSBG	1,291	0	1,291	0
MH Adult: State	248,266	0	248,266	0
SA Adult: IV Drug	24,012	0	24,012	0
SA Adult: HIV	8,033	0	8,033	0
SA Adult: Women State	9,221	0	9,221	0
SA Adult: Women SAPTBG	9,821	0	9,821	0
SA Adult: SSBG	843	0	843	0
SA Adult: SAPTBG	15,740	0	15,740	0
SA Adult: State	98,961	0	98,961	0
SA Adult: Core	1,061	0	1,061	0
SA Adult: Prevention	26	0	26	0



**APPENDIX 40, ATTACHMENT F**



<b>Claims Paid Data by Payer</b>	<b>Total</b>	<b>DMA</b>	<b>DMH</b>	<b>DPH</b>
DD Child: State (0-5 only)	97,522	0	97,522	0
DD Child: EHA (0-3 only)	21,110	0	21,110	0
DD Child: State	51,909	0	51,909	0
DD Child: SSBG	14,525	0	14,525	0
MH Child: SSBG	27,133	0	27,133	0
MH Child: PATH	25	0	25	0
MH Child: CMHBG	14,210	0	14,210	0
MH Child: ARC	201,238	0	201,238	0
MH Child: State	55,352	0	55,352	0
SA Child: Drug-Free	764	0	764	0
SA Child: Prevention	439	0	439	0
SA Child: Women State	0	0	0	0
SA Child: SAPTBG	4,779	0	4,779	0
SA Child: Core	173	0	173	0
SA Child: State	12,237	0	12,237	0
POMCS: HIV Meds.	27,042	0	0	27,042
POMCS: All Other	36,502	0	0	36,502
<b>Total</b>	<b>91,555,132</b>	<b>89,784,255</b>	<b>1,707,333</b>	<b>63,544</b>



## Appendix 40, Attachment G Consolidated List of Reports



DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
CMS 37.7	N/A	Medicaid Program Budget Report: Actual Number of Eligibles		
DPH-N/A	BH 039R1	Transmittal of Refunds/ Claims Budget System	Transmittal of Refunds/ Claims Budget System	Monthly
DPH-N/A	BH001PCS	Expenditure summary by program code	Expenditure summary by program code	Monthly
DPH-N/A	BH020	Detailed Claims for payment (part one)	Detailed claims for payment, detailed by account code	On request
DPH-N/A	BH020	Summary of eligible claims (part two)	Summary of eligible claims, summarized by accounts code	On request
DPH-N/A	BH020R1	Error report for invalid claims	Errored claims due to validation errors	By checkwrite
DPH-N/A	BH020SUM1	Expenditures by RCC within Fund	List of POMCS claims expenditures by RCC within fund	By checkwrite
DPH-N/A	BH020SUM2	Expenditures by Program within Fund	List of POMCS claims expenditures by program code within fund	By checkwrite
DPH-N/A	BH020SUM3	Expenditures by object within Fund	List of POMCS claims expenditures by object code within fund - line item type of service	By checkwrite
DPH-N/A	BH022ETV	Batch check writing for Accounting Code Sheets	Batch check writing for account code sheets by vendor number and julian date	Check Write
DPH-N/A	BH024MHS	Migrant Health Services Payment Summary	Summary of migrant services by type of service and service name including number of claims, amount billed and amount paid and the difference	Fiscal year end
DPH-N/A	BH024SPI	Amt Pd & # of Claims by First Initial of last name	Total amount paid and total number of claims paid by patient first initial of last name	Monthly
DPH-N/A	BH024SPJ2	POC-CBS Amt & # by serv. In program	Amount paid and number of claims by type of service within the program - during the month	Monthly
DPH-N/A	BH024SPJ3	POC-CBS Amt & # by initial of patient last name w/n program	Amount paid and number of claims paid by initial of patient last name within program - year to date	Monthly
DPH-N/A	BH024SPJ4	POC-CBS Amt & # by type serv. w/n program	Amount paid and number of claims by type of service within the program - year to date	Monthly
DPH-N/A	BH024SPJ5	POC-CBS Amt & # Pd.employee w/n serv. Program	Amount paid and number of claims paid by employee within service program - year to date	Monthly
DPH-N/A	BH024SPJ6	POC-CBS Amt & # of claims by employee pd by month	Amount paid and number of claims paid by employee within service program - during the month	Monthly
DPH-N/A	BH024SPJI	POC-CBS Amt & # by first initial of patient last name	Total amount paid and total number of claims paid by patient first initial of last name and by program - during the month	Monthly



## Appendix 40, Attachment G Consolidated List of Reports



DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
DPH-N/A	BH024STS	POC-CBS Amt & # claims by services type	Amount paid and number of claims paid by service type during a month	Monthly
DPH-N/A	BH039R2	Refund Receipt by Budget Code	Break down by budget of refunds received during the month	Monthly
DPH-N/A	BHA0202	HIV quaterly report by variation of all anti retro virals dispensed	HIV quaterly report by variation of all anti retro virals dispensed	Quarterly
DPH-N/A	BHA070R	Detail Listing of NCAS Refund Records	Detailed list of NCAS refund records for public health and for migrant health	Monthly
DPH-N/A	BHA070R2	Deposit and Credit Summary of NCAS refund records	Deposit and Credit Summary of NCAS refund records for DPH and Migrant Health	Monthly
DPH-N/A	BHA2001	Summary of total units, number of scripts and total amount reimbursed by NDC code	Summary of total units, number of scripts and total amount reimbursed by NDC code	Monthly
DPH-N/A	BHA9504N (FY)	Undup. Count of HIV patients and total amt pd	Unduplicated count of HIV patients served and total amount paid - fiscal year monthly summaries	Fiscal year end
DPH-N/A	BHA9504N (Mo)	Undup. Count of HIV patients and total amt pd	Unduplicated count of HIV patients served and total amount paid - during the month	Monthly
DPH-N/A	BHA9809A-1	Prescriptions filled	Total number HIV Cases within Prescription Filled Categories	Monthly
DPH-N/A	BHA9810A	Protease Inhibitors/anti-retrovirals	Tot. number of HIV Cases Receiving Protease Inhibitors and other anti-retrovirals during period	Monthly
DPH-N/A	BHA9811A-1	Total HIV Pgm Expenditures per amount paid category	Total HIV Pgm Expenditures per amount paid category	Monthly
DPH-N/A	BHA9905	Authorized HIV patients	Unduplicated Count of New and Active Authorized HIV Patients during month	Monthly
DPH-N/A	BHA9907	HIV rebate scripts	Summary of units, scrips, \$ tot amt reimbursed (Rebate Pharmacies) - by manufacturer only	Quarterly
DPH-N/A	BHA9908	Rebateable Drugs	Total amt paid to all companies (Rebate Pharmacies)	Quarterly
DPH-N/A	BHA9909	Summary of tot units, # scrips, & amt reimbursed (Rebate Parmacies)	Summary of units, scrips, \$ tot amt reimbursed (Rebate Pharmacies) - by pharmacy	Quarterly
DPH-N/A	BHA9910	Rebate pharmacy	Summary of tot units, # scrips, & tot amt reimbursed (Rebate Parmacies)	Monthly
DPH-N/A	BHA9911	Rebate Pharmacy	Undup count of patients and tot amt pd (Rebate Pharmacies)	Monthly
DPH-N/A	BHA9912	Rebate Pharcy	Summary of tot units, # scrips & tot amt reimbursed to pharmacies	Monthly
DPH-N/A	BHA9915A	Expenditures for Cystic Fibrosis Cases for fiscal yr 2003-2004	Expenditures for Cystic Fibrosis Cases for fiscal yr 2003-2004	Fiscal year end
DPH-N/A	BHA9917	Payments for CSHS by ICD-9 Diagnostic Groups, type of service	Payments for CSHS by ICD-9 Diagnostic Groups, type of service	Monthly





## Appendix 40, Attachment G Consolidated List of Reports



DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
DPH-N/A	BHA9918	Payments for CSHS by Program code and birth year	Payments for CSHS by Program code and birth year	Monthly
DPH-N/A	BHA9919	Payments for CSHS Pgm by type of service	Payments for CSHS Pgm by type of service	Monthly
DPH-N/A	BHA9920	Payments for CSHS by Counties	Payments for CSHS by Counties	Monthly
DPH-N/A	BHA9921	Payments for CSHS Pgm by program code	Payments for CSHS Pgm by program code	Monthly
DPH-N/A	BHA9923	Total Number of Claims and Payment Amount for Service Site Counties	Migrant Health Program Total Number of Claims and Total Cost	Fiscal year end
DPH-N/A	BHA9924	Migrant Health Claims paid by Provider	Migrant Health Total Number and Total Cost of Claims Paid by Provider within county	Monthly
DPH-N/A	BHA9926	Migrant Health Outpatient Hospital Claims	Outpatient claims paid for migrant health by provider name	Monthly
DPH-N/A	BHB0301	Migrant Health Users by Age and Gender	Unduplicated cases by age and by gender, recipients with paid claims sorted by age and by gender	Calendar year
DPH-N/A	BHB0302	Migrant Health users by race, ethnicity	Migrant Health users by race, ethnicity	Annual
DPH-N/A	BHB300CN	Cancer Program counts by yr Authorized	Number of authorizations done during the fiscal year	Annual
DPH-N/A	BHB320	Monthly Liquidations by case number	Detailed list of claims paid by recipient ID	Monthly
DPH-N/A	BHB323	Migrant Health Services Semi-Annual	Expenditure by type of service	Semi-Annual
DPH-N/A	BHB324	Unduplicated count by Patient last name	Unduplicated count of authorizations by patient last name	Monthly
DPH-N/A	BHB327	Outstanding Authorized amts by Object	Outstanding authorized amount by object code, by benefit plan or program	Monthly
DPH-N/A	BHB328	Authorizations & Cancellations by Program	Authorizations and cancellations by program, the amount authorized for prior year services, current year and future years services by program or benefit plan. Includes column for amount cancelled - authorizations taken out of the system.	Monthly
DPH-N/A	BHB9804A	# HIV Patients with Paid Claims (age/race/sex)	Number of HIV patients with paid claims by age, race, gender	Check Write Date
DPH-N/A	BHB9807A-1	# New HIV Patients Authorized during the month (race/sex)	Number new HIV patients authorized during the month by age, race, gender	Monthly



## Appendix 40, Attachment G Consolidated List of Reports



DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
DPH-N/A	BHB9807A-2	# Return HIV Patients Authorized during the month (race/sex)	Number of returned HIV patients authorized during the month by age, race, gender	Monthly
DPH-N/A	BHB9807A-4	# Pending/Denied Patients Authorized during the month (race/sex)	Number of pending/denied patients authorized during the month by age, race, gender	Monthly
DPH-N/A	BHB9807A-6	# Active HIV Patients Authorized during the month (race/sex)	Number of active HIV patients authorized during the month by age, race, gender	Monthly
DPH-N/A	BHO24SPG	POC-CBS Amt & # claims by Program	Total number of claims paid and amount paid by benefit plan	Monthly
IPVR0125	XX-New Report	Addressograph Report	(See DSD)	(See DSD)
IPVR0201	XX-New Report	MMIS Action Reason Code Alert for IPRS Billing Providers	(See DSD)	(See DSD)
IPVR0221	XX-New Report	MMIS Action Reason Code Aleter for IPRS Attending Providers	(See DSD)	(See DSD)
IPVR0291	XX-New Report	Attending Provider List Report	(See DSD)	(See DSD)
IPVR0481	XX-New Report	Provider Changes from Medicaid	(See DSD)	(See DSD)
IPVR105R	XX-New Report	Provider File Maintenance Report – Adds	(See DSD)	(See DSD)
IPVR110R	XX-New Report	Attending Provider File Maintenance Report	(See DSD)	(See DSD)
IPVR115R	Report is no longer necessary, because once a provider record is created in NCLeads, the information cannot be deleted.	Provider File Maintenance Report – Deletes	(See DSD)	(See DSD)
IPVR3001	XX-New Report	Multiple Provider Site Cross Reference Maintenance Report	(See DSD)	(See DSD)
IPVR3201	XX-New Report	Addressograph Report	(See DSD)	(See DSD)
IPVR3401	XX-New Report		(See DSD)	(See DSD)



## Appendix 40, Attachment G Consolidated List of Reports



DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
IPVR3601	XX-New Report	Billing Provider Number Change Report	(See DSD)	(See DSD)
M-CMS 64	XX-New Report	Medicaid Program Expenditures Report	(See DSD)	(See DSD)
MR-O-01	HMGR171C	Medical Assistant Financial Status	Medical Assistance Financial Status	(See DSD)
MR-O-01	HMGR173C	Financial Summary	(See DSD)	(See DSD)
MR-O-02	XX-New Report	Medical Assistance Program Status	(See DSD)	(See DSD)
MR-O-03	HMGR172C	Financial Summary - Month of Payment	Financial Summary	(See DSD)
MR-O-03	HMGR172C	Financial Summary - Month of Payment	Financial Summary	(See DSD)
MR-O-04	XX-New Report	Expenditure Analysis	(See DSD)	(See DSD)
MR-O-05	HMGR302N	Medicare Participation Summary	(See DSD)	(See DSD)
MR-O-06	HMGR301N	Provider Participation Analysis	(See DSD)	(See DSD)
MR-O-08	XX-New Report	Operational Performance Summary	(See DSD)	(See DSD)
MR-O-09	XX-New Report	Claims Processing Performance Analysis	(See DSD)	(See DSD)
MR-O-10	XX-New Report	Claims Processing Throughput Analysis	(See DSD)	(See DSD)
MR-O-11	XX-New Report	Error Distribution Analysis	(See DSD)	(See DSD)
MR-O-12	HMGR301N	Provider Participation Analysis	(See DSD)	(See DSD)
MR-O-15	XX-New Report	Provider Claim Filing Analysis	(See DSD)	(See DSD)
MR-O-16	XX-New Report	Provider Claim Filing Details	(See DSD)	(See DSD)
MR-O-18	XX-New Report	Provider Error Frequency Analysis	(See DSD)	(See DSD)
MR-O-22	XX-New Report	Recipient Participation Summary	(See DSD)	(See DSD)
MR-O-23	HMGR0902	Recipient County Participation Analysis	(See DSD)	(See DSD)
MR-O-24	HMGR0902	Recipient County Participation Analysis	(See DSD)	(See DSD)
MR-O-28	XX-New Report	Recipient Cost Sharing Summary	(See DSD)	(See DSD)



## Appendix 40, Attachment G Consolidated List of Reports



DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
MR-O-30	XX-New Report	Monthly Adjudicated Timely Processing	(See DSD)	(See DSD)
N/A	DFS	Notification of Removal of Endorsement	(See DSD)	(See DSD)
N/A	DFS	Notification of site additions or deletion of sites for wavier programs only	(See DSD)	(See DSD)
N/A	DFS	Notification of change in service levels and pop groups for waiver programs	(See DSD)	(See DSD)
N/A	DFS	Notification of Survey Compliance	(See DSD)	(See DSD)
N/A	DFS	Public Notification in News Paper	(See DSD)	(See DSD)
N/A	DFS	Notice of Noncompliance for facilities	(See DSD)	(See DSD)
N/A	DSCNRRFJ	Security	(See DSD)	W
N/A	EINAMPRT	Security	Available from the EDS Home Page	M
N/A	HCA9301E7	Migrant Health Claims paid by diagnosis	Migrant Health Claims paid by diagnosis	Monthly
N/A	HCA9301E8	Migrant Health top ten number of claims paid by diagnosis	Migrant Health top ten number of claims paid by diagnosis	Annual
N/A	HCA9301E9	Migrant Health top ten amount of claims paid by diagnosis	Migrant Health top ten amount of claims paid by diagnosis	Annual
N/A	HMPR21B1	PAL Utilization Comparison Report		M
N/A	HMZRPCD1	Procedure Reference Master File		Req
N/A	HMZRPCD2	Procedure Reference Master File		Req
N/A	HMZRPCD3	Procedure Reference Master File		Req
N/A	HMZRPCD4	Procedure Reference Master File		Req
N/A	HMZRSTPI	Specialized Therapies Problem Identification		Req
N/A	IPDR5303	Text Management Report		



## Appendix 40, Attachment G Consolidated List of Reports



DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
N/A	LblInvoiceLabeler	Manufacturer Mailing Labels		
N/A	New	Selectd Diagnosis and Services Rendered	Provides a list of paid claim accounts for selected diagnosis and services rendered	Annual
N/A	RGenericNonGeneric	Drug Type Summary Report		(See DSD)
N/A	RMDSID20	Interface FSI Transaction Report	Interface FSI Transaction Report	Check Write
N/A	RMDSID2B	Interface FSI by FRC Transaction Report	Interface FSI by FRC Transaction Report	Check Write
N/A	Rptchkvouchcomp	Check/ Allocation Comparison Report	(See DSD)	(See DSD)
N/A	Rptdisputeactivity	Dispute Activity Report	(See DSD)	(See DSD)
N/A	RptEmployee	Employee Report	(See DSD)	(See DSD)
N/A	Rptinterestactivity	Interest Override Report	(See DSD)	(See DSD)
N/A	RptInterestdtl	Interest Detail Report	(See DSD)	(See DSD)
N/A	RptInvGTPaid	Invoiced Greater than Scripts Paid Report	(See DSD)	(See DSD)
N/A	RptInvNotPaid	Invoices for Quarter Not Paid Report	(See DSD)	(See DSD)
N/A	RptInvoice	Prior Period Invoice Report	(See DSD)	(See DSD)
N/A	RptInvoice	Periodic Balance Report	(See DSD)	(See DSD)
N/A	RptInvoice	Invoice Report	(See DSD)	(See DSD)
N/A	RptJCodes	HCPCS Code Claims Paid Report	(See DSD)	(See DSD)
N/A	RptPPADiff	Prior Period Adjustment Variance Report	(See DSD)	(See DSD)
N/A	RptPPAZero	PPA Current Rate is Zero Report	(See DSD)	(See DSD)
N/A	RptRecap	Dispute Recapitulation Report	(See DSD)	(See DSD)
N/A	SRAJD530	Text Management Report	(See DSD)	(See DSD)
NA	HMKR2361	COBC Eligibility Detail	This report is a detail error listing and summary from the COBC for the eligibility extract sent twice monthly from the MMIS.	OR
OM-O-B01	XX-New Report	Approved Claims Only		
OM-O-B02	XX-New Report	Claims Processing Statistics		
OM-O-B03	XX-New Report	MARS Source Balancing		
OM-O-B04	XX-New Report	MARS Balancing Worksheet		



## Appendix 40, Attachment G Consolidated List of Reports



DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
OM-O-B05	XX-New Report	MARS Provider Enrollment and Participation		
PRDJD710	HMDR7101	Pending Balances A/R Master	List of all pending A/R balances used to initiate refund request letters to provider who have pending system recoupments more than 4 months.	Checkwrite
PRSAD670	IPDR6702	Checkwrite Summary Report	Lists each Provider's three highest EOB's along with an overview of each provider's Checkwrite statistics.	Checkwrite
PRSAG500	IPGR5602	IPRS Utilization Report By Procedure - Annual Version	Provides annual utilization tracking by procedure code in order by billing provider, population group, and procedure code.	Year End
PRSAJD350	IPDR3561	Outstanding Setup and Voided Checks Report	This report shows all Void Checks that have been keyed and their status.	Checkwrite
PRSJA089	IPAR1391	Claims With Crosswalk / Local Procedure Codes Report	Supplies a reference for providers to link up the submitted procedure code and local procedure code by ICN.	Checkwrite
PRSJA090	IPAR0903	Edit Failure (ESC) Inventory Report	Edit Failure list from the Checkwrite. Lists the error status code and the number of claims for each error status code.	Checkwrite
PRSJA130	IPAR1303	Edit Failure (ESC) Inventory Report	Edit Failure list from the Checkwrite. Lists the error status code and the number of claims for each error status code.	Checkwrite
PRSJA130	IPPR2417	Outpatient Behavioral Health Rate By Specialty	This report displays valid rates used for pricing claims with OBH procedure codes.	Weekly
PRSJB100	IPBR1001	Audit File Transaction Log Report	TRLOG lists the population payer, audit number, date/time of update, operator id, memo, and the before and after description.	Maintenance
PRSJB100	IPBR1002	Audit File Master Listing	Audit File Master Listing in order by population payer and audit number.	Maintenance
PRSJB100	IPBR1101	Audit Criteria Transaction Log Report	TRLOG report of changes made to Audit Criteria file using the NC screen in order by population payer and procedure code.	Maintenance
PRSJB100	IPBR1102	Audit Criteria Master Listing	Audit Criteria Master Listing Report in order by population payer and procedure code.	Maintenance
PRSJB100	IPBR1201	Procedure List Maintenance Report	TRLOG report of changes made to Audit Procedure List file in order by population payer and procedure code.	Maintenance
PRSJB100	IPBR1202	Procedure List Master Listing	Procedure List Master Listing in order by population payer and procedure code.	Maintenance
PRSJB100	IPBR1301	Diagnosis List Maintenance Report	TRLOG report of changes made to audit Diagnosis List file using the ND screen in order by population payer and diagnosis code.	Maintenance
PRSJB100	IPBR1302	Diagnosis List Master Listing	Diagnosis List Master Listing in order by population payer and diagnosis code.	Maintenance
PRSJB100	IPBR1401	Claim Type/Audit Transaction Log Report	TRLOG report of changes made to audit Claim Type criteria file in order by population payer and audit number.	Maintenance
PRSJB100	IPBR1402	Claim Type/Audit Master Listing	Claim Type/Audit Master Listing in order by population pay and audit number.	Maintenance



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
PRSJB100	IPBR1501	Modifier List Maintenance Report	TRLOG report of changes made to audit Modifier file in order by population payer and modifier code.	Maintenance
PRSJB100	IPBR1502	Modifier List Master Listing	Modifier List Master Listing in order by population group and modifier code.	Maintenance
PRSJB200	IPBR2002	Duplicate Adj Requests	Report listing duplicate adjustments	Checkwrite
PRSJB320	IPBR3201	Audit Failure Analysis (Failed Claim Details)	Audit Failure Analysis report listing the population group and number of failures.	Checkwrite
PRSJB400	IPBR4001	Recipient profile report	Lists all history requested for a recipient in order by MID, claim type, and ICN (claim number).	On Request
PRSJB400	IPBR4601	Adjustments Entered - Region - 90 Adjustments - Message Summary Totals	The paper copy lists all adjustment requests that do not say "accepted" on them. The Report 2 Web copy lists all adjustment requests with accepted or non-adjustable messages.	Checkwrite
PRSJB400	IPBR4602	Adjustments Entered - Region - 90 Adjustments - Message Summary Totals	The paper copy lists all adjustment requests that do not say "accepted" on them. The Report 2 Web copy lists all adjustment requests with accepted or non-adjustable messages.	Checkwrite
PRSJC250	IPCR1301	Aged Inventory - System	Provides by location, a matrix of age inventory in order by financial payer. Categories are pre-machine and exception location. Inventory is listed in columns that identify claims by a range number of days.	Checkwrite
PRSJC250	IPCR1401	Inventory And Production	Provides by location, a matrix of inventory and production regions in order by financial payer. Categories are pre-machine and exception location. Lists claim percentages, claims received, deleted, and generated.	Checkwrite
PRSJC250	IPCR1501	Error Summary All Regions	Summary report of errors in all regions in order by financial payer.	Checkwrite
PRSJC250	IPCR1851	Claims Suspended For Client Eligibility Reasons Report	Lists in order by referring provider the suspend type (location), claim number, base provider, CNDS number, client name, service dates, and billed amount.	Checkwrite
PRSJC300	HMCP300N	Worksheets	Worksheets produced during the checkwrite cycle.	Checkwrite
PRSJC300	IPCR301R	Work Sheet Totals	This reports lists the total amount of worksheets created for a particular cycle date. The totals are listed by select categories such as location, region, etc. The last category listed on the report is the grand total amount.	Checkwrite
PRSJD020	IPDR0201	NCAS Budget Load Report	Lists information from the NCAS Budget Extract including funding service, commitments, encumbrances, and year to date expenditures in order by financial payer, company, NCAS budget account, and NCAS center.	Weekly - Thursday AM
PRSJD020	IPDR0203	NCAS Negative Budget Report	Lists accounts with a negative budget balance from the NCAS Budget Extract in order by financial payer, company, NCAS budget account, and NCAS center.	Weekly
PRSJD020	IPDR0221	Budget File/Budget Criteria Exceptions Report	Lists budget accounts without established criteria and criteria without corresponding budget accounts by company, NCAS budget account, and NCAS center.	Weekly - Thursday AM
PRSJD030	IPDR0301	NCAS Expenditures Report	Lists IPRS expenditures and account payable amounts generated for posting to NCAS in order by company, NCAS budget account, and NCAS center.	Checkwrite



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
PRSJD050	IPDR0221	Budget File/Budget Criteria Exceptions Report	Lists budget accounts without established criteria and criteria without corresponding budget accounts by company, NCAS budget account, and NCAS center.	Month End - Financial
PRSJD090	IPDR0901	Retroactive Rate Change Report	Details the actual financial impact of retroactive rate changes after claims have been paid in order by ICN (claim number) and procedure code.	Checkwrite
PRSJD090	IPDR0902	Retroactive Rate Change Totals Report	Details the actual financial impact of retroactive rate changes after claims have been paid including totals in order by ICN (claim number) and procedure code.	Checkwrite
PRSJD100	IPDR1501	Adjustment Tracking Report	Lists the adjustments processed during the checkwrite cycle in order by claim type and ICN (claim number).	Checkwrite
PRSJD130	IPDR1301	Void Checks	TR Log Report for the VC online screen	Checkwrite
PRSJD130	IPDR1701	Provider Refunds TR Log Report	TR Log Report for the RC online screen	Checkwrite
PRSJD150	IPDR1508	Denied Claims By Claim Type and EOB	Lists the number of denied claims by financial payer in order by claim type and explanation of benefit code (EOB) and description.	Checkwrite
PRSJD200	HMDR204N	Financial Report # 15 Financial Transaction Control Report	Listing of all dispositions of refunds, recoupments processed and errors in dispositioning refunds, ordered by provider number sequence.	Checkwrite
PRSJD200	IPDR2012	IRS Withholding	Report listing provider name/number, tax ID and amounts of IRS withholding (current, quarter, and ytd)	Checkwrite
PRSJD200	IPDR209N	Provider Reimbursement Report	Provides a matrix of category of claim services by claims, visits, billed, allowed, co-pay, disposition fee, payable, and paid. Claim categories are ambulance, clinics, subtotal screen/clinics/family, subtotal all other categories, and total all other ca	Checkwrite
PRSJD200	IPDR210N	Provider Cash Report	Provides a matrix of combined provider cash by category of service. The categories are ambulance, clinics – free standing, clinics – health, and clinics – mental health. For each of these categories information provided includes void count, void amount,	Checkwrite
PRSJD200	IPDR211N	Monthly Billing Report	Provides a monthly billing report divided into different claim sections. These sections are for non-edit failure claims, edit failure claims – location 27, total of non-edit failure claims and edit failure claims – location 27, total claims, total payable	Checkwrite
PRSJD200	IPDR212N	Monthly Billing Report - Refugee Claims	Provides a monthly billing report divided into different claim sections. These sections are for non-edit failure claims, edit failure claims – location 27, total of non-edit failure claims and edit failure claims – location 27, total claims, total payable	Checkwrite
PRSJD200	IPDR2191	Checkwrite Financial Summary	Lists the financial information from the checkwrite.	Checkwrite





## Appendix 40, Attachment G Consolidated List of Reports



DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
PRSJD200	IPDR2251	Electronic Funds Transfer Activity	Provides a list of electronic fund transfers by provider number, old bank, old account, new bank, new account, DDA status, EFT status, amount and action.	Checkwrite
PRSJD200	IPDR2252	Electronic Funds Transfer Activity - Prenot, Cancel And Bad CD Transactions	Provides a list of electronic fund transfers by provider number, old bank, old account, new bank, new account, DDA status, EFT status, amount and action.	Checkwrite
PRSJD200	IPDR2501	Month-To-Date Claim Payment Summary	Provides in a matrix month-to-date claim payment information by date and MTD. This information includes claim payment, recoupment, IRS withheld, check issue, net pay, principal setup, paid claims, denied claims, adjusted claims, billing units, etc.	Checkwrite
PRSJD200	IPDR270R	Schedule Of Electronic Funds Transfer	Contains the provider numbers, old/new bank and account numbers, DDA savings, EFT status, amount and action taken.	Checkwrite
PRSJD205	IPDR2000	NCDMH RA's	The Remittance and Status Report (Remittance Advice - RA) lists the status of all claims submitted to EDS with the details of the payment in order by provider number and recipient name.	Checkwrite
PRSJD205	IPDR2061	IPRS Debt Report	Lists the financial information from the remittance advice. It includes adjustments, refunds, and payout activity in order by billing provider number.	Checkwrite
PRSJD210	IPDR2551	Remittance Advice/Status Report	Remittance Advice Status Report of all claims processing in the checkwrite cycle in order by claim type and explanation of benefits code.	Checkwrite
PRSJD212	IPDR213N	Yearly Controllers Settlement Report for Denials Due to Budget and Allotment	Displays valid claims submitted by the area programs that were denied due to budget and/or allotment EOBs.	On Request
PRSJD215	IPDR2171	Yearly Provider Settlement Report	List claims paid and denied during the fiscal year to create the Yearly Provider Settlement report	Annual (Year end and after the timely filing cutoff period)
PRSJD280	IPDR2831	Settlement Report (for Controller's Office)	Lists all paid claims with May and June Dates Of Service (DOS) that were paid after July 1, 2003.	Annually
PRSJD300	IPDR202N	The Following Ranges Of External Check Numbers Have Been Voided	Provides a list of checks manually issued. Also provides a range of external check numbers voided.	Checkwrite
PRSJD300	IPDR3003	Provider Check Pull Report	List of providers that have their check or RA sent to them via an overnight service.	Checkwrite
PRSJD300	IPDR3201	Check Register Payment Register# ___	Provides a check register list by external check, internal check, provider number, provider name, claims paid, net pay amount (according to claim), POS and EDI amount, IRS withholding amount, other withholding amount, and adjusted net pay amount.	Checkwrite



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
PRSJD300	IPER2152	Finalized Claim Billing Report Non-Adjusted Claim Data	Provides a list, by claim type, of finalized encounters by financial payer. List fields include claims paid, denied, and total; and details for paid denied and total.	Checkwrite
PRSJD315	IPDR3151	Weekly Checkwrite Totals E210	Contains PER numbers by COS for the checkwrite week.	Checkwrite
PRSJD315	IPDR3152	Weekly Checkwrite Totals E220	Contains FPR numbers by COS for the checkwrite week.	Checkwrite
PRSJD340N	IPDR3401	Cash Receipts Maintenance	Systematic Refunds	On Request
PRSJD345	IPDR3450	Quarterly Refund Report	This report lists claim information related to refunds received from merged providers to pay off their accounts receivable balances.	On Request
PRSJD345	IPDR3451	Quarterly Refund Summary Report	This report summarizes the budget account/centers and original amounts paid from these budget account/centers that are listed in detail on report IPDR3450, the Quarterly Refund Report.	On Request
PRSJD350	IPDR3562	Void Check Error Report	This report lists any Void Check entries that are found to be in error.	Checkwrite
PRSJD350	IPDR3571	Provider Refund Report	This report shows all refund checks that have been keyed and their status.	Checkwrite
PRSJD350	IPDR3572	Provider Refund Error Report	This report lists any refund check entries that are found to be in error.	Checkwrite
PRSJD385	IPDR3811	Budget Tracking Report	Tracks current and expended budget amounts in order by financial payer.	Checkwrite
PRSJD385	IPDR3821	NCAS Executive Summary Report	Provides IPRS NCAS budget and expenditure summaries by account and center.	Checkwrite
PRSJD385	IPDR3831	Detail Expenditure Report - All Sources	Lists expenditure information for each referring provider number including all sources in order by financial payer.	Checkwrite
PRSJD385	IPDR3832	Detail Expenditure Report - Other Sources	Lists expenditure information for each referring provider number including other sources in order by financial payer.	Checkwrite
PRSJD385	IPDR3871	Population Group Budget Alert Report	Lists data that will aid in setting the open/closed indicators on the Router Budget File in order by financial payer, referring provider, population group, and budget code.	Checkwrite
PRSJD385	IPDR3891	Internal Weekly Budget Expenditure Report	Displays weekly detailed and summary budget information by financial payer.	Checkwrite
PRSJD390	IPDR3901	Fiscal EOY IPRS Expenditure Recap Report	List claim units and amounts paid from specific NCAS Billing Providers/Accounts/Centers/Pop Payers/Procedure Codes for both pilot area programs during last fiscal year.	Annually
PRSJD400	IPDR4003	AR Manual Transfers Report	List of all manual recoupments that were transferred to another provider number during the cycle.	Checkwrite
PRSJD500	IPDR0202	North Carolina Title XIX Cash Control System Update Control Totals	Provides update control totals for cash receipts and accounts receivable.	Checkwrite
PRSJD530	IPDR5301	EOB Maintenance	TRLOG of changes made to the EOB file	Maintenance



## Appendix 40, Attachment G Consolidated List of Reports



DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
PRSJD530	IPDR5302	ESC Numbers And Description	Lists the error status codes and their associated text descriptions in order by financial payer and error status code number.	Maintenance
PRSJD530	IPDR5303	EOB Numbers And Description	Lists the explanation of benefit codes and their associated text descriptions in order by financial payer and explanation of benefit code (EOB).	Maintenance
PRSJD530	IPDR5304	EOB Crosswalk	Lists the HIPAA type and code for each EOB.	Weekly
PRSJD530	IPDR53BN	EOB Master List	Master listing of all EOB records on file.	Maintenance
PRSJD600	IPDR0102	Batch Summary	Provides a list of released cash by control number, cash date, released amount and released date.	Checkwrite
PRSJD600	IPDR0140	Accounts Receivable Setups	Provides a list of accounts receivable setups by control number, action code, program code, setup date, provider name, COS and original amount.	Checkwrite
PRSJD600	IPDR0141	Accounts Receivable Settlements	Provides a list of accounts receivable settlements by control number, action code, P/A amount, P/A code, disposition date, original amount, provider name and provider number.	Checkwrite
PRSJD600	IPDR0160	North Carolina Title XIX Cash Control System Issued and Cleared Checks	Provides a list of issued and cleared checks by control number, action code, account number, check MICR number, issue date, check amount, provider number, beneficiary number and internal check number. Also provides submitted and computed totals.	Checkwrite
PRSJD660	IPDR6601	State Recoupment Report	Lists amounts that DMH has requested to be deducted from the IPRS payments for specific providers.	Checkwrite
PRSJD670	IPDR6701	RA Summary Report	Summarizes all claims paid, adjusted and denied for each provider by number of claims and dollar amounts. Includes total checkwrite costs.	Checkwrite
PRSJD700	IPDR0202	North Carolina Title XIX Cash Control System Update Control Totals	Provides update control totals for cash receipts and accounts receivable.	Checkwrite
PRSJD700	IPDR7101	Systematic Checkwrite Balancing	Displays internal checkwrite balancing amounts.	Checkwrite
PRSJD700	IPDR752R	Accounts Receivable Summary Status Report	Lists the weekly status of all outstanding account receivables for the date requested in order by billing provider and cash control number.	Checkwrite
PRSJD710	IPDR710R	Pending Balances	Displays internal Accounts Receivable Master activity for the week. Displays FINANCIAL PAYER, CASH CONTROL NUMBER, PROVIDER NUMBER, ORIGINAL AMOUNT, BALANCE AMOUNT	Weekly Checkwrite
PRSJD755	IPDR3951	Extract File of Expenditures Information for a Fiscal Year	Lists NCAS expenditures and the associated budget code for referring providers for each checkwrite during a fiscal year. The user can export the report to Excel.	Annually
PRSJE200	IPDR752R	Accounts Receivable Summary Status Report (Monthly)	Lists the monthly status of all outstanding account receivables for the date requested in order by billing provider and cash control number.	Month End - Financial



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
PRSJE200	IPER2401	Paid Full	Lists detailed information concerning all claims processed for a billing provider. For each internal control number, lists all service review numbers for which the claim qualifies in order by financial payer, billing provider, client name, and internal c	Month End - Financial
PRSJE210	IPEN237N	Checkwrite Financial Summary (Monthly)	Monthly summary containing record count, suspended credit, accounts receivable, 1099 file, program cost file, and checkwrite cost for program transactions, financial transactions, penalty/interest activity, and control totals.	Month End - Financial
PRSJE380	IPDR3851	Amount Paid Per Eligibility Category Report	Lists the clients and claim amounts paid per eligibility category for each provider in order by financial payer.	Month End - Financial
PRSJE380	IPDR3891	Internal Monthly Budget Expenditure Report	Displays monthly detailed and summary budget information by financial payer.	Month End - Financial
PRSJE382	IPDR3891	Internal Quarterly Budget Expenditure Report	Displays quarterly detailed and summary budget information by financial payer.	Quarter End
PRSJE384	IPDR3891	Internal Yearly Budget Expenditure Report	Displays yearly detailed and summary budget information by financial payer.	Yearly - Calendar/ Fiscal
PRSJE391	IPER3911	Population Group's Expenditures by Source of Funds & Population Group's Expenditures by Source of Funds Summary	By LMA and Account/Center combination, this report list the Budget Amount and Year-To-Date (YTD) expenditures. Under each Account/Center, the report shows each pop group that had claims pay using that combination and the YTD expenditures. At the end of t	Month End - Financial
PRSJE450	IPER4521	Denied Details By Threshold/County/Prov/EOB (Monthly)	Lists the error counts by explanation of benefit codes by financial payer, threshold, county, provider type and specialty for communication and training analysis.	Month End - Financial
PRSJE450	IPER4551	Denied Claims By Threshold and Provider (Monthly)	Lists the counts of claims finalized, paid and denied in order by financial payer, provider number, and provider name.	Month End - Financial
PRSJE470	IPER4761	Utilization Review for Claims Paid with PA	List by provider and procedure code paid and beneficiary information.	Monthly
PRSJE470	IPER4781	Utifization Review for Claims Paid with no PA	Lists the counts of claims finalized, paid, and denied in order by financial payer, provider number, and provider name.	Monthly
PRSJE530	IPDR752R	Accounts Receivable Summary Status Report (Quarterly)	Lists the quarterly status of all outstanding account receivables for the date requested in order by billing provider and cash control number.	Quarter End
PRSJECHO	IPAR0661	IPRS Echo Record Receipt Summary Report	Lists the count of the number of echo records received by the translator by provider. Also gives a total of records submitted from all providers.	Daily
PRSJG500	IPGR5201	IPRS Utilization Report By Population Group And Billing Provider	Provides month-to-date and year-to-date utilization in order by population group and billing provider number.	Month End - Med Policy



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
PRSJG500	IPGR5401	Provider Summary Report File	Lists the monthly summary of finalized claim activity for providers in order by checkwrite date, population group, billing provider, and attending provider.	Month End - Med Policy
PRSJG500	IPGR5601	IPRS Utilization Report By Procedure	Provides monthly utilization tracking by procedure code in order by billing provider, population group, and procedure code.	Month End - Med Policy
PRSJG500	IPGR5701	IPRS UTILIZATION REPORT BY ENHANCED SERVICES PROCEDURE CODES	This is a monthly utilization report by enhanced services procedure codes.	Monthly
PRSJG550	IPGR5501	IPRS Utilization Report by Attending Provider/Pop Group	Provides utilization tracking by Attending Provider, Pop Group and Billing Provider. Sub totals are printed for Attending Provider, Pop Group and Billing Provider. Detail lines are summarized and printed by Procedure Code.	Weekly
PRSJG550	IPGR5502	IPRS Utilization Report by Billing Provider/Attending Provider/Pop Group	Reports on the utilization of claims within the week of the checkwrite cycle.	Weekly
PRSJG580	IPGR5801	Unduplicated units of service report	Reports unduplicated units of service actually provided in order by billing provider and procedure code.	On Request
PRSJG590	IPGR5901	YM645 Expenditure report	This report selects only YM645 procedure code claims for reporting. The report is grouped by pop group in specific MD/DD disability group code. The report is by LME and their corresponding attending providers. Along with the LME name and number and atte	Month End
PRSJG700	IPGR7001	Attending Provider Reimbursement by Agency Report	Total paid to agencies for weekly cycle	Weekly
PRSJK020	IPKR0201	IPRS Client Eligibility Receipt Summary Report	Lists the number of 834 client eligibility enrollment records received from the translator in order by provider number.	Daily
PRSJK106	IPKR1060	Disparate Information Report DISCONTINUED AS OF 7/1/2004	Lists the demographic information discrepancies between eligibility information in the local eligibility system and in CNDS (subsequently IPRS).	Daily
PRSJK106	IPKR1951	Client Xrefs Without Corresponding Eligibility Report	Identifies CNDS Ids established for IPRS local Ids with no corresponding eligibility master records. Also identifies Eligibility Master records that contain NOSEG eligibility segments.	Daily
PRSJK106	IPKR1961	IPRS Cross Reference Listing	Lists the local client ID and the CNDS base client ID for those client's that have been cross-referenced in CNDS.	Daily
PRSJK120	IPKR1201	Prior Approval Pending Beyond Alert Date	List prior approvals with status pending that have exceeded their alert dates in order by issuing provider and alert date.	Checkwrite
PRSJK120	IPKR1202	Prior Approval Eligibility Pending Over 21 Days	Lists prior approval records which have exceeded their 21 day limit to resolve pending eligibility in order by issuing provider and date entered into the system.	Checkwrite



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
PRSJK120	IPKR1203	PA Eligibility Pending Name Mismatch Report	This will report on name mismatches between Prior Approval and Eligibility records in Pending status.	Checkwrite
PRSJK120	IPKR7401	PA request status verification file (File) - MIPRS.HMKMA.MDRA1202	This is the IPRS Prior Approval Request Status Verification file.	Checkwrite
PRSJK150	IPKR1501	Client Eligibility Cross-Reference Updates	Lists all added and deleted cross-references made through CNDS on a daily basis.	Daily
PRSJK160	IPKR1602	Client xreference synchronization report	Master listing of IPRS cross-references.	Misc.
PRSJK161	IPKR1601	Client xreference master listing report	Report comparing the cross-reference rebuild to previous cross-references.	Misc.
PRSJK170	IPKR1801	Suspect Medicaid Client Eligibility Report	Reports non-Medicaid IPRS ID's which are suspected of having a Medicaid eligibility that is not currently cross-referenced by MMIS.	Month End - Med Policy
PRSJK197	IPKR1971	Client with Missing Race/Ethnicity/Language Data	Identifies Local IDs that have missing race, ethnicity, or language data.	Weekly
PRSJK372	IPKR3771	Transitional Non-Covered Target Population Enrollment Report	Identifies statistics for all TNC population groups, as related to the number of client enrollments across funded target population groups and the total population within an LMA.	Monthly
PRSJK372	IPKR5902	Olmstead Client Tracking Summary Report	Summary Report of IPKR5901 that tracks the services that Olmstead clients receive after they are transitioned to area program facilities.	Monthly
PRSJK373	IPKR3731	Client Count Per Eligibility Program Report	List the detail and unduplicated counts of clients by eligibility program in order by billing provider and eligibility program code.	Checkwrite
PRSJK373	IPKR3831	CLIENT COUNT FOR AMOLM ELIGIBILITY PROGRAM REPORT	Lists the detail and unduplicated counts of clients for the AMOLM eligibility program in order by billing provider.	Weekly
PRSJK375	IPKR3751	Client Eligibility Expiration Alert Report	Lists all eligibility segments set to expire in the coming 2 months in order by billing provider and client name.	Month End - Med Policy
PRSJK380	IPKR3801	Client Eligibility Expiration Alert by Attending Provider Report	Lists the attending providers whose claims processed that checkwrite week and their eligibility is expiring in the next 2 months.	Checkwrite
PRSJK594	IPKR5901	Quarterly Olmstead Client Tracking Report by Individual	Cumulative fiscal year report generated each quarter to display a summary of all claim activity for AMOLM eligible clients and their associated LMAs.	Quarterly
PRSJK700	IPKR7001	Audit Reports For Post-Payment Review	Lists all detail claim records applied to a specific prior approval service review number in order by service review number and internal control number.	On Request
PRSJK701	IPKR7021	Active Exhausted Prior Approval Report	Lists all prior approvals which have reached the limit and are still active in order by population group and service review number.	Checkwrite



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
PRSJK701	IPKR7101	Overlapping Prior Approval Alert Report	Notifies billing providers of any overlapping active prior approval segments which may cause a claim to fail when any one segment is exhausted in order by issuing billing provider and client id. (An overlap exists when a client, authorizing provider, and	Checkwrite
PRSJK706	IPKR7071	High Cost Client Alert Report	Lists summary payment information for all IPRS clients who meet the high cost criteria specified in order by client (base) id and population group.	On Request
PRSJK712	IPKR7121	IPRS Provider and Client Base ID Report	Lists all provider numbers and client ids that have been updated and subsequently changed on the prior approval master file by the batch update process in order by service review number. (This report includes any expired or active prior approvals updated	Daily
PRSJK791	IPKR7911	Prior Approval Extension File Listing By Pop Group	Listing that shows all SRN's selected for a claim during processing based on the PA criteria. Fields include ICN, detail number, SRN, client ID, type, start date, end date, authorizing provider and issuing provider.	Checkwrite
PRSJK801	IPKR8011	Retro Medicaid Multi-Detail Claim Report	Lists claims that were not processed due to multiple details in order by billing provider and client id (MID).	Monthly
PRSJK801	IPKR8101	Retro Medicaid Resubmission Single Detail Tracking Report	Lists single detail claims that have the potential of payment by Medicaid during the Monthly Retro-Medicaid cycle.	Monthly
PRSJK801	IPKR8102	Retro Medicaid Recouped Claims Report	Lists claims that were submitted by Direct Enrolled Providers, and have OBH Procedure Codes, with dates of service after 8/31/2005. These are eligible for payment by Medicaid, and will therefore be recouped by IPRS, and should be re-submitted by the prov	Monthly
PRSJK804	IPKR8051	Retro Medicaid Paid Claims Report	Lists the paid amount for Medicaid and the recoup amount for IPRS in order by billing provider and client id (MID).	Checkwrite
PRSJK804	IPKR8061	Retro Medicaid Denied Claims By EOB	Lists summary totals for the different type of explanation of benefits (EOB) denials in order by explanation of benefit code.	Checkwrite
PRSJK804	IPKR8081	Retro Medicaid Provider Level Adjustment Report	Lists the recoup amounts that will require a provider level adjustment to recover retroactive Medicaid amounts for the provider in order by billing provider.	Checkwrite
PRSJK804	IPKR8601	Retroactive Medicaid Denied Detail Claim Report	Lists single detail claims that have been denied payment by Medicaid during the Retro-Medicaid cycle.	Weekly
PRSJK900	IPKR7081	Active Prior Approval Report ISS Prov/Pop Group	Lists all prior approval records with an active date range as of the date of the report in order by issuing provider and population group.	Daily
PRSJK900	IPKR7082	Active Prior Approval Report ISS Prov/MID/Pop Group	Lists all prior approval records with an active date range as of the date of the report in order by issuing provider, client ID (MID), and population group.	Daily
PRSJK900	IPKR9001	Client Eligibility Error Report	Lists errors in eligibility processing. These errors must be corrected and eligibility resubmitted for claims to process successfully in order by billing provider and client id.	Daily



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
PRSJK900	IPKR9002	Client Eligibility Detail Update Report	Lists client eligibility transaction data that was processed successfully.	Daily
PRSJK919	IPKR9961	Prior Approval Expenditure Tracking Report	Reports on prior approval details with activity since the last checkwrite in order by issuing provider, population group, segment type, and service review number.	Misc.
PRSJK995	IPKR3781	CMSED Fiscal Y-T-D Claims Activity Summary	One page summary of monthly/yearly unduplicated counts of claims activity for CMSED clients in IPRS and Medicaid.	Checkwrite
PRSJK995	IPKR3782	ADMRI Fiscal Y-T-D Claims Activity Summary	One page summary of monthly/yearly unduplicated counts of claims activity for ADMRI clients in IPRS and Medicaid.	Checkwrite
PRSJK995	IPKR7051	Claims Denied For Prior Approval	Lists detailed information concerning claims denied due to prior approval in order by population group, client id (MID) and billing provider.	Checkwrite
PRSJP040	IPPR0401	Compare Claims for Profit(P)/Nonprofit(N) Providers	Claims that are equal for profit/nonprofit providers.	On Request
PRSJP075	IPPR0751	PA Units/Dollars of Expended vs. Authorized	PA Units/Dollars of Expended vs. Authorized	On Request
PRSJP090	IPPR0901	Security File Audit Trail Report	TRLOG of changes made to the security master file.	Month End - Med Policy
PRSJP095	IPPR0951	Security File Master Listing	Master listing of all browser security records.	Month End - Med Policy
PRSJP150	IPPR1501	Diagnosis Master TRLOG Report	TRLOG of Diagnosis File online modifications.	Maintenance
PRSJP240	IPDR0611	Retroactive Rate Change Forecast Report	Details the estimated financial impact of retroactive rate changes in order by company, NCAS budget account, and NCAS center.	On Request
PRSJP240	IPPR2411	Rate Processing Error Report	Lists errors detected during the edit of the rate file from DHHS.	On Request
PRSJP240	IPPR2412	Preliminary Rate Processing Report	Displays the before and after images of updates that will be applied to the IPRS rate file.	On Request
PRSJP240	IPPR2441	Rate Processing Critical Error Report	Displays the critical errors detected during the edit of the rate file received from DHHS	On Request
PRSJP241	IPPR2413	Confirmed Rate Processing Report	Displays the before and after images of updates that have been applied to the IPRS rate file.	On Request
PRSJP241	IPPR2414	Valid Rates by Procedure Codes	Displays valid rates sorted by Procedure Code, Pop Group, Billing Provider, Attending Provider, Client ID, Begin Dated & End Date.	On Request
PRSJP241	IPPR2415	Valid Rates by Population Group	Displays valid rates sorted by Population Group, Billing Provider, Procedure Code, Attending Provider, Client ID, Begin Date and End Date.	On Request
PRSJP241	IPPR2416	Unprocessed/Deleted Retro-rate Adj Rpt	List of Adjust Request Retro-rate ICN that have been deleted or are recycled .	On Request





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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
PRSJP300	IPPR3001	Procedure Reference Master File	Lists all procedure code reference records in order by procedure code, modifier, type of service, and population payer.	Maintenance
PRSJP300	IPPR3101	Procedure Reference Master File Transaction Log Report	TRLOG report of changes made via the PR screen in order by procedure code, modifier, type of service, and population payer.	Maintenance
PRSJP300	IPPR3201	Population Group Procedure Master Report	Lists all valid procedure codes used by each population group in order by financial payer, population group, procedure code, and type of service.	Maintenance
PRSJP390	IPPR3921	Valid Procedure Codes Report	Lists all IPRS required data fields from the Procedure Code Master File in order by procedure code.	Misc.
PRSJP410	IPPR4101	System Control Table Transaction Log Report	TRLOG of maintenance activity that has taken place related to the System and Population Group Payer Control Tables.	Maintenance
PRSJP550	IPPR5501	Modifier Master File	Produces the TRLOG reflecting to the diagnosis file.	Weekly
PRSJP550	IPPR5551	Modifier Master File Transaction Log Report	TRLOG for MF screen changes.	Weekly
PRSJP600	IPPR6051	Monthly Transitional Non-Covered (TNC) Population Tracking Report	Reports final claim details by TNC population groups.	Monthly
PRSJP600	IPPR6101	Monthly Transitional Non-Covered (TNC) Population Tracking Summary Report	A cumulative monthly summary report of TNC activity from the beginning of the fiscal year.	Monthly
PRSJP600	IPPR6151	Monthly Transitional Non-Covered (TNC) Population Tracking Report	Report of final claim details filed by TNC population groups. This report is reporting on daily claim detail and monthly sums of diagnosis codes' total billed and total units.	Monthly
PRSJP600	IPPR6201	Monthly Transitional Non-Covered (TNC) Population Tracking Summary Report	A cumulative monthly summary report of TNC activity from the beginning of the fiscal year. This report is reporting on cumulative year to date sums of diagnosis codes' total billed and total units.	Monthly
PRSJP751	IPPR7501	Edit Process Header File TRLOG Report	Audit trail of changes made to the Process Header Criteria file.	Maintenance
PRSJP751	IPPR7511	Edit Process Detail File TRLOG Report	Audit trail of changes made to the Edit Detail Criteria file.	Maintenance
PRSJP751	IPPR7521	Edit Table Header Master File TRLOG Report	Audit trail of changes made to the Edit Table Header Criteria file.	Maintenance
PRSJP751	IPPR7531	Edit Table Detail Master File TRLOG Report	Audit trail of changes made to the Edit Table Detail Criteria file.	Maintenance
PRSJP751	IPPR7541	Edit List Master File TRLOG Report	Audit trail of changes made to the Edit List Criteria Master file.	Maintenance
PRSJP756	IPPR7551	Edit Master Report	Master listing of all the edits used in processing. List includes description, error status codes and EOB codes.	Maintenance



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
PRSJP756	IPPR7561	Population Group Edit Master Report	Master listing of edit processes by population group. List includes description and default pop group.	Maintenance
PRSJP760	IPPR7601	Budget and Funding Budget Master File	TRLOG of the Budget and Funding Master file. Displays the before and after.	Maintenance
PRSJP760	IPPR7611	Budget & Funding Criteria Dtl Master File	TRLOG of the Budget & Funding Criteria Dtl Master file. Displays the before and after.	Maintenance
PRSJP760	IPPR7621	Router Budget Master File	Lists the adds, changes, and deletes made to the IPRS Router Budget Master file.	Maintenance
PRSJP760	IPPR7641	Budget & Funding Criteria Hdr Master File	TRLOG of the Budget & Funding Criteria Hdr Master file. Displays the before and after.	Maintenance
PRSJP760	IPPR7651	Budget & Funding Criteria List Master File	TRLOG of the Budget & Funding Criteria List Master file. Displays the before and after.	Maintenance
PRSJP870	IPPR8741	PA Master File Transaction Log Report	Lists the adds, changes, and deletes made to the IPRS Prior Approval Master file.	Weekly
PRSJV005	IPVR0051	Billing Provider Number Change	Lists changes to the billing provider numbers.	Daily
PRSJV005	IPVR0301	Attending Provider List by Billing Provider	This report will list all attending providers under each billing providers. Also, it will indicate the status of each Attending provider as 'A' - Active or 'I' - Inactive.	Daily
PRSJV011	IPVR0111	Suspect Duplicate Medicaid LMA/Billing Providers	Lists suspected duplicate Medicaid provider numbers using provider tax id in order by provider tax id, type specialty, and billing provider.	Maintenance
PRSJV011	IPVR0121	Suspect Duplicate Medicaid Attending Providers	Lists suspected duplicate Medicaid attending providers using provider tax id in order by billing provider and attending provider.	Maintenance
PRSJV011	IPVR0131	Suspect Duplicate IPRS Attending Providers	Lists IPRS attending providers suspected of having multiple provider numbers with the same type and specialty in order by provider tax id, type specialty, and billing provider.	Maintenance
PRSJV011	IPVR0141	Suspect Multi Site IPRS Providers	Lists IPRS billing providers that are suspected to be multi-site providers without an entry in the cross-reference T table in order by tax id and provider number.	Maintenance
PRSJV011	IPVR0151	MMIS Acton Reason Code Report For IPRS Billing Providers	Lists all actions added through MMIS in the past 10 days for billing providers common to both MMIS and IPRS in order by IPRS billing provider, tax id, and action/reason code.	Maintenance
PRSJV011	IPVR0171	Attending Provider Listing By Base Billing Provider	Lists all attending providers enrolled under each billing provider in order by billing provider, attending provider, and population group.	Maintenance
PRSJV011	IPVR0181	Billing Provider Listing By Population Group	Lists all providers by population group for all active population groups in order by population group and billing provider number.	Maintenance
PRSJV011	IPVR0191	Attending Provider Listing By Population Group	Lists all eligible attending providers by population group for all active population groups in order by population group and attending provider.	Maintenance



## Appendix 40, Attachment G Consolidated List of Reports



DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
PRSJV011	IPVR0201	MMIS Action Reason Code Alert For IPRS Billing Providers	Lists the action reason codes of IPRS attending providers by billing provider number and tax id.	Maintenance
PRSJV011	IPVR0291	Attending Provider List Report	Identifies attending provider names and their associated attending provider number.	Maintenance
PRSJV020	IPVR0161	MMIS Action Reason Code Report For IPRS Attending Provider	Lists all actions added through MMIS in the past 10 days for attending providers common to both MMIS and IPRS in order by IPRS billing provider, tax id, and action/reason code.	Maintenance
PRSJV020	IPVR0221	MMIS Action Reason Code Alert For IPRS Attending Provider	Lists the newly added Medicaid action reason codes for the IPRS billing providers for the latest reporting period of 10 days in order by billing provider and tax id.	Maintenance
PRSJV047	IPVR0481	Provider Changes from Medicaid	All changes updated from Medicaid to the IPRS provider database	Daily
PRSJV055	IPVR0551	Active Medicaid Outpatient Behavioral Health Service	Providers on MMIS that need to be enrolled by IPRS.	Daily
PRSJV055	IPVR0552	Active Medicaid Enhanced Services Providers	Providers that are endorsed to provide certain enhanced services.	Daily
PRSJV100	IPVR1025	Addressograph Report	Report of adds, changes, or deletes made to addresses of providers.	Maintenance
PRSJV100	IPVR105R	Provider File Maintenance Report Additions	TRLOG report of adds made to the provider master file in order by provider number and fin payer.	Maintenance
PRSJV100	IPVR110R	Provider File Maintenance Report Changes	TRLOG report of changes made to the provider master file in order by provider number and fin payer.	Maintenance
PRSJV100	IPVR115R	Provider File Maintenance Report Deletions	TRLOG report of deletions made to the provider master file in order by provider number and fin payer.	Maintenance
PRSJV120	IPVR1201	Active Non-Atypical Attending Providers Without NPI	List active Non-Atypical Attending providers without NPI within LME. Attending provider Type/Specialty must be active on the date the report is generated.	Daily
PRSJV150	IPVR10501	IRS Tax Identification File Maintenance Report	Provides a summary of IRS tax identification maintenance by financial payer.	Weekly
PRSJV220	IPVR2201	Provider Specialty/Type Correlation Report	Lists the number of providers associated with a type code under the specialty code in order by specialty.	Month End - Financial
PRSJV220	IPVR2202	Provider Type/Specialty Correlation Report	Lists the number of providers associated with a specialty code under the type code in order by type code.	Month End - Financial
PRSJV300	IPVR3001	Attending Provider File Maintenance Report	TRLOG report of adds, changes, and deletes made to the Attending Provider Section of the IPRS Provider DB2 file in order by financial payer, transaction type, billing provider, and attending provider.	Maintenance
PRSJV300	IPVR3201	Population Group Provider Enrollment Maintenance Report	TRLOG report of adds, changes, and deletes made to the Population Group Provider Enrollment section of the IPRS Provider DB2 file in order by financial payer, transaction type, and billing provider.	Maintenance



## Appendix 40, Attachment G Consolidated List of Reports



DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
PRSJV300	IPVR3401	Multiple Provider Site Cross Reference	TRLOG report of adds, changes, and deletes made to the Provider Multi-site Cross-reference section of the IPRS Provider DB2 file in order by financial payer, transaction type, and billing provider.	Maintenance
PRSJV300	IPVR3601	Billing Provider Number Change Report	TRLOG report of adds and changes made to the Billing Provider Base Number section of the IPRS Provider DB2 file in order by financial payer, transaction type, and billing provider.	Maintenance
PRSJZ010	IPZR0101	Unduplicated Client Count Report	A Report Of Unduplicated Clients Served During A Specified Fiscal Year Time Frame	On Demand
RA019	HMKR2608	Private Duty Nursing Active PA Segments		
RA080	HMKR940D	North Carolina Prior Approval Maintenance – Specialized Therapy Services		
RAxxx	HMKR940B	Keyed Data Only Report		
RB222	HMKE661R			
RB222	HMKR2181	Medicare Buy-In Transactions Warning Report		
RB224	HMKR510R/511R			
RB230	HMKR6709 HMKR6710			
RB250	XX-New Report	Medicare Buy-In Financial Transactions on Billing File Received from CMS		
RB254	HMKR 6503	Medicare Buy-In premiums Part A/Part B – by County/Program Group/Program Code		
RB254	HMKR550N	Medicare Buy-In premiums Part A/Part B – by County/Program Group/Program Code		
RB270	HMKR2181			
RB275	HMKR5305HMKR6305	Buy-In List of Accretions Effective Two Yrs. Prior to Current Month		



## Appendix 40, Attachment G Consolidated List of Reports



DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
RB280	HMKR5061- 5068	Medicare Buy-In Part – B Code XXXX Report (code – 42XX, 1165, 1167, 1128, 32, 34, 43, 4999)		
RB281	HMKR6601- 6608	Medicare Buy-In Part – A Code XXXX Report (code – 42XX, 1165, 1167, 1128, 32, 43, 4999)		
RB282	HMKR5703	Medicare Buy-In Part B Code XX Reject Report		
RB282	HMKR5704	28,29,49,27,2723 Alert		
RB282	HMKR5705			
RB282	HMKR5706			
RB283	HMKR6703	Medicare Buy-In Part A Code XX Reject Report		
RB283	HMKR6704	29,49,27,2723 Alert		
RB283	HMKR6705			
RB283	HMKR6706			
RB323	HMKR4223	Monthly EDB Mismatch Report		
RB410	XX-New Report	Unduplicated Count of Eligible by Program – MTD		
RB411	XX-New Report	Unduplicated Count of Eligible by Program – YTD		
RB504	XX-New Report	Certificate of Creditable Coverage Extracted Data		
RB610	HMKR6661	List of Buy-In Part X Actions Sent to Baltimore		
RB756	XX-New Report	Transfer of Assets Alert Detail Report		
RB757	XX-New Report	Transfer of Assets Alert Summary Report		
RC001	XX-New Report	Edit Exception Code Analysis by Provider Type		
RC002	XX-New Report	Provider Error Code Report		
RC005	XX-New Report	Claims Processing/Adjudication Summary		



## Appendix 40, Attachment G Consolidated List of Reports



DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
RC006	XX-New Report	CMS-1500 Claims		
RC007	XX-New Report	Inpatient Claims		
RC008	XX-New Report	Long Term Care Claims		
RC010	XX-New Report	Dental Claims		
RC011	XX-New Report	Supply Claims		
RC012	XX-New Report	Outpatient Claims		
RC013	XX-New Report	Capitation Claims		
RC014	XX-New Report	Medicare Outpatient Claims		
RC015	XX-New Report	Medicare Part A Claims		
RC016	XX-New Report	Medicare Part B Claims		
RC017	XX-New Report	Claim Credit/Void Request Exception		
RC018	XX-New Report	Claim Adjustment Exception		
RC020	XX-New Report	Mass Adjustment Analysis		
RC022	XX-New Report	Claims Edit Exception Code Report		
RC023	XX-New Report	Suspended Claim Analysis by Claim Type		
RC024	XX-New Report	Daily Edit Exception Code Suspense Summary		
RC025	XX-New Report	Top 10 Claims Approved for Payment		
RC026	XX-New Report	Services Denied by Claims Examiners		
RC027	XX-New Report	Services Forced by Claim Examiners		
RC028	XX-New Report	Forced/Denied Edit Exception Code Summary		
RC029	XX-New Report	Mass Adjustment Request Report		
RC032	XX-New Report	Claims Edit Exception Code Analysis		
RC033	XX-New Report	Claims Input Analysis		
RC034	XX-New Report	Claims Movement Inventory		
RC035	XX-New Report	Suspense Release Transaction Proof Listing		
RC036	XX-New Report	Deleted TCN Listing		



## Appendix 40, Attachment G Consolidated List of Reports



DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
RC037	XX-New Report	Batch Claim Error Report		
RC038	XX-New Report	Request TCN Report		
RC039	XX-New Report	Claim Suspense Release Error Report		
RC040	XX-New Report	Medicaid Black Hole Provider Report		
RC041	XX-New Report	Medicare Black Hole Provider Report		
RC048	XX-New Report	Medical Review Pended Inventory in Total		
RC049	XX-New Report	Medical Review Pended Since Last Payment Cycle		
RC051	XX-New Report	Batch Analysis Report		
RC053	XX-New Report	Daily Adjudicated Edit Exception Code Suspense Summary		
RC054	XX-New Report	Adjudicated Claims Edit Exception Code Report		
RC067	XX-New Report	State Authorized Payments		
RC080	XX-New Report	Batch Status Report		
RC081	XX-New Report	Batch Control File Listing Deleted Batch Records		
RC082	XX-New Report	Batch Status Aging Report		
RC083	XX-New Report	Batch Control Aging Summary by Receipt Days		
RC084	XX-New Report	Batch Control Aging Summary by Days in Status		
RC085	XX-New Report	Batch Summary		
RC090	XX-New Report	Batches Updated to Used		
RC091	XX-New Report	Batches with Entered Docs Greater than DOCS count		
RC207	XX-New Report	Managed Care		
RC208	XX-New Report	Managed Care Pre-processor Error Report		
RC209	XX-New Report	Third Party Liability (TPL) Balancing Report		



## Appendix 40, Attachment G Consolidated List of Reports



DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
RC210	XX-New Report	TPL Pre-processor Error Report		
RC211	XX-New Report	TPL Accepted/Rejected Report		
RC212	XX-New Report	Health Check Balancing Report		
RC213	XX-New Report	Health Check Pre-processor Error Report		
RC214	XX-New Report	Health Check Accepted/Rejected Report		
RE300	XX-New Report	Health Check Activity Report		
RE310	HMLR6001"E"	Health Check Closure Report		
RE401	XX-New Report	Health Check FTE Audit Report		
RE500	N1.IN1	Introductory Notification Carolina ACCESS Recipient		
RE510	N1.IN4	Introductory Notification Non-Carolina ACCESS Recipient		
RE520	N1.IN7	Introductory Notification HMO Recipient		
RE530	N2.IN2	Introductory Notification Carolina ACCESS Recipient with CSC (Child Service Coordinator) (provider name included)		
RE540	N2.IN5	Introductory Notification Non-Carolina ACCESS Recipient with CSC (Child Service Coordinator)		
RE550	N2.IN8	Introductory Notification HMO Recipient with CSC (Child Service Coordinator)		
RE560	N3.IN3	Introductory Notification Carolina ACCESS Recipient including North Carolina Family Health Resource Line information (provider name included)		





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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
RE570	N3.IN6	Introductory Notification Non-Carolina ACCESS Recipient including North Carolina Family Health Resource Line information		
RE580	N3.IN9	Introductory Notification HMO Recipient including North Carolina Family Health Resource Line information		
RE581	XX-New Report	Health Check (EPSDT) Program Year-to-Year Comparisons Report by Provider		
RE590	N10.RE1	Reminder Notification Carolina ACCESS Recipient with Scheduled Appointment (provider name included)		
RE600	N10.RE5	Reminder Notification Non-Carolina ACCESS Recipient with Scheduled Appointment		
RE610	N11.RE1	Reminder Notification Carolina ACCESS Recipient with Scheduled Appointment (provider name included) and CSC (Child Service Coordinator)		
RE620	N11.RE3	Reminder Notification HMO Recipient with Scheduled Appointment and CSC (Child Service Coordinator)		
RE630	N11.RE5	Reminder Notification Non-Carolina ACCESS Recipient with Scheduled Appointment and CSC (Child Service Coordinator)		



## Appendix 40, Attachment G Consolidated List of Reports



DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
RE640	N12.RE2	Reminder Notification Carolina ACCESS Recipient with No Scheduled Appointment (provider name included)		
RE650	N12.RE4	Reminder Notification HMO Recipient with No Scheduled Appointment		
RE660	N12.RE6	Reminder Notification Non-Carolina ACCESS Recipient with No Scheduled Appointment		
RE670	N13.RE2	Reminder Notification Carolina ACCESS Recipient with No Scheduled Appointment (provider name included) and CSC (Child Service Coordinator)		
RE680	N13.RE4	Reminder Notification HMO Recipient with No Scheduled Appointment and CSC (Child Service Coordinator)		
RE690	N13.RE6	Reminder Notification Non-Carolina ACCESS Recipient with No Scheduled Appointment and CSC (Child Service Coordinator)		
RE700	XX-New Report	Web Requested Informational Notification		
RE710	XX-New Report	Web Requested Delinquent Screening Notification		
RE720	XX-New Report	Web Requested		
RE721	XX-New Report	Missed Screening Notification		
RE730	XX-New Report	Web Requested		
RE731	XX-New Report	Scheduled Appointment Notification		
RE740	XX-New Report	Web Requested		
RE741	XX-New Report	ER Letter # 1 Notification		



## Appendix 40, Attachment G Consolidated List of Reports



DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
RE750	XX-New Report	Web Requested		
RE751	XX-New Report	ER Letter #2 Notification		
RE760	XX-New Report	Web Requested		
RE761	XX-New Report	ER Letter #3 Notification		
RE800	XX-New Report	New User Notification		
RE955	XX-New Report	Health Check State Office Contact Report		
RE961	XX-New Report	Health Check -Active Health Check Coordinators Report		
RE962	XX-New Report	Health Check – Health Check Coordinator Report		
RE965	XX-New Report	Health Check -Active Health Check Coordinator Report by Region		
RE980	XX-New Report	EPSDT/Health Check MAAR < 50/75 Requirement Report		
RF040	XX-New Report	Accounts Receivable Aging Summary		
RF049	XX-New Report	Negative Balance Detail Report		
RF055	XX-New Report	Suspended A/R Balance Report		
RF057	XX-New Report	Recovery Suspense Report		
RF058	XX-New Report	Refund Deposit and Voided Check Summary Report		
RF065	XX-New Report	1099 Report of Providers Paid		
RF118	XX-New Report	Cash Receipts and Dispositions		
RF119	XX-New Report	Cash Receipts and Disposition Summary		
RF127	XX-New Report	“Aged” Provider Receivables		
RF128	XX-New Report	“Aged” Provider Receivables		
RF129	XX-New Report	“Aged” Provider Receivables		
RF130	XX-New Report	“Aged” Provider Receivables All		
RF132	XX-New Report	“Aged” Provider Receivables		
RF133	XX-New Report	“Aged” Provider Receivables		
RF139	XX-New Report	Summary Recovery Suspense Report		



## Appendix 40, Attachment G Consolidated List of Reports



DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
RF148	XX-New Report	Daily Report – Refund Receipts and Cash Dispositions		
RF151	XX-New Report	Letters to Providers with Outstand A/R 31 to 60 Days Past Due		
RF152	XX-New Report	Letters to Providers with Outstand A/R 61 to 90 Days Past Due		
RF601	XX-New Report	Daily Lockbox Transaction Error Report		
RF602	XX-New Report	Daily Lockbox Transaction Report		
RF646	XX-New Report	Unsolved Receipts From Lockbox		
RF648	XX-New Report	Cash Receipt Dispositions for Lockbox		
RF672	BH039R1	Transmittal of Refunds	Transmittal of Refunds Report for POC	
RF675	HMGR171C	Medical Assistant Financial Status	Financial Summary – Month of Service	
RF693	HMER2151	Finalized Claims Billing Report	Finalized Claims Billing Report	
RF702	HMFR976D	PS&R Detail Report		
RF799	XX-New Report	Medicaid Accounting System (MAS) Interface Report		
RG010	HMKR940B HMKR9404	Database Update Activity Report		
RH001	XX-New Report	Auto Assignment: Recipient PCP Selection Letter – Notification of Intent to Auto Assign Letter (Mandatory)		
RH002	XX-New Report	Auto Assignment: Notification of Assigned PCP– Auto Assignment Letter		
RH003	XX-New Report	Auto Assignment: Notification of Non-Auto Assignment Letter		



## Appendix 40, Attachment G Consolidated List of Reports



DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
RH004	XX-New Report	Auto Assignment: Recipient PCP Selection Letter – Notification of Intent to Auto Assign Letter (Optional)		
RH005	XX-New Report	Carolina Access Adult Recipient Override Education Letter		
RH006	XX-New Report	Carolina Access Child Recipient Override Education Letter		
RH011	XX-New Report	Exemption: CA Exemption Request Received (check boxes) – Decision has been made letter		
RH012	XX-New Report	Complaint: Complaint Against CA PCP Letter to Recipient		
RH013	XX-New Report	CA Birthday Letter (Age 21-39, Females)		
RH014	XX-New Report	CA Birthday Letter (Age 40 and over, Females)		
RH015	XX-New Report	CA Birthday Letter (Age 21 and over, Males)		
RH018	XX-New Report	Mass Change: CA Sanctions PCP w/Termination/No Appeal Requested Letter		
RH021	XX-New Report	Mass Change: Terminated Provider Number/Re-link with Physicians New Practice Provider Number		
RH022	XX-New Report	Mass Change: CA Provider Number Change Request Confirmation Letter		
RH025	XX-New Report	Request for CA Application Enclosed Letter		
RH028	XX-New Report	Mass Change – Recipient to Exempt Status Letter		



## Appendix 40, Attachment G Consolidated List of Reports



DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
RH037	XX-New Report	Medical Record Request – Additional Information Requested		
RH038	XX-New Report	CA Complaint Received		
RH041	XX-New Report	Mass Change: Change in Recipients PCP Status Letter		
RH046	XX-New Report	Mass Change: CA Recipient Status Change to Exempt-Program Change		
RH049	XX-New Report	Mass Change: PCP Moves Outside Service Area/Non Contiguous Co.		
RH052	XX-New Report	Mass Change: Individual Practitioner Leaving Group Letter		
RH053	XX-New Report	Medicaid Birthday Letter (Age 21-39, Females)		
RH054	XX-New Report	Medicaid Birthday Letter (Age 40 and over, Females)		
RH055	XX-New Report	Medicaid Birthday Letter (Age 21 and over, Males)		
RH270	XX-New Report	Preliminary Run Report – Recipients Unable to be Auto Assigned to PCP		
RH280	XX-New Report	Preliminary Auto Assignment 30 Day Letter Report		
RH285	XX-New Report	Final Report of Non-Auto Assigned Recipients		
RH290	XX-New Report	Final Auto Assignment Report from EIS		
RH295	XX-New Report	Final Auto Assignment Exception Report from EIS		
RH299	XX-New Report	Final Auto Assignment Comparison Exception Report		
RH420	XX-New Report	PCP Management Fee Error Report		
RH422	XX-New Report	PIHP Capitation Error Report		



## Appendix 40, Attachment G Consolidated List of Reports



DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
RH430	XX-New Report	Front End Generated PCP Management Fee Summary Report		
RH431	XX-New Report	Front End Generated HMO Capitation Summary Report		
RH432	XX-New Report	Front End Generated PIHP Capitation Summary Report		
RH433	XX-New Report	Front End Generated Administrative Entity Payment Summary Report		
RH434	XX-New Report	Front End Generated Supplemental KICK Payment Summary Report		
RH442	XX-New Report	PCP Management Fee Payment Report		
RH443	XX-New Report	Administrative Entity Payment Report		
RH444	XX-New Report	Supplemental KICK Payment Report		
RH447	XX-New Report	PCP Management Fee Exception Report		
RH448	XX-New Report	Administrative Entity Exception Report		
RH449	XX-New Report	Supplemental KICK Payment Exception Report		
RH471	XX-New Report	HMO Monthly Enrollment Report		
RH472	XX-New Report	PIHP Monthly Enrollment Report		
RH475	XX-New Report	Administrative Entity Enrollment Report		
RH476	XX-New Report	Administrative Entity Enrollment Report – Extract Only		
RH477	XX-New Report	Administrative Entity Enrollment Report – Summary Only		
RH500	XX-New Report	CCNC Terminated Provider Report		



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
RH505	XX-New Report	PCP Enrollment Counts		
RH520	XX-New Report	Rate Cohort by Eligibility Report		
RH525	XX-New Report	Rate Cohort by Benefit Plan Report		
RH535	XX-New Report	Adjusted CCNC PCP/Admin Entity Management Fee Report		
RH540	XX-New Report	Managed Care (HMO/PIHP) Capitation Withholding Report		
RH611	XX-New Report	PIHP Comparison Report from Encounter Data – Behavioral Health Services		
RH612	XX-New Report	PIHP Comparison Report from Encounter Data – Innovations Waiver Services		
RH613	XX-New Report	PIHP Comparison Prior YTD from Encounter Data – Behavioral Health Services		
RH616	XX-New Report	PIHP Eligibles Receiving Report for Behavioral Health		
RH620	XX-New Report	HMO Comparison Report from Encounter Data – Primary and Specialist Care		
RH621	XX-New Report	PIHP Comparison Report from Encounter Data – Behavioral Health Provider		
RH622	XX-New Report	PIHP Comparison Prior YTD from Encounter Data – Behavioral Health Provider		
RH623	XX-New Report	HMO Comparison Prior YTD from Encounter Data – Primary and Specialist Care		
RH630	XX-New Report	HMO Comparison Report from Encounter Data – Acute and Chronic Conditions		
RH631	XX-New Report	HMO Comparison Prior YTD from Encounter Data – Acute and Chronic Conditions		





## Appendix 40, Attachment G Consolidated List of Reports



DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
RH640	XX-New Report	HMO Comparison Report from Encounter Data – Children’s Health Services		
RH641	XX-New Report	HMO Comparison Prior YTD from Encounter Data – Children’s Health Services		
RH650	XX-New Report	HMO Comparison Report from Encounter Data – Women’s Health		
RH651	XX-New Report	HMO Comparison Prior YTD from Encounter Data – Women’s Health		
RH700	XX-New Report	CCNC Quarterly Utilization Report – YourPractice Profile		
RH701	XX-New Report	CCNC Quarterly Utilization Report – YourNetwork Profile		
RH702	XX-New Report	CCNC Quarterly Utilization Report – YourProgram Profile		
RH705	XX-New Report	CCNC Quarterly Average by Network		
RH710	XX-New Report	CCNC Quarterly Utilization Summary Report		
RH711	XX-New Report	Carolina Access Quarterly Outlier Report		
RH712	XX-New Report	Access II Quarterly Outlier Report		
RH810	XX-New Report	Mass Change Request Report		
RH815	XX-New Report	Mass Change Request Exception Report		
RH820	XX-New Report	Mass Change Successful/Letters Generated Report		
RH830	XX-New Report	Mass Change EIS Exception Report		
RH840	XX-New Report	Final Mass Change Recipient Comparison Report		
RH950	XX-New Report	CA Provider Changes Report		



## Appendix 40, Attachment G Consolidated List of Reports



DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
RH990	XX-New Report	Legacy Payment Category Criteria Report		
RH995	XX-New Report	Legacy Premium Rate Report		
RP001	XX-New Report	Provider Daily Activity Report		
RP003	XX-New Report	Provider Information Summary Sheet		
RP005	XX-New Report	Address Labels List		
RP006	XX-New Report	Provider Approval Welcome Letter Report		
RP007	XX-New Report	Denial Notice Form Letter		
RP008	RP016	Provider Termination Letter		
RP008	RP201	Provider Termination Letter		
RP008	RP204	Provider Termination Letter		
RP009	XX-New Report	License Renewal/Recertification List		
RP010	XX-New Report	Recertification Letter		
RP011	XX-New Report	Pending Application Reminder Listing		
RP012	XX-New Report	Returned to Provider Letter		
RP013	XX-New Report	Reverification List		
RP014	XX-New Report	Reverification Letter		
RP015	XX-New Report	Reverification Document		
RP019	HMPR9101	CLIA Certification Update Error Report		
RP020	HMV900R	CLIA Certification Update Report		
RP021	XX-New Report	Provider Report Request Criteria Pages		
RP100	RP203	Provider Change Notification Letter		
RP109	HMVR510R HMVR5103	Provider Listing By Type, Specialty, and County		
RP110	XX-New Report	Providers To Be Researched For B-Notices		
RP112	XX-New Report	Providers Sent B-Notices		
RP113	XX-New Report	Providers Changed To Start Withholding		



## Appendix 40, Attachment G Consolidated List of Reports



DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
RP123	XX-New Report	Listing of Provider With Group Affiliation		
RP132	XX-New Report	Year End Provider Totals Report		
RP160	XX-New Report	OIG Exclusion of Providers Report		
RP161	XX-New Report	Applications Approved With Errors		
RP173	XX-New Report			
RP200	XX-New Report	Mass Change: Terminated Provider/Renewal Not Meeting Minimum Requirements Letter		
RP202	XX-New Report	Mass Change: Voluntary CA Termination by PCP		
RP209	XX-New Report	B-Notice Letter to the Provider		
RP210	BHA934A3	HIV Program Listing By Provider Name Report		
RP211	BHA9927	Migran Health Providers	Detail list of paid providers for the migrant health program, unduplicated and by county	Fiscal year end
RP212	HMVP904N	Medicare Crossover Report		
RP212	HMVR8091	Medicare Crossover Report		
RP220	XX-New Report	SB926 Exclusion of Providers Report		
RP221	XX-New Report	Bed Capacity Report		
RP222	XX-New Report	Federal Reporting Requirements Report (ISAT)		
RP223	XX-New Report	Notification of Inactivity Letter		
RP224	XX-New Report	Storing Inactive Applications for 1 Year		
RP225	XX-New Report	Application Tracking Number Letter		
RP226	IPVR0551	Active Medicaid Outpatient Behavioral Health Services Providers		
RP230	XX-New Report	Carolina ACCESS Provider Directory		



## Appendix 40, Attachment G Consolidated List of Reports



DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
RP231	XX-New Report	And Carolina ACCESS Provider Directory: Recipient Version		
RP233	IPR0481	Listing Of Attending Provider Changes By Billing Provider		
RQ001	XX-New Report	DMH Negative Case Action Report		
RQ002	XX-New Report	DMH Negative Case Action Sampling Summary Report		
RQ003	XX-New Report	Recipient Information Sheet		
RQ004	XX-New Report	MEQC Positive Universe/Sample Summary Report		
RQ005	XX-New Report	Positive Sample Detail Report		
RQ006	XX-New Report	MEQC Positive Sample Control Sheet Report		
RQ007	XX-New Report	MEQC Positive Sample Paid Claims Report		
RQ008	XX-New Report	MEQC Positive Sample Record Not Found on History Report		
RQ009	XX-New Report	MEQC Positive Sample Claims Profile Report		
RQ010	XX-New Report	DMA Positive Sample Record Not Found on History Report		
RQ042	XX-New Report	Claims History Profile		
RQ043	XX-New Report	DRG Pricing History Report		
RQ140	XX-New Report	CPAS Sample Listing		
RQ143	XX-New Report	CPAS Control Count Report		
RQ219	XX-New Report	Procedure Code Report		
RQ220	XX-New Report	Diagnosis Code Report		
RQ800	XX-New Report	Provider Information Sheet		
RQ999	XX-New Report	CPAS Sample Labels		
RR025	XX-New Report	Rates Report		
RR029	XX-New Report	Duplicate Utilization Review Criteria Report		



## Appendix 40, Attachment G Consolidated List of Reports



DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
RR033	IPRR7511	Claim Exception Control Summary Report		
RR035	XX-New Report	PA Exception Control Summary Report		
RR038	XX-New Report	Physician Drug Program Procedure Code Report		
RR047	6230-DRG	Accommodation Rate Code File Listing	DRG Code Report	
RR049	XX-New Report	Provider Current Accommodation Rate Report		
RR051	XX-New Report	PA Exception Control Listing Report		
RR120	XX-New Report	Claim Exception Association Report		
RR130	XX-New Report	Benefit Plan Report		
RR131	XX-New Report	Benefit Plan Mapping Report		
RR160	XX-New Report	Budget File/Budget Criteria Report		
RR165	IPRR7511	Claim Exception Control Listing Report		
RR240	IPRR7511	Claim Exception Code Report		
RR260	XX-New Report	ICD-9-CM Surgical Procedure Update Exception Report		
RR261	XX-New Report	ICD-9-CM Surgical Procedure Update Activity Report		
RR262	XX-New Report	Diagnosis Code Update Exception Report		
RR263	XX-New Report	Diagnosis Code Update Activity Report		
RR310	XX-New Report	NDC/JCode Exception Report		
RR311	HMPR2571	Jcode to NDC Cross Reference	NDC/JCode Activity Report	
RR320	XX-New Report	NDC/JCode Rate Update Exception Report		
RR321	XX-New Report	NDC/JCode Rate Update Activity Report		



## Appendix 40, Attachment G Consolidated List of Reports



DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
RR330	XX-New Report	Modifier Update Exception Report		
RR340	XX-New Report	Procedure Code Update Exception Report		
RR341	XX-New Report	Procedure Code Update Activity Report		
RR350	XX-New Report	Level II Procedure/Modifiers Update Exception Report		
RR360	XX-New Report	CPT Procedure/Modifiers Update Exception Report		
RR380	XX-New Report	Ambulatory Surgery Code Update Exception Report		
RR381	XX-New Report	Ambulatory Surgery Code Update Activity Report		
RR390	XX-New Report	HCPCS Procedure Code Text Update Exception Report		
RR391	XX-New Report	HCPCS Procedure Code Text Update Activity Report		
RR400	XX-New Report	DRG Code Update Exception Report		
RR401	XX-New Report	DRG Code Update Activity Report		
RR460	HMVR9201	Accommodation Rate Update Exception	Accommodation Rate Update Exception Report	
RR600	XX-New Report	Category of Service Update Exception Report		
RR601	XX-New Report	Category of Service Share Update Activity Report		
RT001	XX-New Report	TPL Recoupment Report		
RT002	XX-New Report	Post Payment Recovery Claims Under The Threshold		
RT003	XX-New Report	Non Responsive Carrier Billing Report		
RT004	XX-New Report	HIPP Payment Listing		
RT005	XX-New Report	Active TPL Carrier Listing		
RT006	XX-New Report	Detail Audit Report		



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
RT007	XX-New Report	HIPP Check Listing		
RT008	XX-New Report	Trauma Questionnaire Tracking Report		
RT009	XX-New Report	Health Insurance Carrier Verification Survey by Recipient		
RT010	XX-New Report	TPL Worker Daily Planner		
RT011	XX-New Report	Medicaid Eligibles with TPL or Medicare By County		
RT012	XX-New Report	TPL Billing Invoice Print Statistics Report		
RT013	XX-New Report	TPL Recovery Case Invoice Insufficiency Report		
RT014	XX-New Report	Cost Avoidance Savings on Unduplicated Paid Claim Lines Report		
RT015	XX-New Report	Recovery Case Closed Report		
RT016	XX-New Report	TPL Invoice Aging Report		
RT017	XX-New Report	Trauma Diagnosis Questionnaire		
RT022	XX-New Report	Recovery Case Amount Due Notice		
RT023	XX-New Report	Recovery Case Amount Past Due Notice		
RT024	XX-New Report	TPL Billing Duplicate Denial Letter		
RT035	XX-New Report	Excess TPL Report		
RT037	XX-New Report	TPL Invoice Archive Report		
RT038	XX-New Report	TPL Invoice File Monthly Report		
RT039	XX-New Report	Cost Avoidance Savings for Unduplicated TPL Denied Lines		
RT040	XX-New Report	Archived Recovery Case Detail Report		
RT041	XX-New Report	TPL Pharmacy Recovery Invoice Report		
RT042	XX-New Report	TPL Process Error Report		
RT043	XX-New Report	TPL Mass Change Requests		



## Appendix 40, Attachment G Consolidated List of Reports



DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
RT045	XX-New Report	Recipients Affected by Change Request		
RT050	XX-New Report	TPL Suspect Report		
RT051	XX-New Report	TPL Activity Report		
RT052	XX-New Report	TPL Invoice Report		
RT116	XX-New Report	Non Pharmacy Cost Avoidance		
RT118	XX-New Report	Carriers Sent to the State Website		
RT201	XX-New Report	Casualty – Paid Amount – No Change Letter		
RT202	XX-New Report	Estate Recovery – Continuously On Medicaid Letter		
RT203	XX-New Report	Estate Recovery – Disabled Child Letter		
RT204	XX-New Report	Estate Recovery – Low Estate Value Letter		
RT205	XX-New Report	Estate Recovery – No Invoice With Disclaimer Letter		
RT206	XX-New Report	Estate Recovery – Hardship Denied Letter		
RT207	XX-New Report	Estate Recovery – Known Creditor Letter		
RT208	XX-New Report	Estate Recovery – Needs Additional Information To Not Pursue Letter		
RT211	XX-New Report	Casualty – Check Received, Additional Payments Made – Attorney Letter		
RT212	XX-New Report	Casualty – Check Received, No Disbursement Attached Letter		
RT213	XX-New Report	Casualty – Provider Must Refund Letter		
RT214	XX-New Report	Casualty – Recipient Must Refund – Paid By Attorney Letter		
RT215	XX-New Report	Casualty – County Settlement Notice Letter w/Report		





## Appendix 40, Attachment G Consolidated List of Reports



DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
RT216	XX-New Report	Casualty – Subrogation Notice Letter – Attorney		
RT217	XX-New Report	Casualty – Status Letter		
RT218	XX-New Report	Casualty – Subrogation Notice Letter – Insurance		
RT219	XX-New Report	Estate Recovery – Surviving Spouse Letter		
RT220	XX-New Report	Casualty – Initial Claim Letter Notes		
RT221	XX-New Report	Casualty – Update Claim Increase Letter		
RT222	XX-New Report	Estate Recovery – Administrator Letter		
RT223	XX-New Report	Casualty – Not Eligible Letter		
RT224	XX-New Report	Estate Recovery – Open Estate Letter		
RT225	XX-New Report	Estate Recovery – Status Letter		
RT226	XX-New Report	Estate Recovery – File Claim with Clerk Letter		
RT227	XX-New Report	Casualty – DSS Letter for Unanswered Trauma Diagnosis Questionnaire		
RT228	XX-New Report	Casualty – Itemization Letter		
RT229	XX-New Report	Casualty – No Compromise Letter – Attorney		
RT230	XX-New Report	Casualty – ProRata Letter – Attorney		
RT231	XX-New Report	Casualty – Recipient Must Refund Letter – Paid by Insurance Adjuster		
RT232	XX-New Report	Medicare – Post Payment Recovery Notice		
RT233	XX-New Report	Insurance Payment to Recipient/Subscriber		
RT234	XX-New Report	Check Letter for Vendor		
RT235	XX-New Report	Detail Report Explanation Letter		
RT236	XX-New Report	Detail Letter with Everything		



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
RT237	XX-New Report	Hardship Medicaid Letter		
RT238	XX-New Report	Facsimile Cover Letter		
RT239	XX-New Report	Casualty – Check Received, Additional Payments Made – Insurance Adjuster Letter		
RTAJH012	RTAR0121	POS Claim Submission Report (In Provider / ICN Order)	Provides a used of electronic claim submission by provider., sorted by ICN.	W-Fri
RTAJH012	RTAR0122	POS Claim Submission Report (In ICN Order)	Provider a list of list of electronic claim submission by ICN.	W-Fri
RTAJH013	RTAR0131	Daily POS Transaction Performance Plan	This report shows the response times that have occurred on point of sale transactions. It identifies the number of transactions per hour, and reports the average response time.	W-Fri
RTAJH030	RTAR0351	Pharmacy Prior Approval file Transaction Log	Listing of all added and changed records for the Pharmacy Prior Approval File.	D
RTAJH035	RTAN0353	POS Transaction Log		W-Fri
RTAJH550	RTAR5501	EDI Provider Revenue Detail	By provider, the amount of monies billed and collected for EDS proprietary transactions.	W-Fri
RTAJH550	RTAR5502	EDI Provider Revenue Summary	Summarizes the number of transactions, billed amounts, and collected amounts of the EDS proprietary activity.	W-Fri
RTAJH550	RTAR5551	Point of Sale Accounts Receivable By Provider		W-Fri
RTAJH550	RTAR5552	Eligibility Verification System Accounts Receivable By Provider		W-Fri
RTAJH550	RTAR5553	Electronic Remit Advice Accounts Receivable By Provider		W-Fri
RTAJH560	RTAR5601	NC Point of Sale Monthly Summarized VAN Charge Report	Shows the amount that will be manually billed to VAN.	M-1st day of month
RTAJH560	RTAR5602	NC Eligibility Verification Monthly Summarized VAN Charge Report	Shows the amount that will be manually billed to VAN.	M-1st day of month
RTAJH560	RTAR5651	NC EDI Monthly Summarized VAN Charge Report		M-1st day of month
RTAJH570	RTAR5751	NC POS Top 100 Drugs - By Total Amount Paid	This report providers Focus on drug most popularly prescribed by total dollar amount during the month, and is useful in budget and cost containment.	M-1st day of month



## Appendix 40, Attachment G Consolidated List of Reports



DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
RTAJH570	RTAR5752	NC POS Top 100 Drugs --By Total Number of Rxs	This report provides focus on the drugs most popularly prescribed by total number of prescriptions filled during the month, and is useful in drug utilization review processes.	M-1st day of month
RTAJH570	RTAR5761	NC POS Top 100 Drugs --By Drug Description	This report provides an alphabetical listing of the drugs from the "Top 100 Drugs by Total Amount Paid". Useful as a cross reference tool.	M-1st day of month
RTAJH570	RTAR5771	Drug Claims With Overrides for early Refill Alert	This report shows all claims entered in POS that had an override in the early refill. During alert. The prescription clarification code field.	M-1st day of month
RTAJH570	RTAR5791	Top 200 Drugs by Total Amount Paid	A Top 200 report that lists the top 200 brand/multisource/generic drugs grouped by GCN Seq # , ordered by decreasing total amount paid.	M-1st day of month
RTAJH570	RTAR57A1	POS Hospice Overrides - Paid Claims	This report summarizes provider overrides of the Hospice edit for which medicaid paid the claim.	M-1st day of month
RTAJH570	RTAR57C1	Recipient Lockin Report	This report lists all locked-inpaid claim activity for the reporting month.	M-1st day of month
RTAJH570	RTAR57C2	Recipient Lockin Summary	A listing of the locked in provider information for each locked in recipient.	M-1st day of month
RTAJH580	RTAR5741	NC POS Recipients Using More Than One Provider During First Month of Quarter	This report displays a list of the recipient who requested prescriptions from more than one provider during a one month period.	Q-First day of quarter
RTAJH580	RTAR5742	NC POS Recipients Using More Than One Provider During Second Month of Quarter	This report displays a list of the recipients who requested prescriptions from more than one provider during a one month period.	Q-First day of quarter
RTAJH580	RTAR5743	NC POS Recipients Using More Than One Provider During Third Month of Quarter	This report displays a list of recipients who requested prescriptions from more than one provider during a one month period.	Q-First day of quarter
RTAJH810	RTAR8201	NC PRO DUR - DUR Summary Activity Report By Therapeutic Class	Grouped by Alert, this report provides a monthly summary for PRO DUR, by Therapeutic Class.	M - First day of month
RTAJH810	RTAR8202	NC PRO DUR - DUR Summary Activity Report By GCN Sequence Number	Grouped by Alert, this report provides a monthly summary for PRO DUR, by GCN Sequence Number.	M - First day of month
RTAJH810	RTAR8301	NC PRO DUR - DUR Intervention Report	This report summarizes Pharmacist Intervention Codes against Action Taken in response to overridden alerts.	M - First day of month
RTAJH810	RTAR8401	NC MMIS ---- Top 10 Provider Alert Activity Report	This report focuses on 10 providers ranked with the highest alert override records over the past month.	M - First day of month
RTAJH810	RTAR8551	NC MMIS ----- Therapeutic Class Summary Report	This report provides a one page summary of alert activity, grouped therapeutic class, summarizing the number of alerts, number of non-response and reversal activity with each class.	M - First day of month



## Appendix 40, Attachment G Consolidated List of Reports



DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
RTAJH810	RTAR8651	NC MMIS ---- DUR Cost Savings By Drug Conflict Rpt	A Top 200 report that lists the top 200 brand/multisource/generic drugs grouped by GCN Seq # , ordered by decreasing total amount paid.	M - First day of month
RTAJH820	RTAR8203	NC PRO DUR - DUR Summary Activity Report By Conflict Code	This report is a on page summary of all drug alert activity for the month, by Alert type. Useful in PRO DUR review and analysis of alert trends.	other
RTAJH870	RTAR8801	Weekly Synagis Utilization	This report, intended for ACCESS Care, provides utilization information on this very expensive drug to ensure proper controls are in use by identified providers.	W
RTAJH970	RTAR8204	NC PRO-DUR DUR amummary Activity Report by GCN Sequence Number for Fiscal Year	Grouped by alert, this report providesan annual summary for PRO DUR by GCN Sequence Number Similar to RTAR8202 Monthly Summary, but this report omits MTD summary	A
RTAJH970	RTAR8204	NC PRO DUR - DUR Summary Activity Report By GCN Sequence Number For Fiscal Yr	Grouped by Alert, this report provides an annual summary for PRO DUR, by GCN Sequence Number. Similar to RTAR8202 Monthly Summary, but this reprot omits MTD Data.	A-First day of October
RX039	XX-New Report	Recipient Claim Explanation of Medicaid Benefits Selection Errors		
RX043	XX-New Report	State Fiscal YTD Summary of Check Runs		
RX044	XX-New Report	MMIS Explanation of Medical Benefits		
RX045	XX-New Report	Final Payment Summary		
RX046	XX-New Report	Final MMIS Payment Register		
RX047	XX-New Report	Financial Transaction Summary		
RX048	XX-New Report	Register by Provider Type		
RX051	XX-New Report	Preliminary Payment Summary		
RX053	XX-New Report	Remittance Activity Control Totals		
RX054	HMDR2000 (aka CHEKPRNT)	Remittance Advice		
RX059	XX-New Report	Check Register Summary Report		
RX064	XX-New Report	Fiscal Payment Summary Report		



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
RX103	XX-New Report	REOMB Summary Report – Recipient Sequence		
RX104	XX-New Report	REOMB Control Report Provider Sequence		
RX121	XX-New Report	POS Pharmacy Listing		
RX124	XX-New Report	Payment Cycle Category of Service Summary		
RX126	XX-New Report	Annual Category of Service Summary		
RX134	XX-New Report	New Financial Transactions Report		
RX140	HMDR209N IPDR209N	Claims Reimbursement by Category of Service		
RX165	BH024SPG	POC-CBS Amt & # claims by program	POMCS – Amount Paid and Number of Claims by Program	
RX167	BH024SPJ1	POC-CBS Amt & # claims by first initial patients last name within program	POMCS – Payment Amount and Number of Claims by First Initial of Recipient's Last Name Within Benefit Plan	
RX210	HMER1051	Pharm Mcare Cost Avoidance Claims Denied	Pharmacy Medicare Cost Avoidance Claims Denied	
RX213	BHA9914	Expenditures for Cystic Fibrosis Cases for fiscal yr 2003-2004	Types of Service Eliminated: Formula, Supplies, Physical and Speech Therapy, Appliances & Special Instruction	
RX216	HMDRS01N (a.k.a HMDRSOON_01 or HMDRSOON01)	Duplicate Claim Statistics		
RX217	HMDRS02N (a.k.a. HMDRSOON_02 or HMDRSOON02)	Monthly Summary of Returned Claims		
RX244	HMDR2003 (a.k.a. ANPAGOWH)	Withholding Report		
RX247	HMDS219N	Checkwrite Financial Summary		
RX285	IPGR5501	Utilization Report by Attending Provider/Benefit Plan		



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
RX298	XX-New Report	Denied Details By Threshold/County/Prov/EOB (Monthly)		
RX298	XX-New Report	Denial Report (AB-I)		
RX298	XX-New Report	Denial Report (AB-III)		
RX298	XX-New Report	Denial Report (C-I)		
RX354	(a.k.a HMDRSOON04 or HMDRS00N_04)	Financial Aged Analysis From System Entry to Payment Date		
RX416	XX-New Report	Fiscal Pend Claims – Insufficient Funds		
RX417	XX-New Report	Pended Claims – Provider On Hold		
RX430	XX-New Report	Invalid Provider ID Report		
RX434	BH024MH	POMCS: Migrant Health Services Payment Summary Rpt	POMCS: Migrant Health Services Payment Summary Rpt	
RX437	HCA9301E-7	Migrant Health Program - Special Rpt - Tot # of Clms & Tot Cost of Claims Paid	Migrant Health Program – Special Rpt – Tot # of Clms and Tot Cost of Claims Paid By Diagnosis	
RX438	HCA9301E-8	Migrant Health Program - Top Ten # of Claims Paid	Migrant Health Program– Top Ten # of Claims Paid	
RX439	HCA9301E-9	Migrant Health Program - Top Ten Amt of Claims Paid	Migrant Health Program – Top Ten Amt of Claims Paid	
RX460	IPKR3831	Client Count for AMOLM Eligibility Program Report		
SRACA010	HMAI031R	Activated Claims	Listing of claims activated the previous day.	D
SRACA010	HMAR010N	Batch Acceptance Report	Listing of batches transmitted in-house.	D
SRACA010	HMAR011N	Total Claim Activity	Breakdown by claim type and number of batches transmitted in-house.	D
SRACA010	HMAR012N	Rolling Transaction File Activity	Listing of non-claim transactions transmitted in-house, such as adjustments.	D
SRACA015	HMAR010N	Batch Acceptance Report	Listing of batches transmitted from DSA.	D
SRACA015	HMAR011N	Total Claim Activity	Breakdown by claim type and number of batches transmitted by DSA.	D
SRACA015	HMAR012N	Rolling Transaction File Activity	Listing of non-claim transactions transmitted by DSA, such as adjustments.	D
SRAJA004	HMAR0041	ICN Activation Log	List of Julian Dates and ICN's by Claim Type for each work day of the year for batch activation.	A - Dec
SRAJA004	HMAR0041	ICN Activation Log	List of Julian Dates and ICN's by Claim Type for each work day of the year for batch activation.	A - Dec



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
SRAJA030	HMAR030N-01	Batch Activity	Lists of claims status on claims that have been keyed and activated. If a claim has been activated and not keyed, it is reported. If a claim has been keyed and not activated, it is reported. Keyed and activated claims are not reported.	W-Fri
SRAJA030	HMAR030N-02	Deleted Claims & Activations	Lists of unactivated claims deleted and activations deleted.	W-Fri
SRAJA030	HMAR030N-03	Total Activity Report	Shelf inventory counts.	W-Fri
SRAJA030	HMAR3501	EPSDT Claims	Listing of system generated EPSDT claims. These are region 45, developed from the HCFA 1500 claim with the same batch and sequence number.	W-Fri
SRAJA040	HMAR0401	Tape Billing Title XIX Claim Statistics	Lists each provider with the total claims submitted and the total billed amounts.	D
SRAJA040	HMAR0671	Tape Bill Claims Region 15	Provides a list of tape billings by provider (region 15 claims).	D
SRAJA040	HMAR960N	UTS Error Report for Tennessee	Lists error messages about the record sequence.	D
SRAJA040	HMAR9611	Texas BCBS Claims	Claims crossed over from Blue Cross Blue Shield of Texas.	D
SRAJA040	HMAR9611	Wisconsin BCBS Crossover Claims	Claims crossed over from Blue Cross Blue Shield of Wisconsin.	D
SRAJA040	HMAR9611	Tennessee BC/BS Riverbnd Crossover Claims	Claims crossed over from Blue Cross Blue Shield of Tenn (rural health). List is by Financial Payer	D
SRAJA040	HMAR9611	NC BCBS Crossover Claims	Claims crossed over from Blue Cross Blue Shield of North Carolina.	D
SRAJA040	HMAR961N	Trailblazer UTS Error	Lists error messages about the record sequence.	D
SRAJA040	HMAR962N	Palmetto Part A UTS Error	Lists error messages about the record sequence.	D
SRAJA040	HMAR963N	Wisconsin UTS Error	Lists error messages about the record sequence.	D
SRAJA050	HMAR0501	Encounters Claims	Encounter claims submission claims	D
SRAJA050	HMAR0511	MCO Activity Report (HCFAs)	Describes the number of encounter claims received on the HCFA format and tells number of records supplied; missing, and ignored.	D
SRAJA050	HMAR0521	MCO Activity Report (Ubs)	Describes the number of encounter claims received on the uniform billing format and tells number of records supplied, missing, and ignored.	D
SRAJA054	HMAR0551	Encounters Error Rpt (Replacements not applied)	Complete claim replacements for error correction.	W-Fri
SRAJA060	HMAR0605	SE Totals & Provider Totals	Listing of the total number of electronic claims (region 25) submitted by claim type and provider number	D
SRAJA060	HMAR0606	ECS - Error Claims	Daily report of electronically submitted claims not accepted due to format errors.	D
SRAJA060	HMAR0608	Bad Record Report	Lists records with invalid information, invalid record ID, bad From Date of Service, etc...	D
SRAJA060	HMAR0672	ECS Claims Region 25	Provides a list of electronic claim submissions (region 25 claims) by financial payer and population group	D
SRAJA061	3780 & CLMXMIT	3780 and MicroECS Xmit	Claims data as transmitted by the provider prior to input conversion.	D



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
SRAJA061	HMAR0590	Processed Recoupments for NCXIX	The claims reported here are voided claims submitted to Medicaid in the HIPAA compliant format that have more 28 details billed, because current claims processing can process up to 28 details only, these are extracted from upon entry and reported here. T	D
SRAJA061	HMAR0591	Processed Recoupments For NCDMH	The claims reported here are voided claims submitted to Mental Health in the HIPAA compliant format that have more 28 details billed, because current claims processing can process up to 28 details only, these are extracted from upon entry and reported here	D
SRAJA061	HMAR0605	SE Totals & Provider Totals	Listing of the total number of electronic claims (region 25) submitted by claim type and provider number	D
SRAJA061	HMAR0608	Bad Record Report	Lists records with invalid information, invalid record ID, bad From Date of Service, etc...	D
SRAJA061	HMAR0672	ECS Claims Region 25	Provides a list of electronic claim submissions (region 25 claims) by financial payer and population group	D
SRAJA062	HMCR3051	Claims Submission Report	Provides Claims Submission totals by claim type and provider type/specialty.	D
SRAJA066	HMAR0661	Transaction Log for 276/277 Claim Status Request and Response	Transaction Log to record pertinent 276 and 277 transaction data entering and exiting the system.	W-Th
SRAJA070	HMAR0711	Data Corrections Activity	Report of all data corrections applied to claims. Identifies the change transaction, the clerk applying the change, and the outcome (accepted or rejected).	W-Fri
SRAJA070	IPAR0711	Data Corrections Activity	Report of all data corrections applied to claims. Identifies the change transaction, the clerk applying the change, and the outcome (accepted or rejected).	Weekly
SRAJA080	HMAR0801	EPSDT Claims-Tape	Daily list of EPSDT Claims with Encounters data.	D
SRAJA082	HMAR0821	EPSDT Claims-Encounter	A list of Encounter claims that create Health Check L Claims.	D
SRAJA085	HMAR0851	DHS Immuniz. & EPSDT Claims-ECS	Daily list of DHS Immunizations and EPSDT claims submitted electronically.	D
SRAJA086	HMPR210N	Separated Claims Report	Displays claims were separated and the total numbers that were separated.	W-Fri
SRAJA088	HMAR088N	Failed Payout Report	Report showing errors from weekly payouts.	W-Fri
SRAJA095	HMPR0952	Security File Master Summary	Summary of the security master file with one entry per clerk ID.	M-Last Sun in month
SRAJA098	HMBR2001	Bene Profile Current Hx Requests	Lists all profile requests for current and purged history.	W-Fri
SRAJA110	HMAR1111	Mcare Part C Rejected From Spreadsheet	Rejected records from spreadsheet sent from Third Party Recovery Department at DMA for Part C claims for processing.	W





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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
SRAJA110	HMAR1112	Mcare Part C Accepted From Spreadsheet	Accepted records from spreadsheet send from Third Party Recover Department at DMA for Part C claims for processing. History adjustment requests and data corrections built for these claims processes thru production cycle.	W
SRAJA130	HMAR1303	Edit Failure (ESC)		W-Fri
SRAJA160	HMAR1612	Drug Utilization Review - Claims with DEA Number Not on File	Claims with DEA Number not on File.	W-Fri
SRAJA160	SWRA1621	Provider Addresses		W-Fri
SRAJA220	LABELS	Labels		D
SRAJA280	HMAR2801	Cheshire Labels		OR
SRAJA280	LABELS	Special Provider File Listing	Print labels for providers.	OR
SRAJA280	LABELS	Peel & Stick Labels		OR
SRAJA950	HMAR9591	HCFA 1400 NSF COB Claims	Region 40 Claims Report for HCFA Medicare Crossovers (Equicor)	D
SRAJA950	HMAR9591	Daily Displays		D
SRAJB100	HMBR1001	Audit Record (NR) Transaction Log		W-Wed
SRAJB100	HMBR1002	Audit Record (NR) Master Rpt	This report lists all of the criteria for each audit record on the master file.	W-Wed
SRAJB100	HMBR1101	Audit Criteria (NC) Transaction Log	TRLOG report of changes made to Audit Criteria file using the NC screen	W-Wed
SRAJB100	HMBR1102	Audit Criteria (NC) Master Rpt	Master listing of all records on the Audit Criteria File.	W-Wed
SRAJB100	HMBR1201	Audit Procedure (NP) Trans. Log	TRLOG report of changes made to Audit Procedure List file using the NP screen	W-Wed
SRAJB100	HMBR1202	Audit Procedure (NP) Master Rpt	Complete master listing of all records on the procedure list (NP) screen.	W-Wed
SRAJB100	HMBR1301	Audit Diagnosis(ND) Trans. Log	TRLOG report of changes made to audit diagnosis list file using the ND screen	W-Wed
SRAJB100	HMBR1302	Audit Diagnosis(ND) Master Rpt	Audit Dignosis master report.	W-Wed
SRAJB100	HMBR1401	Audit Claim Type(NT) Trans. Log	TRLOG report of changes made to audit claim type criteria file using the NT screen	W-Wed
SRAJB100	HMBR1402	Audit Claim Type(NT) Master Rpt	Master report of all records on the audit claim type file (NT) screen.	W-Wed
SRAJB100	HMBR1501	Audit Modifier (NM) Trans. Log	TRLOG report of changes made to audit modifier file using the NM screen	W-Wed
SRAJB100	HMBR1502	Audit Modifier (NM) Master Rpt		W-Wed
SRAJB175	HMBR1781	Pharmacy Claims TPL Override Codes Weekly Override Usage	Lists all POS claims from the week that had override usage by the pharmacy.	W-Fri



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
SRAJB200	HMAR1501	Encounters Error Report - Healthcheck Combined Records	Report of errors resulting from combining L and J claims that were separated earlier for HealthCheck processing.	W-Fri
SRAJB200	HMBR2002	Duplicate Adjustment Request	Report listing duplicate adjustments	W-Fri
SRAJB200	HMBR2211	PCG Upfront Audit Report	List of PCG Repayments that were already paid.	W-Fri
SRAJB320	HMBR3201	NC Audit Failure Analysis	Weekly report listing the number of failures for each audit process. Contains the audit number and the number of failures.	W-Fri
SRAJB320	HMBR3251	Audit 9940 Overrides	Weekly report listing the claims that had audit 9940 overridden. Audit 9940 is the high payment claim review edit.	W-Fri
SRAJB350	HMBR3661	Recipients with Recorded FTD		W-Fri
SRAJB400	HMBR4001	Recipient Profiles - current hx	The purpose of this report is to provide detail information about a recipient of Medicaid services. This report can be requested on any recipient. The user has the ability to select certain records for a recipient, based upon cloaim type, provide number	W-Fri
SRAJB400	HMBR4601	Adjustment Message Summary Totals	There is two versions of this report. Hmbr4601-Ncxix reflects adjustment entered for regions 90,93,95, and 98. There is also an adjustment message summary total section.  The second version of this report is HMBR4601- other. This version reflects adjust	W-Fri
SRAJB400	HMBR4602	Adjustments Entered	This adjustments entered report is specific to region 93 adjustments with batch range 930 (Drug Rebate) along with an adjustment message summary total section.	W-Fri
SRAJB607	HMBR4001	Recipient Profiles - current hx	The purpose of this report is to provide detail information about a recipient of Medicaid services. This report can be requested on any recipient. The user has the ability to select certain records for a recipient, based upon cloaim type, provide number	W-Fri
SRAJB607	HMBR6001	Recipient Profile Purged History Request	Lists all profile requests for purged history.	W-Fri
SRAJB670	HMBI6761	Estate Recovery Mailing Labels	Labels produced to mail out estate recovery invoices.	W-Fri
SRAJB670	HMBR6701	Estate Recovery Recipients Invoiced	Invoices for services received.	W-Fri
SRAJB670	HMBR6821	Estate Recovery Invoices	Invoices for deceased recipients maintained in a long term care facility. Printed in Troy on 8 1/2 x 11 white laser paper.	W-Fri



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
SRAJB680	HMBR6811	Estate Recover Invoice Detail	Weekly listing of recipients deceased more than 59 days and data used in the invoice computation. Printed in Troy on 8 1/2 x 11" white laser paper	W-Fri
SRAJB680	HMBR6821	ER Reprint	Reprint of estate recovery invoices. Printed in Troy on 8 1/2 x 11" white laser paper.	W-Fri
SRAJB800	HMBR8100	Monthly Sterilization	Monthly listing of all sterilizations paid during the month.	ME/MP
SRAJB800	HMBR8300	Monthly Hysterectomy	Monthly listing of all hysterectomies paid during the month.	ME/MP
SRAJB800	HMBR9511	Monthly Abortion - Life of the Mother	Monthly list of Medicaid recipients receiving abortions to save the mother's life.	M
SRAJB800	HMBR9512	Monthly Abortion - Rape	Monthly list of Medicaid recipients receiving abortions due to rape.	M
SRAJB800	HMBR9513	Monthly Abortion - Incest	Monthly list of Medicaid recipients receiving abortions due to incest.	M
SRAJB800	HMBR9514	Monthly Abortion - Other	Monthly list of Medicaid recipients due to all other reasons	M
SRAJB820	HMBR8201	DME Procedures Ranked by Provider Total Amount Paid - State Fiscal Year Sequenced by Provider Number.	This report contains DME procedures ranked by provider total amount paid.	
SRAJB820	HMBR8202	HH Procedures Ranked by Provider Total Amount Paid - State Fiscal Year Sequenced by Provider Number	This report contains Home Health procedures ranked by provider total amount.	
SRAJB820	HMBR8203	DME Procedures Ranked by Provider Total Amount Paid - State Fiscal Year	This report contains DME procedures ranked by provider total amount paid.	
SRAJB820	HMBR8204	HH Procedures Ranked by Provider Total Amount Paid - State Fiscal Year	This report contains Home Health procedures ranked by provider total amount.	
SRAJB820	HMBR8205	DME Summary By Procedure Code	This report contains a summary of DME procedures.	
SRAJB820	HMBR8206	HH Summary by Procedure Code	This report contains a summary of Home Health procedures.	
SRAJB820	HMBR8207	DME by Procedure Code by Provider - Ranked Total Paid Amount Descending	This report contains DME procedures by procedure code and provider ranked by the total paid amount.	
SRAJB820	HMBR8208	HH By Procedure Code by Provider - Ranked Total Paid Amount Descending	This report contains Home Health procedures by procedure codes and ranked by the total paid amount.	
SRAJB850	HMBR8531	Estate Recovery In-process	Monthly listing of estate invoices not yet recovered.	M-1st Sat



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
SRAJB850	HMBR8541	Estate Recovery Financial	Monthly listing of estate recoveries versus the invoiced amount. Gives month to date and year to date totals.	M -1st Sat
SRAJB900	HMBR9500	Hysterectomy & Ster. - Sterilization Summary	Quarterly summary of hysterectomies and sterilizations	Q
SRAJB900	HMBR9503	Hysterectomy & Ster. - Hysterectomy details	Quarterly report on sterilizations and hysterectomies with hysterectomy details.	Q
SRAJB900	HMBR9504	Hysterectomy & Ster. - Sterilization details	Quarterly report on sterilizations and hysterectomies with sterilization details.	Q
SRAJB900	HMBR9511	Qtrly Abortion - Life of the Mother	Quarterly statistics of Medicaid recipients receiving abortions to save the mother's life.	Q
SRAJB900	HMBR9512	Qtrly Abortion - Rape	Quarterly statistics of Medicaid recipients receiving abortions due to rape.	Q
SRAJB900	HMBR9513	Qtrly Abortion - Incest	Quarterly statistics of Medicaid recipients receiving abortions due to incest.	Q
SRAJB900	HMBR9514	Qtrly Abortion - Other	Quarterly statistics of Medicaid receiving abortions for all other reasons.	Q
SRAJC200	HMC1202R	Location 25 Report	A list of claims suspending worksheets to location 25.	W-Fri
SRAJC200	HMC1203R	Location 21 Report	A list of claims suspending worksheets to location 21.	W-Fri
SRAJC200	HMC1204R	Location 24 Report	A list of claims suspending worksheets to location 24.	W-Fri
SRAJC210	HMCR2101	Suspended Providers	This report identifies providers that have an action reason code of 21 or 22 on the provider file. These providers' claims have suspended to prevent payment until a financial decision and action can be performed on the provider's funds. These claims are	W-Fri
SRAJC210	HMCR2151	Providers With Bad Address on Provider File	This report shows all providers that have been flagged with action reason code 25. This code is only given to providers that have an incorrect address on the provider database. The report shows all suspended provider activity and specific provider infor	Fri
SRAJC250	HMCR1201	Aged Inventory by Location	Provides, by location, a matrix of aged inventory by financial payer. Categories are pre-machine and exception location; which are further broke down. The inventory is separated into columns that identify claims by a range number of days.	W-Fri
SRAJC250	HMCR1301	Aged Inventory -System	Provides, by location, a matrix of age inventory by financial payer. Categories are pre-machine and exception location, which are further broke down. The inventory is separated into columns that identify claims by a range number of days.	W-Fri
SRAJC250	HMCR1401	Inventory & Production Regions	Provides, by location, a matix of inventory and production regions by financial payer. Categories are pre-machine and exception location, which are further broke down. Related column information includes beginning and ending inventory Clms PCT, and clai	W-Fri



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
SRAJC250	HMCR1451	Medicaid Program Status	Provides a status of Medicaid Program Codes by Claim type. Checkwrite report listing claim category inventory, claims >3 days in suspense, finalized claims and receipts.	W-Fri
SRAJC250	HMCR1501	Error Summary	Provides a list of claim errors by financial payer. Claim errors are further broke down into two types: new claims and corrected claims. Within these types are the categories drug, medical, dental, EPSDT, and outpatient. For each category within both t	W-Fri
SRAJC250	HMCR1601	Released to Finance	Provides a list of claims and cutback amounts by claim type, by financial payer. List fields for claims include total, denied, paid, returned, and are followed by total billed amount. List fields for cutback amounts include other, pricing, medical revie	W-Fri
SRAJC250	HMCR1801	Weekly Aged Claim Listing	Provides, by region, weekly aged claims by financial payer. List fields include location, claim type, claim number, provider name, recipient ID, recipient name, service dates, billed, system, and lcoation.	W-Fri
SRAJC250	HMCR1951	Error Analysis Report	Provides an error analysis report by financial payer and population group. Report fields are by number of times this error was set on claim type and include a description and number of errors for each claim type.	W-Fri
SRAJC250	HMCR2601	System Generated Adjustments	Provides a list of system-generated adjustments by financial payer.	W-Fri
SRAJC300	HMCP300N	Fixed Worksheets		W-Fri
SRAJC300	HMCP300T	Audits		W-Fri
SRAJC300	HMCR3001	Worksheet Totals	This reports lists the total amount of worksheets created for a particular cycle date. The totals are listed by select categories such as location, region, etc. The last category listed on the report is the grand total amount.	W-Fri
SRAJC300	XX-New Report	MSGSET	This report lists the total amount of worksheets created for a particular cycle date. The totals are listed by select categories such as region, location, etc. The last category listed on the report is the grand total amount.	W-Fri
SRAJC400	HMCR4501	Audit Reports for Post-Payment Review	Lists claims for review. Contains current/historical claim details, audit number, and test message.	W-Fri
SRAJC600	HMCR6001	DEHNR Immunization Claims	Weekly system generated K305 claims for immunizations from thr Department of Environmental Health and Natural Resources.	W-Fri
SRAJD130	HMDR1301	Void Check TR Log	TR Logs for the VC online screen.	other
SRAJD150	HMDR1506	Denied Claims >= 300 Days with EOB 297	Reports Claims over 300 days old which were denied with EOB 297.	CW
SRAJD150	HMDR1507	Location 82 Claims by Provider and EOB	Report contains, by provider, the total number of claims, total by EOB number and number of claims.	CW



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
SRAJD150	HMDR1508	Denied Claims by Claim Type and EOB	Provides, by date and EOB, a list of denied claims by financial payer. List fields include claim type, EOB, number of claims	CW
SRAJD150	HMDR1509	Crossover Paid B Zero/Denied	Reports claims/providers that either receive a paid zero amount or claims that are denied, by EOB and ESC as a result of pricing comparison to straight medicaid allowed amounts.	CW
SRAJD150	HMDR1571	Denied Claims fo new Providers by Number and EOB	List of denied claims from new providers by provider number and EOB number.	CW
SRAJD170	HMDR1701	Provider Refunds TR Log	TR Log for the RC online screen.	CW
SRAJD200	CHEKSUMY	Checkwrite Financial Summary	Summarization of net checkwrite cost to DMA for the checkwrite cycle. Bottom line is the amount to be deposited by DMA to cover checks. (Report 2 Web report name is HMDR2191)	CW
SRAJD200	CHKFINXLS	Checkwrite Financial Summary		
SRAJD200	HMDR2000	Remittance Advice Status Report	The Remittance and Status Report, or Remittance Advice (RA), is a computer generated document showing the status of all claims submitted to EDS, along with a detailed breakdown of payment. The RA is produced at the same time that checks or electronic fun	CW
SRAJD200	HMDR2003	99999AGO After Net Pay Withholding	After net pay AGO Withholdings	CW
SRAJD200	HMDR2004	99999IRS After Net Pay Withholding	After net pay Internal Revenue Service Withholdings	CW
SRAJD200	HMDR2006	99999IECS After Net Pay Withholding	After net pay electronic claims submission withholdings	CW
SRAJD200	HMDR2007	99999NCR After Net Pay Withholding	After net pay North Carolina Revenue Withholdings (automail file name is ANPNCRWH)	CW
SRAJD200	HMDR2008	99999DMA After Net Pay Withholding	After net pay Division of Medical Assistance Withholdings	CW
SRAJD200	HMDR2012	IRS Withholding Report	Report listing provider name/number, tax ID and amounts of IRS withholding (current, quarter, and ytd)	CW
SRAJD200	HMDR204N	Financial Reports Financial Transaction Control	Listing of all dispositions of refunds, recoupments processed and errors in dispositioning refunds, ordered by provider number sequence.	CW
SRAJD200	HMDR209N	Provider Reimbursement Rpt	Provides a matrix of category of claim services by claims, visits, billed, allowed, co-pay, disposition fee, apyable, and paid. Claim categories are ambulance, clinics, subtotal screen/clinics/family, subtotal all other categories, and total all other ca	CW
SRAJD200	HMDR210N	Provider Cash Report	Provides a matrix of combined provider cash by category of service. The categories are ambulance, clinics – free standing, clinics – health, and clinics – mental health.	CW



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
SRAJD200	HMDR211N	Monthly Billing Report	Provides a monthly billing report divided into different claim sections. These sections are for non-edit failure claims, edit failure claims – location 27, total of non-edit failure claims and edit failure claims – location 27, total claims, total payable	CW
SRAJD200	HMDR212N	Monthly Billing Report	Report is the second page of HMDR211N. Provides a monthly billing report divided into different claim sections. These sections are for non-edit failure claims, edit failure claims – location 27, total of non-edit failure claims and edit failure claims –	CW
SRAJD200	HMDR2191	Checkwrite Financial Summary	Summarization of net checkwrite cost to DMA for the checkwrite cycle. Bottom line is the amount to be deposited by DMA to cover checks.	CW
SRAJD200	HMDR2251	Electronic Funds Transfer Activity	Provides a list of electronic fund transfers by provider number, old bank, old account, new bank, new account, DDA status, EFT status, amount and action.	CW
SRAJD200	HMDR2252	EFT Activity Prenot, Cancel & Bad Co Txn	Provides a list of electronic fund transfers by provider number, old bank, old account, new bank, new account, DDA status, EFT status, amount and action.	CW
SRAJD200	HMDR2281	PGC Repayment Request	Reports on PCS-initiated repayment requests that were paid.	CW
SRAJD200	HMDR2282	Provider Repayment Request	Reports on all provider-initiated repayment requests that were made.	CW
SRAJD200	HMDR2283	PCG/Provider Repayment Request	Grand total report on all PCG/Provider paid amounts and number of adjustments.	CW
SRAJD200	HMDR2291	Provider Bank Status Update	Provides a list of providers/financial payers updated when their EFT prenotification is activated.	CW
SRAJD200	HMDR2501	MTD Claim Payment Summary	Provides in a matrix month-to-date claim payment information by date and MTD. This information includes claim payment, DMA authorized payouts, reissue, recoupment, IRS withheld, point-of-sale, check issue, interest payout, and penalty payout, etc.	CW
SRAJD200	HMDR270R	Schedule of Electronic Funds Transfers	Contains the provider numbers, old/new bank and account numbers, DDA savings, EFT status, amount and action taken.	CW
SRAJD200	RAF	RA MicroF		CW
SRAJD205	CHEKPRNT	Checks	Refer to report HMDR2000	CW
SRAJD205	RAPRINTL	Large RA's	Printed Ras to mail to the providers. Over 10 pages.	CW
SRAJD205	RAPRINTS	Small RA's	Printed Ras to mail to the providers. Under 10 pages.	CW
SRAJD230	ANPAGOWH	After Net Withholding	After Net Pay AGO Withholdings (Report 2 Web report name is HMDR2003)	CW
SRAJD230	ANPDMAWH	After Net Withholding	After Net Pay Division of Medical Assistance Withholdings (Report 2 Web report name is HMDR2008)	CW
SRAJD230	ANPECSWH	After Net Withholding	After Net Pay Electronic Claims Submission Withholdings (Report 2 Web report name is HMDR2006)	CW
SRAJD230	ANPIRSWH	After Net Withholding	After Net Pay Internal Revenue Service Withholdings (Report 2 Web report file name sent is HMDR2004)	CW



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
SRAJD230	ANPNCRWH	After Net Withholding	After Net Pay North Carolina Revenue Withholdings (Report 2 Web report name is HMDR2007)	CW
SRAJD245	HMDR2451	Management Transaction Processing Fees report	Detail count of eligibility transactions fees incurred by fin payer/provider for each checkwrite cycle.	CW
SRAJD250	HMDR1501	Adjustment Tracking Report	Report listing the paid, denied, and pending adjustments. Only a partial report continue to print on paper.	CW
SRAJD250	HMDR1601	EOB 7700	This report shows the claim details that denied with EOB 7700, which means that the type of treatment (TOT) code submitted by the provider does not match the type of service (TOS) on the claim. The TOS is assigned based upon the modifier submitted on the	CW
SRAJD250	HMDR1801	Drug Claims Paid More Than \$500	List all batch and POS paid claims with paid amount > \$1000	CW
SRAJD250	HMDR1811	Drug Claims Overrides for Edit 907	This report shows all claims entered in batch or POS that had an override for the maximum quantity edit 907	CW
SRAJD300	DETLDATA	Mental Health Detail File		
SRAJD300	HMDR202N	External Checks Voided Manual Issue Checks	Provides a list of checks manually issued. Also provides a range of external check numbers voided.	CW
SRAJD300	HMDR3003	Provider Check Pull Report	List of providers that have their check or RA sent to them via an overnight service.	CW
SRAJD300	HMDR3201	Check Register	Provides a check register list by external check, internal check, provider number, provider name, claims paid, net pay amount (according to claim), POS and EDI amount, IRS withholding amount, other withholding amount, and adjusted net pay amount.	CW
SRAJD300	HMDR3601	Manual Check Report	Lists manual checks. The federal and non-federal shares are reflected in both the detail and totals	CW
SRAJD300	HMDR3602	Manual Check Error Report	Lists manual checks not produced during the checkwrite cycle. This report should not have any data. Notify Sys if there are checks listed on this report.	CW
SRAJD300	HMDR3603	Manual Check Input Records	Lists the input for manual checks.	CW
SRAJD300	HMER2152	Finalized Claim Billing Report	Provides a list for each checkwrite by claim type, for finalized claims by financial payer. List fields include claims paid, denied, and total; and details paid, denied, and total	CW
SRAJD300	MANLDATA	Manual Check FTP File	Report listing all providers who received manual checks.	CW
SRAJD300	MANLDATA	Manual Check FTP File	Report listing all providers who received manual checks.	
SRAJD300	MANLLET	Adresses		CW
SRAJD300	MANLLETT	Manual Check Letter	Information to print manual check letters to be sent to providers.	
SRAJD300	PROV3601	Manual Check		
SRAJD300	SUMMDATA	Mental Health Summary File		CW





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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
SRAJD310	HMDR3131	Weekly Budget Expenditure Report	Shows detailed and summary budget information by payer.	CW
SRAJD315	HMDR3151	Program Expenditure Report	Contains PER numbers by COS for the checkwrite week.	CW
SRAJD315	HMDR3152	Weekly Financial Participation Report	Contains FPR numbers by COS for the checkwrite week.	CW
SRAJD315	HMDR3155	Weekly QPH	This report contains the weekly combined FPR amounts for the Qualified Public Hospitals	W
SRAJD350	HMDR3501	Cash Receipt Totals	Provides a list of cash receipts totals by Financial RTF records and their total count and total amount.	CW
SRAJD350	HMDR3502	Totals	Provides a summary of total void setups, total refunds, setups, 016, 017, total void dispositions, and total refund dispositions.	CW
SRAJD350	HMDR350D	Cash Receipts Dispositions	Provides a list of cash receipt dispositions by control number, action code, disposition code, RSN code, disposition date, original amount, disposition amount, benefit MID, AR CCN, P/I observed.	CW
SRAJD350	HMDR350H	Void Dispositions Held	Provides a list of void dispositions held by CCN, transaction type, clerk, date keyed, MID, ICN, disposition amount, and history indicator.	CW
SRAJD350	HMDR350S	Cash Receipts Setups	Provides a list of cash receipt setups by control number, action code, cash date, provider name, provider number, internal check number, MICR number, and check amount.	CW
SRAJD350	HMDR3561	Outstanding and Setup Voided Checks	Shows the Void Check Setup information.	CW
SRAJD350	HMDR3562	Void Check Errors	Shows the Void check Setup Error information.	CW
SRAJD350	HMDR3571	Provider Refund	Shows the Refund Check information.	CW
SRAJD350	HMDR3572	Provider Refund Error	Shows the Refund Check Setup Error information.	CW
SRAJD400	HMDR0101	Report of Reports	Provides a list of reports by report number and report title.	CW
SRAJD400	HMDR0102	Batch Summary	List of batch totals entered and whether they are suspended or released.	CW
SRAJD400	HMDR0104	Input Exceptions	Invalid cash receipt items.	CW
SRAJD400	HMDR0120	Cash Receipt Setups	Details of each cash receipt batch entered	CW
SRAJD400	HMDR0121	Cash Receipt Dispositions	List of all dispositions of refunds keyed during the cycle, ordered by batch number and julian date.	CW
SRAJD400	HMDR012A	Cash Receipt Setups	Cash receipt setups	CW
SRAJD400	HMDR0140	Account Receivable Setups	Provides a list of accounts receivable setups by control number, action code, program code, setup date, provider name, provider number, COS, and original amount.	CW
SRAJD400	HMDR0141	Account Receivable Settlements	List of all account receivable corrections of bad debt write offs	CW
SRAJD400	HMDR0142	Accounts Receivable Changes	List of changes to existing accounts	CW



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
SRAJD400	HMDR014A	Accounts Receivable Changes	Accounts Receivable Changes To Header.	CW
SRAJD400	HMDR0161	Check Dispositions	List of all checks previously issued by EDS which are now being voided.	CW
SRAJD400	HMDR4003	AR Manual Transfers Report	List of all manual recoupments that were transferred to another provider number during the cycle.	CW
SRAJD450	HMD4101	Corrected 1099	Corrected 1099 information such as dollar amount and provider information.	OR
SRAJD450	HMD4102	Provider Copy of 1099 (MSWORD)	Forms for printing corrected 1099's	OR
SRAJD450	HMD4103	Labels	Labels for corrected 1099's	OR
SRAJD450	HMDR4101	Corrected Misc 1099 Audit Report	Report contains provider number, year, new and old TIN, old and new IRS name, new IRS name amount, and IR ytd total.	OR
SRAJD450	HMDR4102	Provider Copy of 1099 (MSWORD)	Forms for printing corrected 1099's	
SRAJD450	HMDR4103	Labels	Labels for addressing the 1099's.	
SRAJD455	HMDR4001	1099 Mismatch Report	Report contains the group number, group TIN, group IRS name, individual number, individual TIN, individual IRS name and IRS ytd amount.	OR
SRAJD455	HMDR4002	1099 Labels	Labels for addressing the 1099's.	OR
SRAJD460	HMDR4201	IRS Tape Corrected Misc 1099 Audit Report	Audit report of new 1099 requests to be sent to Irs.	A-Mar
SRAJD462	HMDR4221	1099 Reporting	This report is run one time for current MISC 1099 reporting and up to 2 additional times showing prior year 1099 corrections.	A
SRAJD500	HMDR0201	Report of Reports	Provides a list of reports by report number and report title.	CW
SRAJD500	HMDR0202	Update Control Totals	Provides update control totals for cash receipts and accounts receivable.	CW
SRAJD500	HMDR0220	Update Exceptions - Cash	This report lists any checks that could not process in the system.	CW
SRAJD500	HMDR0240	Accounts Receivable-Update Exceptions	List of duplicate AR CCN's	CW
SRAJD500	HMDR0242	Accounts Receivable -Detail Status (RSN CD GRP)	Accounts Receivable Detail Status ( RSN, CD, GRP).	CW
SRAJD500	HMDR024A	Accounts Receivable Detail Status		CW
SRAJD530	HMDR5301	EOB Maintenance Report	Audit trail of changes made to the EOB file	W-Sun
SRAJD530	HMDR53BN	EOB Master List	List of all EOB records on file.	W-Sun
SRAJD600	HMDR0101	Report of Reports	Provides a list of reports by report number and report title.	CW
SRAJD600	HMDR0102	Batch Summary	List of batch totals entered and whether they are suspended or released.	CW
SRAJD600	HMDR0104	Input Exceptions	Invalid cash receipt items.	CW
SRAJD600	HMDR0120	Cash Receipt Setups	Details of each cash receipt batch entered	CW
SRAJD600	HMDR0121	Cash Receipt Dispositions	List of all dispositions of refunds keyed during the cycle, ordered by batch number and julian date.	CW



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
SRAJD600	HMDR012A	Cash Receipt Setups	Cash receipt setups	CW
SRAJD600	HMDR0140	Account Receivable Setups	Provides a list of accounts receivable setups by control number, action code, program code, setup date, provider name, provider number, COS, and original amount.	CW
SRAJD600	HMDR0141	Account Receivable Settlements	List of all account receivable corrections of bad debt write offs	CW
SRAJD600	HMDR0142	Accounts Receivable Changes	List of changes to existing accounts	CW
SRAJD600	HMDR014A	Accounts Receivable Changes	Accounts Receivable Changes To Header.	CW
SRAJD600	HMDR0160	Issued & Cleared Checks	Listing of total dollar and number of checks issued during the checkwrite	CW
SRAJD600	HMDR0161	Check Dispositions	List of all checks previously issued by EDS which are now being voided.	CW
SRAJD660	HMDR6601	State Recoupment Report	List of all account receivable corrections of bad debt write off.	CW
SRAJD700	HMDR0201	Report of Reports	Provides a list of reports by report number and report title.	CW
SRAJD700	HMDR0202	Update Control Totals	Provides update control totals for cash receipts and accounts receivable.	CW
SRAJD700	HMDR0220	Update Exceptions - Cash	This report lists any checks that could not process in the system.	CW
SRAJD700	HMDR0222	Cash Receipts - Detail Status (By Name)	Post checkwrite details of refunds and dispositions in provider name order.	CW
SRAJD700	HMDR0224	Cash Receipts - Detail Status (By Control Number)	Post checkwrite details of refunds and dispositions in cash control number order.	CW
SRAJD700	HMDR0226	Cash Receipts - Detail Status (By Payer Number)	Post checkwrite details of refunds and dispositions in provider number order.	CW
SRAJD700	HMDR022A	Update Exceptions - Cash	Updated Cash Exceptions	CW
SRAJD700	HMDR0240	Accounts Receivable-Update Exceptions	Provides a list of accounts receivable update exceptions by control number, action code, TX code, PG code, date, original amount, disposition amount, and cross-reference number.	CW
SRAJD700	HMDR0242	Accounts Receivable -Detail Status (RSN CD GRP)		CW
SRAJD700	HMDR024A	Accounts Receivable Detail Status		CW
SRAJD700	HMDR0270	Bank Recon - Voids For Research	List of Checking account information void for research.	CW
SRAJD700	HMDR7101	Systematic Checkwrite Balancing	Lists amounts that DMA has requested to be deducted from the Medicaid payments for specific providers.	CW
SRAJD700	HMDR752R	Summary Report	Provides a list of weekly accounts receivable by provider number, principal CCN, prior month balance due, current month principal, current period adjustments, P and I assessed refunds written off, collected and balance due.	CW



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
SRAJD710	HMDR7101	Pending Balances A/R Master	List of all pending A/R balances used to initialte refund request letters to provider who have pending system recoupments more than 4 months.	CW
SRAJD750	XX-New Report	Refunds Received for TPL With No TPL Indicated On Eligibility File.		M
SRAJD750	XX-New Report	Refunds Received for TPL With TPL Indicated On Eligibility File.		M
SRAJD770	HMDR7701	Cash Receipts Pending Report	Report contains the CCN, original amount, balance amount, provider number, MID, keyed ICN, dips amount, reason H code, detail indicator, and AR CCN.	CW
SRAJD800	HMDR890N	Positive Adjustment Error Report	List of refund CCNs that could not process to an adjustment record.	CW
SRAJD911	HMDR9111	Cover Letters & Special W-9 Documents	Printed in Troy on 8 1/2 x 11 plain cut sheet zerox	OR
SRAJD920	HMDR902S	Listing of South Carolina Providers for Year End CCYY	Annual listing of South Carolina providers.	A -Dec
SRAJD920	HMDR9921	Annual provider earnings detail report	Provides a detailed list of provider earnings summarized by provider.	A
SRAJD930	HMDR9351	NC CP2100 Records with Corrected Name or Tax ID	Reports providers on the CP2100 tape that sent in a correction since last year	A -OR
SRAJD930	HMDR9352	EDS CP2100 Records for Exempt Providers	Reports providers on the CP2100 tape that are exempt (provider types 26 & 92)	A -OR
SRAJD931	HMDR9341	EDS CP2100 Second Notice Last Year and Still in Error	Reports providers who received a second notice last year and are still in error (still on the CP2100 tape)	A -OR
SRAJD931	HMDR9361	B Notice Sent the Same Calendar Year	Report of providers that have already received a CP 2100 notice from a previous run within the same calendar year.	SA
SRAJD932	HMDR9323	EDS CP2100 First Notices Outstanding	Reports providers on the CP2100 tape that are received a first notice and have not responded.	A -OR
SRAJD932	HMDR9324	EDS CP2100 First Notices Completed	Reports providers on the CP2100 tape that are received a first notice and have sent in a response.	A -OR
SRAJD932	HMDR9325	EDS CP2100 Second Notices Outstanding	Reports providers on the CP2100 tape that are received a second notice and have not responded.	A -OR
SRAJD932	HMDR9326	EDS CP2100 Second Notices Completed	Reports providers on the CP2100 tape that are received a second notice and have sent in a response.	A -OR
SRAJD933	LABELS	CP2100 Address Labels		A -OR
SRAJD933	LABELS	CP2100 Provider Number Labels		A -OR



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
SRAJD940	HMDR9401	CCYY Penalty Records with Corresponding CP2100 recs	Reports providers who are on the penalty tape and on the CP2100 tape.	A -OR
SRAJD940	HMDR9402	CCYY Penalty Records with no Corresponding CP2100 recs	Reports providers who are on the penalty tape but not on the CP2100 tape.	A -OR
SRAJD951	HMDR9501	A/R Provider Override Transaction Log Report (A3)	The A/R provider override transaction log report reflecting change to the accounts receivable information to the provider. This only reports the changes that were made to the segment of the provider file, no other provider file information is reported	W-Wed
SRAJD951	HMDR9502	Penalty Records With No Corresponding CP 2100 Record	This report lists IRS Penalty records that do not correspond to our CP2100 listing.	SA
SRAJD990	HMDR991R	Provider Earnings Fiscal Year CCYY (By County)	Provides a listing, by county, of provider's year-end earnings. The information provided includes financial payer, provider number, provider name, provider address, IRS number, and net amount paid.	SA-June, Dec
SRAJE110	HMER1801	Penalty Report	Provides month ending penalty assessment list by provider.	M
SRAJE110	HMER1802	Interest Report	Provides month ending interest assessment list by provider.	M
SRAJE110	WRITEOFF	A/R Write Off Memo - 120 Days Old - DMA Copy	Report of write-offs; provider number, name ICN, and dollar amounts.	
SRAJE110	WRITEOFF	A/R Write Off Memo - 120 Days Old - EDS Copy	Report of write-offs; provider number, name ICN, and dollar amounts.	
SRAJE110	WRITEOFF	A/R Write Off Memo - 150 Days Old - DMA Copy	Report of write-offs; provider number, name ICN, and dollar amounts.	
SRAJE110	WRITEOFF	A/R Write Off Memo - 150 Days Old - EDS Copy	Report of write-offs; provider number, name ICN, and dollar amounts.	
SRAJE120	FIRSTNOT	First Notices	First notice stale date letters that are sent to the providers.	
SRAJE120	HMER1202	Provider Number Error Report	Contains the provider number, check number, RA date, and the check amount.	M-On Request
SRAJE120	HMER1203	Respool RA's for Stale Dated Checks	Report contains the provider number, check number, RA date, check amount, and comments.	M-On Request
SRAJE120	HMER1204	Stale Dated Check Report	Report contains the provider number, check number, RA date, and the check amount.	M-On Request
SRAJE121	SECONDNT	Second Notices		M-On Request
SRAJE130	HMER1301	Outstanding Check Report	Lists the outstanding checks in date, check number order. Both the federal and non-federal shares are displayed. Subtotals are given for each date in addition to a report total. The bank sends a file of outstanding checks that is then used as input to	M-On Request



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
SRAJE130	HMER1302	Outstanding Check Error Report	The current outstanding check errors for the month. File is received from Wachovia.	M-On Request
SRAJE130	OCHKDATA	Check Data	List of outstanding checks on file with the bank.	
SRAJE140	HMER1401	Void Check Report	A report of voided checks. Lists the checks voided during the month . Both the federal and non-federal shares are displayed. Subtotals are given for each void type. The report totals give the total check amounts for void, manuals and the sum of the two.	M-On Request
SRAJE140	HMER1402	Void Check Error Report	Lists the void checks or corresponding manual check not found on the Check Master file	M-On Request
SRAJE140	VCHKDATA	Void Check Data	List of void checks.	
SRAJE150	HMER1501	Adjustments to Outstanding Checks Report	Lists the adjustment to outstanding checks in check number order. Both the federal and non-federal shares are displayed. A report total is given.	
SRAJE150	HMER1502	Adjustments to Outstanding Checks Error Report	Lists the adjustment to outstanding checks that were not found on the Check Master file.	
SRAJE21\0	HMER2351	EMC Statistics Report - By Claim Type	Monthly report of the number of claims entered into the system, the total paid and denied, and the percentage of pay versus denied claims ordered by claim.	M
SRAJE210	HMDR752R	AccountsReceivable Summary Status Report	Provides a list of monthly accounts receivable by provider number, principal CCN, prior month balance due, current month principal, current period adjustments, P and I assessed refunds written off, collected and balance due.	M
SRAJE210	HMDR8001	Purged Records - A/R Aged > 18 Months	Provides a list of A/R purged records greater than 18 months by principal CCN, provider number, provider name, and their associated financial information.	M
SRAJE210	HMDR8008	Records to Purge Report	Provides a list of records to purge by provider name, CCN, original amount, date, and RSN.	M
SRAJE210	HMEN237N	Checkwrite Financial Summary	Monthly summary containing record count, suspended credit, accounts receivable, 1099 file, program cost file, and checkwrite cost for program transactions, financial transactions, penalty/interest activity, and control totals.	M
SRAJE210	HMER210N	Monthly Budget Expenditure Report	Shows detailed and summary budget information by Financial Payer.	M
SRAJE210	HMER2151-M	Finalized Claim Billing Report	Provides a List, by claim type, of finalized claims by financial payer. List fields includes claims paid, denied, and total; and details for paid, denied, and total.	M
SRAJE210	HMER2251	Duplicates of Previously Denied Claims	Monthly list of claims that have gone to a paid status the same claims were previously denied.	M
SRAJE210	HMER2361	EMC Statistics Report - By Detail		M



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
SRAJE215	HMER2401	NC Paid Fulls	The Paid Full report lists, for a month, all claims adjudicated in the MMIS. This includes paid, denied, and adjusted claims. Most of the information carried on the claim record, including data submitted by the provider and system plugged data, is printed	M
SRAJE300	HMEN311N	MMIS Monthly REOMB Recipient Listing	Provides a list of monthly REOMB recipients by financial payer. The list includes recipient MID and recipient name.	M
SRAJE300	HMER340R	Third Party Liability Suspect List	Provides, by county, a list of suspected liable third party by financial payer. The list includes provider, BENE name, BENE ID, ICN from and to DOS, diagnosis code, medical record number, billed, insurance paid, and paid TPL indicator.	M
SRAJE300	HMER346N	Absent Parent Liability List	Monthly listing of claims that the Eligibility file indicates has third party coverage being provided by the absent parent.	M
SRAJE300	HMER350N	Deceased Recipient Listing	Monthly report of recipients where the claim indicates a date of death and the Eligibility file does not.	M
SRAJE300	LETTERS	TPL Letters	Letters generated indicating recipients with third party liability.	M
SRAJE300	REOMBS	REOMBS	Letters generated to a sampling a recipients asking for verification of Medicaid services rendered.	M
SRAJE300	RESREOM	RESREOM	Letters generated to a sampling a recipients asking for verification of Medicaid services rendered.	M
SRAJE342	HMFR975D	Provider Statistical and Reimbursement Reports		other
SRAJE342	HMFR975S	Provider Statistical and Reimbursement Reports		M
SRAJE342	HMFRPSR1	Provider's Fiscal Year End Report	Batch DB2 output listing of the provider database that shows the fiscal year end of the providers	M
SRAJE342	HMFRPSR2	PS & R Cost Settlement Report	Verification Report	M
SRAJE342	HMFRPSR3	Full Refund and Can Check Transaction	Hospital's Statistical and Reimbursement report of provider's full refund or cancel check transactions.	M
SRAJE342	HMFRPSR4	Fix Fee Full Refund and Can Check Transactions	This is a hospital's statistical and Reimbursement report of a provider's full refund transactions or cancel check for fixed fee details.	M
SRAJE400	HMDRS01N	Duplicate Claim Statistics	Provides a list of duplicate claim statistics (drug activity summary) by financial payer. Claim statistic fields are broken down into two categories: exact duplicates with fields for age, claim, line-items, PC, ACC-PC, services and amount denied; suspect	M
SRAJE400	HMDRS02N	Monthly Summary of Returned Claims	Provides a list of monthly returned claims by financial payer. Fields are provider number, vendor code, return code, number returned, amount returned, number processed, and MBT.	M



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
SRAJE400	HMDRS03N	Cutback Summary Analysis by Tape; APAP Audit Detection	Provides a matrix for cutback analysis by type of cutback, by financial payer. The cutback categories are denied, pricing, med-review, and claims. Each category has subcategories. All categories and subcategories are further defined by number services	M
SRAJE400	HMDRS04N	Financial Aged Analysis From System Entry to Payment Date	Provides a matrix for financial aged analysis from system entry to claim payment date by number of day incremented every 30 days, by financial payer. Categories for the claims are drug, medical, dental, PROF screen, outpatient, PROF X-over, MED vendor, i	M
SRAJE400	HMDRS05N	Late Billing Report	Provides a list of late billing by financial payer. The list includes billing time, total late services, total denied, and total paid.	M
SRAJE410	HMER4101	Monthly Provider Performance Comparison	Monthly report ranking the statistics on provider claim activity within cost of services, ranked with regard to billing time, processing time, and returns to provider.	M
SRAJE420	HMDRV00N	EOB Savings By Cutback Categories	Contains the explanation of benefit savings by cutback categories showing detail and dollar amounts and the cut back percentage	M
SRAJE430	HMEP430N	EOB Reports	Annual explanation of benefits	A-June
SRAJE440	HMER4401	Deleted Claims By Cycle For Region 10 & 30 (Location Code 82, 90, & 95)	Quarterly report of deleted ICNs for SPR/Audit purposes. Contains the ICN, location code, and the cycle date.	Quarterly
SRAJE450	HMER4521	Denied Details By Threshold/County/Provider/EOB	Provides details, by threshold, county, provider, and EOB of denied claims by financial payer.	M
SRAJE450	HMER4551	Denied Claims By Threshold and Provider	Monthly denied claims for the provider by threshold and provider.	M
SRAJE450	HMERAB01	Denial Report (AB-I)		M
SRAJE450	HMERAB02	Denial Report (AB-II)		M
SRAJE450	HMERAB03	Denial Report (AB-III)		M
SRAJE450	HMERC001	Denial Report (C-I)		M
SRAJE450	HMERC002	Denial Report (C-II)		M
SRAJE460	HMER4601	Dental Services Expenditures Report	Monthly listing of expenditures for dental services.	A-June
SRAJE510	HMDRY20N	N. C. Recipient Register (By County)	Provides a list, by county, of NC recipients (sorted alphabetically). The information provided includes recipients name (last and initials), recipients identification number, provider name, type of service, to and from dates of service, claim control num	M





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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
SRAJE510	HMDRY40N	N . C. IndoChinese Register	This report presents a listing by recipient name of every claim paid during the month. The report is in county of residence and recipient name order and only includes refugee recipients.  Printed in Troy on 8 1/2 x 11 plain 3-hole top laser paper.	M
SRAJE520	HMDRY30A	N. C. Financial Participation Report (By County)	This report presents a summary of monies paid by the federal, state and local governments for the Medicaid program. And contains no refugee claim information.	M
SRAJE520	HMDRY30C	N. C. Financial Participation Report (By County) - State Totals	This report presents a summary of monies paid by the federal, state and local governments for the Medicaid program. And contains no refugee claim information.	M
SRAJE520	HMDRY35F	N. C. Financial Participation Report-Refugees - State Total	This report presents a summary of monies paid by the federal, state, and local governments for the Medicaid program for refugees.	M
SRAJE520	HMDRY35N	N. C. Financial Participation Report-Refugees	This report presents a summary of monies paid by the federal, state and local governments for the Medicaid program. And contains refugee claim information only.  Printed in Troy on 8 1/2 x 11 plain 3-hole top laser paper	M
SRAJE520	HMDRY35P	N. C. Financial Participation Report - Payouts (By County)	Printed in Plano. Listing of monthly payouts, by county, of NC's financial participation  Printed in Troy on 8 1/2 x 11 plain 3-hole top laser paper.	M
SRAJE520	HMDRY36P	N. C. Financial Participation Report - Payouts-Std FFP	Printed in Plano. Monthly report listing the standard federal financial participation payout.  Printed in Troy on 8 1/2 x 11 plain 3-hole top laser paper.	M
SRAJE520	HMDRY37P	N. C. Financial Participation Report - Payouts-100% St Fund	Monthly report listing the 100% payout from state funds for financial participation.  Printed in Troy on 8 1/2 x 11 plain 3-hole top laser paper.	M
SRAJE520	HMDRY38P	N. C. Financial Participation Report --- Payouts - 100% CT Fund	Monthly report listing the 100% payout from county funds to financial participation  Printed in Troy on 8 1/2 x 11 plain 3-hole top laser paper.	M



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
SRAJE520	HMDRY39P	N. C. Financial Participation Report --- Payouts - 50/50 ST / Cnty	Monthly report listing the payouts from state and county funded at the rate of 50/50. Printed in Troy on 8 1/2 x 11 plain 3-hole top laser paper.	M
SRAJE520	HMEP5201	N. C. Financial Participation Report---Medicaid Non Federal Share	Monthly report listing the non federal share for the Medicaid program. Printed in Troy on 8 1/2 x 11 plain 3-hole top laser paper.	M
SRAJE520	HMER5201	Financial Participation Report Breast/Cervical Cancer Coverage	This report will be created monthly. It is intended to show the total monthly expenditures for Breast/Cervical Cancer Coverage recipients listed by county.	M
SRAJE520	HMER5202	FPR Breast/Cervical Coverage Group		
SRAJE520	HMER5203	Combined Financial Participation Report (State Totals Only)	This report will be created monthly. It is intended to report the regular and breast/cervical cancer combined State Totals.	M
SRAJE520	HMER5204	Monthly Hurricane Katrina Evacuee Alabama FPR by County and State Totals	This report contains the monthly FPR amounts for the hurricane evacuees from Alabama	M
SRAJE520	HMER5205	Monthly Hurricane Katrina Evacuee Louisiana FPR by County and State Totals	This report contains the monthly FPR amounts for the hurricane Katrina evacuees for Louisiana.	M
SRAJE520	HMER5206	Monthly Hurricane Katrina Evacuee Mississippi FPR by County and State Totals	This report contains the monthly FPR amounts for the hurricane evacuees from Mississippi.	M
SRAJE520	HMER5207	FPR State Totals Only - Hurricane Katrine - Alabama	This report contains the monthly FPR amounts for the hurricane Katrina evacuees for Alabama.	M
SRAJE520	HMER5208	FPR State Totals Only - Hurricane Katrine - Louisiana	This report contains the monthly FPR amounts for the hurricane Katrina evacuees for Louisiana.	M
SRAJE520	HMER5209	FPR State Totals Only - Hurricane Katrine - Mississippi	This report contains the monthly FPR amounts for the hurricane Katrina evacuees for Mississippi.	M
SRAJE520	HMER520A	FPR - Hurricane Rita - Louisiana	This report contains the monthly FPR amounts for the Hurricane Rita evacuees for Louisiana.	M
SRAJE520	HMER520B	FPR - Hurricane Rita - Texas	This report contains the monthly FPR amounts for the Hurricane Rita evacuees for Texas.	M
SRAJE520	HMER520C	FPR State Totals Only - Hurricane Rita - Louisiana	This report contains the monthly FPR amounts for the Hurricane Rita evacuees for Louisiana.	M



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
SRAJE520	HMER520D	FPR State Totals Only - Hurricane Rita - Texas	This report contains the monthly FPR amounts for the Hurricane Rita evacuees for Texas.	M
SRAJE520	HMER520E	FPR - Family Planning	This report contains the monthly FPR for the Family Planning transactions having an eligibility program code beginning with MAFD.	M
SRAJE520	HMER520F	FPR State Totals Only - Family Planning	This report contains the monthly FPR amounts for the Family Planning transactions having an eligibility program code beginning with MAFD.	M
SRAJE520	HMER520G	M-SCHIP Monthly FPR	This report contains the monthly FPR amounts for the M-SCHIP transactions having an eligibility program code of "MIC1N"	M
SRAJE520	HMER520H	M-SCHIP Monthly FPR	This report contains the monthly FPR amounts for the M-SCHIP transactions having an eligibility program code of "MIC1N"	M
SRAJE522	HMER5222	Monthly Qualified Public (QPH) Combined State Totals	This report contains the monthly combined FPR amounts for the Qualified Public Hospitals	M
SRAJE522	HMER5224	Monthly Qualified Public Hospital (QPH) Regular FPR State Totals	This report contains the monthly regular FPR amounts for the Qualified Public Hospitals	M
SRAJE522	HMER5228	Monthly Qualified Public Hospital (QPH) Hurricane Rita - Louisiana FPR State Totals		M
SRAJE522	HMER522A	Monthly Qualified Public Housing (QPH)	This report contains the monthly hurricane Rita - Texas FPR amounts for the Qualified Public Housing.	M
SRAJE522	HMER522C	Monthly Qualified Public Hospital (QPH) MSCHIP FPR State Totals	This report contains the monthly MSCHIP FPR amounts for the Qualified Public Housing.	M
SRAJE522	HMER5322	Quarterly Qualified Public (FPR) Hospital BCC FPR	This report contains the quarterly FPR state total amounts for the QPH BCC transactions	Q
SRAJE522	HMER5323	Quarterly Qualified Public (FPR) Hospital Hurricane Rita - Louisiana Evacuee FPR	This report contains the quarterly FPR state total amounts for the QPH Hurricane Rita - Louisiana Evacuee transactions.	Q
SRAJE522	HMER5324	Quarterly Qualified Public (FPR) Hospital Hurricane Rita - Texas Evacuee FPR	This report contains the quarterly FPR state total amounts for the QPH Hurricane Rita - Texas Evacuee transactions.	Q
SRAJE522	HMER5325	Quarterly Qualified Public (FPR) Hospital MSCHIP FPR	This report contains the quarterly FPR state total amounts for the MSCHIP transactions.	Q
SRAJE5222	HMER5226	Monthly Qualified Public Hospital (QPH) BCC FPR State Totals	This report contains the monthly BCC FPR amounts for Qualified Public Hospitals	M



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
SRAJE530	HMDR752R	Summary Report	Provides a list of quarterly accounts receivable by provider number, principal CCN, prior month balance due, current month principal, current period adjustments, P and I assessed refunds written off, collected, and balance due.	Q
SRAJE530	HMER5301	N. C. Financial Participation Report - State Totals For Quarter	Lists the state financial participation data.	Q
SRAJE530	HMER5302	Financial Participation Report Breast/Cervical Cancer Coverage		Q
SRAJE530	HMER5303	Quarterly Hurricane Katrina Evacuee Alabama FPR	This report contains the quarterly FPR state total amounts for the Hurricane Katrina evacuees for Alabama.	Q
SRAJE530	HMER5304	Quarterly Hurricane Katrina Evacuee Louisiana FPR	This report contains the quarterly FPR state total amounts for the Hurricane Katrina evacuees for Louisiana.	Q
SRAJE530	HMER5305	Quarterly Hurricane Katrina Evacuee Mississippi FPR	This report contains the quarterly FPR state total amounts for the Hurricane Katrina evacuees for Mississippi.	Q
SRAJE530	HMER5306	Quarterly Hurricane Rita Evacuee Louisiana FPR	This report contains the quarterly FPR State Total amounts for the Hurican Rita evacuees for Louisiana.	Q
SRAJE530	HMER5307	Quarterly Hurricane Rita Evacuee Texas FPR	This report contains the quarterly FPR State Total amounts for the Hurican Rita evacuees for Texas.	Q
SRAJE530	HMER5308	Quarterly Family Planning FPR	This report contains the quarterly FPR state total amounts for the Family Planning transactions having an eligibility program code beginning with MAFD.	Q
SRAJE530	HMER5371	Penalty and Interest Quarterly Report	Provides quarter beginning balance, penalty and interest assessment, collections, write-offs and ending balances by financial payer and county.	Q
SRAJE530	HMER5703	Quarterly Piedmont FPR	This report contains the quarterly FPR state total amounts for the Piedmont recipients.	Q
SRAJE530	HMER5708	Quarterly Piedmont M-SCHIP FPR State Totals	This report contains the quarterly FPR amounts for the Piedmont recipients including M-SCHIP data only.	Q
SRAJE530	HMER5709	Quarterly Piedmont BCC FPR State Totals	This report contains the quarterly FPR amounts for the Piedmont recipients including BCC data only.	Q
SRAJE532	HMER5321	Quarterly Qualified Public (FPR) Hospital Regular FPR	This report contains the quarterly FPR Hospital Regular FPR	Q
SRAJE550	HMERMR18	Error Frequency Analysis	Provides a list, by county, of error frequency analysis by financial payer. The list includes category of service, provider number, number of paid claims, number of claims suspended, percent paid from suspense, number of rejected claims, number of claims	Q
SRAJE570	HMER5701	Piedmont FPR		M



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
SRAJE570	HMER5702	Piedmont FPR		M
SRAJE600	HMER6001	System Performance Review Claim Sample Report	This report is a sample report of the system performance review claim report	M
SRAJE700	HMER7002	EPSDT Physician & Dentist Paid Claims Report	Report of EPSDT claims paid to physicians and dentists listing recipient count, claim count, and amount paid.	Q
SRAJE700	PHYSDNTQ	Physician / Dentist Data		Q
SRAJE750	HMER7001	Physician & Dentist Paid Claims Report	Annual report of all claims paid to physicians and dentists.	A-June
SRAJE750	HMER7002	Physician & Dentist Paid Claims Report (EPSDT only)	Annual report of all EPSDT claims paid to EPSDT providers	A-June
SRAJE750	HMER7003	Physician & Dentist Paid Claims Report---State Totals	Annual report listing total state totals for all claims paid to physicians and dentists.	A-June
SRAJE750	PHYSDNNTA	Physician / Dentist Data		A-June
SRAJE855	HMER8551	Provider Summary Transaction Log Report	Weekly log summary of provider transactions. Report contains the provider number, provider name, withholding action, and activate/deactivate date.	W-Wed
SRAJE940	HMER9411	Disproportionate Share Report	This report identifies the amount of disproportionate share monies that providers have received during the reporting period. It also shows quarter to date accumulations	M
SRAJE960	HMER9601	Hospital Payment Reports (For Previous Fed Fiscal Year)	Annual report of payments made to hospitals for the previous federal fiscal year.	A-Jan
SRAJE990	HMER9901	TPR Cost Avoidance Report	Monthly cost avoidance for third party recovery from Medicaid coverage.	M
SRAJF200	HMFR2001	Hospital/Nursing Home Audit Summaries	Requested detail and summary claim data by provider number.	W
SRAJF300	HMFR3301	Disproportionate Stratified Random Sampling - All Recipients by Provider and Stratum	This report contains stratified random sampling information about recipients, including the provider, the amounts paid and billed , and the medical record number.	M
SRAJF300	HMFR3302	Disproportionate Stratified Random Sampling - Recipient Totals for Provider by Stratum and Sample	This report contains recipient totals for stratified random sampling.	M
SRAJF300	HMFR3401	Disproportionate Stratified Random Sampling - Selected Recipients in Sample by Provider	Contains report of selected sample recipients within provider number.	M
SRAJF500	HMFR5004	Home Health Summary Input Report	A summary of home health input information.	M



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
SRAJF510	HMFR5205	Home Health Summary Report	A summary of home health input information.	M
SRAJF550	HMFR5501	FQHC Audit Summary Request Report	Edit of data input used for the federally qualified health center audit summary.  Printed in Troy on 8 1/2 x 11 plain 3-hole laser paper.	M
SRAJF550	HMFR5502	RHC Audit Summary Request Report	Edit of data used for the rural health clinic audit summaries.  Printed in Troy on 8 1/2 x 11 plain 3-hole laser paper.	M
SRAJF550	HMFR5801	FQHC Audit Summary Report	Monthly summary of the days of service and payments to specific federally qualified health center facilities for a specific time period.	W
SRAJF550	HMFR5802	RHC Audit Summary Report	Monthly summary of the days of service and payments to specific rural health clinic facilities for a specified time period.	W
SRAJF601	HMFR6011	Denials by Claim Type and Provider – Section I	This report will list by claim type the total claim count for P claims and electronic claims along with their denial percentage rates. In addition the report will list the top five denial EOB 's within that claim type.	M
SRAJF601	HMFR6012	Denials by Claim Type and Provider – Section II	This report lists by claim type the total claim count for paper claims and electronic claims along with their denial % rates. In addition the report lists the top 5 denial EOB Within a claim type. The report also lists the 10 providers with most denials p	M
SRAJF680	HMFR6801	Mental Health Audit Summary Report	Requested detail and summary claim data by provider for mental health providers.	M
SRAJG010	HMFR100S	State Audit Input Acceptance State Audit Input Errors	Contains an acceptance report lists and providers information about state audit inputs and input error.	W-Fri
SRAJG010	HMGR0101	State Audit Request Input Report - Rural Health Centers	Contains all of the state audit transactions.	M
SRAJG010	HMGR0501	State Audit Request Input State Audit Request Deletion	Contains all the state audit request transactions.	M
SRAJG020	HMGR0241	Medicaid Eligibility Statistics	The report identifies unduplicated counts of the number of eligible recipients in the report month as well as a trend analyses ( six month average, same month last year, percent change). The report shows counts by county and state wide.	M
SRAJG050	HMGR501N	Statistical Report on Medical Care (MARS 2082 Report)	Monthly report on the distribution of payment by category of service and aid category. Lists recipients and dollars paid.	M
SRAJG060	HMGR171N	Financial Summary - Month of Service	Monthly report of budgeted, actual, adjusted cost for monthly service.	M
SRAJG070	HMGR0721	Medicare Participation Summary	The Medicare Participation Summary gives information about the Medicaid and Medicare programs for recipients eligible for both programs. Medicaid and Medicare expenditures for Medicaid/Medicare recipients are shown. Information about Medicare coinsuran	M



## Appendix 40, Attachment G Consolidated List of Reports



DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
SRAJG070	HMGR3011	Provider Participation Analysis	Monthly Analysis of provider participation by provider type listing current and YTD totals for current and prior year. This month, same month, last year, six month average, year-to-date (this year and last year).	M
SRAJG070	HMGR3012	Medicare Participation Summary	The Medicare Participation Summary gives information about the Medicaid and Medicare programs for recipients eligible for both programs. Medicaid and Medicare expenditures for Medicaid/Medicare recipients are shown. Information about Medicare coinsurance	M
SRAJG090	AIDSPER		Automail version of Program Expenditure Statewide Totals.	
SRAJG090	HMGR__	Number of Transactions		M
SRAJG090	HMGR0901	Program Expenditure Report (By County)	Provides a matrix, by county and financial payer  Printed in Troy on 8 1/2 x 11 plain laser paper.	M
SRAJG090	HMGR0903	PER: Breast and Cervical Cancer Coverage	Provides a matrix by county and FP, expenditures by claims, transactions and premium matrix is broken down by service categories and associated paid amounts, number of recipients, number of units, claims/transactions, paid units, paid recipients, and other	M
SRAJG090	HMGR0904	Combined Program Expenditure Report (State Totals Only)	This will be created monthly. It is intended to report the regular and breast/cervical cancer combined State Totals. The report layout is exactly like the regular PER, HMGR0901.	M
SRAJG090	HMGR0905	Hurricane Katrina & Rita Evacuees Program Expenditure (State Totals Only)	This is created monthly. It is intended to report the Hurricane Katrina and Rita evacuee state totals. The report layout is exactly like the regular PE\$R - HMGR0901	M
SRAJG090	HMGR0906	PER - Family Planning	This will be created monthly. This report contains the monthly PER amounts for the Family Planning transactions having an eligibility program code beginning with MAFD. This report will be the same format as HMGR0901.	M
SRAJG090	HMGR090N			
SRAJG125	HMGR125N	PML Report for Inpatient Crossover "X" Claims	Patient eligibility of the amount and grand total s for inpatient crossover claims.	M
SRAJG126	HMGR126N	PML Report for Inpatient "S" Claims	Patient month liability report of the amount and grand totals for inpatient claims.	Q
SRAJG128	HMGR1281	1275 Denial For Inpatient Adult / Home Care "T" Claims	Report of adult care ( c/t) claims from MTD claims history that received EOB (275 DENIAL).	M
SRAJG140	HMGR1401	Linkages For Prevention Denial Report (By Provider #)	Monthly report for Dr. Margo;les which indicates the total number w810 health check screening billed, paid and denied for certain providers.	M
SRAJG140	HMGR1451	Eligibility Recyles	List of claims that actually pay of those that were recycled for eligibility.	M



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
SRAJG160	HMGP165R	Medicare 87 (Part A) and 89 (Part B) Overrides	Monthly override that identifies claims that were submitted with UB92 condition codes 87 ( partA) or 89 ( partB) . These condition codes override the medicare edits.	M
SRAJG160	HMGP165R	87/89 Override	Monthly provider override. This report identifies claims that were submitted with UB92 condition codes 87 (Part A) or 89 (Part B). These condition codes override medicare edits.	M
SRAJG170	HMGR1701	Drug Cost Avoidance	Lists any "D" claim from the month that was denied and contains ESC 0259.	M
SRAJG170	HMGR1702	Pharmacy Claims - TPL - Dollar Review	Lists any "D" claim from the month that was paid and contains a Third Party money amount.	M
SRAJG350	HMGR3511	Annual Report on Home and Community Based Services Waivers - Children	Waiver report required by the federal government in order for the State to provide Community Alternatives Program; a program by which people who might otherwise be institutionalized can remain in their homes.	A - Request
SRAJG350	HMGR3512	Annual Report on Home and Community Based Services Waiver - Disabled	Waiver Report required by the federal government in order for the State to provide Community Alternatives Program; a program by which people who might otherwise be institutionalized can remain in their homes.	A-Request
SRAJG350	HMGR3513	Annual Report on Home and Community Based Services Waiver - Mentally Retarded.	Waiver Report required by the federal government in order for the State to provide Community Alternatives Program; a program by which people who might otherwise be institutionalized can remain in their homes.	A-Request
SRAJG350	HMGR3514	Annual Report on Home and Community Based Services Waiver - Aids	Waiver Report required by the federal government in order for the State to provide Community Alternatives Program; a program by which people who might otherwise be institutionalized can remain in their homes.	A-Request
SRAJG431	AVGPMTS			
SRAJG431	PROVPART	Provider Participation Data		
SRAJG640	HMGR6401	MSIS Error Tolerance Report	This report is produced quarterly when the MSIS eligibility tape is created. It reports the achieved error rates on each of the data elements contained on the tape.	Q
SRAJG640	HMGR6451	MSIS Eligibility Tape Summary	This report is produced quarterly when the MSIS eligibility tape is created. It reports the number of master records read, updates in and updates out, and the number of correction records, retroactive, and correction records created. The number of MSIS	Q
SRAJG650	HMGR6501	MSIS Summary Report	This report is produced monthly when the MSIS claims are created from the month-end paid claims data. It identifies the number of claims written to the MSIS tapes along with the total paid amount represented on those tapes. There are four sections – one f	M
SRAJG650	HMGR6502	MSIS Error Tolerance Report	This report is produced monthly when the MSIS monthly tapes are produced. It reports the achieved error rates on each of the data elements contained on each of the four "claim type" tapes.	M





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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
SRAJG655	HMGR6561	MSIS Summary Report	This report is produced quarterly when the MSIS claims are created from the last 3 MSIS monthly extract files. It identifies the number of claims written to the MSIS tapes along with the total paid amount represented on those tapes.	Q
SRAJG670	HMGR6701	HCFA-2082 Report - N.C. Statistical Report on Medical Care: Eligibles, Recipients, Payments, & Services	HCFA report identifying services and eligible by federal category of service and eligibility categories.	A-Jan
SRAJG800	HMGR802N	MARS report Periodic Screening Cost Analysis	This report contains a list of total children ( by age group) total claim cost, and average claim cost for children who have and haven't been screened for each local office.	A-July (4th Fri)
SRAJG810	HMGR8121	Drug Summary Report	Annual report of the drug usage data by aid category.	A-July (4th Fri)
SRAJG820	HMGR8241	Dental Provider Participation Report	Annual report of participating dental providers.	A-July (4th Fri)
SRAJG840	HMGR8921	Provider Ranking List (N.C. Providers Ranked By Provider Type)	Quarterly list of providers, the amount of claims submitted, and amount paid sorted by provider type.	Q
SRAJG840	HMGR8922	Provider Ranking List (N.C. Providers Ranked By Provider Type / Name)	Quarterly list of providers, the amount of claims submitted, and amount paid, sorted by provider type.	Q
SRAJG840	HMGR8923	Provider Ranking List (Out of State Providers Ranked By Provider Type)	Quarterly list of out of state providers, the amount of claims, submitted and amount paid, sorted by provider type	Q
SRAJG840	HMGR8924	Provider Ranking List (Out of State Providers Ranked By Provider Type / Name)	Quarterly list of out of state providers, the amount of claims submitted, and amount paid, sorted by provider type and name.	Q
SRAJG840	HMGR8941	Third Party Payment Analysis	Provides a list of third party payments by financial payer. List fields include provider type, provider specialty, provider number, number of claims, total claim amount, TPL by number PCT, amount, and PCT.	Q
SRAJG870	HMGR881N	Drug Usage Frequency Analysis (MARS Annual Rpt)	Contains totals and percentages for the total number of prescriptions, total amount paid, and the usage rank. Lists the commonly most used drugs. Only the top 500 drugs are listed by NDC. Each drug is ranked according to the usage.	A-July (4th Fri)
SRAJG885	HMGR8851	Drug Claim Analysis	This report identifies the cost of drugs for four quarters in the state fiscal year, as well as an annual section. It displays certain drug billing accumulators, and also consists of information specifically related to AWP (average wholesale price) and MA	M



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
SRAJG899	HMGR8991	Medicaid Report On The Elderly	Provides a matrix, by county, of elderly on Medicaid by financial payer. The matrix includes the totals and categories of inpatient hospital, mental inpatient hospital, nursing homes, ICF-MRC, physician/lab and x-ray, prescribed drugs, and clinic/outpati	A-July (4th Fri)
SRAJG900	HMGR900N	Benefit Usage Analysis Report	Provides a matrix of eligible users for a specific service by percentage and number of usrs by financial payer. Services included are ambulatory and prescription drugs for each month of the year. This report mimics certain processes for certain claim ty	other
SRAJG910	LDHUNIT	Local Health Dept Data		OR
SRAJG965	ELIG	Eligibility Data		OR
SRAJG965	ELIG	Eligibility Extract		
SRAJH100	HMHR1001	Physician Inventory Report For Uncorrected Encounter Claims	Physician inventory report for uncorrected claims - these claims produced ETADS.	M-Last Fri in month
SRAJH100	HMHR1002	HMO Inventory Report For Uncorrected Encounter Claims	HMO to indicate length of time the claim has been in wait status for replacement or to be voided (these claims produced ETADs)	M-Last Fri in month
SRAJH200	HMHR2001	HCFA Error Turn-Around Document (Encounter ETAD)	Health Care Financing Administration error turn around form	M-Last Fri in month
SRAJH200	HMHR2002	Physician Error Summary Rpt	Shows each error for the physician error report.	M-Last Fri in month
SRAJH200	HMHR2002	HMO Error Summary Report	Shows each error for the HMO summary report.	M-Last Fri in month
SRAJH250	HMHR2511	HMO Error Summary Report For Shadow Denied Claims	Provides a summary for each HMO of the number of errors the claim received Encounters shadow processing. This report includes the error number, a description of each error, the total occurrences of the error, and the occurrence percentage of all errors.	M
SRAJH300	HMER2153	Finalized Encounter Billing	Provides a list for each checkwrite by claim type, fo finalized encounters by financial payer. List fields include claims paid, denied, and total; and details paid, denied, and total	W-Fri
SRAJH400	HMHR4001	M-E-Finalized Encounter Billing Rpt	Provides a list, for the month, by claim type, of finalized encounters by financial payer. List fields include claims paid, denied, and total; and details for paid denied and total.	M
SRAJH500	HMHR5001	Compliance Report For MCO Encounters	Calculates monthly error percentage of HMO's. Used by DMA to determine if an HMO withhold should be imposed.	M
SRAJH500	HMHR5501	Compliance Report For MCO Encounters Part II	Managed care organization encounter compliance reports. There are three formats for this one report. One format is for invalid cunty data. The second is for the late ETAD return data. The third format is for late claims data.	M



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
SRAJH870	RTAR8851	Pamc '1' Usage for overriding POS Medicare -B edit 946		POS
SRAJK	Denial Letters	Denial Notification		D
SRAJK	Denial Letters	Informal Appeal		D
SRAJK	Denial Letters	Change Notification		D
SRAJK	Denial Letters	Requested Information		D
SRAJK090	HMKR0901	Transaction Log for TXN 278 Health Care Services Review and Response	The transaction log file records 278 transaction data coming in and out of the system.	other
SRAJK100	HMKR1001	Eligibility Edit Error Report	Daily report summarizing the number of eligibility records written and in error. Also lists the number of cross referenced records written, permanent and temporary recipient Ids received, and the number of records rejected for no eligibility details.	D
SRAJK100	HMKR1002	Eligibility Edit Control Totals	Daily report of the eligibility edit control totals.	D
SRAJK100	HMKR1003	Eligibility Program Code Error Report	Daily listing the recipient ID, case ID, and the error message	D
SRAJK100	HMKR1011	Eligibility Segments Dropped Report	Daily listing of recipients MID, case ID, history from date, authorization date, history to date, and error message	D
SRAJK100	HMKR1012	Eligibility Segments Dropped Activity Totals	A report that shows the eligibility segments that were dropped from the activity totals.	D
SRAJK100	HMKR1031	Eligibility Records Deleted Report	Daily report listing the record type, recipient ID, base recipient ID, and the type deleted message.	D
SRAJK100	HMKR1101	Duplicate Cross Reference Error Report	This report will have previous recipient ID order, duplicate Recipient ID's and duplicate change extract error message.	D
SRAJK110	HMKP1301	Estate Recovery Master File Error Report	List of estate recovery update transactions that failed. The report includes error messages.	D
SRAJK150	HMKR1501	Eligibility Cross Reference ID Updates	This report identifies updates that hve occurred to the cross-reference ID file.	D
SRAJK160	HMKR1610	Part D Master Maintenance (XREF)	Audit Log of systematic maintenance on the Medicare Part D Master due to xref indentification	D
SRAJK210	HMKR218N	Buy In Maintenance Report - Part B	Lists the accepted transactions.	D
SRAJK210	HMKR2191	Estate Recovery Closures Due To Eligibility Deletion	Provides a list of Medicaid ID numbers on the Estate Recovery Master in an active status that are no longer on the Eligibility File.	D
SRAJK210	HMKR280N	Buy In Added Report Buy In Error Report	Report that shows the buy in records that failed to successfully add back to the eligibility file during the eligibility update process.	D



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
SRAJK225	HMKR2251	Duplicate HICS on the Eligibility File	A list of records in which duplicate HIC numbers appear on the eligibility file for 1 or more recipients.	M
SRAJK260	HMKR2601	HMO Eligibles By Age Group and County (Component of the HCFA-420 Report)	Quarterly listing of all HMO eligible recipients ordered by age group and county	M-Last Wed in month
SRAJK270	HMKR2701	Potential Termination	Any Family Planning Waiver recipient who receives a sterilization will be terminated from the Family Planning Waiver program. This report displays steri procedures billed for Family Planning Waiver recipients.	W
SRAJK270	HMKR2702	Family Planning Expenditure	This report will summarize claims expenditures for each Family Planning Waiver recipient. If a Family Planning Waiver recipient has no claims for a week, a line will still be displayed for the recipient showing zero dollars expended.	W
SRAJK280	HMKR2802	Enhanced Care PA - Mental Health Case Managers Report	A report of recipients who have been approved for Enhanced Care by a mental health case manager.	Q-Jan, April, July, Oct -First day of month
SRAJK280	HMKR2803	Enhanced Care PA - DSS Case Managers Report	Report that shows DSS Case Managers	Q-Jan, April, July, Oct -First day of month
SRAJK310	CERTxxxx	Certificates of Creditable Coverage		D
SRAJK315	HMKR3151	HIPAA Certificate Report	Daily HIPAA certificates available for print	D
SRAJK317	HMKR3171	Monthly Certificate Report	Monthly HIPAA certificate totals by zip code	M-24th day of month
SRAJK340	HMKR3401	Procedure Code PA VRS Report	Report of prior approval procedure code containing provider number, procedure code, and type of service or modifier and approval status for each record.	W-Sun
SRAJK350	HMKR3501	Dental Automated Voice Response (AVR) Report	Report of dental prior approval status from the voice response system.	W-Sun
SRAJK360	HMKR3601	Refraction VRS Report	Report of optical prior approval status from the voice response system.	W-Sun
SRAJK370	HMKR3701	Transfer of Assets Alert Detail Report	Listing of claims and recipients who have received targeted services, but have not yet been assigned by the DSS county office for transfer of assets. These claims have paid, but no assesment was completed from the county office.  This report is transmit	W-Fri



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
SRAJK370	HMKR3702	Transfer of Assets Alert Summary Report	Summary report showing counts of claims reported on the transfer of assests alert detail report. Report totals are brokes out by county and district. At report conclusion, ststewide totals are also presented. This report is transmitted to the DIRM mainfr	W-Fri
SRAJK400	HMKR4001	Beneficiary State Tape	This report contains a listing of all Medicare beneficiaries in North Carolina	OR
SRAJK410	HMKR4101	Bendex Monthly Transmit Error Report	This report contains information on invalid Bendex updates.	M
SRAJK410	HMKR4111	Bendex Monthly DOB Discrepancy Report	This report displays recipient date of birth discrepancies between the Monthloy Bendex file and the MMIS Eligibility File.	M
SRAJK410	HMKR4112	Bendex Monthly Name Discrepancy Report	This report displays recipient name discrepancies between the Monthly Bendex file and the MMIS Eligibility File.	M
SRAJK410	HMKR4114	Bendex Monthly SSN Discrepancy Report	This report displays recipient SSN discrepancies between the Monthly Bendex file and the MMIS Eligibility file.	M
SRAJK410	HMKR4115	Bendex Monthly HIC Discrepancy Report	This report displays recipient HIC discrepancies between the Monthly Bendex file and the MMIS Eligibility file.	M
SRAJK420	HMKR4221	Monthly EDB - Mcare Extract - Transactions	For new records added to the monthly EDB updated master, all data fields will be shown in the "adds" section of this formatted report. For existing records with some data changes, only the changed fields (before and after image) will be shown in the "Cha	M
SRAJK420	HMKR4222	Annual EDB - Mcare Extract Master File	This is an annual report of all records on the EDB master file. The report format is the same as HMKR4221 "adds" section of the monthly transaction report.	M
SRAJK420	HMKR4231	Annual EDB Mcare Extract - Age 20 and Under	Annual report to provide basic key information of the Age 20 and Under recipients on theEDB master. The report will show Base MID, Xref MID, HIC, Xref HIC, Name, DOB, DOD,. SSN	A
SRAJK420	HMKR4241	Monthly Medicare EOBExtract Reject Report	Mothly EOB Reject report will show unique combination of error by Base MID, error flags , and cycle. Report details show the data discrepancies that caused the 2 or more error conditions when comparing the following EIS request data vs the CMS respo	M
SRAJK435	HMKR4311	Discount Drug Cards Error	Lists information from CMS's Discount Drug Card Error response file.	M
SRAJK440	HMKR4401	MMA Enrollment File to CMS	This is a list of the MMA transactions sent to CMS.	M
SRAJK440	HMKR4402	MMA Enrollment File Dual Status Code 99	This is a list of the MMA transactions sent to CMS with a status code 99	M
SRAJK445	HMKR4471	MMA Part D Error Records	This is a list of the MMA error transactions sent from CMS	M
SRAJK455	HMKR4601	Buy In - MQB Special Leads Tape - Category 1	Report of Q Class eligilbility/QMB file matches.	M-OR



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
SRAJK455	HMKR4602	Buy In - MQB Special Leads Tape - Category 2 - Non-SSI	Report of non-Q class eligibility/QMB matches without SSI status.	M-OR
SRAJK455	HMKR4603	Buy In - MQB Special Leads Tape - Category 2 - SSI	Report of non-Q class eligibility/QMB matches with SSI status.	M-OR
SRAJK455	HMKR4604	Buy In - MQB Special Leads Tape - Category 3	Report of QMB records that had no matching eligibility records.	M-OR
SRAJK470	HMKR4701	Invalid Status Code 4/5 - Part A	A list of Buy In Part A records that have invalid status codes on the file due to posting error.	M-OR
SRAJK470	HMKR4702	Invalid Status Code -4/5 Part B	A list of Buy In Part B records that have invalid status codes due to posting error.	M-OR
SRAJK480	HMKR4801	Buy In - Part B - Non BA Manual Txns - DY Rpt	A list of dialysis records in which Buy In term dates have been received.	M
SRAJK480	HMKR5702	Buy-In Part B - Code 3662 Exception Report	Monthly listing of recipients whose accretion to Buy In Part B errored because there was no match on the SSA Master Record	M
SRAJK480	HMKR5703	Buy-In Part B - Code 29 Exception Report	A list of rejects for recipients with death dates on the SSA file	M
SRAJK480	HMKR5704	Buy-In Part B - Code 49 Exception Report	A list of rejects for recipients in which certain critical recipients information failed to match.	M
SRAJK480	HMKR5705	Buy-In Part B - Code 27 Exception Report	A list of rejects for recipients with invalid transaction codes.	M
SRAJK480	HMKR5706	Buy-In Part B - Code 25 Exception Report	A list of rejects for recipients with duplicate requests.	M
SRAJK480	HMKR5707	Buy In - Part B - Code 20 Error Reports	A list of rejects due to HIC number non-match.	M
SRAJK480	HMKR5708	Buy-In Part B - Code 28 Exception Report	This report is a listing of state request to add or correct data that is rejected by SSA, if the item submitted does not match the identifying information already shown on the state's billing records.	M
SRAJK480	HMKR5709	Buy In - Part B - Code 21 Action Taken	A list of rejects due to personal characteristics failed to match SSA records.	M
SRAJK480	HMKR5710	Buy In - Part B - Code 21 Rejects	A summary of individual reject records.	M
SRAJK480	HMKR5711	Buy-In Part B - Pending Actions Report	A summary of records per transaction codes.	M
SRAJK480	HMKR5712	Buy-In Part B - Initial SSA Tape Transaction Ledger	A summary of transaction codes and premiums for reconciliation.	M
SRAJK480	HMKR5713	Buy-In Part B - Code 33 Exception Report	A list of rejects for recipients that are on the Buy In in another State.	M



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
SRAJK480	HMKR5714	Buy-In Part B - Code 24 Rejects	A list of rejects for recipients that will be Medicare eligible on a future date.	M
SRAJK480	HMKR5715	Buy-In Part B - Code 23 Report	A list of recipients in which the HIC numbers are different from the eligibility file.	M
SRAJK480	HMKR5716	Buy-In Part B - Code 64 Exception Report	A list of recipients that are CMS controlled and the Buy In history doesn't reflect the same.	M
SRAJK480	HMKR5752	Buy-In Part B - Medicaid Recipients Reaching Age 65 w/o Valid HIC Number	A list of recipients that are over age 65 without a valid HIC number on the file. Printed in Troy on 8 1/2 x 11 plain laser paper.	M
SRAJK480	HMKR5791	Buy-In Part B - Multiple Txns Received from HCFA	A list of recipients with multiple transaction codes for current month.	M
SRAJK490	HMKR6702	Buy-In Part A - Code 3662 Exception Report	A list of rejects due to non eligible for Medicare.	M
SRAJK490	HMKR6703	Buy-In Part A - Code 29 Exception Report	A list of rejects for recipients with death dates on the SSA file.	M
SRAJK490	HMKR6704	Buy-In Part A - Code 49 Exception Report	A list of rejects for recipients due to identifying information non-match.	M
SRAJK490	HMKR6705	Buy-In Part A - Code 27 Exception Report	A list of rejects for recipients with invalid transaction codes.	M
SRAJK490	HMKR6706	Buy-In Part A - Code 25 Exception Report	A list of rejects for recipients with invalid transmission codes.	M
SRAJK490	HMKR6707	Buy In - Part A - Code 20 Error Reports	Recycle - A list of rejects due to HIC number non-match.	M
SRAJK490	HMKR6708	Buy-In Part A - Code 28 Exception Report	A list of rejects for recipients already on the Buy In.	M
SRAJK490	HMKR6709	Buy In - Part A - Code 21 Worksheets	A list of rejects due to personal characteristics failed to match SSA records.	M
SRAJK490	HMKR6710	Buy In - Part A - Code 21 Rejects	A summary of individual reject records.	M
SRAJK490	HMKR6713	Buy-In Part A - Code 33 Exception Report	A list of rejects for recipients that are on Buy In in another state.	M
SRAJK490	HMKR6714	Buy-In Part A - Code 24 Rejects	A list of rejects for recipients that will be Medicare eligible on a future date.	M
SRAJK490	HMKR6715	Buy-In Part A - Code 23 Report	A list of recipients with code 15 deletes without a code 23 change record.	M
SRAJK500	HMKR5061	Buy-In Part B - Code 42XX Report	A list of recipients in which CMS is sending credits due to billing errors.	M



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
SRAJK500	HMKR5062	Buy-In Part B - Code 1165 Report	A list of recipients that CMS accreted to the Buy In due to letters from the State.	M
SRAJK500	HMKR5063	Buy-In Part B - Code 1167 Report	A list of Public Welfare accretions that CMS added to the Buy In.	M
SRAJK500	HMKR5064	Buy-In Part B - Code 1128 Report	A list of recipients in which CMS moved the requested date forward due to prior Buy In coverage in another state.	M
SRAJK500	HMKR5065	Buy-In Part B - Code 32XX Report	A list of recipients in which the Buy In action has been delayed due to prior Buy In coverage.	M
SRAJK500	HMKR5066	Buy-In Part B - Code 34XX Report	A list of recipients in which the delete request rejected.	M
SRAJK500	HMKR5067	Buy-In Part B - Code 43XX Report	A list of recipients in which the Buy In start date or stop date has been adjusted.	M
SRAJK500	HMKR5068	Buy-In Part B - Code 4999 Report	A list of recipients in which the requests rejected due to HIC number non-match.	M
SRAJK500	HMKR5069	Buy-In Part B Transfer Codes w/out New Accretion Codes	A list of recipients in which a transfer code was received without a new accrete code.	M
SRAJK505	HMKR500N	Buy-In Part B SSA Edit Report	Monthly editing of Part B Buy In transactions sent to the Social Security Administration.	M
SRAJK510	HMKR500N	Buy-In Part B SSA Edit Report	Monthly editing of Part B Buy In transactions sent to the Social Security Administration.	M
SRAJK510	HMKR510R	Buy-In Part B Transactions Not Applied to Error File	A list of records that were not applied due to errors.	M
SRAJK510	HMKR511R	Buy-In Part B Manual Transactions Applied Report	Monthly listing of the changes which were applied to the file	M
SRAJK510	HMKR515R	Buy-In Part B List of Premium Txns Previously Assigned to Unknown County	A list of recipients that appeared in the unknown county in prior months.	M
SRAJK520	HMKR520R	Buy In Part B Manual Transactions Keyed in Error	A list of manually keyed transactions that failed due to eligibility file non match.	M
SRAJK520	HMKR521R	Buy-In Part B Valid Txns Keyed	A list of valid manual transactions keyed.	M
SRAJK530	HMKR5305	Buy-In Part B - List of Accretions Effective Two Years Prior to Current Month	A list of recipients with new accretes that are more than 2 years retroactive.	M
SRAJK530	HMKR5306	Buy-In Part B - Buyin Update Messages	A list of recipients that rejected due to requested start date invalid.	M
SRAJK530	HMKR5308	HCFA Exception	A list of CMS controlled records and CMS failed to accrete or transfer responsibility.	M





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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
SRAJK550	HMKR5501	Buy-In Part B - Transactions Billed	A list of recipients in which Buy In premiums have been billed to the state.	M
SRAJK550	HMKR5502	Buy-In Part B - State Totals by Program Code and Unknown County	State totals for classification, recipients, and premium amount	M
SRAJK550	HMKR5503	State Report Totals - Part B	A summary of recipients and premiums for specified classification groups.	M
SRAJK550	HMKR5511	Buy-In Part B - Date of Birth Discrepancies	A list of recipients in which the date of birth is different from the eligibility file.	M
SRAJK560	HMKR560R	Buy-In Part B Edit Report	Monthly editing of Part B Buy In transactions	M
SRAJK560	HMKR561R	Buy-In Part B Error Transaction Report	A summary of all actions taken on the previous month's error transaction report.	M
SRAJK560	HMKR5651	List of Buy-In Part B Actions Sent to Baltimore	The report is a listing of all transactions submitted to CMS showing accretions, deletions, and changes for the current month.	M
SRAJK600	HMKR6061	Buy-In Part A - Code 42XX Report	A list of recipients in which CMS is sending credits due to billing errors.	M
SRAJK600	HMKR6062	Buy-In Part A- Code 1165 Report	A list of recipients that CMS accreted to the Buy In due to letters from the State.	M
SRAJK600	HMKR6063	Buy-In Part A- Code 1167 Report	A list of Public Welfare accretions that CMS has added to the Buy In	M
SRAJK600	HMKR6064	Buy-In Part A- Code 1128 Report	A list of recipients in which CMS moved the requested date forward due to prior Buy In coverage in another state.	M
SRAJK600	HMKR6065	Buy-In Part A - Code 32XX Report	A list of recipients in which the Buy In action has been delayed due to prior Buy In coverage.	M
SRAJK600	HMKR6066	Buy-In Part A - Code 34XX Report	A list of recipients in which the Buy in date or stop date has been adjusted.	M
SRAJK600	HMKR6067	Buy-In Part A - Code 43XX Report	A list of recipients in which the requests rejected due to HIC number non-match.	M
SRAJK600	HMKR6068	Buy In Part B Code 49999	A list of recipients in which the requests rejected dur to HIC number non-match.	M
SRAJK600	HMKR6069	Transfer W/O New Accrete Codes	A list of recipients in which a transfer code was received without a new accrete code.	M
SRAJK605	HMKR600N	Buy-In Part A SSA Edit Report	Monthly editing of part A Buy In transactions sent to the Social Security Administration.	
SRAJK610	HMKR600N	Buy-In Part A SSA Edit Report	Monthly editing of part A Buy In transactions sent to the Social Security Administration.	M
SRAJK610	HMKR610R	Buy-In Part A Transactions Not Applied to Error File	A list of records that were not applied due to errors.	M



## Appendix 40, Attachment G Consolidated List of Reports



DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
SRAJK610	HMKR611R	Buy-In Part A Manual Transactions Applied Report	A list of manual transactions that were applied.	M
SRAJK610	HMKR615R	Buy-In Part A List of Premium Txns Previously Assigned to Unknown County	A list of recipients that appeared in the unknown county in prior months.	M
SRAJK620	HMKR620R	Buy-In Part A Manual Txns Keyed in Error	A list of manually keyed transactions that failed due to eligibility file non-match.	M
SRAJK620	HMKR621R	Buy-In Part A Valid Txns Keyed	A list of valid manual transactions keyed.	M
SRAJK630	HMKR6305	Buy-In Part A - List of Accretions Effective Two Years Prior to Current Month	Monthly list of recipients who are being bought in whose start date of service is greater than 2 years.	M
SRAJK630	HMKR6306	Buy-In Part A - Buyin Update Messages	A list of recipients that have transfer codes due to inadequate premium fields.	M
SRAJK630	HMKR6351	New ACC w/Prior BA History	A list of recipients with new accretes that have prior Buy In history.	M
SRAJK650	HMKR6501	Buy-In Part A - Transactions Billed	This report is a listing of all valid Buy-In transactions that are being billed to the state and counties for the month	M
SRAJK650	HMKR6502	Buy-In Part A - State Totals by Program Code	A summary of recipients and premiums per program code group.	M
SRAJK650	HMKR6502	Buy-In Part A - Unknown County	A summary of recipients that have HIC numbers that are different from the eligibility file.	M
SRAJK650	HMKR6503	State Report Totals - Part A	State totals for classification, recipients, and premium amount	M
SRAJK650	HMKR6511	Buy-In Part A - Date of Birth Discrepancies	A list of recipients in which the date of birth is different from the eligibility file.	M
SRAJK660	HMKR660R	Buy-In Part A Edit Report	A list of records with MID number non-match.	M
SRAJK660	HMKR661R	Buy-In Part A Error Transaction Report	A summary of all actions taken on the previous month's error transaction report.	M
SRAJK660	HMKR6651	List of Buy-In Part A Actions Sent to Baltimore	A list of all requests for CMS to process for current month.	M
SRAJK670	HMKR6711	Buy-In Part A - Pending Actions Report	A summary of records per transaction codes.	M
SRAJK670	HMKR6712	Buy-In Part A - Initial SSA Tape Transaction Ledger	A financial summary of transaction codes and premiums for reconciliations.	M
SRAJK670	HMKR6717	Buy-In Part A - Multiple Txns Received from HCFA	Reports the multiple transaction received from HCFA	M
SRAJK700	HMKR7051	Multiple PML Amount Within Same Month	Daily reports with the multiple patient monthly liability amounts.	D, M-T



## Appendix 40, Attachment G Consolidated List of Reports



DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
SRAJK730	HMKR732N	Long Term Care Deceased Recipient Report	Annual listing of deceased recipients who were in long term care facilities.	A- July-First Wed in the month
SRAJK750	HMKR7501	Patient Liability Positive Balance Discrepancy Report	Listing of all recipients with a positive patient liability for the selected month.	M-Third Fri in the month
SRAJK770	HMKR7701	PASARR Pending to Master Report	This report is a listing of all Pending File PASARR records that have been able to obtain an MID and are being moved to the PASARR Master File.	D
SRAJK770	HMKR7702	PASARR Pending Mismatch Report	This report is a listing of all Pending File PASARR records that have been assigned an MID via Browser and have had a different MID determined during batch processing.	D
SRAJK770	HMKR7711	PASARR Mater File Update Report	This report is a listing of all PASARR numbers added to or changed on the PASARR Master File.	D
SRAJK770	HMKR7712	PASARR Pending File Update Report	This report is a listing of all PASARR numbers added to or changed on the PASARR Pending File.	D
SRAJK770	HMKR7713	PASARR Error Report	This report is a listing of all PASARR numbers received from First Health that were not processed and an error message indicating the reason they were not processed.	D
SRAJK780	HMKR7801	Pending PASARR Purged Records	Lists records that were purged from the pending PASAAR that meet the following criteria: 1. PASARR records contains an MID and the transmission date is greater than one year or 2. PASARR doesn not contain an MID and the transmission date is greater tha	Q
SRAJK785	HMKR7851	Master PASARR Purged Records	Lists records that were purged from the Master PASARR that meet the following criteria: if the record has an end date over 5 years.	Q
SRAJK800	HMKR8001	Ad hoc Invoice Reprints	Printed in Troy on 8 1/2 x 11 plain laser paper.	OR
SRAJK820	HMKR8220	TPL Drug Recovery Report-Total Available for Recovery Company Code Order	This report lists the total new claims available for drug recovery from each insurance carrier by insurance company code. Includes the total number of claims; the amount billed to Medicaid and amount Medicaid paid.	Q
SRAJK820	HMKR8230	TPL Drug Recovery Report-Total Available for Recovery Billed Amount Order	This report lists the total new claims available for drug recovery from each insurance carrier by billed amount. Includes the total number of claims, the amount billed to Medicaid and amount Medicaid paid.	Q
SRAJK830	HMKR8301	Third Party Drug Recovery Invoices	Third party drug recovery invoice forms.	Q
SRAJK830	HMKR8302	Third Party Drug Recovery Invoices for DMA Manual Processing	Printed in Troy on 8 1/2 x 11 plain laser paper. Third party drug recovery invoices used for manual processing.	Q
SRAJK830	HMKR8303	Third Party Drug Recovery Codes List	Printed in Troy on 8 1/2 x 11 plain laser paper. List of insurance company codes for which DMA has requested manual processing.	Q



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
SRAJK830	HMKR832R	TPL Drug Recovery Inquiry Summary Report	Printed in Troy on 8 1/2 x 11 plain laser paper. This report displays a summary of Third Party Drug Recovery invoices for insurance company. The report includes the recipient name, MID, ICN, date of service, billed and paid amount for each claim include	Q
SRAJK860	XX-New Report	Drug Recovery Labels		Q
SRAJK900	HMKR9021	MHMA Prior Approval Listing		W-Fri
SRAJK900	HMKR9110	MHMA Prior Approval Listing - By Name	A listing of all error received on PA transactions for recipient from outside vendors such as Value Option.	W-Fri
SRAJK905	HMKR9061	Rejected Transactions for MH/SAS	A listing of all error received on PA transactions for recipients from outside vendors such as ValueOptions.	D
SRAJK905	HMKR9081	Activity of MH/SAS	A listing of all valid activity received on PA transactions from all outside vendors such as ValueOptions.	D
SRAJK910	HMKR1201	Prior Approval Pending Beyond Alert Date	This will report on Prior Approval pending records that have exceeded their Alert Dates.	D
SRAJK910	HMKR1202	Prior Approval Eligibility Pending Over 21 Days	This will report on Prior Approval records which have exceeded their 21 day limit to resolve Eligibility Pending status.	D
SRAJK910	HMKR1203	PA Eligibility Pending Name Mismatch	This will report on name mismatches between Prior Approval and Eligibility records in Pending status.	D
SRAJK910	HMKR8132	Daily Unsuccessful PA Letter		M
SRAJK910	HMKR9133	Monthly Successful Letter		M
SRAJK910	HMKR9213	Prior Approval Maintenance PDN Transaction Summary Report	Daily summary of the total private duty nursing transactions read, applied, rejected, wrapped, pending, and dropped.	D
SRAJK910	HMKR9214	Prior Approval Maintenance MHMA Transaction Summary Report	A summary of prior approval activity by transaction code placed on the eligibility file for the current cycle.	D
SRAJK911	HMKR9131	Daily Successful PA Letter	List of the PA denial letters, change letters, and additional information letters that were produced that day.	D
SRAJK911	HMKR9141	Daily Unsuccessful PA Letters	List of the PA denial letters, change letters, and additional information letters which could not be produced because of a failure.	D
SRAJK911	HMKR9182	Daily PA Denials by No Letters	List of the prior approval requests that were denied but no letter was generated because the PA status code was an "E".	D
SRAJK911	HMKR9211	Prior Approval Summary Report (In-House Programs)	Daily summary of prior approval activity by transaction code placed on the eligibility file for the current cycle.	D
SRAJK912	HMKR9181	Denial by Reason Cod		W



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
SRAJK912	HMKR9211	Aged Weekly PA Denial Letters	Summary of the letters produced bucketing the number of letters by the time it took to produce based on the difference between to received date and the letter sent date	other
SRAJK919	HMKR9961	Prior Approval Expenditure Tracking Report	This will report on Prior Approval records with activity since the last CHECKWRITE.	W-Fri
SRAJK921	HMKR9215	Dropped Prior Approval Details		M-Last day of month
SRAJK930	HMKR930A	FTD update error	Listing of all submitted transactions to either update or add records to Specialized Therapy first Treatment Date Master file that failed and reason for failure.	D
SRAJK930	HMKR930B	FTD update activity	Listing of all submitted transactions to either update or add records to the Specialized Therapy First Treatment Date Master File.	D
SRAJK932	HMKR932A	Recipients with recorded		D
SRAJK940	HMKR9431	PASARR Trlog	Reports on all MID changes to PASARR records.	D
SRAJK940	HMKR9452	Errored Transactions - FMH Transmitted Data	MHMA maintenance errored transaction report.	D
SRAJK940	HMKR9453	MHMA Activity Report	MHMA transactions activity.	D
SRAJK940	HMKR9461	Activity for MRNC Transmitted Data	This report identifies all specialized therapies prior approval activity entered via the Browser from Mrnc on a daily basis. This transaction activity report is placed on the Lan for retrieval by Mrnc and also R2W.	D
SRAJK940	HMKR9801	PA Added Report and Error		D
SRAJK950	HMKR9501	Eligibility Voice Inquiry	This report indicates the date and time an eligibility voice inquiry is made and recipient's eligibility status.	M
SRAJK990	HMKR9921	Orthodontic Provider Information	This report displays a list of Orthodontic Providers and shows an accumulative list of how many prior approvals have been authorized to that particular provider.	A-Jan-15th day of month
SRAJL400	HMLR2101	Health Check Referral Error Report	Monthly report listing the diagnosis used by doctors as referrals but not listed in the referral table.	M-Last Fri in month
SRAJL400	HMLR4201	Health Check Notice Control Report	Monthly control report of the total monthly health check notice generated.	M
SRAJL410	HMLR45XX	Monthly Report on Recipients who are delinquent for their Health Check Screenings	Printed in Troy on 11 x 14 green bar impact. Monthly report on recipients who are delinquent for the Health Check screenings. The XX in the report name is the key to identify which of the 141 Carolina Access II or III providers should receive a particul	M-First day of month



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
SRAJL540	HMLR5501	Health Check (EPSDT) Program Year-to-Year Comparisons Report	This report is a year to year comparison of the screening and participation rates for Health Check recipients in the state of North Carolina.	Qtly 3,6,9,12
SRAJL540	HMLR5502		This report is a year to year comparison of the screening rates for Health Check recipients in the State of North Carolina.	Qtly 3,6,9,12
SRAJL540	HMLR5601	Health Check (EPSDT) Screening Provider Report - Unduplicated Count of Responsibility and Provider	This report displays screening and participation rates listed by age group, provider group, and county.	Qtly 3,6,9,12
SRAJL540	HMLR5602	Health Check (EPSDT) Screening Provider Report - Duplicated Count by County of Responsibility and Provider	This report displays screening rates listed by county, by provider group, and by age.	Qtly 3,6,9,12
SRAJL540	HMLR5701	Health Check (EPSDT) Eligibility Participation Report - Health Check Counties	This report displays the screening rates for those counties that are participating within the Health Check program.	Qtly 3,6,9,12
SRAJL540	HMLR5702	Health Check (EPSDT) Eligibility Participation Report - Non-Health Check Counties	This report shows the screening rates for those counties that are not participating in the Health Check program.	Qtly 3,6,9,12
SRAJL540	HMLR5703	Health Check (EPSDT) Eligibility Participation Report - All North Carolina Counties	This report displays the screening rates for all counties in the state of North Carolina.	Qtly 3,6,9,12
SRAJL540	HMLR5901	Form HCFA-416; Annual EPSDT Participation Report	Reports of the annual EPSDT participation rates. These rates are used to judge the success or failure of the Health Check/EPSDT program in the state of North Carolina. HCFA, a federal agency, uses it as a type of report card. This is probably the most	Qtly 3,6,9,12
SRAJL600	HMLR6001	MCC Information Summary Report	This report shows the number of eligible health check recipients who received MCC services as well as those who didn't receive MCC services. This report is listed by age group.	M-Last Fri in month
SRAJL600	HMLR6001	Mental Health CSC Information Summary Report	Reports a summary of mental health CSC information.	M-Last Fri in month
SRAJL600	HMLR6001	Health Check Information System	Health Check information tracking report.	M-Last Fri in month
SRAJL600	HMLR6001	CSC Health Check Information System	Reports the CSC health check information for a particular county.	M-Last Fri in month
SRAJL600	HMLR6001	MCC Health Check Information System	Reports the CSC health check information for a particular county.	M-Last Fri in month



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
SRAJL600	HMLR6001	Mental Health CSC Health Check Information System	This report shows the mental health CSC health check information age groups.	M-Last Fri in month
SRAJL600	HMLR6001	Health Check Closure Report	This is a closure report for a particular county.. It shows which recipients left the program over the last month.	M-Last Fri in month
SRAJL600	HMLR6001	Health Check Information Summary Report	This report summarizes all of the AINS/EPSTD data for a particular county.	M-Last Fri in month
SRAJL600	HMLR6001	CSC Information Summary Report	Reports the CSC health check information for a particular county.	M-Last Fri in month
SRAJL610	HMLR6101	Screening Claim Analysis by County/Prov/EOB for Health Dept	Health Check Claims Denial Report for ALL EPSTD providers. This report only displays information from Health Check or "L" claims sorted by denial rate, number of denied claims, denied claims, paid claims, provider number, and EOB.	M
SRAJL610	HMLR6102	Health Check Claims Denial for all EPSTD Providers	Health Check Claims denial report for all EPSTD providers. This denial report only displays information from Health Check or "L" claims sorted by county number, denial rate, denied claims, paid claims, and EOB.	M
SRAJL620	HMLR6201	Health Check Management Fees Claims Created	Reports the total number of Health Check Management Fee Claims that were generated to pay specific providers for employing Health Check Coordinators throughout the state.	M-First Friday in month
SRAJL710	XX-New Report	Health Check Counts		M-Last Fri in month
SRAJL710	XX-New Report	Std Listing	Lists the number of Health Check pages printed for each county.	M-Last Fri in Month
SRAJL720	XX-New Report	Health Check Counts		M-Last Fri in month
SRAJL800	HMLR8001	Health Check County Options Error Report	Reports the errors, if any, that occurred when the Health Check County Option file was updated.	M-OR
SRAJL810	HMLR8101	Health Check County Options Master Report	Reports all of the data on each county record of the Health Check County Options file.	M-OR
SRAJL940	HMLR9401	Health Check Management Options Master Report	This report displays all of the pertinent information on each county record of the Health Check Management Fee Option file.	OR
SRAJP050	HMPR0501	Sterilization Consent Form Information Inquiry - Weekly Maintenance Txn Report (Additions)	Transaction log report of Sterilization Consent File online modifications (adds/changes/deletes)	W-Sun



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
SRAJP050	HMPR0502	Sterilization Consent Form Information Inquiry - Weekly Maintenance Txn Report (Changes)	Transaction log report of Sterilization Consent File online modifications (adds/changes/deletes)	W-Sun
SRAJP050	HMPR0503	Sterilization Consent Form Information Inquiry - Weekly Maintenance Txn Report (Deletions)	Transaction log report of Sterilization Consent File online modifications (add/changes/deletes)	W-Sun
SRAJP050	HMPR0551	Sterilization Consent Form Pull Report	Transaction log report of Sterilization Consent File online modifications (adds/changes/deletes)	W-Sun
SRAJP060	HMPR0601	Hysterectomy Information Inquiry - Weekly Maintenance Txn Report (Additions, Changes, Deletions)	Transaction log report of Hysterectomy File online modifications	W-Sun
SRAJP060	HMPR0651	Hysterectomy Consent Form Pull Report	Transaction log report of Hysterectomy File online modifications	W-Sun
SRAJP070	HMPR0701	Weekly Dialysis Activity Transaction Log ( Additions, Changes, Deletions)	A list of dialysis records that have flagged for Buy -In in follow up.	W-Wed
SRAJP090	HMPR0901	Trlog for Security File	Audit trail of changes made to the Data Definition File	W-Sun
SRAJP095	HMPR0951	Security File Master Listing	Transaction log report of Diagnosis File online modifications	M-Last Sun in month
SRAJP150	HMPR1501	Dialysis Master TRLOG Report (Additions, Changes, Deletions)	Transaction log report of Diagnosis File online modifications	W-Wed
SRAJP150	HMPR1551	Diagnosis Master Listing	Produces the TRLOG reflecting to the diagnosis file.	Q
SRAJP201	HMPR2011	Fee Schedule Trlog	Transaction log report.	D - report produced only when changes are made
SRAJP211	HMPR2141	PAL-CS Statewide Brand	This report contains usage information and average cost per unit for GCN-Sequences within their PAL clases; statewide.	M
SRAJP211	HMPR2142	PAL-CS Statewide Generic	This report contains usage information and average cost per unit for GCN-Sequences within their PAL clases; statewide.	M
SRAJP211	HMPR2151	PAL-CS County Brand	This report contains usage information and average cost per unit for GCN sequences within their PAL classes; by county.	M





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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
SRAJP211	HMPR2152	PAL-CS County Generic	This report contains usage information and average cost per unit for GCN sequences within their PAL classes; by county.	M
SRAJP211	HMPR2161	PAL-CS Provider Specialty Brand	This report contains usage information and average cost per unit for GCN sequences within their PAL classes, by provider specialty.	M
SRAJP211	HMPR2162	PAL-CS Provider Specialty Generic	This report contains usage information and average cost per unit for GCN sequences within their PAL classes, by provider specialty.	M
SRAJP211	HMPR2171	PAL-CS Age Range Brand	This report contains usage information and average cost per unit for GCN sequences within their PAL classes by recipient age range.	M
SRAJP211	HMPR2172	PAL-CS Age Range Generic	This report contains usage information and average cost per unit for GCN sequences within their PAL classes by recipient age range.	M
SRAJP211	HMPR2181	PAL-CS County Brand	This report contains usage information and average cost per unit for GCN sequences within their PAL classes; by provider specialty within county.	M
SRAJP211	HMPR2182	PAL-CS County Generic	This report contains usage information and average cost per unit for GCN sequences within their PAL classes; by provider specialty within county.	M
SRAJP220	HMPR2201	Recipient Pharmacy Lock-In	TrLog of Pharmacy lock in file	W
SRAJP236	HMPR2331	PAL Reporting Part One: Brand	This report lists Brand/multisource drug NDC's, grouped by their broader PAL group ID's and includes classification and pricing information about each drug.	Q
SRAJP236	HMPR2332	PAL Reporting Part One: Generic	This report lists Generic drug NDC's, grouped by their broader PAL group ID's and includes classification and pricing information about each drug.	Q
SRAJP236	HMPR2341	PAL Reporting Part II.: Brand	This report lists Brand/multisource drug NDC's grouped by their GCN sequence numbers and includes classification and pricing information about each drug.	Q
SRAJP236	HMPR2342	PAL Reporting Part II: Generic	This report lists generic drug NDC's grouped by their GCN sequence numbers and includes classification and pricing information about each drug.	Q
SRAJP236	HMPR2351	PAL Part III: Final PAL Report	This report lists drug GCN sequence numbers and arranges them by their PAL group ID. Averages and variances are calculated for the group.	Q
SRAJP238	HMPR2381	PAL Reporting Part One: Brand Year End	This report lists Brand/multisource drug NDC's, grouped by their broader PAL group ID's and includes classification and pricing information about each drug.	A
SRAJP238	HMPR2382	PAL Reporting Part One: Generic Year End	This report lists Generic drug NDC's, grouped by their broader PAL group ID's and includes classification and pricing information about each drug.	A
SRAJP238	HMPR2383	PAL Reporting Part II: Brand Year End	This report lists Brand/multisource drug NDC's grouped by their GCN sequence numbers and includes classification and pricing information about each drug.	A



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
SRAJP238	HMPR2384	PAL Reporting Part II: Generic Year End	This report lists generic drug NDC's grouped by their GCN sequence numbers and includes classification and pricing information about each drug.	A
SRAJP238	HMPR2384	PAL Reporting Part III: Final PAL Report Year End	This report lists drug GCN sequence numbers and arranges them by their PAL group ID. Averages and variances are calculated for the group.	A
SRAJP250	HMPR2501	First Databank Drug File Update Report	Lists new drugs that will be added to the drug file on Friday night. Also lists drugs which have a change in the generic indicator.	W-Wed
SRAJP260	HMPR2502	First Databank Drug File Update Report	Lists new drugs that will be added to the drug file on Friday nights.	W-Wed
SRAJP260	HMPR2601	PDDS Maintenance System Drug Listing (by NDC)	Drug listing containing descriptions of drugs.	M-Last Wed in month
SRAJP260	HMPR2602	PDDS Maintenance System Drug Listing (by Drug Name)	Drug listing containing descriptions of drugs.	M
SRAJP280	HMPR2801	State MAC Trlog	Trlog for online updates for the State MAC file.	other
SRAJP283	HMPR2841	State MAC Drug Pricing Provider Exception	Reports on providers that are the only Medicaid provider for their respective county and will not be subject to State MAC Drug Pricing.	W
SRAJP284	HMPR2821	State MAC File Master Listing	Listing of the contents of the State MAC master file.	M
SRAJP285	HMPR2851	State MAC Drug Pricing Load	Reports on any issues regarding the load of the Mercer Update file to the State MAC master file. A control page with totals is also produced.	A-Dec
SRAJP290	HMPR2921	PA/PDL Requirement File Load Error	Details rejects from the PA/PDL Requirement update.	Sun
SRAJP290	HMPR2931	PA/PDL File Master Listing	Listing of the contents of the Requirement Master File.	Sun
SRAJP290	HMPR2961	PA/PDL Requirement File Load Alert	Details alerts from the PA/PDL Requirement update. The details are laid out according to Alerts according to the primary update, and additional adds as a result of a secondary update. The additional adds will be reported in a slightly different format.	Sun
SRAJP300	HMPR3001	Procedure Reference Master File (Level III)	Listing of all Procedure Code Reference Records	W-Sun
SRAJP300	HMPR3101	Procedure Reference Master File Transaction Log Report (Level III)	TRLOG report of changes made via the PR Screen	W-Sun
SRAJP410	HMPR4101	System Control Table Population Group Payer NCXIX Transaction Log Report	A standard audit log of maintenance activity that has taken place related to the System and Population Group Payer Control Tables	W-Sun
SRAJP550	HMPR5501	Modifier Master File	Master listing of the Modifier Criteria file	W-Sun
SRAJP550	HMPR5551	Modifier Master File Transaction Log Report	TRLOG for MF screen changes	W-Sun



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
SRAJP580	HMPR5811	Modifier Combination File Transaction Log Report	TRLOG for MM screen changes	W-Sun
SRAJP580	HMPR5821	Modifier Combination File Master	TRLOG for MM screen changes	W-Sun
SRAJP600	HMPR6001	Manual Price Report	Quarterly list of procedures that have a prior approval code 1 in the Level III file.	Q
SRAJP650	HMPR6551	Physician Fee Schedule Procedures not on Level III	Report contains procedure code and type of service code.	Q
SRAJP650	HMPR6560	Physician Fee Schedule Procedures with End Date on Level III	Master report for Physician Fee Schedule. Procedures with end-date on the Procedure Reference File.	Q
SRAJP700	HMPR7001	Fee Schedule Master List	Master report for the Fee Schedule.  Printed in Troy on 8 1/2 x 11 plain laser paper.	Q-Last Thurs in quarter
SRAJP700	HMPR7101	Procedure Codes for Surgery and the After Care Period	Printed in Troy on 8 1/2 x 11 plain laser paper.	Q-Last Thurs in quarter
SRAJP700	HMPR7102	Anesthesia Base Units	Printed in Troy on 8 1/2 x 11 plain laser paper. This report identifies the procedure codes for anesthesia (PAC=6) and base units for those codes.	Q-Last Thurs in quarter
SRAJP700	HMPR7201	Fee Schedule Records not on Level III	Master report for Fee Schedule records not on the Procedure Reference file.	Q-Last Thurs in quarter
SRAJP700	HMPR7301	Ambulatory Surgery Codes w/ Invalid Level Pricing	This report contains level 3 ambulatory surgery codes that have invalid rate information.	Q-Last Thurs in quarter
SRAJP751	HMPR7501	Edit Process Header File TR Log	Transaction log for all actions taken (changes, additions, deletions) on the Edit Process Header File.	W-Wed
SRAJP751	HMPR7511	Edit Process Detail File TR Log	Transaction log for all actions taken (changes, additions, deletions) on the Edit Process Detail File.	W-Wed
SRAJP751	HMPR7521	Edit Table Header Master File TR Log	Transaction log for all actions taken (changes, additions, deletions) on the Edit Table Header file.	W-Wed
SRAJP751	HMPR7531	Edit Table Detail File TR Log	Transaction log for all actions taken (changes, additions, deletions) on the Edit Table Detail file.	W-Wed
SRAJP751	HMPR7541	Edit List Master File TR Log	Transaction log for all actions taken (changes, additions, deletions) on the Edit List.	W-Wed
SRAJP760	HMPR7601	Budget and Funding Master	TRLOG for the Budget and Funding Budget Master File (HMONBUDR)	W-Wed
SRAJP760	HMPR7611	Budget and Funding Criteria Detail Master File	TRLOG for the Budget and Funding Criteria Detail Master File (HMONBFDR)	W-Wed
SRAJP760	HMPR7621	Budget and Funding Master File	TRLOG for the Budget and Funding, Funding Master File (HMONFUNR)	W-Wed



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
SRAJP760	HMPR7631	Budget and Funding General Budget Master File	TRLOG for the Budget and Funding General Budget Master File (HMONBFGR)	W-Wed
SRAJP760	HMPR7641	Budget and Funding Criteria Header Master File	TRLOG for the Budget and Funding Criteria Header Master File (HMONBFHR)	W-Wed
SRAJP760	HMPR7651	Budget and Funding Criteria List Master File	TRLOG for the Budget and Funding Criteria List Master File (HMONBFLR)	W-Wed
SRAJP810	HMPR8101	DRG Pricing File Transaction Log Report	Transaction log for all actions taken (changes, additions, deletions) on the DRG file.	W-Wed
SRAJP820	HMPR8201	Special Pricing Transaction Log Report	Transaction log report of Special Pricing File online modifications	W-Wed
SRAJP840	HMPR8401	Premium Payment Category Master File Listing	Provides a summary of premium payment categories by financial payer. Fields include eligibility code, memo, effective date, end date, last update, sex, from and to age, and pay category.	W-Wed
SRAJP845	HMPR8451	Premium Payment Category Update Audit Report	Provides a list of premium payment category updates by financial payer. List fields include eligibility code, memo, effective date, end date, last update, sex, from and to age, pay category, VD, KICK, and sex.	W-Wed
SRAJP850	HMPR8501	Premium Payment Amount Master File Listing	Provides premium payment category update audit by financial payer. Fields include eligibility code, memo, effective date, end date, last update, sex, from and to ages, and pay category.	W-Wed
SRAJP855	HMPR8551	Premium Payment Amount Update Audit Listing	Provides a list of premium payment category updates by financial payer.	W-Wed
SRAJP860	HMPR8601	Out-of-Plan Benefits Master File Listing	Provides a summary of out-of-plan benefits by financial payer. Fields include plan number, county, DTL, effective date, termination date, last update, memo, provider type/spec, and diagnosis from/thru	other
SRAJP870	HMPR8701	Enhanced Care PA Transaction Log Report	Weekly report information for the Trlog report from the EC screen data.	W-Sun
SRAJP870	HMPR8702	Ambulation Locomotion PA Transaction Log Report	This report reflects changes made to the ambulation locomotion prior approval file.	W-Sun
SRAJP870	HMPR8711	High Risk PA Transaction Log Report	The high risk PA transaction log report reflects changes made to the high risk PA file.	W-Sun
SRAJP870	HMPR8731	Hospice Care Transaction Log Report	The hospice care transaction log report reflects changes made to the hospice care file.	W-Sun
SRAJP870	HMPR8741	PA Master File TR Log	The report contains the prior approval master records before and after changes have been made to the records.	W-Sun
SRAJP880	HMPR8801	Time Limit Override Update Audit Listing	Transaction log report of Time Limit Override File online modifications	W-Wed



## Appendix 40, Attachment G Consolidated List of Reports



DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
SRAJP890	HMPR8901	Premium Reduction Master File Listing	Provides a list of premium reduction by financial payer. The list includes plan number, memo number, region, last update, effective date, end date percentage, and release (Y/N)	W-Wed
SRAJP895	HMPR8951	Premium Reduction Update Audit Listing	Transaction log for all actions taken (changes, additions, deletions) on the Premium Reduction file.	W-Wed
SRAJP920	HMPR9201	DRG Weight File	The report contains the Drug Related Grouping weight information.	A-Oct
SRAJP920	HMPR9201	DRG Weight File	The report contains the Drug Related Grouping weight information.	A-Oct
SRAJP920	HMPR9201	DRG Weight File	The report contains the Drug Related Grouping weight information.	A-Oct
SRAJP920	HMPR9201	DRG Weight File	The report contains the Drug Related Grouping weight information.	A-Oct
SRAJP920	HMPR9201	DRG Weight File	The report contains the Drug Related Grouping weight information.	A-Oct
SRAJP920	HMPR9201	DRG Weight File	The report contains the Drug Related Grouping weight information.	A-Oct
SRAJP920	HMPR9201	DRG Weight File	The report contains the Drug Related Grouping weight information.	A-Oct
SRAJP920	HMPR9201	DRG Weight File	The report contains the Drug Related Grouping weight information.	A-Oct
SRAJP920	HMPR9201	DRG Weight File	The report contains the Drug Related Grouping weight information.	A-Oct
SRAJP920	HMPR9201	DRG Weight File	The report contains the Drug Related Grouping weight information.	A-Oct
SRAJP920	HMPR9201	DRG Weight File	The report contains the Drug Related Grouping weight information.	A-Oct
SRAJP950	HMPR702N	Fee Schedule Update Acceptance List	Fee Schedule Weekly Maintenance	A-OR
SRAJP950	HMPR9501	Fee Schedule Updates	The report contains updates to the fee transactions.	A-OR
SRAJP950	HMPRF01N	Fee Schedule Update Error List	Fee Schedule Weekly Maintenance	A-OR
SRAJP970	HMPR3101	Procedure Reference Master File Transaction Log Report (Additions, Changes, Deletions)	This report contains additions, changes, and deletions made to the Procedure Reference master file.	A-Dec
SRAJR760	HMRR7601	Paid Therapeutic Leave as Reported by Nursing Homes	Provides, by nursing homes, a list of recipients on paid therapeutic leave by financial payer. List fields include provider and recipient information and indicate by month the number of recipients on paid therapeutic leave.	M-Last Fri in month
SRAJR760	HMRR7602	Paid DOM Care Therapeutic Leave Reported	Provides, by county, a list of recipients on paid DOM care therapeutic leave by financial payer. List fields include provider and recipient information and indicate by month the number of recipients on paid DOM care therapeutic leave.	M-Last Fri in month
SRAJR760	HMRR7603	Paid PRTF AMH Level 2 - 4 Therapeutic Leave		M-Last Fri in month
SRAJR770	HMNR7701	Therapeutic Leave as Reported By Nursing Homes		W-Fri



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
SRAJR770	HMNR7702	Dom Care Therapeutic Leave as Reported by Nursing Homes		W-Fri
SRAJR770	HMNR7703	Psych Therapeutic Leave as Reported by nursing homes		W-Fri
SRAJR770	HMRN7701	Therapeutic leave by NH by PT Last Nmae		M
SRAJR770	HMRN7702	Dom Care		M
SRAJR770	HMRN7703	Psych Therapeutic leave		M
SRAJS100	HMSR1001			M
SRAJS100	HMSR1201			other
SRAJS1102	HMSR1102	Carolina Access Primary Care Provider Enrollment Report - Delimited Version		M
SRAJS170	HMSR1703	Carolina Access Statewide Summary	Provides a summary for provider group file maintenance by financial payer. Fields include by provider number, terminal number, and operator number additions and deletions.	M-Last day of month
SRAJS180	HMSR1811	CA Emergency Authorized Overrides	Requested information on Carolina ACCESS Emergency authorization overrides.	W
SRAJS200	HMSR2151	POP Group Provider/Administrator Sanctioned	Displays all sanctions that have been applied to a Carolina Access provider.	M-4rth day from end
SRAJS206	HMSR1101	Carolina Access Primary Care Provider Enrollment Report	Carolona Access Primary Care Provider Enrollment Report.	M
SRAJS300	HMSR3001	Primary Care Providers Emergency Room Management Report	This report is the same as HMSR300N. It is published in a delimited format to be available to the providers in a spreadsheet format.	M
SRAJS300	HMSR3002	ACCESS II Emergency Room Management Report	This report is the same as HMSR310N. It is published in a delimited format to be available to the providers in a spreadsheet format.	M
SRAJS300	HMSR300N	Primary Care Providers Emergency Room Management Report	Printed in Troy on 8 1/2 x 11 plain 3-hole top laser paper. Provides, by county and Primary Care Provider (PCP), a list of emergency room recipients by financial payer and population group. List fields include recipient name, recipient Medicaid number,	M
SRAJS300	HMSR300N	Primary Care Providers Emergency Room Management Report Labels	Emergency Room Management address labels.	M



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
SRAJS300	HMSR310N	ACCESS II Emergency Room Management Report	Provides, by county and Primary Care Provider (PCP), a list of emergency room recipients by financial payer and population group	M
SRAJS350	HMSR3003	Referral Report for Carolina Access II Primary Care Providers	This report is the same as HMSR3501. It is published in a delimited format to be available to the providers in a spreadsheet format.	M
SRAJS350	HMSR3004	Referral Report for Carolina Access II Administrators	This report is the same as HMSR3502. It is published in a delimited format to be available to the providers in a spreadsheet format.	M
SRAJS350	HMSR3501	Referral Report for Carolina Access II Primary Care Providers	Provides, by primary care provider, a list of the referrals for the month.	M
SRAJS350	HMSR3502	Referral Report for Carolina Access II Administrators	Provides, by administrator and primary care provider, a list of the referrals for the month.	M
SRAJS390	HMSR3901	Referral Report for Area Mental Health Center Programs	Monthly report listing mental health services referred by Area Mental Health Programs (AMHP) that have been provided to children by independent mental health providers.	M
SRAJS405	HMSR4051	Carolina Access Quarterly Utilization Report - Primary Care Provider Enrollment >= 50	Provides, by primary care provider, a list of services rendered for the current quarter. Printed in Troy on 8 1/2 x 11 plain 3-hole top laser paper.	Q-Third workday prior to the end of the quarter
SRAJS405	HMSR4051	Labels for Carolina Access Quarterly Utilization Report - Primary Care Provider Enrollment >= 50		Q-Third workday prior to the end of the quarter
SRAJS405	HMSR4052	Carolina ACCESS Quarterly Utilization Report – Primary Care Provider Enrollment < 50	Provides, by primary care provider, a list of services rendered for the current quarter. Printed in Troy on 8 1/2 x 11 plain 3-hole top laser paper.	Q-Third workday prior to the end of the quarter
SRAJS405	HMSR4053	Carolina ACCESS Utilization Summary	Quarterly per member/per month paid totals by CA Provider type.	Q-Third workday prior to the end of the quarter
SRAJS430	HMSR4301	Carolina Access Expenditures	This report compares budgeted per member/ per month expenses to actual expenses for Carolina access. The report includes year to date totals.	M-third workday prior to the end of the month



## Appendix 40, Attachment G Consolidated List of Reports



DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
SRAJS500	HMSR5501	Managed Care Withhold Error Report	This report lists withholds where the plan is subject to release and where there is no enrollment record for that recipient, covering the month of service of the withhold, for the plan for which the withhold was created.	M-Third workday prior to the end of the month
SRAJS600	HMSR6001	HMO (Managed Care) Enrollment Exception Report	This report contains all potential HMO premiums and kicks for which claims are not created as a result of enrollment errors.	M-Third workday prior to the end of the month
SRAJS600	HMSR6101	HMO Prepaid Piedmont Enrollment	List of individuals enrolled in an HMO.	M-Third workday prior to the end of the month
SRAJS750	HMSR7501	Managed Care Withhold Error Report	This report lists withholds where the plan is subject to release and where there is no enrollment record for that recipient, covering the month of service of the withhold, for the plan for which the withhold was created.	M-Third workday prior to the end of the month
SRAJS800	HMSR8001	HMO (Managed Care) Enrollment Exception Report	This report contains all potential HMO premiums and kicks for which claims are not created as a result of enrollment errors.	M-Third workday prior to the end of the month
SRAJS800	HMSR8101	HMO (Pre-Paid) Enrollment Report	List of individuals enrolled in an HMO.	M-Third workday prior to the end of the month
SRAJS800	HMSR8301	HMO (Managed Care) Capitation Fee Claims	Listing of recipients for whom a managed care capitation fee is being paid.	M-Third workday prior to the end of the month
SRAJS860	HMSR8601	Pre-paid Payment Category Report by County and Plan	This summary report contains pre-paid payment information for the county and plan.	M-Third workday prior to the end of the month
SRAJS870	HMSR8701	Pre-paid Payment Category Report by County and Plan	This report contains a summary of the pre-paid payment information for the county and plan.	M-Third workday prior to the end of the month
SRAJS920	HMSR9201	Adjusted MC Claims Report	This report contains a listing of all managed care claim adjustments.	CW





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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
SRAJS930	HMSR9301	Managed Care Denied Claims Report	Listing of denied claims for each county.	M
SRAJS950	HMSR9501	Managed Care Premium Financial Activity Report	This report reports the total HMO financial activity for the current quarter and month as well as previous quarters. Its main purpose is to track the withheld and released kicks and capitated premiums.	M-Third workday prior to the end of the month
SRAJT010	HMTR0101	NCDRS Adjustments in Error	Reports Drug Rebate adjustment errors.	W-Fri
SRAJT205	HMTR2051	Weekly Drug File Transaction Log Report	Shows any changes to the drug file that were entered by the pharmacy staff the previous week.	W-Thur
SRAJT400	HMTR4001	Recipient Management Fee Report	Listing of management fees created monthly.	M
SRAJT510	HMTR5101	Drug Rebate Family Planning Invoice Distribution (HCFA 64 Report)	Report Drug Rebate collection and federal, county share by county.	Q-OR
SRAJT570	HMTR5701	Drug Rebate Excluded Provider Report	PHS provider that should be excluded from the drug rebate invoice cycle.	Q-OR
SRAJT580	HMTR5801	Abortion Tracking Information Report	Weekly Trlog report of Abortion Tracking File online modifications	W-Thur
SRAJT650	HMTR6501	Drug Rebate Excluded Providers Claim Listing	Lists pharmacy payments to providers excluded from Drug Rebate	Qtly 3,6,9,12
SRAJT650	HMTR6501	Drug Rebate Excluded Providers Claim Listing	Lists pharmacy payments to providers excluded from Drug Rebate.	Q-OR
SRAJT700	HMTR7001	Drug File Purge	Listing of NDC's purged quarterly from the Drug Master based on the criteria. Criteria is Run Date minus 6 Years.	Q
SRAJT700	HMTR7051	Drug File Term Date Comparison With CMS	Listing of NDC's whose Term Date does not match with CMS Term Date.	Q
SRAJT700	HMTR7202	Listing of XIX-HCFA Utilization Mismatches	Lists HCFA drug utilization NCD mismatches.	Q-OR
SRAJT700	HMTR7400	Drug Rebate Invoice Totals	Summary report of drug utilization billed to manufacturers for the quarter.	Q-OR
SRAJV060	HMVR0601	Provider Trading Partner Maintenance	Report of provider trading partner information that has been added, changed, or deleted.	W-Wed
SRAJV080	HMVR0801	Terminated Providers Letters	This report shows all providers whose medicaid status has been terminated due to incorrect mailing addresses on the file. These providers have all been assigned action/reason code 44.	M
SRAJV100	HMSR5001	Carolina Access Emergency Access Authorization Changes	Emergency room authorization statewide summary. Identifies emergency authorization additions and changes.	W-Wed



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
SRAJV100	HMSR9601	Population Group Provider Sanctions (PW) Screen	Trlog for the PW screen	W-Wed
SRAJV100	HMVR1025	Addressograph Report	Provides an addressograph (address) report by financial payer.	W- Wed
SRAJV100	HMVR105R	Provider File Maintenance Report - Additions	TRLOG report of adds made to the provider master file	W- Wed
SRAJV100	HMVR110R	Provider File Maintenance Report - Changes	TRLOG report of changes made to the provider master file. Only changed fields are shown in BEFORE/AFTER section of report.	W - Wed
SRAJV100	HMVR1111	Population Group Maintenance Report - Additions and Changes	TRLOG report of population group additions and changes.	W-Wed
SRAJV100	HMVR1121	Carolina ACCESS Practioner Maintenance	TR log of Carolina Access Practitioner additions, charges, and deletions.	W-Wed
SRAJV100	HMVR115R	Provider File Maintenance Report - Deletions	TRLOG report of deletes made to the provider master file	W - Wed
SRAJV100	HMVR120R	Accommodation File Maintenance Report	Provides list of information for maintenance of the accommodation file by financial provider. List fields include provider number, accommodation code, action code, description, old high rate, old low rate, old start and end; and new high rate, new low ra	W-Wed
SRAJV100	HMVR1751	P1 Action Reason Codes Maintenance	P1 action reason codes maintenance	W - Wed
SRAJV130	HMVR130R	Provider File Maintenance Report (By Clerk)	TRLOG report of additions made to the provider master file by entry clerk.	W - Wed
SRAJV150	HMVR1501	IRS Tax Identification File Maintenance Report	Provides a summary of IRS tax identification by financial payer. Fields include terminal number, IRS number, operator number, IRS control name, IRS name, effective date, end date, and add date.	W - Wed
SRAJV170	HMVR1701	Provider Group File Maintenance Report	Provides a summary for provider group file maintenance by financial payer. Fields include by provider number, terminal number, and operator number additions and deletions.	W - Wed
SRAJV185	HMVR1801	Carolina Access Provider File Maintenance Report - - Errors	Report of DIRM errors.	D
SRAJV185	HMVR1802	CA II Provider / Admin Group File Maintenance Report - Errors	Invalid administrator or provider number	D
SRAJV185	HMVR1803	Provider Cross Reference File Maintenance Report	List adds and deletes to cross reference report	D



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
SRAJV185	HMVR1804	CA II Provider / Admin Group File Maintenance Report - Changes	Changes to CA group provider/administrator file.	D
SRAJV200	HMVR200R	Provider Accommodation Rate Listing	Lists provider accommodation information by financial payer for a specific report period (to/from). Fields include provider number, provider name and address, high and low rate, effective date, end date, and date of last change.	W - Wed
SRAJV220	HMVR2201	Provider Specialty/Type Correlation Report	This report is the number of provider associated with a type code under the specialty code	Q
SRAJV220	HMVR2202	Provider Type/Specialty Correlation Report	This report is the number of provider associated with a specialty code under the type code	Q
SRAJV300	HMVP904N-2	XOVR / EDS Provider Number Cross Reference File Listing	XOVR/EDS Provider number cross reference file listing.	W-Wed
SRAJV300	HMVP904N-3	EDS / XOVR Provider Number Cross Reference File Listing	EDS/XOVR provider number cross reference file listing.	W-Wed
SRAJV400	HMVR4001	Cigna Provider File	CIGNA Provider File	A-OR
SRAJV420	HMVR4201	Exact Match - Provider For Black Hole Claims	Comparison of CIGNA and Master Provider file, exact match of specific provider number.	M-Last Thur in month
SRAJV420	HMVR4202	Partial Match - Provider For Black Hole Claims	Comparison of CIGNA and Master Provider Files.	M-Last Thur in month
SRAJV420	HMVR4203	No Match -----Provider For Black Hole Claims	Comparison of CIGNA and Master Provider Files.	M-Last Thur in month
SRAJV435	HMVR4451	Terminate Provider Letters	This letter notifies a provider that the NC medicaid system has not received a claim associated with their provider number within the past 12 months. To remain an active provider, the provider must send in a request to remain active.	Q
SRAJV502	HMVR5103	Provider Listing Report - Sequence by Name Type - NonDrug	Reports non-drug providers by name.	SA-Jan, July- First day of month
SRAJV503	HMVR5105	Provider Listing Report - Sequence by Number Type - NonDrug	Reports non-drug provider by provider number.	SA-Jan, July- First day of month
SRAJV504	HMVR5106	Provider Listing Report - Sequence by Number Type - Drug	Reports drug providers by provider number.	SA-Jan, July- First day of month
SRAJV505	HMVR5104	Provider Listing Report - Sequence by Type - Drug	Reports drug providers by provider type.	SA-Jan, July- First day of month



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
SRAJV600	HMVR600R	Provider On-Review Report - Provider Name Sequence	Reports the provider listing report from an extract file sorted on provider last name.	M-First Wed in month
SRAJV600	HMVR601R	Provider Listing - Invalid Type Codes	Listing of invalid type codes.	M-First Wed in month
SRAJV600	HMVR605R	Provider On-Review Report - Provider Number Sequence	Lists those providers which are on review	M-First Wed in month
SRAJV660	HMVR6601	DEA TRLOG	Reports the TRLOG reflecting adds, changes, and deletes made to the DEA master file.	W-Wed
SRAJV730	HMVR735N	Quarterly Missing UPIN Report	Provides a list of quarterly missing UPIN by financial payer. List fields include Medicaid number, provider name, and provider address information an telephone number.	Q= 3, 6, 9, 12
SRAJV740	LABELS	DUR Mailing Labels		Q= 3, 6, 9, 12
SRAJV800	HMVR8001	Purged Providers Report	Report contains a listing of purged providers because the provider is not a health department and 1) provider end date is greater than 5 years from date job run; or 2) provider end date is greater than 3 years from date job run and provider is deceased.	A-March-Last Wed in month
SRAJV800	HMVR8101	Updated Provider Cross Reference Report	Provides a list of provider cross reference information by financial payer. List fields include provider number, provider name, and purged provider number.	A-March-Last Wed in month
SRAJV800	HMVR8151	Provider Base Reassignment XREF Report	Provides a summary, by old and new base records, of provider base reassignment by financial provider. Summary information for both old and new base records include provider number, provider type, and provider XREF indicator.	A-March-Last Wed in month
SRAJV800	HMVR8201	Deleted / Updated Group Providers	Provides an updated list of deleted (purged) providers by financial payer. List fields include purged provider, group provider, and XREF group provider. The group provider and XREF provider identify group number and individual.	A-March-Last Wed in month
SRAJV800	HMVR8202	Deleted / Updated Group Providers -Error Report	Provides an updated list of deleted (purged) providers by financial payer. List fields include purged provider, group provider, and XREF group provider. The provider and XREF provider identify group number and individual.	A-March-Last Wed in month
SRAJV800	HMVR8601	Purged Medicaid Crossover Provider Report	This report serves as an audit trail for the crossover provider.	A-March-Last Wed in month
SRAJV830	HMVR8301	Year-End Tax Id File Purge	Provides a list of year-end recipient tax ID file purge by financial payer. List fields include tax ID and recipient name.	A
SRAJV850	HMVR850R	Report Of Mismatched UPINs	Mismatch UPIN report.	A-OR
SRAJV870	HMVR8701	Medicare Cross Over Provider Cross Reference	Report contains a before and after picture of what was added, changed, or delted.	W - Wed



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
SRAJV890	HMVR8901	Current Medicare Cross Over Provider Report - Medicare Provider Number Sequence	Provides a list of current Medicare crossover providers by financial payer. List fields are carrier, Medicare, and Medicaid provider, contact person (or organization), date last changed, and clerk ID.	W - Thur
SRAJV890	HMVR8902	Current Medicare Cross Over Provider Report - Medicaid Provider Number Sequence	Provides a list of current Medicaid crossover providers by financial payer. List fields are carrier, Medicare, and Medicaid provider, contact person (or organization), date last changed, and clerk ID.	W - Thur
SRAJV910	HMPV9000	CLIA Certification Trlog Report - Updates made based on the OSCAR file	This report displays the TR Log reflecting adds, charges, and deletes made to the clia certification master file. It will only display the fields that have been modified.	W-Wed
SRAJV910	HMVP900R	Error Report from Oscar Upload to Cert File	This report displays the TRLOG reflecting adds, changes, and deletes made to the CLIA certification master file. It will only display the fields that have been modified.	W-Wed
SRAJV950	HMPV9000	CLIA Certification Trlog Report - Updates made on-line by the user	This report displays the TR Log reflecting adds, charges, and deletes made to the clia certification master file. It will only display the fields that have been modified.	W- Wed
SRAJV990	HMVP9901	Changes to Provider Master File UPINS from the UPIN Master Screen	Lists Changes to UPINS	W -Wed
SRAJZ150	HMDR1501 (HMZR1501 on banner)	IRS Withholding - All Providers Subject to Backup Withholding	Lists withholding amounts (Current & YTD) for all providers with a withholding indicator of "Y"; Tax-ID , Tax-name, and WH Start date are also displayed; Totals of multi-payer providers are given	OR
XA001	XX-New Report	PA Process Measures of Service Report		
XA002	XX-New Report	Call Center Measures Report		
XA003	XX-New Report	Communication Methods Report		
XA004	XX-New Report	Professional Level of Handling		
XA005	XX-New Report	Professional Level of Handling – Escalations		
XA006	XX-New Report	Professional Level of Handling – Escalations		
XA007	XX-New Report	Number of Complaints		
XA008	XX-New Report	Complaints by Type		
XA009	XX-New Report	Complaints Per PA Drug		
XA010	XX-New Report	Complaints Percent Trend		
XA011	XX-New Report	PA Requests by Drug – Monthly		



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
XA012	XX-New Report	PA Requests by Drug – Year-to-Date Totals		
XA013	XX-New Report	Denial Report by Reason Code		
XA014	XX-New Report	Monthly Reporting – Training		
XA015	XX-New Report	Monthly Reporting – Website		
XA016	XX-New Report	Monthly Reporting –Accounting Team		
XA017	XX-New Report	Monthly Reporting – Call Center Pharmacist Staffing Coverage		
XA018	XX-New Report	ADHD Drugs Prescription Rate Per 100,000 Members Per Quarter		
XA019	XX-New Report	ADHD Drugs Prescription Rate Per 100,000 Members Per Quarter – Grouped by Age Range		
XA020	XX-New Report	North Carolina Medicaid Chronological History of PA		
XA022	XX-New Report	POS PA Provider DMA3501 Request for Additional Information Letter		
XA023	XX-New Report	POS PA Participant DMA-2001 Denial of Service Request Letter		
XA024	XX-New Report	POS PA Provider DMA-2001 Denial of Service Request Letter		
XA025	XX-New Report	POS PA Participant DMA-3502 Request for Additional Information Letter		
XA030	XX-New Report	MMIS DPH PA Update Report		
XA031	XX-New Report	POS PA Pending Report		
XA032	XX-New Report	POS PA Pending-To-Denial Report		
XA033	XX-New Report	PA Miscellaneous Drug Request Form		



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
XA034	XX-New Report	PA Neupogen Prior Authorization Request Form		
XA035	XX-New Report	POS PA Procrit/Epogen /Aranesp Request Form		
XA036	XX-New Report	Denied Letter Activity Report		
XA037	XX-New Report	Pending Letter Activity Report		
XA038	XX-New Report	PA Form Activity Report		
XA039	XX-New Report	Denied POS PA EPSDT Report		
XA040	XX-New Report	Improper Submissions Report		
XB002	XX-New Report	MMIS-POS Recipient Interface Error Report		
XB010	XX-New Report	Participant Merge Update Report		
XB011	XX-New Report	Participant Merge Error Report		
XB012	XX-New Report	PA Merge Report		
XB013	XX-New Report	Participant Merge Discrepancy Report		
XB014	XX-New Report	PA Intervention Merge Error Report (Oracle)		
XB021	XX-New Report	MMIS-POS Recipient Reconciliation Discrepancy Report		
XB030	XX-New Report	TPL Participant Update Process Summary Report		
XB031	XX-New Report	TPL Participant Update Error Report		
XB032	XX-New Report	Participant Eligible for Retro-Medicaid Report		
XB999	XX-New Report	MMIS-POS Recipient Interface Process Summary Report		
XB999	XX-New Report	MMIS-POS Recipient Reconciliation Process Summary Report		
XC002	XX-New Report	Batch Claims Transaction Error Report		
XC003	XX-New Report	Batch Control File Listing Deleted Batch Records		



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DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
XC005	XX-New Report	Batch Control Aging Summary by Receipt Days		
XC007	XX-New Report	Batch Summary		
XC008	XX-New Report	Error Analysis by Pharmacy Provider Specialty		
XC009	XX-New Report	Pharmacy Provider Error Code Report		
XC010	XX-New Report	Suspense Release Transaction Proof Listing		
XC012	XX-New Report	Claims Processing Adjudication Summary		
XC015	XX-New Report	Mass Adjustment Analysis		
XC016	XX-New Report	Aged Detail Suspense Report		
XC017	XX-New Report	Suspended Claim Analysis by Claim Type		
XC018	XX-New Report	Daily Exception Suspense Summary		
XC019	XX-New Report	Services Denied by Claims Examiners		
XC020	XX-New Report	Services Forced Paid by Claims Examiners		
XC021	XX-New Report	Forced/Denied Exception Summary		
XC022	XX-New Report	Mass Adjustment Request Report		
XC023	XX-New Report	Claims Error Analysis Report		
XC025	XX-New Report	Error Log Report		
XC026	XX-New Report	Most Prescribed GCNs Ranked by Amount Paid		
XC027	XX-New Report	Most Prescribed GCNs Ranked by Number of Prescriptions		
XC029	XX-New Report	Switch Vendor Monitoring		
XC030	XX-New Report	Top 100 Utilized Pharmacies Ranked by Amount Paid		
XC031	XX-New Report	Most Utilized Pharmacies Ranked by Amount Paid		





## Appendix 40, Attachment G Consolidated List of Reports



DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
XC032	XX-New Report	Top Prescribing Physicians Ranked by Ingredient Cost (By Group or Plan)		
XC033	XX-New Report	Top Prescribing Physicians Ranked by Ingredient Cost (By All Groups)		
XC034	XX-New Report	Top Prescribing Physicians Ranked by Average Prescription Cost (By Group or Plan)		
XC035	XX-New Report	Top Prescribing Physicians Ranked by Average Prescription Cost (By All Groups)		
XC036	XX-New Report	Top Prescribing Physicians Ranked by Number of Prescriptions		
XC037	XX-New Report	Top Prescribing Physicians Ranked by Number of Prescriptions		
XC038	XX-New Report	Top Prescribing Physicians Ranked by Percentage of Brand Prescriptions (By Group or Plan)		
XC039	XX-New Report	Top Prescribing Physicians Ranked by Percentage of Brand Prescriptions (By All Groups)		
XC044	XX-New Report	Most Prescribed OTC Drugs Ranked by Amount Paid		
XC045	XX-New Report	Therapeutic Utilization Summary Report		
XC046	XX-New Report	Pharmacy Generic Usage Ranked by Percent of Generic Prescriptions Report		
XC047	XX-New Report	Pharmacy Generic Usage Ranked by Percent of Generic Prescriptions Report		



## Appendix 40, Attachment G Consolidated List of Reports



DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
XC048	XX-New Report	Ingredient Cost Savings Report		
XC049	XX-New Report	Claims Payment Summary Report		
XC050	XX-New Report	Monthly Payment Summary Report		
XC051	XX-New Report	Drug Audit Report		
XC053	XX-New Report	Age/Sex Utilization Summary		
XC054	XX-New Report	Total Claims Paid/Total Number of Claims Paid by County and Provider		
XC056	XX-New Report	Claims Archival/Profile Request Edit Report		
XC057	XX-New Report	Claims Archival/Profile Report		
XC058	XX-New Report	Pro-DUR Savings Ranked by Amount Paid		
XC060	XX-New Report	Participant Exception Report		
XC061	XX-New Report	Physician Profile Report		
XC062	XX-New Report	Physician Profile Report by National Drug Code		
XC063	XX-New Report	Physicians Profile Detail		
XC064	XX-New Report	Pharmacy Profile Report		
XC065	XX-New Report	Pharmacy Profile Report (DUR Conflict)		
XC066	XX-New Report	Therapy Duration Exception Report		
XC069	RTAR8201/RTAR8202	DUR Summary Activity Report by Therapeutic Class		
XC071	XX-New Report	Pro-DUR Intervention Summary (by Intervention Code)		
XC072	XX-New Report	Pro-DUR Intervention Summary (By Override Code)		
XC073	XX-New Report	Top Drugs by DUR Intervention		
XC074	XX-New Report	Top Drugs per DUR Conflict by DUR Outcome and Intervention Ranked by Total Number of Overrides		



## Appendix 40, Attachment G Consolidated List of Reports



DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
XC092	RTAR5741/RTAR5742/RTAR5743	Participants Using More Than One Provider Report		
XC093	RTAR5711	NC POS Savings By Drug	Savings by Drug Report	
XC094	RTAR5721	NC POS Rx Profile Of Providers With No POS UCR Savings	RX Profile of Providers with no POS UCR Saving Report	
XC095	RTAR5731	NC POS Savings By Provider From UCR	Savings by Provider from UCR Report	
XC096	HMPR2141/HMPR2142	Brand/Generic PAL Cost Report		
XC097	HMPR2151/HMPR2152	Brand/Generic PAL Cost Report		
XC098	HMPR2161/HMPR2162	Brand/Generic PAL Cost Report		
XC099	HMPR2171/HMPR2172	Brand/Generic PAL Cost Reporting		
XC100	HMPR2181/HMPR2182	Brand/Generic PAL Cost Reporting		
XC101	HMPR2191	PAL-CS County by PS Brand	Brand/Generic PAL Cost Reporting	
XC101	HMPR2191/HMPR2192	Brand/Generic PAL Cost Reporting		
XC103	340B New 1	340B Provider Submitting Claims w/o 340B Claim Indicator – New 1		
XC104	340B New 2	340B Claim Received/Non 340B Provider – New 2		
XC105	340B New 3	340B Claims Report - New 3		
XC115	XX-New Report	Mass Adjustment Summary Report		
XC116	XX-New Report	Mass Credit/Replacement Request Report		
XC119	XX-New Report	To be Paid DPH Claims Report		
XC121	XX-New Report	Participant Aberrant Pattern Drug Date Report		
XC130	XX-New Report	Retroactive J Code Suspect Dupe Report		
XC132	XX-New Report	Batch Claim Balance Report		



## Appendix 40, Attachment G Consolidated List of Reports



DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
XC133	XX-New Report	Drug Claims Paid More Than \$1000		
XC134	XX-New Report	POS Daily History Only Adjustment Report		
XC135	XX-New Report	POS Out of Balance Claims Report		
XC999	XX-New Report	Claims Payment Process Summary Report		
XG001	XX-New Report	Security Users by Security Group Report		
XG002	XX-New Report	Security Users by User ID Report		
XG003	XX-New Report	Security Groups and Actions Report		
XP002	XX-New Report	MMIS Provider Update Process Summary Report		
XP003	XX-New Report	MMIS Provider Update		
XP999	XX-New Report	MMIS Provider Interface		
XX-New Report	IPVR0121	Suspect Duplicate Medicaid Attending Providers		
XX-New Report	XX-New Report	Invoice Register	Detail listing of invoice transactions for the report period	Daily or date range
XX-New Report	XX-New Report	Cash Receipts Register	Detail listing of Cash Receipts for the report period	Daily or date range
XX-New Report	XX-New Report	Daily Lockbox Deposit Report	Daily listing of Lockbox deposits for the business day	Daily or date range
XX-New Report	XX-New Report	Recoupments Register	Per checkwrite listing of accounts receivable recoupments from provider claims payable	Daily or date range
XX-New Report	XX-New Report	Provider Withholding Register	Per checkwrite list of provider withholding transactions	Daily or date range
XX-New Report	XX-New Report	FA Cash Disbursements Register	Listing of FA cash disbursements for the report period	Daily or date range
XX-New Report	XX-New Report	State Disbursements Register	Listing of State authorized disbursements for the report period	Daily or date range
XX-New Report	XX-New Report	Debit Adjustments Register	Listing of Debit Adjustments for the report period	Daily or date range



## Appendix 40, Attachment G Consolidated List of Reports



DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
XX-New Report	XX-New Report	Credit Adjustments Register	Listing of Credit Adjustments for the report period	Daily or date range
XX-New Report	XX-New Report	Open Item Transfers Register	Listing of Open Item Transfers for the report period	Daily or date range
XX-New Report	XX-New Report	System Interest Register	Listing of Interest charges for the report month	Daily or date range
XX-New Report	XX-New Report	System Penalty Register	Listing of Penalty Register charges for the report month	Daily or date range
XX-New Report	XX-New Report	Manual Interest Register	Listing of Interest charges for the report month	Daily or date range
XX-New Report	XX-New Report	Manual Penalty Register	Listing of Penalty Register charges for the report month	Daily or date range
XX-New Report	XX-New Report	Bad Debt Write off Register	Listing of bad debt write off transactions for the report period	Daily or date range
XX-New Report	XX-New Report	Aged Account Receivable Trial Balance Detail Report	Aging of open accounts receivable items as of the report date	Monthly or demand
XX-New Report	XX-New Report	Summary of Aged Accounts Receivable by Company	Summary of Aged Accounts Receivable by Company	Monthly or demand
XX-New Report	XX-New Report	Summary of Aged Accounts Receivable by Division	Summary of Aged Accounts Receivable by Division	Monthly or demand
XX-New Report	XX-New Report	Aged Unapplied AR Credit Balances Report	Aged Unapplied AR Credit Balances Report	Monthly or demand
XX-New Report	XX-New Report	Customer Past Due Dunning Letters	Customer Past Due Dunning Letters	Monthly or demand
XX-New Report	XX-New Report	30 Days Past Due Letter	30 Days Past Due Letter	Monthly or demand
XX-New Report	XX-New Report	60 Days Pas Due	60 Days Pas Due	Monthly or demand
XX-New Report	XX-New Report	Set-off Debt Interface File	Set-off Debt Interface File The FA must produce in attached format (see Attachment XX. This file must be able to be saved to diskette or tape.	Monthly or demand
XX-New Report	XX-New Report	Set-off Debt Listing (This is a report)	Set-off Debt Listing (This is a report)	Monthly or demand
XX-New Report	XX-New Report	Attorney General Referral Listing	Attorney General Referral Listing	Monthly or demand
XX-New Report	XX-New Report	Collection Agency Interface File	Collection Agency Interface File (The FA must provide in the attached format)	Monthly or demand



## Appendix 40, Attachment G Consolidated List of Reports



DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
XX-New Report	XX-New Report	Collection Agency Listing	Collection Agency Listing	Monthly or demand
XX-New Report	XX-New Report	Customer Statements	Customer Statements	Monthly or demand
XX-New Report	XX-New Report	AR Recommend for Write-off	AR Recommend for Write-off	Monthly or demand
XX-New Report	XX-New Report	Quarterly Accounts Receivable Report to OSC	Quarterly Accounts Receivable Report to OSC	Quarterly
XX-New Report	XX-New Report	New Accounts Receivable Aging Over 60 days in this Quarter	New Accounts Receivable Aging Over 60 days in this Quarter	Quarterly
XX-New Report	XX-New Report	XX-New Report - Currently Unnamed	Report detailing contracted PA vendors submissions that indicates the date and time file received, date and time processed, number of transactions received, number of transactions processed, number of transactions updated, and number of transaction errors	Daily
XX-New Report	XX-New Report	XX-New Report - Currently Unnamed	Quarterly report of the number of Prior Approval Requests received, number entered into the system within one (1) State business day and the number entered into the system after more than one (1) State business day	Quarterly
XX-New Report	XX-New Report	XX-New Report - Currently Unnamed	Report that indicates the date and time the file was received, date and time processed, number of transactions received, number of transactions processed, number of transactions updated, number of transactions errored, listing each error transaction and e	Weekly
XX-New Report	XX-New Report	XX-New Report - Currently Unnamed	Report monthly when it takes more than two (2) business days from receipt to process and render a decision on a non-emergency Prior Approval Request that does not require additional research or additional information	Monthly
XX-New Report	XX-New Report	XX-New Report - Currently Unnamed	Report monthly when it takes more than two (2) business days from receipt of all required information to process and render a decision on a non-emergency Prior Approval Request that required additional information or research	Monthly
XX-New Report	XX-New Report	XX-New Report - Currently Unnamed	Report on when it takes more than five (5) business days to process, render a decision, and mail a status report on a Prior Approval Request for level of care, retrospective, and therapeutic days	Weekly
XX-New Report	XX-New Report	Drug Rebate Invoice Report	List all invoices for a specified rebate program and quarter	Quarterly
XX-New Report	XX-New Report	Drug Rebate Amounts Due Report	Show quarterly changes to amounts due	Quarterly



## Appendix 40, Attachment G Consolidated List of Reports



DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
XX-New Report	XX-New Report	Drug Rebate Payment Summary Report	Display payments received during specified date range and balances due by manufacturer	As needed
XX-New Report	XX-New Report	Drug Rebate Summary Report	Display payments received, invoiced amounts and disputed amounts by quarter and year	Quarterly
XX-New Report	XX-New Report	Drug Rebate Quarterly Payment Report	Display payments received compared to original and current invoiced amounts	Quarterly
XX-New Report	XX-New Report	Drug Rebate NDC Detail Report	Provides summary data by quarter for selected NDCs	Quarterly
XX-New Report	XX-New Report	Drug Rebate NDC History Report	Displays all activities which have occurred for a selected drug by quarter	Quarterly
XX-New Report	XX-New Report	Drug Rebate Manufacturer Summary Report	Displays info by manufacturer by quarter on amounts invoiced, paid and disputed.	Quarterly
XX-New Report	XX-New Report	Drug Rebate ROSI/PQAS Report	Display amounts allocated for a selected manufacturer or NDC	Quarterly
XX-New Report	XX-New Report	Drug Rebate Unallocated Balance Report	Display unallocated balances selected according to user-supplied criteria	Quarterly
XX-New Report	XX-New Report	Drug Rebate Adjusted Claims Report	Display claims where number of units considered for invoicing differed from those originally supplied by claims processing system	Quarterly
XX-New Report	XX-New Report	Drug Rebate Distribution	Lists drug rebate collections by county with federal, state and county shares specified	Quarterly
XX-New Report	XX-New Report	Drug Rebate Excluded Provider Report	Listing of providers (pharmacies) whose claims will not be included in drug rebate invoices	Quarterly
XX-New Report	XX-New Report	Drug Rebate Excluded Provider Listing	Listing of claims from providers who are not participating rebate providers	Quarterly
XX-New Report	XX-New Report	Drug Rebate XIX-CMS Utilization Report	Shows drugs where unit type from CMS does not match that on the drug file	Quarterly
XX-New Report	XX-New Report	Drug Rebate Invoice Billing for Quarter Report	Summary of drug utilization billed to manufacturers by quarter	Quarterly
XX-New Report	XX-New Report	Drug Rebate Balance Due Report	List of top 10 credit balances due	As needed
XX-New Report	XX-New Report	Drug Rebate Balance Due Report	List of top 20 credit balances due	As needed
XX-New Report	XX-New Report	Drug Rebate Check Deposit Comparison Report	Compares deposits with deposit slips	Quarterly
XX-New Report	XX-New Report	Drug Rebate Check Voucher Comparison Report	Compares check voucher total and interest voucher total with the check table total	Quarterly



## Appendix 40, Attachment G Consolidated List of Reports



DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
XX-New Report	XX-New Report	Drug Rebate Disputes Activity Report	Displays disputes by unassigned, assigned and resolved dispute types	Quarterly
XX-New Report	XX-New Report	Drug Rebate Interest Activity Report	Display all interest overrides	Quarterly
XX-New Report	XX-New Report	Drug Rebate Interest Detail Report	Display all interest for a labeler and a quarter	Quarterly
XX-New Report	XX-New Report	Drug Rebate Invoice Exceptions Report	Displays invoiced amounts greater than the sum of claim reimbursement amounts	Quarterly
XX-New Report	XX-New Report	Drug Rebate Invoice Not Paid Report	Displays all outstanding invoices	Quarterly
XX-New Report	XX-New Report	Drug Rebate Medical Claims Report	Listing of all codes from medical claims including J-codes, M-codes, Q-codes and others which have been converted to NDCs.	Quarterly
XX-New Report	XX-New Report	Drug Rebate Monthly Balance Report	Summarize balance due per labeler per quarter and across all labelers	Quarterly
XX-New Report	XX-New Report	Drug Rebate URA Report	Payments received for drugs with CMS URA of zero	Quarterly
XX-New Report	XX-New Report	Drug Rebate Rcap Report	Corrected balances after dispute resolution procedures have been completed for one or more quarters	Quarterly
XX-New Report	XX-New Report	Drug Rebate Generic/Non-Generic Report	List of drug rebate amounts invoiced by brand, generic and multi-source for a selected period	Quarterly
XX-New Report	XX-New Report	Recipient ID Cross-References Within and Across Lines of Business	Provides capability to produce a report of CNDS cross reference ID updates within and across lines of business (LOB)	Daily
XX-New Report	XX-New Report	Recipient Premium Payment/Cost-Sharing Reports	Provides capability to produce reports for recipient premium payment and cost-sharing processes	As needed-The state does not currently have Medicaid programs requiring these reports, but it is expected they will be implemented within the foreseeable future. (kb)





## Appendix 40, Attachment G Consolidated List of Reports



DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
XX-New Report	XX-New Report	MMA Enrollment File Report(s)	Provides capability to produce a report of all records transmitted on the MMA enrollment file	Whenever the MMA enrollment file is transmitted, currently monthly.
XX-New Report	XX-New Report	MMA Response File Report(s)	Provides capability to produce a report of all records received on the MMA response file, identifying any errors, records unable to be matched to a recipient on the Replacement MMIS and records unable to be processed	Whenever the MMA response file is received, currently monthly.
XX-New Report	XX-New Report	DPH Financial Application Weekly Aging Report	Provides capability to produce a weekly aging report that lists work queue status	Weekly
XX-New Report	XX-New Report	COCC Monthly Report	The Fiscal Agent shall generate Certificates of Creditable Coverage and log the mail date for each Certificate of Creditable Coverage mailed. The Fiscal Agent shall provide a monthly report with the number of recipients/clients terminated from each health	Monthly
XX-New Report	XX-New Report	CNDS Interface Error Report	Listing of records received from CNDS that were not able to be processed due to errors or unable to be matched to one and only one MMIS recipient.	Daily
XX-New Report	XX-New Report	ICD-9-CM (10) Covered/Non-covered Update Report	Produce a report that demonstrates the differences of all covered and non-covered ICD-9-CM(10) Diagnosis codes and any field value differences based upon a match of the legacy MMIS+ Diagnosis Codes to the Diagnosis Update Tape/Data for State use in determ	Annually (October) and as needed
XX-New Report	XX-New Report	Pharmacy Bypass Report	Produce a report that identifies contracted drug updates bypassed identifying the data on the database and the update received from the State-owned or contracted drug update service.	Weekly
XX-New Report	XX-New Report	Status Reports Online	Generate an online status report of State memos	On request
XX-New Report	XX-New Report	Fee Schedule and Web Fee Schedule Reports	To create Fee Schedule reports including those that are available on the Division web site. The fee schedule report in Report of Reports breaks the fee schedule in to several manual reports that do not have report numbers. Fee schedules and related Fee S	On request
XX-New Report	XX-New Report		CAP/Children, CAP/DA, CAP/MR/DD, DRG Weight Table, Dental services, Durable Medical Equipment (DME), Federally Qualified Health Center (FQHC), Home Health Agency services, Home Infusion Therapy (HIT), Hospice, Local Education Agency Practitioners (LEA), L	



## Appendix 40, Attachment G Consolidated List of Reports



DSD Project Report Number	Legacy Report Number	Report Name	Report Description	Frequency
XX-New Report	XX-New Report	Fee Schedule and Related Rate Reports	To create fee schedules and related rate reports for State users and Division Web site including Dialysis centers, Nurse Midwife, Portable X-ray, Optical and Visual Aids, Private Duty Nursing, Targeted Case Management	On request
XX-New Report	XX-New Report	Rate Reports for State internal use	To create rate reports for internal State use only including ICF/MR Facility Rates, ICF/MR Facility Rates (Non-State Owned), Lower Level SNF/ICF Rates, Outpatient Hospital Pricing (RCC), Psychiatric Hospital Rates, Psychiatric Residential Treatment Facili	On request
XX-New Report	XX-New Report	Activity Logging Report	To create a parameter driven ad hoc activity logging report using the same format as Reference batch update activity reports. The State currently obtains this information from the current vendor via a CSR. A CSR is required for each CSR activity log anal	On request
XX-New Report	XX-New Report	Consistency Audit Details Report		
XX-New Report	XX-New Report	Number of Medicaid Enrolled Children and Health Check Participation		
XX-New Report	XX-New Report	Address Labels Not Printed Due to Previous Returned Mail		
XX-New Report	XX-New Report	Inactivity Report – Not necessary as event codes pertaining to “Inactivity” will be reported on the Maintenance Event Code Report.		
XX-New Report	XX-New Report	Trading Partner Maintenance Report – State confirmed that baseline report that EDI currently provides would satisfy this need.		
XX-New Report	XX-New Report	Urgent Review Status Report – Maintenance Event Code Report will report any events pertaining to Urgent Review status.		



## Appendix 40, Attachment G Consolidated List of Reports



<b>DSD Project Report Number</b>	<b>Legacy Report Number</b>	<b>Report Name</b>	<b>Report Description</b>	<b>Frequency</b>
XX-New Report	XX-New Report	Notification of Change In Certified Beds for Inpatient Facilities – Add this change to current Provider Change Notification Letter		
XX-New Report	XX-New Report	Productivity Letter based on SLAs		

## REPLACEMENT MMIS EXTERNAL INTERFACES

The following interfaces represent the external interfaces for systems that process within the Replacement MMIS domain. The interfaces are separated by the Replacement MMIS processing system name, by the designation of whether the interface is an input or an output, by the external entity name (or designation), and by the interface name. The external entities listed below are a State division or agency, a third party vendor, a Federal agency, or a county agency.

**Note**  
All current (existing) external interfaces are listed as well as interfaces that will be considered to be in scope for the RFP and procurement process.

Recipient System External Interface – Input

Entity: CMS via DIRM	Interface: CMS Buy-In Updates
Entity: EIS	Interface: DMA Recipient Info
Entity: CNDS	Interface: Demographic/Xref Updates
Entity: CMS via DIRM	Interface: CMS EDB Updates (Enrollment Database)
Entity: CMS via DIRM	Interface: Medicare Part D response file
Entity: LME	Interface: ANSI X12N 834 Enrollment transactions
Entity: SSA via DIRM	Interface: BENDEX (Beneficiary Data Exchange)
Entity: DIRM	Interface: Eligibility Updates

Recipient System External Interface – Output

Entity: CMS via DIRM	Interface: CMS Buy-In Updates
Entity: EIS	Interface: Buy-In Updates (State)
Entity: COB Contractor - GHI	Interface: Recipient Eligibility File
Entity: CMS via DIRM	Interface: Medicare Part D – Enrollment File
Entity: CNDS	Interface: Demographic/Xref Updates
Entity: DIRM	Interface: Transfer of Assets Report Data
Entity: DMA	Interface: Eligibility File
Entity: PCG	Interface: Eligibility File
Entity: CCME	Interface: Recipient Eligibility File
Entity: Advance Medical	Interface: Eligibility File
Entity: HMS	Interface: Eligibility File
Entity: DMA	Interface: EOB Master File – DRIVE
Entity: PCG	Interface: HMO Enrollment Tape
Entity: DMA	Interface: Buy-In PER Register extract
Entity: DMA	Interface: Enrollment Master – DRIVE
Entity: DMA	Interface: Buy-In Report
Entity: AMS	Interface: Referral Report
Entity: Carolina Medical Center	Interface: HMO Exempt
Entity: DMA	Interface: EOB HIPAA XREF file
Entity: DMA; DIRM	Interface: Buy-In Register Tape Part A
Entity: DMA; DIRM	Interface: Buy-In Register Tape Part B
Entity: Advance Medical	Interface: Buy-In Register Part A
Entity: Advance Medical	Interface: Buy-In Register Part B
Entity: Advance Medical	Eligibility Cross-Reference
Entity: Advance Medical	EOB Master File

EVS System External Interface – Input

Entity: ANSI ASC X12N 270	Interface: Eligibility Inquiry Transactions
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## APPENDIX 40, ATTACHMENT H



### EVS System External Interface – Output

Entity: ANSI ASC X12N 271      Interface: Eligibility Response Transactions

### Provider System External Interface – Input

Entity: Provider	Interface: SB926 Provider Info
Entity: DEA	Interface: DEA Info
Entity: IRS	Interface: B-Notice Info
Entity: CMS via DIRM	Interface: OIG Info
Entity: CMS via DIRM	Interface: CLIA Info
Entity: EIS	Interface: Provider Info Queries

### Provider System External Interface – Output

Entity: CDW	Interface: Provider Info
Entity: EIS	Interface: Provider Info Responses
Entity: (Licensing/Cert)	Interface: (Licensing Requests)
Entity: HSIS\HIS	Interface: Provider Info
Entity: Value Options	Interface: Provider Info
Entity: EIS	Interface: Provider Info Extract File
Entity: DIRM	Interface: MC Provider Directory Extract File
Entity: Data Niche	Interface: Provider Info
Entity: DIRM	Interface: Pricing Provider Info
Entity: DMA	Interface: Provider Earnings – DRIVE
Entity: DMA	Interface: Provider Info
Entity: HMS	Interface: Provider Info
Entity: PCG	Interface: Provider Info
Entity: Advance Medical	Interface: Provider Info
Entity: IRS	Interface: 1099 Info on Providers
Entity: DMA	Interface: CLIA Master File
Entity: DMA	Interface: DEA Master File
Entity: Data Niche	Interface: Provider Extract
Entity: DMA	Interface: Physician Billing Report extract
Entity: HMS	Interface: Provider Cross-Over Cross Reference
Entity: NCXIX	Interface: Provider Earnings Report
Entity: MMIS	Interface: Provider Earnings
Entity: Advance Medical	Interface: Provider Info
Entity: Advance Medical	Interface: DEA Master File

### Reference System External Interface – Input

Entity: CMS via DIRM	Interface: Healthcare Common Procedure Coding System HCPCS
Entity: CMS via DIRM	Interface: Current Procedural Terminology (CPT)
Entity: CMS via DIRM	Interface: Resource Based Relative Value Scale (RBRVS)
Entity: CMS via DIRM	Interface: CBSA - Ambulatory Surgery Code Payment Rate Update
Entity: DMH	Interface: Budget Office DMH Rate Info
Entity: DMA	Interface: Financial Operations Accommodation Rate Info
Entity: CMS via DIRM	Interface: International Classification of Disease (ICD-9/10-CM) Diagnosis Info
Entity: DRG Weight Vendor	Interface: DRG Weight and outlier Major Diagnostic Category (MDC) Info
Entity: DIRM	Interface: County Mailing Addresses
Entity: CMS via DIRM	Interface: ICD-9/10-CM Procedure Codes
Entity: CMS via DIRM	Interface: American Dental Association Codes (ADA)



## APPENDIX 40, ATTACHMENT H



Entity: CMS via DIRM	Interface: CLIA Certification levels
Entity: CIGNA	Interface: Laboratory Rates
Entity: NTIS	Interface: DRG and Medicare Code Editor (MCE)
Entity: DMA	Interface: Financial Operations – Crossover percentages
Entity: First Data Bank	Interface: NDC Drug File
Entity: CMS via DIRM	Interface: NDC to HCPCS Crosswalk Files
Entity: DMA	Interface: Financial Operations Nursing Facility rate updates
Entity: DMA	Interface: Budget Office-Gross National Product (GNP) information
Entity: DIRM	Interface: County DSS mailing addresses

### Reference System External Interface – Output

Entity: Advance Medical	Interface: Procedure code file
Entity: Advance Medical	Interface: Accommodation rate info
Entity: Advance Medical	Interface: DRG Header extract
Entity: DMA	DRG Weight file – DRIVE
Entity: Medical Review	Interface: DRG extracts
Entity: PCG	Interface: Diagnosis file
Entity: DMA	Interface: Diagnosis file
Entity: Advance Medical	Interface: Diagnosis file
Entity: HMS	Interface: Diagnosis file
Entity: Data Niche	Interface: Drug Extract file
Entity: PCG	Interface: Drug file
Entity: HMS	Interface: Drug file
Entity: DMA	Interface: Drug file
Entity: DMA	Interface: Elderly Extract
Entity: DMA and DIRM	Interface: Fee Schedule
Entity: DMA	Interface: Modifier Master File
Entity: DMA and DIRM	Interface: Modifier Combination file (Bridge file)
Entity: DIRM	Interface: Medicaid Cost Summary file
Entity: DIRM	Interface: Drug Pricing File
Entity: DSS	Interface: Pharmacy Drug Requirements
Entity: Advance Medical	Interface: Drug Master File
Entity: Advance Medical	Interface: Fee Schedule
Entity: HMS	Interface: Drug Recovery file
Entity: PCG	Interface: Drug Recovery file

### Claims Systems External Interface – Input

Entity: PharmaCare	Interface: HIV Medication Encounter Interface file
Entity: COB Contractor	Interface: Medicare Crossover Claims

### Claims Systems External Interface – Output

Entity: DIRM for CSDW	Interface: HIV claims information extract (PA, Recipient, Provider, Claims)
Entity: DIRM for CSDW	Interface: Medicaid claims extract (PA, Recipient, Provider, Claims)
Entity: Advance Medical	Interface: Crossover Xref
Entity: Claims Activity	Interface: MMIS
Entity: Claims Activity	Interface: HMS

### Prior Approval System External Interface – Input

Entity: LME	Interface: Inquiry/Response
Entity: Vendor	Interface: Adjudication Authorization Info
Entity: Vendor	Interface: Inquiry/Request/Response (Psychiatric Services)



## APPENDIX 40, ATTACHMENT H



Entity: Vendor Interface: Inquiry/Request/Response (PASARR)  
 Entity: Vendor GCN/NDC Prior Approval update file

### Prior Approval System External Interface – Output

Entity: Vendor Interface: Inquiry/Request/Response (Optical Services)  
 Entity: LME Interface: Inquiry/Response (PA Activity)  
 Entity: LME Interface: Inquiry/Response (PA Error)  
 Entity: Vendor Interface: HIV Auth Info (PharmaCare)  
 Entity: Nash Optical Interface: Adjudicated PAs for optical PA type  
 Entity: DMA Interface: Prior Approval file – DRIVE  
 Entity: DMA Interface: Pharmacy Prior Approval record  
 Entity: Advance Medical Interface: Prior Approval file

### Managed Care System External Interface – Input

Entity: EIS Interface: MC Assignment Info  
 Entity: Geo Info Vendor Interface: Provider Match

### Managed Care System External Interface – Output

Entity: EIS Interface: MC Assignment Info  
 Entity: Geo Info Vendor Interface: Auto-Assignment Preliminary  
 Entity: Geo Info Vendor Interface: Auto-Assignment/Mass Change Final  
 Entity: NC State Health Plan Interface: PCP/Adm. Entity Enrollment Info for Health Choice Recipients

### EDI System External Interface – Input

Entity: ANSI ASC X12N 837I Interface: Institutional Claims Transaction  
 Entity: ANSI ASC X12N 837D Interface: Dental Claims Transaction  
 Entity: ANSI ASC X12N 837P Interface: Professional Claims Transaction  
 Entity: ANSI ASC X12N 278 Interface: Prior Authorization Inquiry Transaction  
 Entity: ANSI ASC X12N 834 Interface: Benefit Enrollment Transaction

### EDI System External Interface – Output

Entity: ANSI ASC X12N 835 Interface: Remittance Advice Transaction  
 Entity: ANSI ASC X12N 278 Interface: Prior Authorization Response Transaction  
 Entity: ANSI ASC X12N 834 Interface: Benefit Enrollment Transaction  
 Entity: ANSI ASC X12N 820 Interface: Premium Payment Transaction  
 Entity: ANSI ASC X12N 277U Interface: Claim Status Transaction  
 Entity: ANSI ASC X12N 824 Interface: Application Advice Transaction  
 Entity: ANSI ASC X12N 997 Interface: Transaction Acknowledgement

### POS Participant System External Interface – Input

Entity: NCPDP Interface: NCPDP E1 Request Interface

### POS Participant System External Interface – Output

Entity: NCPDP Interface: NCPDP E1 Response Interface

### POS Reference System External Interface – Input

Entity: SMAC Drug Vendor Interface: SMAC Pricing Info  
 Entity: Drug Update Vendor Interface: Drug Info

### POS Prior Approval System External Interface – Input

Entity: MMIS PA Interface: Add/Update Adjudicated DPH PAs

### POS Claims System External Interface – Input



## APPENDIX 40, ATTACHMENT H



Entity: Switch Vendor	Interface: POS Claim Submission
Entity: Provider	Interface: Claim Submission Other Media
Entity: Payment	Interface: Claim Info/Updates

### POS Claims System External Interface – Output

Entity: Switch Vendor	Interface: POS Claims Response
Entity: Payment	Interface: Claim Info/Updates

### Payment System External Interface – Input

Entity: Bank (TBD)	Interface: Positive Pay
Entity: Switch Vendor	Interface: Inquiry/Response
Entity: State	Interface: Inquiry/Response
Entity: Financial	Interface: Budget/1099 Info
Entity: State	Interface: Inquiry/Response/History Request
Entity: DSS	Interface: History Request/Web
Entity: Provider	Interface: WEB/AVRS
Entity: State Auth	Interface: History Request
Entity: DMA	Interface: COS Share Info

### Payment System External Interface – Output

Entity: Bank (TBD)	Interface: Positive Pay
Entity: Bank (TBD)	Interface: EFT
Entity: DIRM	Interface: DMH Paid Claims Info for CDW
Entity: Switch Vendor	Interface: Inquiry Response
Entity: EDMS	Interface: RA/REOMB/Profiles
Entity: Reporting	Interface: Category of Service
Entity: POS	Interface: Claim Info/Updates
Entity: Financial	Interface: Budget/Pay Cycle/1099 Info
Entity: Provider	Interface: WEB/AVRS/RA/EDI
Entity: State	Interface: Inquiry/Response
Entity: DIRM for CSDW	Interface: DPH Paid claims info
Entity: DMA	Interface: Paid Claims Activity file –DRIVE
Entity: NCXIX	Interface: NC Paid fulls
Entity: DHHS	Interface: Data from claims paid to local health depts.
Entity: DHHS	Interface: Data from claims paid to CDSAs

### Financial System External Interface – Input

Entity: FA Bank Account	Interface: Cleared Checks/EFTs
Entity: NCAS	Interface: Unexpended Authorized Budget
Entity: State Designated Bank	Interface: Lockbox Receipts
Entity: TPL Vendor	Interface: Information (data) receipt
Entity: DIRM	Interface: Available Funds Info
Entity: DIRM	Interface: Information (data) Indian file
Entity: DIRM	Interface: EPICS

### Financial System External Interface – Output

Entity: EDMS	Interface: Report Info
Entity: NCAS	Interface: Program Expenditures by CAC codes
Entity: IRS	Interface: 1099 A/R Info
Entity: MAS FPR	Interface: Summary of Paid Claims by MCC
Entity: Collection Agency	Interface: Collection Agency information
Entity: TPL Vendor	Interface: Receipt Info
Entity: DOR	Interface: A/R Info
Entity: State Auth	Interface: Budget Info
Entity: Indian File	Interface: CMS64





## APPENDIX 40, ATTACHMENT H



Entity: EPICS	Interface: CMS64
Entity: State	Interface: FPR files
Entity: DMA	Interface: Financial Participation

### Third Party Liability System External Interface – Input

Entity: DIRM	Interface: Updates to TPL data via dynamic update service
Entity: ACTS	Interface: Inquiries to TPL and carrier data
Entity: EIS	Interface: Inquiries to TPL and carrier data
Entity: DOD Report Systems	Interface: DEERS Enrollees – Def. Enrollment & Eligibility Re-
Entity: ACTS	Interface: Recipient data updates from CSE for TPL
Entity: CMS	Interface: Co-ordination of Benefits
Entity: CNDS	Interface: Responses to queries for policyholder demographic data

### Third Party Liability System External Interface – Output

Entity: DIRM	Interface: Acknowledgement/error msg. for TPL data update
Entity: ACTS	Interface: Response to inquiry of TPL and carrier data
Entity: EIS	Interface: Response to inquiry of TPL and carrier data
Entity: ACTS	Interface: Recipient updates from TPL for CSE
Entity: DIRM for EIS	Interface: TPL recipient data extract
Entity: DIRM for EIS and ACTS	Interface: TPL carrier data extract
Entity: DIRM for CSDW	Interface: TPL recipient data extract
Entity: DIRM for CSDW	Interface: TPL carrier data extract)
Entity: CNDS	Interface: Queries for policyholder demographic data
Entity: HMS	Interface: Invoices
Entity: Carriers	Interface: Invoices
Entity: TPL Vendors	Interface: Carrier and TPL policy resource data
Entity: TPL Vendors	Interface: Invoice Data Summary Extract
Entity: TPL Vendors	Interface: Invoice Data Detail Extract
Entity: CMS	Interface: Co-ordination of Benefits
Entity: HMS	Interface: TPL Carriers and their codes
Entity: DMA and HMS	Interface: TPL Procedure Code Pricing Master

### MEQC System External Interface – Input

Entity: DIRM/EIS	Interface: Recipient Samples
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### Reporting Repository System External Interface – Input

Entity: CMS via DIRM	Interface: CMS Drug Rebate Data
Entity: CMS	Interface: Drug Rebate File from CMS

### MMIS System External Interface – Output

Entity: CMS via DIRM	Interface: MSIS Extract (Federal MSIS Eligibility)
Entity: CMS via DIRM	Interface: MSIS Extract (Federal MSIS Claims Inpatient)
Entity: CMS via DIRM	Interface: MSIS Extract (Federal MSIS Claims Long Term Care)
Entity: CMS via DIRM	Interface: MSIS Extract (Federal MSIS Claims Pharmacy)
Entity: CMS via DIRM	Interface: MSIS Extract (Federal MSIS Claims Other)
Entity: DMA	Interface: Encounters SHF

### Drug Rebate System External Interface – Input

Entity: CMS via DIRM	Interface: URA/Labeler
Entity: CMS via DIRM	Interface: Usage (FTP)
Entity: MAS	Interface: Drug Rebate adjustments

### Drug Rebate System External Interface – Output

Entity: CMS	Interface: Drug Rebate Info to CMS
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## APPENDIX 40, ATTACHMENT H



Entity: Innovative Health Strategies  
Entity: DIRM

Interface: Drug Rebate Info  
Interface: PPA File for Drug Rebate

### Acronyms List

ACTS	Automated Collection Tracking System
ASC	Ambulatory Surgical Code
CAC	Company Account Center
CBSA	Core Based Statistical Area
CDW	Client Data Warehouse
COB	Coordination of Benefits
CLIA	Clinical Laboratory Improvement Act
CMS	Center for Medicaid Services
CNDS	Common Name Data System
COCC	Certificates of Creditable Coverage
COS	Category of Service
CPT	Current Procedural Terminology
CSE	Child Support Enforcement
DEA	Drug Enforcement Agency
DEERS	Defense Enrollment Eligibility Reporting System
DIRM	Division of Information Resource Management
DMA	Division of Medical Assistance
DMH	Division of Mental Health Services
DOD	Department of Defense
DRG	Diagnosis Related Group
EDB	Entitlement Database (Medicare)
EDMS	Electronic Data Management System
EFT	Electronic Funds Transfer
EIS	Eligibility Information System
EVS	Eligibility Verification System
FA	Fiscal Agent
GPCI	Geographic Practice Cost Indices
FPR	Financial Participation Report
HCPCS	Healthcare Common Procedure Coding System
HMS	Health Management Services
HSIS	Health Services Information System
IRS	Internal Revenue Service
LME	Local Managing Entity
MARS	Management and Administrative Reporting
MAS	Medicaid Accounting System
MC	Managed Care
MCC	Medicaid Cost Calculation
MDC	Major Diagnostic Category
MEQC	Medicaid Eligibility Quality Control
MSIS	Medicaid Statistical Information System
NCAS	North Carolina Accounting System
NCPDP	National Council for Prescription Drug Programs
NDC	National Drug Code
NDC/J	National Drug Code/Injection Code
OCR	Optical Character Recognition
OIG	Office of Inspector General
PA	Prior Approval
PASARR	Pre-Admission Screening and Annual Resident Review
POS	Point of Sale
RBRVS	Resource Based Relative Value Scale
SB926	Senate Bill 926



## APPENDIX 40, ATTACHMENT H

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SMAC            State Maximum Allowed Cost  
TPL            Third Party Liability



## APPENDIX 40, ATTACHMENT I



### SYSTEM AVAILABILITY

	Category	Production Hours of Operations			
		Normal State Business Days (8:00 A.M.–5:00 P.M.)	Extended State Business Days/Hours	24 x 7 x 365 (except for scheduled down-times)	Other Hours
System/Application support	Citizen				
	Eligible Program Recipient				
	State Employee/ Contractor			X	
	Government/ Business (individuals or systems)			X	
Web Portal	Citizen			X	
	Eligible Program Recipient			X	
	State Employee/ Contractor			X	
	Government/ Business (individuals or systems)			X	
POS	Citizen				
	Eligible Program Recipient				
	State Employee/ Contractor	X			
	Government/ Business (individuals or systems)			X	
	Citizen				
	Eligible Program Recipient			X	



## APPENDIX 40, ATTACHMENT I



	Category	Production Hours of Operations			
		Normal State Business Days (8:00 A.M.–5:00 P.M.)	Extended State Business Days/Hours	24 x 7 x 365 (except for scheduled down-times)	Other Hours
AVRS	State Employee/ Contractor	X			
	Government/ Business (Individuals or systems)			X	
EVS	Citizen				
	Eligible Program Recipient				
	State Employee/ Contractor			X	
	Government/ Business (Individuals or systems)			X	
EDI	Citizen				
	Eligible Program Recipient				
	State Employee/ Contractor			X	
	Government/ Business (Individuals or systems)			X	
Document Management	Citizen				
	Eligible Program Recipient				
	State Employee/ Contractor		7 A.M. to 11 P.M. Monday through Saturday 7 A.M. to 7 P.M. Sunday		
	Government/ Business (Individuals or systems)				



## APPENDIX 40, ATTACHMENT I



	Category	Production Hours of Operations			
		Normal State Business Days (8:00 A.M.–5:00 P.M.)	Extended State Business Days/Hours	24 x 7 x 365 (except for scheduled down-times)	Other Hours
Call Center - Pharmacy Prior Approval	Citizen				
	Eligible Program Recipient		7 A.M. to 11 P.M. Monday through Friday		
			7 A.M. to 6 P.M. Saturday & Sunday		
	State Employee/ Contractor		7 A.M. to 11 P.M. Monday through Friday		
		7 A.M. to 6 P.M. Saturday & Sunday			
Government/ Business (Individuals or systems)		7 A.M. to 11 P.M. Monday through Friday			
		7 A.M. to 6 P.M. Saturday & Sunday			
Call Center – Non Pharmacy Prior Approval	Citizen				
	Eligible Program Recipient		7 A.M. to 7 P.M. Monday through Friday		
			8 A.M. to 5 P.M. Saturday		
	State Employee/ Contractor		7 A.M. to 7 P.M. Monday through Friday		
		8 A.M. to 5 P.M. Saturday			
Government/ Business (individuals or systems)		7 A.M. to 7 P.M. Monday through Friday			
		8 A.M. to 5 P.M. Saturday			
Call Center/Help Desk – All other	Citizen				



**APPENDIX 40, ATTACHMENT I**



	Category	Production Hours of Operations			
		Normal State Business Days (8:00 A.M.–5:00 P.M.)	Extended State Business Days/Hours	24 x 7 x 365 (except for scheduled down-times)	Other Hours
	Eligible Program Recipient	X			
	State Employee/Contractor	X			
	Government/Business (individuals or systems)	X			

**Legend**

*Citizen: Anyone; no secure sign-on required.*

*Eligible Program Recipient: Citizen who receives or has a dependent who receives DHHS benefits; secure sign-on required.*

*State Employee/Contractor: State employees and contractor staff; DMH Local Managing Entity (LME) staff; secure sign-on required.*

*Government/Business (Individuals or systems): DHHS providers and business associates; county department of social services (DSS) staff in each of the 100 North Carolina counties; local health department staff; Health Check Coordinators; Eligibility Information System (EIS) and Division of Information Resource Management (DIRM) systems and applications. Secure sign-on/handshake required.*

## Desktop Standards

**These are the current Standard Configurations for Desktops and laptops as of July 2007.**

*Note: These are the minimum standards/specifications that will be accepted.*

	<b>Basic Desktop</b>	<b>High-End Desktop</b>
Type	Microsoft Windows Vista-compatible/business class desktop; must include all applicable Windows XP devices drivers	Microsoft Windows Vista-compatible/business class desktop; must include all applicable Windows XP devices drivers
Processor	Intel Core 2 Duo E6300 (1.86Ghz,1066FSB,2MB) <b>OR</b> AMD Athlon 64 X2 3800+ (2.00GHz)	Intel Core 2 Duo E6600 (2.40Ghz,1066FSB,4MB)
Memory	2.0GB Non-ECC SDRAM 667MHZ with two (2) free slots for additional memory	2.0GB Non-ECC SDRAM 800MHZ with two (2) free slots for additional memory
Video Card	PCIe 128MB DVI and VGA compatible	PCIe256 MB, (non-shared memory) Dual Monitor DVI and VGA compatible
Cables / Connectors	DVI and VGA	DVI and VGA, including Y-adapters and/or other connectors as necessary to support dual monitor configuration
Hard Drive	160GB SATA 3.0Gb/s	160GB SATA 3.0Gb/s
Floppy Drive	Yes	Yes
Optical Drive	16X DVD+/-RW	16X DVD+/-RW
PCI Slots	Two (2) Free Slots	Two (2) Free Slots
USB Ports	Five (5) Total : Two (2) in Front, Three (3) in Back USB v2.0	Five (5) Total : Two (2) in Front, Three (3) in Back USB v2.0
Operating System Software	Microsoft Vista Business (OEM) with media; must include all applicable Windows XP devices drivers	Microsoft Vista Business (OEM) with media; must include all applicable Windows XP devices drivers
Integrated NIC	Integrated Gigabit Ethernet (10/100/1000) Card	Integrated Gigabit Ethernet (10/100/1000) Card
Keyboard	Enhanced USB Keyboard	Enhanced USB Keyboard
Mouse	USB, 2-button, Optical mouse with Scroll	USB, 2-button, Optical mouse with Scroll
Audio	Internal 16-Bit Stereo	Internal 16-Bit Stereo
Expansion bays	Two (2) available: One (1) Internal and One (1) External	Two (2) available: One (1) Internal and One (1) External





## APPENDIX 40, ATTACHMENT J



	Basic Desktop	High-End Desktop
Form Factor	Small / Desktop	Minitower



**APPENDIX 40, ATTACHMENT J**



	<b>Basic Laptop</b>	<b>High-End Laptop (Desktop Replacement)</b>
Type	Microsoft Windows Vista compatible/business class laptop; must include all applicable Windows XP devices drivers	Microsoft Windows Vista compatible/business class laptop; must include all applicable Windows XP devices drivers
Processor	Intel Core 2 Duo (1.80GHz, 2MB, 800Mhz) Dual Core <b>OR</b> AMD 64 X2 Mobile (2.0GHz, 1M)	Intel Core 2 Duo (2.20GHz, 4MB, 800Mhz) Dual Core
Memory	2.0GB DDR2-667 SDRAM.	2.0GB, DDR2-667 SDRAM.
Video	Intel integrated	256 MB (non-shared memory)
Video Display	14.1 Inch, WXGA	15.4 Inch, WXGA
Hard Drive	80GB, 7200 RPM	120GB, 7200 RPM
Floppy Drive	None	None
Optical Drive	8X DVD+/-RW	8X DVD+/-RW
USB Ports	Three (3) USB V2.0	Three (3) USB V2.0
Serial Ports	None	One (1) Serial Port
Operating System Software	Microsoft Vista Business (OEM) with media	Microsoft Vista Business (OEM) with media
Integrated NIC	Integrated Gigabit Ethernet (10/100/1000)	Integrated Gigabit Ethernet (10/100/1000)
Integrated Modem	Integrated V.92 56K Modem with Fax	Integrated V.92 56K Modem with Fax
Internal Wireless Adapter	Supports 802.11 a/g WPA2	Supports 802.11 a/g WPA2
Power / Battery	A/C adapter / 6-cell primary	A/C adapter / 6-cell primary
Cables / Connectors	3' power cord w/ adapter	3' power cord w/ adapter
Resource CD	Resource CD that contains System Diagnostics and Drivers; must include XP driver versions for all applicable devices	Resource CD that contains System Diagnostics and Drivers; must include XP driver versions for all applicable devices

	<b>Ultra-Portable Laptop</b>
Type	Microsoft Windows Vista compatible/business class "ultra-portable" laptop; less than 4 lbs total weight configured with all options listed below.
Processor	Intel Core2 Duo (1.2GHz, 533Mhz FSB)
Memory	2.0GB DDR2 SDRAM
Video	Mobile Intel
Video Display	12.1 Inch, WXGA
Hard Drive	60GB, 7200 RPM
Floppy Drive	None
Optical Drive	8X DVD+/-RW
USB Ports	Three (3) USB V2.0
Serial Ports	None
Operating System Software	Microsoft Vista Business (OEM) with media
Integrated NIC	Integrated Gigabit Ethernet (10/100/1000)
Integrated Modem	Integrated V.92 56K Modem with Fax
Internal Wireless Adapter	Supports 802.11 a/g
Power / Battery	A/C adapter / 6-cell primary
Cables / Connectors	3' power cord w/ adapter



### Replacement MMIS Proposal Submission Requirements Checklist

This appendix identifies the requirements for the Proposal responding to RFP 30-DHHS-1228-08-R. Failure to respond in whole or in part to a specific requirement may result in rejection of the Proposal during the evaluation process.

Proposal Submission Requirements	<u>Acknowledgement</u> "Yes" or "No"	For NC DHHS Use Only
1. (RFP Section 50.1) Was the Technical Proposal submitted by the date and time specified in the RFP Cover Letter?		
2. (RFP Section 50.1) Was the Technical Proposal package(s) labeled as indicated in the RFP Cover Letter?		
3. (RFP Section 50.1) Are number of originals, copies, and electronic versions of the Technical Proposal as indicated in the RFP Cover Letter included?		
4. (RFP Section 50.1) Are the originals clearly marked as such?		
5. (RFP Section 50.1) Did the Offeror include a table of contents in its proposal?		
6. (RFP Section 50.1) Did the Offeror provide the completed Appendix 50, Attachments A, B, C-Exhibit 1, C-Exhibit 2, D, and E in their native formats?		
7. (RFP Section 50.1) Did the Offeror provide the Integrated Master Schedule (IMS) in MS Project and in its native format?		



**APPENDIX 50, ATTACHMENT A**



<p align="center"><b>Proposal Submission Requirements</b></p>	<p align="center"><b><u>Acknowledgement</u> "Yes" or "No"</b></p>	<p align="center"><b>For NC DHHS Use Only</b></p>
<p>8. (RFP Section 50.1) Did the Offeror use 8-1/2 X 11 paper and 12-point font, single-spaced with 6 point spacing between rows?</p>		
<p>9. (RFP Section 50.2) Is the Technical Proposal comprised of the following eleven (11) separate sections, individually tabbed, in the following sequence:</p> <ul style="list-style-type: none"> <li>• Section A—Transmittal Letter and Execution Page (Page 1 of 2 of RFP Cover Page)</li> <li>• Section B—Proposal Submission Requirements Checklist</li> <li>• Section C—Executive Summary</li> <li>• Section D—Proposed Solution Details</li> <li>• Section E—Project Management Plan</li> <li>• Section F—Operations Management Approach</li> <li>• Section G—Contract Data Requirements List (CDRL)</li> <li>• Section H—Security Approach</li> <li>• Section I—Turnover Approach</li> <li>• Section J—Corporate Capabilities</li> <li>• Section K—Oral Presentations and Demonstrations</li> </ul>		
<p>10. (RFP Section 50.2) Did the Offeror provide the Subsection Number preceding its response explaining its fulfillment in the Technical Proposal?</p>		
<p>11. (RFP Section 50.2.1) Was a Transmittal Letter and Execution Page (Page 1 of 3 of RFP Cover Page) included in the Proposal as Section A?</p>		



**APPENDIX 50, ATTACHMENT A**



<p align="center"><b>Proposal Submission Requirements</b></p>	<p align="center"><b><u>Acknowledgement</u> "Yes" or "No"</b></p>	<p align="center"><b>For NC DHHS Use Only</b></p>
<p>12. (RFP Section 50.2.1) Is the Transmittal Letter within the limit of three (3) pages, excluding the attached copies of the required certifications and representations from the Appendices and excluding the attached copies of the RFP Addenda issued by the State?</p>		
<p>13. (RFP Section 50.2.1) Is the Transmittal Letter on official business letterhead of the prime Vendor and signed by an individual authorized to legally bind the company?</p>		
<p>14. (RFP Section 50.2.1) Does the Transmittal Letter include the 15 items listed?</p>		
<p>15. (RFP Section 50.2.2) Was a completed Proposal Submission Requirements Checklist included in the Proposal as Section B?</p>		
<p>16. (RFP Section 50.2.3) Was an Executive Summary included in the Technical Proposal as Section C?</p>		
<p>17. (RFP Section 50.2.3) Is the Executive Summary within the limit of fifteen (15) pages?</p>		
<p>18. (RFP Section 50.2.3) Is the completed High-Level System Functionality Matrix (Appendix 50, Attachment B) included in the Technical Proposal as a part of Section C?</p>		
<p>19. (RFP Section 50.2.4.1) Is the Proposed System Solution and Solution for DDI included in the Technical Proposal as Section D?</p>		
<p>20. (RFP Section 50.2.4.1.1) Is the Overview of System Solution and Solution for Design,</p>		



**APPENDIX 50, ATTACHMENT A**



<p align="center"><b>Proposal Submission Requirements</b></p>	<p align="center"><b><u>Acknowledgement</u> "Yes" or "No"</b></p>	<p align="center"><b>For NC DHHS Use Only</b></p>
<p>Development and Installation included in Section D?</p>		
<p>21. (RFP Section 50.2.4.1.1) Is the Overview of System Solution and Solution for Design, Development and Installation within the limit of 500 pages?</p>		
<p>22. (RFP Section 50.2.4.1.2) Is the Software Development and Systems Engineering Methodology included in Section D?</p>		
<p>23. (RFP Section 50.2.4.1.2) Is the Software Development and Systems Engineering Methodology within the limit of 50 pages?</p>		
<p>24. (RFP Section 50.2.4.1.3) Is the Data Conversion and Migration Approach included in Section D?</p>		
<p>25. (RFP Section 50.2.4.1.3) Is the Data conversion and Migration Approach within the limit of 20 pages?</p>		
<p>26. (RFP Section 50.2.4.1.4) Is the Deployment/Rollout Approach included in Section D?</p>		
<p>27. (RFP Section 50.2.4.1.4) Is the Deployment/Rollout Approach within the limit of 20 pages?</p>		
<p>28. (RFP Section 50.2.4.1.5) Did the Offeror complete appendix 50, Attachment C, Part I, DDI Requirements Matrix, as required?</p>		



**APPENDIX 50, ATTACHMENT A**



<p align="center"><b>Proposal Submission Requirements</b></p>	<p align="center"><b><u>Acknowledgement</u> "Yes" or "No"</b></p>	<p align="center"><b>For NC DHHS Use Only</b></p>
<p>29. (RFP Section 50.2.4.1.6) Did the Offeror complete Appendix 50, Attachment C, Part II, Adjusted Function Point Count, as required?</p>		
<p>30. (RFP Section 50.2.4.2.1) Did the Offeror describe how it plans to meet the Operations Requirements outlined in RFP section 40 in its Section D?</p>		
<p>31. (RFP Section 50.2.4.2.1) Is the Proposed Solution for Operations within the limit of 150 pages?</p>		
<p>32. (RFP Section 50.2.4.3) Is the Offeror's Statement of Work included in Section D?</p>		
<p>33. (RFP Section 50.2.4.3) Is the Offeror's Statement of Work formatted per Appendix 50, Attachment D?</p>		
<p>34. (RFP Section 50.2.4.4) Is the Offeror's Training Approach provided in Section D?</p>		
<p>35. (RFP Section 50.2.4.4) Is the Offeror's Training Approach limited to 20 pages?</p>		
<p>36. (RFP Section 50.2.5) Did the Offeror include a Project Management Plan?</p>		
<p>37. (RFP Section 50.2.5) Is the Project Management Plan within the limit of 50 pages excluding the IMP and IMS and other elements of this Plan with page limitations assigned?</p>		
<p>38. (RFP Section 50.2.5.1) Did the Offeror submit its Integrated Master Plan?</p>		





**APPENDIX 50, ATTACHMENT A**



<p align="center"><b>Proposal Submission Requirements</b></p>	<p align="center"><b><u>Acknowledgement</u> "Yes" or "No"</b></p>	<p align="center"><b>For NC DHHS Use Only</b></p>
<p>39. (RFP Section 50.2.5.2) Did the Offeror submit its Integrated Master Schedule?</p>		
<p>40. (RFP Section 50.2.5.3) Did the Offeror describe its Master Test Process and Quality Assurance Approach?</p>		
<p>41. (RFP Section 50.2.5.3) Is the Master Test Process and Quality Assurance Approach within the limit of 20 pages?</p>		
<p>42. (RFP Section 50.2.5.4.1) Did the Offeror provide its comprehensive Organizational Chart for DDI and a description of its organization?</p>		
<p>43. (RFP Section 50.2.5.4.1) Did the Offeror propose the positions and staff to be designated as key personnel for DDI and provide its Corporately Certified Position descriptions for the key personnel and resumes and references for any key personnel currently identified?</p>		
<p>44. (RFP Section 50.2.5.4.1) Did the Offeror limit its Organization Chart for DDI to 2 pages?</p>		
<p>45. (RFP Section 50.2.5.4.1) Did the Offeror limit its position descriptions to 1 page each and its resumes, including references, to 3 pages each?</p>		
<p>46. (RFP Section 50.2.5.4.2) Did the Offeror provide its comprehensive Organizational Chart for Operations?</p>		
<p>47. (RFP Section 50.2.5.4.2) Did the Offeror</p>		



**APPENDIX 50, ATTACHMENT A**



<p align="center"><b>Proposal Submission Requirements</b></p>	<p align="center"><b><u>Acknowledgement</u> "Yes" or "No"</b></p>	<p align="center"><b>For NC DHHS Use Only</b></p>
<p>propose the positions and staff to be designated as key personnel for Operations and provide its Corporately Certified Position descriptions for the key personnel and resumes and references for any key personnel currently identified?</p>		
<p>48. (RFP Section 50.2.5.4.2) Did the Offeror limit its Organization Chart for Operations to 2 pages?</p>		
<p>49. (RFP Section 50.2.5.4.2) Did the Offeror limit its position descriptions for Operations to 1 page each and its resumes, including references, to 3 pages each?</p>		
<p>50. (RFP Section 50.2.5.5) Did the Offeror describe its communications approach?</p>		
<p>51. (RFP Section 50.2.5.5) Did the Offeror limit its Communications Approach to 15 pages?</p>		
<p>52. (RFP Section 50.2.5.6) Did the Offeror submit its Risk and Issue Management Plan?</p>		
<p>53. (RFP Section 50.2.5.6) Did the Offeror limit its Risk and Issue Management Plan to 30 pages?</p>		
<p>54. (RFP Section 50.2.5.7) Did the Offeror submit an Initial Risk Assessment, including known risks associated with the implementation of the proposed solution?</p>		
<p>55. (RFP Section 50.2.5.7) Did the Offeror limit its Initial Risk Assessment to no more than 1 page per identified risk?</p>		



**APPENDIX 50, ATTACHMENT A**



<p align="center"><b>Proposal Submission Requirements</b></p>	<p align="center"><b><u>Acknowledgement</u> "Yes" or "No"</b></p>	<p align="center"><b>For NC DHHS Use Only</b></p>
<p>56. (RFP Section 50.2.5.8) Did the Offeror submit its Change Management Approach?</p>		
<p>57. (RFP Section 50.2.5.8) Did the Offeror limit its Change Management Approach to 20 pages?</p>		
<p>58. (RFP Section 50.2.6) Did the Offeror provide its Operations Management Approach in Section F?</p>		
<p>59. (RFP Section 50.2.6) Did the Offeror limit its Operations Management Approach to 30 pages?</p>		
<p>60. (RFP Section 50.2.6.1) Did the Offeror include its Change and Configuration Management approach for Operations in its Change Management Approach (see RFP Section 50.2.5.8)</p>		
<p>61. (RFP Section 50.2.6.2) Did the Offeror's Risk and Issue Management Plan include Operations as well as Systems and DDI? (see RFP Section 50.2.5.6)</p>		
<p>62. (RFP Section 50.2.6.3) Did the Offeror submit its Business Continuity/Disaster Recovery Approach?</p>		
<p>63. (RFP Section 50.2.6.3) Did the Offeror limit its Business Continuity/Disaster Recovery Approach to 15 pages?</p>		
<p>64. (RFP Section 50.2.6.4) Did the Offeror include a description of its approach for Ongoing Training in its Training Approach (see RFP Section 50.2.4.4)</p>		



**APPENDIX 50, ATTACHMENT A**



<p align="center"><b>Proposal Submission Requirements</b></p>	<p align="center"><b><u>Acknowledgement</u> “Yes” or “No”</b></p>	<p align="center"><b>For NC DHHS Use Only</b></p>
<p>65. (RFP Section 50.2.6.5) Did the Offeror include a description of its communications approach for Operations in its Operations Management Approach (see RFP Section 50.2.6)</p>		
<p>66. (RFP Section 50.2.7) Did the Offeror provide the CDRL, updated with additional data requirements in Section G?</p>		
<p>67. (RFP Section 50.2.8) Did the Offeror describe its approach to security in Section H of the Technical Proposal?</p>		
<p>68. (RFP Section 50.2.8) Did the Offeror limit its Security Approach to 30 pages?</p>		
<p>69. (RFP Section 50.2.9) Did the Offeror describe its Turnover Approach in its Technical Proposal, Section I?</p>		
<p>70. (RFP Section 50.2.9) Did the Offeror limit its Turnover Approach to 20 pages?</p>		
<p>71. (RFP Section 50.2.10) Is the response to Corporate Capabilities included in the Proposal as Section J?</p>		
<p>72. (RFP Section 50.2.10) Is the response to Corporate Capabilities within the limit of 40 pages?</p>		
<p>73. (RFP Section 50.2.10.) Are the five (5) sections specified in RFP Section 50.2.10.2 for Corporate Capabilities included in Section J?</p>		
<p>74. (RFP Section 50.2.11) Did the Offeror</p>		



**APPENDIX 50, ATTACHMENT A**



<b>Proposal Submission Requirements</b>	<b><u>Acknowledgement</u> "Yes" or "No"</b>	<b>For NC DHHS Use Only</b>
acknowledge in Section K that it understands and agrees to perform the requirements of the Oral Presentations and System Demonstrations?		
75. (RFP Section 50.2.11.2) Did the Offeror identify the state(s) where its "baseline system" is installed?		
76. (RFP Section 50.2.11.2) Did the Offeror sign the statement in Appendix 50, Attachment H representing that its baseline system for the system demonstration complies with the description of a "baseline" solution as described in this RFP Section?		



**HIGH-LEVEL SYSTEM FUNCTIONALITY MATRIX**

Business Area	System Product(s)	High Level Functionality Overview	Additional Benefits
General			
Recipient			
Eligibility Verification System (EVS)			
Automated Voice Response (AVRS)			
Reference			
Prior Approval			
Claims Processing (with Pricing and Payment)			
Managed Care			
Health Check			
TPL			
Drug Rebate			
MARS			
Financial			
Provider			

*Note: If the Offeror is proposing a separate but integrated POS, the Offeror may add an additional row to the address.*

## Appendix 50, Attachment C, Exhibit 1: State Requirements Matrix

Table Legend:

- (A) System capability is in the Baseline System or COTS and configuration is required via manual table updates to meet proposed solution (Y/N)\*
- (B) System capability is in the Baseline System or COTS and software modification is required to meet proposed solution (Y/N)\*
- (C) System capability is not in the Baseline System and requires new functionality via software modification to meet proposed solution (Y/N)
- (D) Enter the Proposal Section (A–L) that reflects the fulfillment of the Section 40 of this RFP requirement and page number(s).
- (E) Will meet requirement (Y/N)

\* If both A and B above apply, indicate Yes (Y) in each column.

\*\* Non-Medicaid only

### 40.1 General Requirements

#### 40.1.1 General System Requirements

Requirement #	Requirement Description	A	B	C	D	E
	<b>Multi-Payer Requirements</b>					
40.1.1.1	Provides capability in a Replacement MMIS to provide a single system process to coordinate recipient benefits among the DMA, DMH, DPH, and the Migrant Health Program in the Office of Rural Health and Community Care (ORHCC) and to ensure the proper assignment of the financially responsible payer, benefit plan, and pricing methodology for each service tendered in a claim					
40.1.1.2	Provides capability to create and maintain each health benefit program offered and administered by the State; health benefit programs shall be realized by one or more benefit plans that define the scope of benefits, eligibility criteria, and pricing methods applicable to a health benefit program					



## APPENDIX 50, ATTACHMENT C, EXHIBIT 1

Requirement #	Requirement Description	A	B	C	D	E
40.1.1.3	Provides capability to allow recipients and providers to enroll in one (1) or more benefits plans					
40.1.1.4	Provides capability for benefits plan to be implemented through a rule or a design that allows simple and easy implementation of new benefit programs and modifications to existing benefit programs with little or no programmatic changes to the claims processing software					
40.1.1.5	Provides capability for benefits plans to be maintained and administered through user-interface views with entries for defining and configuring the scope of benefits, eligibility criteria, and the pricing method criteria that will be used for determining admissibility under a given benefit plan					
40.1.1.6	Provides capability for the claims adjudication process to use information from the benefit plans applicable to both the recipient and provider of a submitted claim to identify and assign the financially responsible payer and benefit program applicable to each service tendered in the claim, including retrospective review of eligibility and funding availability					
40.1.1.7	Provides capability for the determination of the financially responsible payer and benefit program for each claim service using a set of payer and benefit program ranking criteria to resolve any potential contention when the claim service is covered by more than one benefit plan					
40.1.1.8	Provides capability for the claims adjudication process to use information from the pricing method criteria tables to identify and assign the pricing methodology applicable to each service tendered in the claim					
40.1.1.9	Provides capability for financially responsible payers, benefit programs, and pricing methodologies assigned to a claim to be used to support and direct various aspects of the claims adjudication process, including the edits, audits, pricing, payment (e.g., checkwrite), and financial (e.g., budget management) functions					
40.1.1.10	Provides capability to track and report current and historical claims detail and associated funding sources					





**APPENDIX 50, ATTACHMENT C, EXHIBIT 1**

Requirement #	Requirement Description	A	B	C	D	E
40.1.1.11	Provides capability for batch and/or online real-time access between external systems and Replacement MMIS functional areas using Application Program Interface (API) - based Service-Oriented Architecture (SOA) concepts					
40.1.1.12	Provides capability to track, report, reproduce, and/or forward recipient mail that is undeliverable					
40.1.1.13	Fiscal Agent shall shred recipient correspondence that is returned to the Fiscal Agent as non-deliverable					
40.1.1.14	Provides capability for data validation editing for all online and Web entry views					
	<b>Data Transfer and Conversion</b>					
<b>Requirement Deleted</b> 40.1.1.15	<del>Provides capability to make all historic and new electronic documents available to Fiscal Agent and State staff from implementation of any and all Replacement MMIS capabilities</del>					
	<b>Interfaces</b>					
40.1.1.16	Provides capability to interface in a timely manner "To" and "From" all external interfaces, to include, without limitation, those listed in Appendix 40, Attachment H of this RFP					
	<b>Security</b>					
40.1.1.17	Provides capability to adopt current industry and State standards and address the State's Security Program Planning and Management, Access Controls, Application Software Development and Change Controls, System Software Controls, and Service Continuity Controls					
40.1.1.18	Provides capability for initial batch loading of security records and profiles prior to implementation					
	<b>User Access Authentication and Authorization</b>					



**APPENDIX 50, ATTACHMENT C, EXHIBIT 1**



Requirement #	Requirement Description	A	B	C	D	E
40.1.1.19	Provides capability for a user interface design to incorporate the North Carolina Identity Enterprise Service (NCID), version 7 (or later), Model 2  Refer to <i>DHHS Application Integration with NCID</i> in the Procurement Library.					
40.1.1.20	Provides capability to adhere to the role-based access control model in compliance with NC DHHS Security policies  Refer to <i>Replacement MMIS Security Business Rules</i> in the Procurement Library.					
	<b>Architecture</b>  Reference <i>Appendix 40, Attachment B, DMA Network Diagram</i> and <i>Appendix 40, Attachment C, DMH Network Diagram</i> of this RFP for information purposes only.					
40.1.1.21	<b>Goal:</b> Provides capability for the architecture to be: <ul style="list-style-type: none"> <li>▪ Adaptable</li> <li>▪ Available</li> <li>▪ Extensible</li> <li>▪ Interoperable</li> <li>▪ Manageable</li> <li>▪ Redundant</li> <li>▪ Resilient</li> <li>▪ Scalable</li> <li>▪ Securable</li> </ul>					
40.1.1.22	<b>Goal:</b> Provides capability for the architecture to align with the principles and practices in the North Carolina Statewide Technical Architecture (STA)					
40.1.1.23	Provides capability for all applicable components of the proposed solution to perform efficiently on State desktop office tools consistent with the current State standards and versions (i.e., no more than [1] major release behind the current supported levels). See					



**APPENDIX 50, ATTACHMENT C, EXHIBIT 1**



Requirement #	Requirement Description	A	B	C	D	E
	Appendix 40, Attachment J for State Standards.					
40.1.1.24	<b>Goal:</b> Provides capability for the client user interface to be decoupled (a clear physical separation) from the business rules layer and limited to presentation of data, capturing of input, and control of application flow					
40.1.1.25	<b>Goal:</b> Provides capability for the architecture to use Web services-based solutions that are designed using either a 3/N-tier or Service-Oriented Architecture (SOA) approach					
	<b>System Software Controls</b>					
40.1.1.26	Provides capability to update records to reflect changes such as merging or decoupling of recipient and provider IDs					
	<b>User Interface and Navigation</b>					
40.1.1.27	Provides capability for standard user interface characteristics, data accessibility, and navigation across all Replacement MMIS business areas					
40.1.1.28	Provides capability for compliance with language and accessibility requirements as defined in the Regulatory Compliance Section					
40.1.1.29	<b>Goal:</b> Provides capability for a secure, interactive Web Portal for users twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year					
40.1.1.30	Provides capability for a secure, interactive Web Portal to have an informational/introductory Web page twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year					
40.1.1.31	Provides capability for real-time interaction with all business areas, enabling routine inquiries					
40.1.1.32	Provides capability for multiple business area views to be displayed concurrently and to facilitate interaction between business area views					



## APPENDIX 50, ATTACHMENT C, EXHIBIT 1

Requirement #	Requirement Description	A	B	C	D	E
40.1.1.33	Provides capability for consistency in displaying view/file/report titles, dates, times, and other business area-specific requirements					
40.1.1.34	Provides capability to display error messages, interactive help views and tables, accessible reference files, and hypertext links to appropriate additional files/reports					
<b>Document Management and Correspondence Tracking</b>						
40.1.1.35	Provides capability to electronically store and view online in an easily readable format all inbound and outbound transactions and correspondence within the Replacement MMIS					
40.1.1.36	Provides capability for integrated document management and correspondence tracking across all Replacement MMIS business areas					
40.1.1.37	Provides capability for online access to Replacement MMIS and document management and correspondence tracking with a single log-on					
40.1.1.38	Provides capability to capture and electronically store all documents, both incoming and outgoing, including claims, claim attachments, data entry forms, images, medical records, X-rays, correspondence, incoming and outgoing fax documents and system-generated reports, tracking date, and time of receipt					
40.1.1.39	Provides capability to receive, electronically store, and retrieve intraoral/extraoral photographs, digital radiographs, and digital versions of orthodontic models (casts)					
40.1.1.40	Provides capability to link incoming documents, correspondence, and supporting documentation to related documents and correspondence already on file					
40.1.1.41	Provides capability to assign a unique document identifier to each document					
40.1.1.42	Provides capability to retrieve all linked documents with one (1) request					
40.1.1.43	Provides capability for documents to be electronically stored by unique document identifier and accessible by online search via hypertext link from all views that reference					



**APPENDIX 50, ATTACHMENT C, EXHIBIT 1**



Requirement #	Requirement Description	A	B	C	D	E
	the image					
40.1.1.44	Provides capability to retain electronic documents for ten (10) years online; once the electronic document has been verified, it becomes the official copy of the document					
40.1.1.45	Provides capability to archive electronic documents offline after ten (10) years and retrieve them for online viewing within two (2) business days of a request					
40.1.1.46	Provides capability for data retrieved from offline storage to be retained online for ten (10) business days, unless otherwise requested					
40.1.1.47	Provides capability to print hard copies of electronically stored documents					
40.1.1.48	Provides capability to print and fax documents					
40.1.1.49	Provides capability for State and Fiscal Agent staff to retrieve and display any electronically stored documents within eight (8) seconds for the first page, within five (5) seconds for the second page, and within three (3), two (2), and one (1) second(s) or less for subsequent pages					
40.1.1.50	Provides capability to make all documents available to the State within two (2) business days of creation					
40.1.1.51	Provides capability to accept input in frequencies as defined in business areas and from multiple sources, types, and formats, including: <ul style="list-style-type: none"> <li>▪ Required electronic transaction formats, (e.g., X12)</li> <li>▪ Scanners (e.g., paper claims/written correspondence)</li> <li>▪ Electronic text (e.g., e-mail, e-fax, voice media files)</li> <li>▪ Paper documents (e.g., correspondence, claims forms, faxes)</li> <li>▪ Portable media (e.g., magnetic tapes, 3.5" floppy drives, CD/DVD drives)</li> </ul>					
40.1.1.52	Provides capability for all data input (e.g., images of scanned paper documents, voice media files, electronic and EDI transactions) to be transformed as needed for further					



**APPENDIX 50, ATTACHMENT C, EXHIBIT 1**



Requirement #	Requirement Description	A	B	C	D	E
	processing					
40.1.1.53	Provides capability to protect all stored images and electronic copies from direct access while allowing authorized copies to be used for further processing					
	<b>Audit Trail</b>					
40.1.1.54	Provides capability to track through audit trail data with date/time stamps: <ul style="list-style-type: none"> <li>▪ All access, activity, and system identifier of users or persons making adds, changes, deletes, or queries</li> <li>▪ All activity that causes any additions, changes, deletions, or queries</li> <li>▪ All transactions that result in a claim being entered into the system, including EDI transactions, a prior approval being entered into the system, Third Party Liability (TPL) transactions, a financial result (incoming and outgoing financial transactions and system-generated financial transactions), adding, changing, or deleting recipient or provider data, adding, changing, or deleting reference or code data, drug rebate activity, financial activity, and reference file changes</li> </ul>					
40.1.1.55	Provides capability to maintain an automated audit trail of all update transactions, both batch and online, including date and time of change, before and after data field contents, and operator identifier or source of the update					
40.1.1.56	Provides capability to create audit trail data that can be accessed online in a user-friendly, indexed, searchable format that has the capability to reflect the complete history of the transaction					
	<b>Online Help</b>					
40.1.1.57	Provides capability for selectable online help views for user functionality that duplicate or link to system documentation					
40.1.1.58	Provides capability for online help for all features, functions, and data element fields as well as descriptions and resolutions for error messages, using help features, including indexing, searching, tool tips, mouse-over, field value options, hypertext links to files,					



**APPENDIX 50, ATTACHMENT C, EXHIBIT 1**

Requirement #	Requirement Description	A	B	C	D	E
	reports, and context-sensitive help topics					
40.1.1.59	Provides capability for context-sensitive help to view, window, or dialog					
	<b>Search and Query</b>					
40.1.1.60	Provides capability to allow all records to be selectable and searchable by record elements, as specified within business areas					
40.1.1.61	Provides capability to query and search information based on user-defined criteria or by data elements as specified within the business areas					
40.1.1.62	Provides capability for search by phonetic/mnemonic, full-text, partial-text, keyword, Boolean operators, specific date, date ranges, partial Postal/zip code, and wildcard					
40.1.1.63	Provides capability for users to query via parameterized standard reports and view online production data					
40.1.1.64	Provides capability to generate descriptive alerts that specify any invalid query parameter(s) and to generate alerts when the anticipated return time on a query or search exceeds a defined time limit					
40.1.1.65	Provides capability to permit users to easily locate specific information in the online documentation, e.g., user manual, operating procedures, and online system help					
40.1.1.66	Provides capability to govern queries so that run time does not exceed defined limits					
	<b>Correspondence and Letters</b>					
40.1.1.67	Provides capability to produce system-generated standardized letters as specified in business area requirements and to electronically store saved images of each letter produced					
40.1.1.68	Provides capability to produce updatable, form-based, version-controlled, customized templates for letter generation with capability for free-form text as specified in business					



## APPENDIX 50, ATTACHMENT C, EXHIBIT 1

Requirement #	Requirement Description	A	B	C	D	E
	area requirements and to electronically store saved images of each letter produced from the templates in an easily accessible, searchable format					
40.1.1.69	Provides capability for letter and template generation to comply with US DHHS Title VI Language Access Policy based on flag that defines recipient language preference					
40.1.1.70	Provides capability to create and manage stakeholder correspondence, clinical policy documentation, bulletins/publication, business rules, and business forms					
40.1.1.71	Provides capability to perform desktop publishing of documents for all stakeholders					
40.1.1.72	Provides capability for on-demand and batch-driven correspondence creation and mailing					
40.1.1.73	Provides capability for letter-generation solution that has the flexibility to use form letters and/or on-demand text generation					
40.1.1.74	Provides capability for all stakeholders to create and electronically store correspondence templates for private and community use					
40.1.1.75	Provides capability to use spellchecker functionality					
40.1.1.76	Provides capability to use business rules intelligence to determine the best choice for correspondence communication and allow for the identification of the best selection for combination of address(es), USPS, fax, e-mail					
40.1.1.77	Provides capability to bulk distribute to target populations messages and communications via e-mail, fax, or Really Simple Syndication (RSS) feed					
40.1.1.78	Provides capability to integrate the letter-generation solution with the Replacement MMIS and import required data elements identified in the business rules that must be included in the letter text					
40.1.1.79	Provides capability to send correspondence through workflow management for approval, where business rules require secondary approval					





## APPENDIX 50, ATTACHMENT C, EXHIBIT 1



Requirement #	Requirement Description	A	B	C	D	E
40.1.1.80	Provides capability to integrate and link all correspondence to the document management solution in real-time from point of origin (State, county, Fiscal Agent, or other State-contracted entity's location)					
40.1.1.81	Provides capability to track the correspondence creator, date, recipient, and time stamp and maintain this information historically					
40.1.1.82	Provides capability to enclose attachments to meet recipient's language requirements					
40.1.1.83	Provides capability to create and distribute documents to multiple addresses					
40.1.1.84	Provides capability to redistribute static letters					
40.1.1.85	Provides capability to create performance reporting associated with correspondence					
40.1.1.86	Provides capability to allow user to designate address to be used					
40.1.1.87	Provides capability to enforce security rules to control who issues each type of letter and to designate and enforce a chain of review for certain letters					
40.1.1.88	Provides capability for a user-friendly, English-text index that allows easy access to templates and easy retrieval of initial letters generated per requested parameters: business area, date of generation, topic, recipient name, etc.					
	<b>Reports</b>					
40.1.1.89	Provides capability for system-generated reporting to include, without limitation: <ul style="list-style-type: none"> <li>▪ Federal- and State-required report and distribution</li> <li>▪ Reports identified in Appendix 40, Attachment G of this RFP</li> <li>▪ Fiscal Agent operations and system performance</li> <li>▪ Contract compliance</li> <li>▪ Cost allocation</li> </ul>					



**APPENDIX 50, ATTACHMENT C, EXHIBIT 1**



Requirement #	Requirement Description	A	B	C	D	E
	<ul style="list-style-type: none"> <li>▪ Contract invoicing</li> <li>▪ Standard pre-formatted reports with parameters selection criteria</li> </ul>					
40.1.1.90	Provides capability for online access for users (based on role-based security) to reports, enabling downloads for export/import into multiple software formats and availability for use in multiple media					
40.1.1.91	Provides capability to maintain all reports that cannot be regenerated to reflect the report contents as originally represented					
	<b>Workflow Management</b>					
40.1.1.92	<p>Provides capability to maximize work queue technologies that enable a business rule empowered workflow, end-to-end enterprise-wide strategic solution that generates prioritized, sequential first-in/first-out delivery of work items that are generated as either media event or application event work items</p> <p>Provides capability to support:</p> <ul style="list-style-type: none"> <li>▪ Documentation retrieval (link to imaged documentation)</li> <li>▪ Alert agent on events such as work item creation, assignment, work item updates, and status changes</li> <li>▪ Assignment tracking and retrieval</li> <li>▪ Aging report(s)</li> <li>▪ Work item monitoring</li> <li>▪ Work item reassignment</li> </ul>					
40.1.1.93	Provides capability to input requests/inquiries into the workflow/imaging application to enable processing to be automated and forwarded to designated work and print queues					
40.1.1.94	Provides capability to move requests to the next work queue based on expertise required for completion					



**APPENDIX 50, ATTACHMENT C, EXHIBIT 1**



Requirement #	Requirement Description	A	B	C	D	E
40.1.1.95	Provides capability to allow the assignment or routing of tasks by the user					
40.1.1.96	Provides capability for tickler and/or to-do list capability					
40.1.1.97	Provides capability to support the tracking and resolution of contacts, including calls, on-site visits, override requests, prior approvals, and written inquiries					
40.1.1.98	Provides capability for the unlimited entry of notes with date/time stamp, user identity, and categorization as to type of note					
40.1.1.99	Provides capability to designate certain notes as confidential and restrict access to notes to authorized users					
40.1.1.100	Provides capability for automated work load balancing					
40.1.1.101	Provides capability for convenient, instant access to current and historical information without requiring a separate sign-on beyond the initial Replacement MMIS sign-on					
40.1.1.102	Provides capability to produce work management reports to include, without limitation, performance measures online by individual business unit and business process and compare them to actual performance					
40.1.1.103	Provides capability to use user-defined templates that support various workflow processes					
40.1.1.104	Provides capability for a graphical interface to support the development and maintenance of the business processes; provides capability to allow users to create a visual capability or flowchart that controls the sequencing of manual and automated tasks performed throughout the business cycle					
40.1.1.105	Provides capability of integrating with a rules engine					
40.1.1.106	Provides capability to allow State access to work queue to assist in evaluation and disposition of work queue items					



**APPENDIX 50, ATTACHMENT C, EXHIBIT 1**



Requirement #	Requirement Description	A	B	C	D	E
	<b>Rules Engine</b>					
40.1.1.107	Provides capability to register, classify, inquire, manage, and automate date-specific business rules in a graphical, user-friendly rules engine					
40.1.1.108	Provides capability to modify rules, allowing the application to be adaptable with the dynamic rules					
40.1.1.109	Provides capability for generating media events or application events as a result of the execution of a business rule					
40.1.1.110	Provides capability to structure in a modular concept so the same rules engine can be used by different services or be called as a service itself					
40.1.1.111	Provides capability for a debugging process that automatically analyzes and identifies logical errors (i.e., conflict, redundancy, and incompleteness) across business rules					
40.1.1.112	Provides capability to allow for rules to be tested against production data prior to installation					
40.1.1.113	Provides capability for a built-in rule review and approval process that will identify any conflicts in business rules as they are being developed					
40.1.1.114	Provides capability to track and report rules usage					
40.1.1.115	Provides capability to produce and maintain documentation regarding all business rules					
40.1.1.116	Provides capability for integration with a workflow management process					
40.1.1.117	Provides capability to identify impact of business rule changes to claims adjudication					
40.1.1.118	Provides capability to reuse business rules across processes					
40.1.1.119	Provides capability to change business rules independent of process					



**APPENDIX 50, ATTACHMENT C, EXHIBIT 1**

Requirement #	Requirement Description	A	B	C	D	E
<b>New Requirement</b> 40.1.1.120	Provides capability to apply Procedure Code Pricing (PR) File Cleanup business rules against current Procedure Code Pricing (PR) File					
	<b>Integrated Test Facility</b>					
40.1.1.121	Provides capability for an Integrated Test Facility (ITF) with multiple test environments to allow for different phases of testing to be conducted concurrently during the DDI Phase and throughout the life of the Contract					
40.1.1.122	Provides capability for the ITF environment to operate independently from production, either physically or logically separated, so that performance within the production and ITF environments are not adversely affected by the other, regardless of activity level					
40.1.1.123	Provides capability to maintain the ITF environment as a mirror image of the production system environment to be used for testing all Replacement MMIS changes throughout the life of the Contract					
40.1.1.124	Provides capability for the automated migration of new business areas and application fixes between the ITF environments and production environment					
40.1.1.125	Provides capability to perform assessments without affecting production and/or data					
40.1.1.126	Provides capability for State access to all test system files					
40.1.1.127	Provides capability for version control in the ITF					
40.1.1.128	Provides capability to synchronize the ITF with the production environment when updating the Replacement MMIS production system					
	<b>Training</b>					
40.1.1.129	Provides capability for computer-based-training (CBT) courses for all users (State staff, Fiscal Agent staff, county staff, local agency staff, and providers)					



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Requirement #	Requirement Description	A	B	C	D	E
40.1.1.130	Provides capability for online CBT courses for all Replacement MMIS application systems					
40.1.1.131	Provides capability for proficiency testing, quality reviews, and retraining, as needed, for Fiscal Agent staff					
40.1.1.132	Provides capability to deliver provider training through Web-based services and electronic media					
40.1.1.133	Provides capability for a Web Portal to access training news, schedules, training registration and evaluation forms, CBT and Web-based training content, provider bulletins, and frequently asked questions (FAQs) by provider type and subject					
40.1.1.134	Provides capability for the Web Portal to include document management, version control, and contextual queries related to Replacement MMIS rules and operations					
40.1.1.135	Provides capability for Web-accessible downloads of training documentation that will be synchronized with provider policy and billing updates					
40.1.1.136	Provides capability for a training evaluation tool to analyze and report to the State on training effectiveness					
	<b>Call Center Services</b>					
40.1.1.137	Provides capability for Customer Service Call Center/Help Desk to include, without limitation, hardware, software, and toll-free telephone access to operate the Customer Service Call Center/Help Desk System					
40.1.1.138	Provides capability for an automatic phone attendant that provides a hierarchical, menu-driven capability for directing calls to appropriate Replacement MMIS Program Fiscal Agent or State staff					
40.1.1.139	Provides capability to receive, appropriately route, and manage all telephone inquiries from Federal, State, local, and county workforce members, recipients, and in-state and out-of-state providers regarding prior approval, technical support, provider services, etc.					



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Requirement #	Requirement Description	A	B	C	D	E
40.1.1.140	Provides capability to integrate voice and electronic transactions into a single workflow with integrated queues that allow work blending and load balancing					
40.1.1.141	Provides capability to support requirements of Civil Rights Act for Persons of Limited English Proficiency (LEP) and Hearing Impaired					
40.1.1.142	Provides capability for call monitoring by supervisors and State monitors					
40.1.1.143	Provides capability for automated call-tracking of all calls received to include, without limitation, online display, inquiry, and updating of call records that will also be available to State staff					
40.1.1.144	Provides capability to maintain free-form notes for each call record, coordinate these notes in the document management and correspondence tracking business area, and make the notes available for State and Fiscal Agent access					
40.1.1.145	Provides capability for the automated population of call views with relevant recipient and provider information; provides capability for the system to track information such as time and date of call, identifying information on caller (provider, recipient, and others), call type, call category, inquiry description, customer service clerk ID for each call, and response description					
40.1.1.146	Provides capability to automatically fax back (or e-mail back, when there is no protected health information involved) to callers with attachments containing requested information, such as claims histories, copies of pertinent policy or rules, and provider letters					
40.1.1.147	Provides capability to transfer calls, along with all related documentation that was collected					
40.1.1.148	Provides capability for callers to interact with an automated attendant or speak to a customer service representative					
40.1.1.149	Provides capability for technical help desk to support inquiries on system processes and system troubleshooting from providers, value-added networks (VANs), State, and Fiscal					



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Requirement #	Requirement Description	A	B	C	D	E
	Agent users					
	<b>System Availability</b>					
40.1.1.150	Provides capability for the system to be consistently and persistently accessible to authorized users in compliance with the System Availability Policy in Appendix 40, Attachment I of this RFP					
40.1.1.151	Provides capability for the system to be available and substantially compliant with its complete specification for ninety-nine and six tenths (99.6) percent of the time on a monthly basis during production hours of operations, excluding planned system down-time					
40.1.1.152	Provides capability for transaction response time to be consistent for all users directly interacting with the production environment, based on a common Web Portal access for network access point, processed and returned to the network access point; provides capability for: <ul style="list-style-type: none"> <li>▪ Ninety (90) percent of transactions to occur in four (4) seconds or less</li> <li>▪ Ninety-five (95) percent of transactions to occur in five (5) seconds or less</li> <li>▪ Ninety-seven (97) percent of transactions to occur in six (6) seconds or less</li> <li>▪ Ninety-nine (99) percent of transactions to occur in seven (7) seconds or less</li> </ul>					
	<b>Customer Service Request Tracking System</b>					
40.1.1.153	Provides capability for online tracking and workflow management of requests for service					
40.1.1.154	Provides capability to track the system Change Management Life Cycle Phases, schedule, and work breakdown structure (WBS) for systems maintenance and modification requests					
40.1.1.155	Provides capability to track resources for all CSR work breakdown structure, including maintenance and modification requests during the DDI and Operations Phases					





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Requirement #	Requirement Description	A	B	C	D	E
40.1.1.156	Provides capability for tracking CSR status by multiple data elements consistent with the Change Management Process					
40.1.1.157	Provides capability to generate reports for request management tracking, with flexibility for variable content, format, sort, and selection criteria to meet State and Fiscal Agent reporting needs					
40.1.1.158	Provides capability to maintain accessibility to all completed project requests for analytical purposes throughout the life of the Contract					
	<b>Web Portal</b>					
40.1.1.159	Provides capability for Web Portal access to the Replacement MMIS by the State staff, providers, government employees, and the general public					
40.1.1.160	Provides capability for a Web Portal that adheres to the State's User Interface and Navigation requirements and simplified sign-on					
40.1.1.161	Provides capability for browser independence and to ensure the browser has broad usage (approximately 500,000 users nationally) and the version is consistent with State usage					
40.1.1.162	Provides capability to post announcements or alerts that are displayed at user sign-on					
40.1.1.163	Provides capability to maintain archives of posted announcements and non-provider specific alerts, including the date and message					
40.1.1.164	Provides capability to access, complete, and submit online surveys					
40.1.1.165	Provides capability to link to CBT course presentations					
40.1.1.166	Provides capability to create, organize by topic, and post FAQs and responses online					
40.1.1.167	Provides capability to maintain version history of previous forms, user manuals, etc.					



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Requirement #	Requirement Description	A	B	C	D	E
40.1.1.168	Provides capability to create configurable Web pages of Replacement MMIS functions					
40.1.1.169	Provides capability to view and download standard Replacement MMIS reports in a readable format					
40.1.1.170	Provides capability to request and view parameter-driven standard formatted reports					
40.1.1.171	Provides capability to link to stakeholder Web sites					
40.1.1.172	Provides capability to populate user/security profile-related data for Web Portal access prior to implementation					
	<b>Data Integrity</b>					
40.1.1.173	Provides capability for each record or file to be saved as created, not overwritten by updates or changes, to allow a historical review of individually dated versions					

**40.1.2 General Operational Requirements**

Requirement #	Requirement Description	A	B	C	D	E
	<b>Fiscal Agent Data Center and Offices</b>					
40.1.2.1	Fiscal Agent (DDI and Operations Phases) shall perform all Fiscal Agent functions at State-approved facilities and sites, including the Fiscal Agent's data center and any subcontractor locations unless otherwise contractually agreed on. These facilities and sites must comply with appropriate State and Federal privacy and physical safeguards.					
40.1.2.2	Fiscal Agent (Operations Phase) shall perform all operations, system maintenance, and modifications or other work under this Contract at prior-approved locations.					



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Requirement #	Requirement Description	A	B	C	D	E
40.1.2.3	Fiscal Agent (DDI and Operations Phases) shall locate its local facility within fifteen (15) miles of the State office at NC DHHS headquarters or as directed by the State.					
40.1.2.4	Fiscal Agent (DDI and Operations Phases) shall locate key personnel, business units, and the mailroom at the local site.					
40.1.2.5	Fiscal Agent (DDI and Operations Phases) shall include secure, private office space for three (3) State employees. Fiscal Agent shall also provide assistance and access to any operations, information, or data set elements necessary to support State staff responsibilities. The private office space should include, without limitation: <ul style="list-style-type: none"> <li>▪ Lockable desks</li> <li>▪ Ergonomically correct chairs</li> <li>▪ IBM-compatible PCs, monitors, and printers with appropriate LAN/WAN connections, Internet access, and e-mail access, at a minimum meeting State standards</li> <li>▪ Lockable file cabinets</li> <li>▪ Telephones</li> <li>▪ Office supplies.</li> </ul>					
40.1.2.6	Fiscal Agent (DDI and Operations Phases) shall provide a common area with three (3) or more computers for Internet access for State employees.					
40.1.2.7	Fiscal Agent (DDI and Operations Phases) shall retain ownership of the equipment issued to the State and shall procure, manage, and bear the cost of repairs or replacement, if required, during the life of the Contract.					
40.1.2.8	Fiscal Agent (DDI and Operations Phases) shall upgrade and maintain the personal computers (PCs) and desktop software issued by the Fiscal Agent for State use commensurate with Fiscal Agent PC and software upgrades.					
40.1.2.9	Fiscal Agent (DDI and Operations Phases) shall provide access for the on-site State staff					



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Requirement #	Requirement Description	A	B	C	D	E
	to use copier, scanner, and fax machines.					
40.1.2.10	Fiscal Agent (Operations Phase) shall provide equipment for traveling Fiscal Agent representatives that include laptops and cellular telephones that comply with Fiscal Agent's security plan.					
40.1.2.11	Fiscal Agent (DDI and Operations Phases) shall meet periodically as directed by the State to review programs, issues, and status with State operational area staff.					
	<b>Regulatory Compliance</b>					
40.1.2.12	<p>Fiscal Agent (DDI and Operations Phases) shall ensure that the Replacement MMIS incorporates compliance with appropriate Federal and State regulations, statutes, and policies concerning the protection of personally identifiable information and/or financial information. Regulations, statutes, and policies include, without limitation:</p> <ul style="list-style-type: none"> <li>▪ 45 CFR Parts 160, 164 (Health Insurance Portability and Accountability Act)</li> <li>▪ 42 U.S.C. 1320(d) (Public Health, Approval of Special Projects)</li> <li>▪ 42 CFR Parts 2, 51, 431 (Confidentiality of Mental Health and Substance Abuse information)</li> <li>▪ 42 CFR Parts 430-502 (Applicable to Medicare/Medicaid)</li> <li>▪ 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act.</li> <li>▪ Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d et. seq.</li> <li>▪ Title XIX, Section 1903 (42 U.S.C. 1396b) Social Security: Payment to States</li> <li>▪ Title XIX, Section 1927 (42 U.S.C. 1396r-8) Social Security: Payment for covered outpatient drugs</li> <li>▪ Federal MMIS certification standards</li> <li>▪ Financial Accounting Standards Board Generally Accepted Accounting Principles (GAAP)</li> <li>▪ Part 11 of the State Medicaid Manual</li> </ul>					



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Requirement #	Requirement Description	A	B	C	D	E
	<ul style="list-style-type: none"> <li>▪ North Carolina State Plans for Medicaid, Mental Health, Developmental Disabilities, and Substance Abuse, and Public Health</li> <li>▪ US DHHS Title VI Language Access Policy</li> <li>▪ Recipient eligibility policies from the NC DHHS Eligibility Information System (EIS) and the Common Name Data Service (CNDS)</li> <li>▪ NC State Law S 1048 (Identity Theft Protection Act)</li> <li>▪ 10A NCAC Chapters 21 &amp; 22, Medical Assistance</li> <li>▪ 10A NCAC 26B (Confidentiality Rules For Mental Health, Developmental Disabilities, and Substance Abuse Services)</li> <li>▪ 10A NCAC Chapter 45, DPH Payment Programs</li> <li>▪ NC DHHS OSP. 2005. DHHS Application Security Policy.</li> <li>▪ NC OSCIO. 2004. Application Security Policy with Guidelines, Statewide Information Technology Policy.</li> <li>▪ N.C.G.S. §126: State Personnel System</li> <li>▪ N.C.G.S. § 131D: Inspection and Licensing of Facilities</li> <li>▪ N.C.G.S. §131E: Health Care Facilities and Services</li> <li>▪ N.C.G.S. § 132: Public Records</li> <li>▪ The Privacy Act of 1974 5 U.S.C. § 552a</li> <li>▪ NCAC 10A Chapter 13 - NC Medical Care Commission</li> <li>▪ NCAC 10 A Chapter 14 - Division of Facility Services</li> <li>▪ NCAC 10A Chapter 26 - Mental Health, General</li> <li>▪ NCAC 10A Chapter 27 - Mental Health, Community Facility and Services</li> <li>▪ NCAC 10A Chapter 28 - Mental Health, State Operated Facilities</li> <li>▪ Government Auditing Standards (<a href="http://www.gao.gov/govaud/yb2003.pdf">http://www.gao.gov/govaud/yb2003.pdf</a>)</li> <li>▪ Information Systems Audit Standards (<a href="http://www.isaca.org/stand1.htm">http://www.isaca.org/stand1.htm</a>).</li> </ul>					



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Requirement #	Requirement Description	A	B	C	D	E
	<ul style="list-style-type: none"> <li>▪ NC DHHS Privacy and Security policies</li> <li>▪ Federal Section 508(<a href="http://www.section508.gov">http://www.section508.gov</a>)</li> </ul>					
	<b>Data Transfer and Conversion</b>					
40.1.2.13	Fiscal Agent (DDI and Operations Phases) shall lead the coordination with the State and the incumbent Fiscal Agent to perform all activities required for the successful transfer and conversion of legacy data for the DDI Phase and ongoing operations.					
40.1.2.14	Fiscal Agent (DDI and Operations Phases) shall provide the converted data to other State users and/or vendors as required for its processing needs identified by the State.					
40.1.2.15	Fiscal Agent (DDI and Operations Phases) shall provide hardware, software, and data support for the State during all phases of conversion and testing during the DDI Phase and throughout the life of the Contract.					
40.1.2.16	Fiscal Agent (DDI and Operations Phases) shall provide capability for storing all conversion-related artifacts in an easily retrievable format for access by the State for the later of life of the Contract or the commencement of processing by a subsequent contractor.					
40.1.2.17	Fiscal Agent (Operations Phase) shall convert all the claim TIFF images with claim numbers and all the associated claim electronic files and related index information from Legacy MMIS+ in an indexed and retrievable format.					
40.1.2.18	Fiscal Agent (Operations Phase) shall transfer, or convert where appropriate, all existing Legacy MMIS+ reports and report-related data, including reports in Legacy MMIS+ and/or stored in Report2Web (R2W).					
40.1.2.19	Fiscal Agent (Operations Phase) shall convert all legacy data from DMA, DMH, DPH, and the Migrant Health Program in the ORHCC.					
40.1.2.20	Fiscal Agent (Operations Phase) shall convert all legacy data from DMA, DMH, DPH, and the Migrant Health Program in the ORHCC to maintain benefit plans and data					



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Requirement #	Requirement Description	A	B	C	D	E
	relationships in a multi-payer aspect.					
40.1.2.21	Fiscal Agent (DDI Phase) shall convert and configure all business rules data into a rules engine.					
	<b>Interfaces</b>					
40.1.2.22	Fiscal Agent (DDI and Operations Phases) shall coordinate with the Reporting and Analytics (R&A) Vendor for the activities required for interfacing with R&A system.					
40.1.2.23	Fiscal Agent (DDI and Operations Phases) shall develop and maintain a complete inventory of Replacement MMIS internal and external interfaces with all relevant information throughout the life of the Contract.					
40.1.2.24	Fiscal Agent (DDI and Operations Phases) shall provide the specifications for interfaces that will be created and maintained throughout the life of the Contract.					
40.1.2.25	Fiscal Agent (DDI and Operations Phases) shall maintain data sharing capability, either manual or electronic as required, between the Replacement MMIS and DHSR.					
	<b>Security</b>					
40.1.2.26	Fiscal Agent (DDI and Operations Phases) shall be required to test backup and recovery plans annually through simulated disasters and lower-level infrastructure failures and provide awareness training on recovery plans to Fiscal Agent and State staff.					
40.1.2.27	Fiscal Agent (DDI Phase) shall assess and document the security threats and vulnerabilities for the proposed Replacement MMIS and shall implement the recommended controls and countermeasures to eliminate or reduce the associated risks.					
40.1.2.28	Fiscal Agent (DDI) shall develop, implement, and test an approach that will protect individually identifiable health information (IIHI) and protected health information (PHI) exchange during DDI Phase testing and conversion of legacy files, including acceptance and return or disposal of the data or media containing the data.					



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Requirement #	Requirement Description	A	B	C	D	E
40.1.2.29	Fiscal Agent (DDI Phase) shall develop, implement, and test a security incident response plan for responding to and reporting about service interruptions that do not lead to disaster recovery initiation, including a central means of collection and correlation of events for resolution and prevention of future problems.					
40.1.2.30	Fiscal Agent (DDI Phase) shall prepare for and comply with an internal security assessment/audit performed by NC DHHS representatives, based on documentation assembled during DDI Phase prior to the formal acceptance of Replacement MMIS.					
	<b>Data Protection Assurance</b>					
40.1.2.31	Fiscal Agent (DDI and Operations Phases) shall use commercial best practices to safeguard and protect physical data and media, documents, files, tapes, disks, diskettes, and other materials received from the State or the agency from loss, destruction, or erasure during performance of any contractual obligation. Practices shall include encryption technologies where applicable.					
40.1.2.32	Fiscal Agent (DDI and Operations Phases) shall use commercial best practices to safeguard and protect all information transmitted internally (within the Fiscal Agent Offices and network) or externally (beyond the Fiscal Agent network perimeter), protecting from alteration, capture or destruction. Practices shall include encryption technologies where applicable.					
40.1.2.33	Fiscal Agent shall provide all encryption or identification codes or authorizations that are necessary or proper for the operation of the licensed Software.					
40.1.2.34	Fiscal Agent (DDI and Operations Phases) shall provide audit evidence that all of its employees and third party contractors or subcontractors are subject to a non-disclosure and confidentiality agreement enforceable in North Carolina.					
	<b>Enterprise Security Approach</b>					
40.1.2.35	Fiscal Agent (DDI and Operations Phases) shall establish a technical management organizational structure to manage and protect the system and data for all environments					





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Requirement #	Requirement Description	A	B	C	D	E
	(e.g. development, test, load, UAT, production).					
40.1.2.36	Fiscal Agent (DDI and Operations Phases) shall demonstrate security awareness and provide training to Fiscal Agent and State staff in security policies and procedures.					
40.1.2.37	Fiscal Agent (Operations Phase) shall initiate, implement, test, and document on an annual basis a risk assessment policy and process to mitigate the overall enterprise security risk. This policy and plan shall include, without limitation, security process review, controls testing, mitigation procedures, personnel responsibility, and a process for State notification.					
40.1.2.38	Fiscal Agent (Operations Phase) shall develop the policy and plans for an annual Business Impact Analysis (BIA) and Business Criticality Analysis (BCA) that shall identify the impacts resulting from major disruptions and set or modify the appropriate Recovery Time Objectives (RTO) and Recovery Point Objectives (RPO). The RTOs and RPOs shall be established in consultation with and approved by the State.					
40.1.2.39	Fiscal Agent (DDI and Operations Phases) shall document policies to implement operational practices preventing any person(s) from establishing unauthorized control over the privacy, security, and processing of critical information. Operational procedures must conform to the NC DHHS Privacy and Security policies and procedures.					
40.1.2.40	Fiscal Agent (DDI and Operations Phases) shall maintain preventive, detective, and corrective audit and control features of the Replacement MMIS for the duration of the Contract in conformance with NC DHHS Privacy and Security Policy.					
40.1.2.41	Fiscal Agent (Operations Phase) shall assist the State in the annual Replacement MMIS security audit in accordance with Government Auditing Standards and Information Systems Audit Standards.					
40.1.2.42	Fiscal Agent (Operations Phase) shall be required to test backup and recovery plans annually through simulated disasters and lower-level failures and provide awareness training on recovery plans to Fiscal Agent and State staff. These tests must include, without limitation, joint participation by the Fiscal Agent and State staff.					



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Requirement #	Requirement Description	A	B	C	D	E
40.1.2.43	Fiscal Agent (DDI and Operations Phases) shall include, without limitation, audit evidence in system testing results (e.g., from system change management, upgrades, backups, etc.) cross-referenced to the expected test.					
	<b>Facility Access</b>					
40.1.2.44	Fiscal Agent (DDI and Operations Phases) shall implement controls to restrict access to data processing facilities and secured electronic or physical storage areas only to authorized individuals.					
40.1.2.45	Fiscal Agent (DDI and Operations Phases) shall provide accountability control to record facility access.					
40.1.2.46	Fiscal Agent (DDI and Operations Phases) shall record and supervise visitor and unauthorized user access to the Fiscal Agent's local site as well as any other sites used by the Fiscal Agent for Replacement MMIS processing or related activities and shall control access by unauthorized persons in conformance with NC DHHS Security Policy.					
40.1.2.47	Fiscal Agent (DDI and Operations Phases) shall safeguard processor site(s) through provision of uninterruptible power supply, power conditioning, internal environmental controls, fire retardant capabilities, and smoke and electrical detectors and alarms monitored by security personnel.					
40.1.2.48	Fiscal Agent (DDI and Operations Phases) shall restrict access to the facility server area during regular operations and in disaster and emergency situations in accordance with NC DHHS Security Policy.					
<b>New Requirement</b> 40.1.2.49	Fiscal Agent (DDI and Operations Phases) shall document policies to implement operational practices preventing unauthorized access to data or systems and prevent fraudulent activities that may result from the use of this information. Operational procedures must conform to the NC DHHS Privacy and Security policies and procedures.					
	<b>User Access Authentication and Authorization</b>					



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Requirement #	Requirement Description	A	B	C	D	E
40.1.2.50	Fiscal Agent (Operations Phase) shall provide all authorized users (employees, contractors, providers, citizens, other government workers) of the Replacement MMIS with access to appropriate business areas, databases, files, reports, archives, etc. through a common, consistent interface that restricts access based on authentication and authorization to appropriate data derived from role-based security.					
40.1.2.51	Fiscal Agent (Operations Phase) shall implement a managed workflow process for user account provisioning to eliminate the use of paper documents, ensure timely response to requests, and retain profiles for each user containing identification, authorization, organizational demographics, group memberships, and functional permissions derived from role-based security.					
	<b>Application Systems Change Control</b>					
40.1.2.52	Fiscal Agent (DDI and Operations Phases) shall perform security impact reviews of the change management process and share and collaborate on such reviews with State staff during the DDI Phase and throughout the life of the Contract.					
	<b>System Software Controls</b>					
40.1.2.53	Fiscal Agent (DDI and Operations Phases) shall control and monitor global access to systems and files such that no single individual will be able to affect system operations in isolation.					
40.1.2.54	Fiscal Agent (Operations Phase) shall monitor application platforms with industry standard technology and tools (hardware and software) and respond according to agreed-upon Service Level Agreements to developing problems.					
40.1.2.55	Fiscal Agent (DDI and Operations Phases) shall implement a comprehensive security monitoring solution to include, without limitation, industry standard technology and tools, including monitoring of wireless communication to monitor all aspects of the proposed solution (e.g., perimeter and internal network, server farms, operating systems, application software, and application data). Wireless communication at the Fiscal Agent site shall conform to the established NC DHHS Security Policy.					



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Requirement #	Requirement Description	A	B	C	D	E
40.1.2.56	Fiscal Agent (Operations Phase) shall retain copies of all server operating system and configuration software, system utilities and tools, network device configuration settings, and software license agreements in a location remote from the production server location, updating the copies as the operating environment changes.					
	<b>Logging and Reporting</b>					
40.1.2.57	Fiscal Agent (DDI and Operations Phases) shall identify and document all network activity events involved with the non-application operations of the Replacement MMIS.					
40.1.2.58	Fiscal Agent (Operations Phase) shall produce an alert notification for the Operations Incident Management function for follow up and review to every event that precipitates a security incident.					
	<b>Service Continuity Controls</b>					
40.1.2.59	Fiscal Agent (Operations Phase) shall initiate and document an Operations Incident Management function and group to act as a single, central point of notification, review, and assessment of all incidents that affect the continuous operations of the production environment and access to the data and information.					
40.1.2.60	Fiscal Agent (Operations Phase) shall respond to each network activity and personally observed incident with a mitigation plan that follows standard data collecting, evidence preservation practices, and organizational escalation procedures in accordance with guidelines established by the NC DHHS Privacy and Security Office					
	<b>Data Backup and Recovery</b>					
40.1.2.61	Fiscal Agent (Operations Phase) shall store backup system data and files separately from the production server storage at a remote location sufficiently distant from the production servers to prevent a simultaneous disastrous loss of both environments.					
40.1.2.62	The Fiscal Agent (Operations Phase) shall ensure that individual files, collections of files,					



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Requirement #	Requirement Description	A	B	C	D	E
	data base instances and other production information can be recovered from the back-up storage to production servers upon inadvertent deletion or corruption of the production information.					
	<b>Records Retention</b>					
40.1.2.63	Fiscal Agent (Operations Phase) shall archive information, including, without limitation, data files, images, transactions, master files, system and source program libraries, and other appropriate records and electronically store the information physically or logically separate from production information in compliance with State Record Retention Policy.					
	<b>User Interface and Navigation</b>					
40.1.2.64	Fiscal Agent (DDI and Operations Phases) shall employ industry standards and best practices for user interface design and navigation consistently throughout the Replacement MMIS throughout the life of the Contract.					
40.1.2.65	<p>Fiscal Agent (DDI and Operations Phases) shall standardize all views, windows, and reports, including:</p> <ul style="list-style-type: none"> <li>▪ Format and content of all views</li> <li>▪ All headings and footers</li> <li>▪ Current date and time.</li> </ul> <p>Zip codes shall display nine digits.</p> <p>All references to dates shall be displayed consistently throughout the system (MM/DD/YYYY).</p> <p>All data labels and definitions used shall be consistent throughout the system and clearly defined in user manuals and data element dictionaries.</p> <p>All Replacement MMIS-generated messages shall be clear, user-friendly, and sufficiently descriptive to provide enough information for problem correction.</p> <p>All Replacement MMIS views shall display the generating program identification name and/or number. The display shall be consistent from view to view.</p>					



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Requirement #	Requirement Description	A	B	C	D	E
<b>Workflow Management</b>						
40.1.2.66	Fiscal Agent (Operations Phase) shall perform manual workload balancing.					
40.1.2.67	Fiscal Agent (Operations Phase) shall perform work item reassignments.					
<b>Rules Engine</b>						
40.1.2.68	Fiscal Agent (Operations Phase) shall configure and maintain all business rules in the rules engine throughout the life of the Contract.					
40.1.2.69	Fiscal Agent (Operations Phase) shall maintain up-to-date business rule documentation.					
40.1.2.70	Fiscal Agent (Operations Phase) shall perform business rule changes on a release basis.					
<b>Integrated Test Facility</b>						
40.1.2.71	Fiscal Agent (DDI and Operations Phases) Fiscal Agent shall provide the State with access to the ITF as required for testing on site, from State office, and/or remotely throughout the life of the Contract.					
40.1.2.72	Fiscal Agent (DDI Phase) shall support a minimum of twenty-five (25) simultaneous State testers, either at the local Fiscal Agent site and/or remotely.					
40.1.2.73	Fiscal Agent (DDI and Operations Phases) shall coordinate with State agencies for online and batch testing and execute online and batch testing as required to support State applications throughout the life of the Contract.					
40.1.2.74	Fiscal Agent (DDI and Operations Phases) shall execute online testing and batch test cycles and related activities to support State testing.					
40.1.2.75	Fiscal Agent (DDI and Operations Phases) shall support all ITF functions, files, and data elements necessary to meet the RFP requirements.					



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Requirement #	Requirement Description	A	B	C	D	E
40.1.2.76	Fiscal Agent (DDI and Operations Phases) shall coordinate with the State and DHSR IT system vendor to perform appropriate system tests during implementation of the DHSR IT system.					
	<b>Training</b>					
40.1.2.77	Fiscal Agent (DDI and Operations Phases) shall develop training to incorporate policy, procedures, regulatory guidelines, business rules, and claim processes to ensure a comprehensive approach to meeting the training requirements of the State.					
40.1.2.78	Fiscal Agent (DDI and Operations Phases) shall develop State-approved training materials for all users and make them available online.					
40.1.2.79	Fiscal Agent (Operations Phase) shall submit the Training Plan to the State no less than ninety (90) days prior to the beginning of each Contract year.					
40.1.2.80	Fiscal Agent (DDI and Operations Phases) shall conduct instructor-led classroom training for all users prior to Replacement MMIS implementation and throughout the life of the Contract.					
40.1.2.81	Fiscal Agent (DDI and Operations Phases) shall provide and maintain a training classroom(s) and equipment within the Fiscal Agent's Raleigh, NC, facility, providing at least one (1) pre-scheduled classroom session per month for all users. Sessions shall accommodate up to fifty (50) attendees.					
40.1.2.82	Fiscal Agent (DDI and Operations Phases) shall monitor, track, and evaluate effectiveness of training using training industry standard methodologies.					
40.1.2.83	Fiscal Agent (DDI and Operations Phases) shall provide blended, consistent training for State, local agency, and Fiscal Agent staff for all Replacement MMIS application systems.					
40.1.2.84	Fiscal Agent (Operations Phase) shall report to the State monthly on Fiscal Agent staff training and proficiencies.					



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Requirement #	Requirement Description	A	B	C	D	E
40.1.2.85	Fiscal Agent (DDI and Operations Phases) shall develop instructor-led classroom and CBT courses for provider education and training for all provider types.					
40.1.2.86	Fiscal Agent (Operations Phase) shall conduct seventy (70) instructor-based training workshops annually on State-approved content in geographical areas across the State after Replacement MMIS implementation.					
40.1.2.87	Fiscal Agent (Operations Phase) shall participate in semi-annual Finance and Reimbursement Officers (FARO) conferences as requested by the State.					
40.1.2.88	Fiscal Agent (Operations Phase) shall plan, organize, and conduct the annual Medicaid Fair.					
40.1.2.89	Fiscal Agent (Operations Phase) shall conduct on-site training sessions based on claims processing performance criteria or requests from providers, billing groups, or State/county staff.					
	<b>Call Center Services</b>					
40.1.2.90	Fiscal Agent (Operations Phase) shall provide sufficient staff for all call centers and help desks so that ninety (90) percent of all phone calls are not on hold for more than sixty (60) seconds before a staff person, not an automated answering device, answers.					
40.1.2.91	Fiscal Agent (Operations Phase) shall provide sufficient staff and phone lines for all call centers and help desks so that less than one (1) percent of all phone calls are abandoned, dropped, or receive a busy signal.					
40.1.2.92	Fiscal Agent (Operations Phase) shall provide technical Help Desk support during all hours of system availability.					
	<b>LAN/WAN Management Operational Requirement</b>					
40.1.2.93	Fiscal Agent (Operations Phase) shall provide technical expertise for the management, performance, and configuration of the Replacement MMIS network, LAN/WAN					





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Requirement #	Requirement Description	A	B	C	D	E
	management, and support.					
	<b>Audit</b>					
40.1.2.94	Fiscal Agent (Operations Phase) shall provide assistance to the State, or any reviewing entity identified by the State, with resources, data, and reports in the audit of Fiscal Agent performance, compliance, and system reviews.					
40.1.2.95	Fiscal Agent (Operations Phase) shall contract with an independent qualified audit firm to perform a Statement on Auditing Standards (SAS) 70 audit of the Replacement MMIS and produce a SAS 70 Type 2 Report. The audit and report shall include the operations of the Fiscal Agent's local site as well as any other sites used by the Fiscal Agent for Replacement MMIS processing or related activities. Specific requirements of the SAS 70 Type 2 Report are identified in Appendix 40, Attachment D of this RFP.					
	<b>System/Software Maintenance</b>					
40.1.2.96	Fiscal Agent (Operations Phase) shall be required to perform system maintenance to the Replacement MMIS based on State-approved CSRs.					
40.1.2.97	Fiscal Agent (Operations Phase) shall develop specifications, impact statements, cost analysis, and consideration as to the long-term value of performing the maintenance requirements for the State's evaluation.					
40.1.2.98	Fiscal Agent (Operations Phase) shall perform timely updates to system and user documentation, desk procedures, provider manuals, and training materials prior to the release of changes into production.					
40.1.2.99	Fiscal Agent (Operations Phase) shall perform maintenance to include, without limitation: <ul style="list-style-type: none"> <li>▪ activities necessary for the system to meet the requirements described in the RFP;</li> <li>▪ activities related to file growth and partitioning;</li> <li>▪ support of updates to all files and databases;</li> </ul>					



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Requirement #	Requirement Description	A	B	C	D	E
	<ul style="list-style-type: none"> <li>▪ software and hardware updates, as directed by the State;</li> <li>▪ RDBMS routine activities;</li> <li>▪ LAN/WAN administration and maintenance to ensure performance standards are met;</li> <li>▪ activities necessary to ensure that all data, files, programs, utilities, and system and user documentation are current and that errors found are corrected;</li> <li>▪ file maintenance, including manual table entry and programming, to support file maintenance changes, performance tuning, capacity planning, backup and recovery tasks, and archival tasks;</li> <li>▪ all ongoing tasks, such as CPT, Healthcare Common Procedure Coding System (HCPCS), and Diagnosis-Related Group (DRG) International Classification of Diseases (ICD)-9/ICD-10 updates, to ensure system tuning, performance, response time, capacity planning, database stability, and processing conforming to the minimum requirements of this Contract;</li> <li>▪ changes to tables for edit criteria;</li> <li>▪ activities in support of updates to all files and databases, including the rules engine;</li> <li>▪ add new values or changes to existing values found within internal program tables;</li> <li>▪ enact rate changes, individual or mass adjustments, purging of files, research, system recycling, minor modifications, and repetitive requests that are done on a set frequency that have not been incorporated into the system by the Fiscal Agent, e.g., Healthcare Coordinator monthly payments, 1099s, monthly, quarterly, year-end, and fiscal year-end reporting;</li> <li>▪ process improvements;</li> <li>▪ State-approved recoupments and adjustments not related to errors and omissions that are the responsibility of the Fiscal Agent requiring programming support Operations Incident Reporting; and</li> <li>▪ Rules engine configuration and maintenance.</li> </ul>					



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Requirement #	Requirement Description	A	B	C	D	E
	<b>System Modifications</b>					
40.1.2.100	Fiscal Agent (DDI and Operations Phases) shall perform system modifications when the State or the Fiscal Agent determines that an additional requirement must be met or that a modification to an existing file structure or current processing (outside of those discussed above as maintenance activities) is needed. Fiscal Agent billing for modification shall be in compliance with Section 30 of this RFP.					
40.1.2.101	Fiscal Agent (DDI and Operations Phases) shall develop specifications, impact statements, cost analysis, and consideration as to long-term value of performing the modification requirements for the State's evaluation.					
40.1.2.102	Fiscal Agent (Operations Phase) shall perform timely updates to system and user documentation, desk procedures, provider manuals, and training materials prior to the release of the modification into production.					
40.1.2.103	Fiscal Agent (Operations Phase) shall allocate system modification tasks against productive hours.					
40.1.2.104	Fiscal Agent (DDI and Operations Phases) shall manage system modification activities using the change management process.					
40.1.2.105	Fiscal Agent shall submit to the State for review and approval all modifications and other work estimate prior to beginning the work.					
40.1.2.106	Fiscal Agent (Operations Phase) shall assess only productive work hours against the modification hour pools, and the hours shall directly contribute to the modification of the Replacement MMIS.					
40.1.2.107	Fiscal Agent (Operations Phase) shall not allocate supervisory or other project work accomplished by key personnel towards the productive hours. The hours devoted to supervision or management by non-key personnel may be counted as productive hours, but they can make up no more than fifteen (15) percent of the total hours reported.					



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Requirement #	Requirement Description	A	B	C	D	E
	<b>Data Integrity</b>					
40.1.2.108	Fiscal Agent (DDI and Operations Phases) shall maintain a copy of all documentation related to all versions of changed records and files that were saved and a mechanism to retrieve in their historical format					

**40.1.3 Personnel Staffing**

Requirement #	Requirement Description	A	B	C	D	E
40.1.3.1	The Fiscal Agent shall maintain documentation regarding current license and certification status for all who are required to be licensed or certified throughout the life of the Contract. The Fiscal Agent shall provide such documentation to the State, when requested.  Refer to Appendix 50, Attachment I.					

**40.2 Recipient Requirements**

**40.2.1 Recipient System Requirements**

Requirement #	Requirement Description	A	B	C	D	E
40.2.1.1	Provides capability for access to recipient data using any combination of name or partial name, date of birth (DOB), gender, Medicare Health Insurance Claim Number (HICN), and/or county					
40.2.1.2	Provides capability for access to recipient data using any recipient ID number or SSN without other qualifiers					
40.2.1.3	Provides capability for name and partial-name search through use of a proven					



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Requirement #	Requirement Description	A	B	C	D	E
	phonetic/mnemonic algorithm, such as Soundex or a State-approved alternative					
40.2.1.4	Provides capability to maintain an online audit trail of all updates to recipient data and provides online access to audit trail for all State-authorized individuals					
40.2.1.5	Provides capability to support classification of recipients into multiple concurrent eligibility groups by health benefit program and benefit plan based on State entities' concurrency rules					
40.2.1.6	Provides capability to accept and process online and batch update transactions of recipient data for all recipients from the State eligibility systems, EIS, CNDS, local managing entities (LMEs), and other State-authorized users					
40.2.1.7	Provides capability to perform editing of eligibility transactions and report on transactions that updated successfully, transactions that updated successfully but received soft edits, and transactions that did not update due to receiving hard edits					
40.2.1.8	Provides capability to identify and report on exact duplicate and potential duplicate recipient records within and across lines of business					
40.2.1.9	Provides capability for maintenance of current and historical recipient identification numbers					
40.2.1.10	Provides capability to de-link recipient data when it is discovered that a recipient's eligibility has been collapsed erroneously into another recipient or re-link recipient's eligibility that has been erroneously split out from the recipient; this includes eligibility data, TPL, buy-in data, prior approvals, service limits, consents, and any other data identified by the State					
40.2.1.11	Provides capability to use Enrollment Database (EDB) information to detect Medicare and Medicare HMO entitlement for use in claims processing					
40.2.1.12	Provides capability to maintain five (5) years of historical recipient information online and five (5) years near-line, including history of changes to name, DOB, SSN, and recipient address					



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Requirement #	Requirement Description	A	B	C	D	E
40.2.1.13	Provides capability for notes tracking by recipient to accommodate tracking of calls regarding claims, complaints, customer service, and TPL, and provides easy access to the call information by authorized users					
40.2.1.14	Provides capability for updating recipient letter templates with free-form text to support cases specific to a recipient data issue or specific applicant/recipient					
40.2.1.15	Provides capability to reconcile CNDS data with Replacement MMIS data each State business day in order to verify that all records and segments received through the CNDS interface are processed or are listed on error reports					
40.2.1.16	Provides capability to reconcile State-entity DMA eligibility data with the Replacement MMIS each State business day in order to verify that all records and segments received through the EIS interface are processed or are listed on error reports					
40.2.1.17**	Provides capability to reconcile DMH Accredited Standard Committee (ASC) X12N 834 transactions eligibility data with the Replacement MMIS each State business day in order to verify that all records and segments received via the 834 transaction are processed or are listed on error reports					
40.2.1.18	Provides capability for State staff to enter online recipient-specific overrides to the timely billing edit for claims processing					
40.2.1.19	Provides capability to receive and process State entities' Eligibility History data from DIRM or ITS prior to operational startup					
40.2.1.20	Provides capability for Recipient/Client Eligibility Cross-Reference data for State entities, including all CNDS updates by participating organizations as appropriate to the State entity					
40.2.1.21	Provides capability to allow access to the entire recipient record via a common CNDS ID for recipients with multiple cross-referenced IDs, regardless of the number of cross-references, including claims data, eligibility data, TPL data, buy-in data, prior approvals, service limits, and consents					



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Requirement #	Requirement Description	A	B	C	D	E
40.2.1.22	Provides capability to retain the CNDS ID used for Federal reporting when recipient IDs are combined					
40.2.1.23	Provides capability for online updates to the CNDS for maintenance of cross-reference and demographic information					
40.2.1.24	Provides capability for online updates for performing client “combine” functions when multiple CNDS IDs are identified for a single client, according to CNDS rules					
40.2.1.25	Provides capability to produce a report of CNDS cross-reference ID updates within and across lines of business					
40.2.1.26	Provides capability for online updates of fields not updated through the State’s eligibility update					
40.2.1.27	Provides capability to receive and process deductible information from the recipient eligibility record and make it available for claims processing					
40.2.1.28	Provides capability to process updates to recipients of North Carolina Health Choice for Children (NCHC) as any other recipient eligibility update (NCHC is equivalent to State Children's Health Insurance Program.)					
40.2.1.29	Provides capability to accept recipient eligibility segments from EIS and CNDS with no limitations on the number of eligibility segments maintained within the Replacement MMIS					
40.2.1.30	Provides capability to process and reconcile the full file of EIS and the Replacement MMIS recipient eligibility records					
40.2.1.31	Provides capability for transmission and receipt of buy-in data to and from CMS via DIRM interface in accordance with CMS Redesign practices					
40.2.1.32	Provides capability to produce buy-in update transactions for Warrant Calculation and Previously Unknown County Warrant Calculation for Medicare Parts A and B					



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Requirement #	Requirement Description	A	B	C	D	E
40.2.1.33	Provides capability to edit all buy-in transactions for completeness of required fields, reasonability of dates, accuracy of converted Railroad Retirement numbers, presence on the Replacement MMIS eligibility file, and unwanted duplication					
40.2.1.34	Provides capability for online inquiry into buy-in current status and full buy-in history for all affected individuals on the Replacement MMIS eligibility file(s)					
40.2.1.35	Provides capability to automatically create a buy-in deletion transaction in the month in which death of the recipient or termination of the Medicaid case is recorded on the Replacement MMIS file  Date of death and termination of the Medicaid case are included in the eligibility record received from EIS.					
40.2.1.36	Provides capability to process buy-in updates from CMS via DIRM interface in accordance with CMS Redesign practices					
40.2.1.37	Provides capability to produce reports after each buy-in update to identify all transactions received, all transactions that processed successfully, and all transactions that had errors, invalid data, and/or could not be matched to a recipient in accordance with CMS Redesign practices					
40.2.1.38	Provides capability to void eligibility segments					
40.2.1.39**	Provides capability for State staff to enter an online request for a recipient ID card					
40.2.1.40	Provides capability for system notification from MMIS Recipient business area to MMIS Managed Care business area whenever retroactive managed care enrollment/disenrollment occurs					
40.2.1.41	Provides capability to notify TPL electronically whenever retroactive Medicare enrollment occurs					
40.2.1.42	Provides capability to notify claims electronically whenever retroactive Medicaid eligibility occurs for a recipient eligible in another health benefit program					





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Requirement #	Requirement Description	A	B	C	D	E
40.2.1.43	Provides capability to create claim financial transactions for each CMS buy-in update record					
40.2.1.44	Provides capability to allow adjustments to buy-in claim financial transactions					
40.2.1.45	Provides capability to run the final buy-in cycle for receipt by CMS no later than the 25 <sup>th</sup> of each month  Date of final monthly cycle runs shall be directed by the State.					
40.2.1.46	Provides capability upon completion of the final cycle run to immediately produce buy-in final cycle reports on paper, if requested, and deliver to the State within two (2) business days					
40.2.1.47	Provides capability to accept and process updates to the EDB from CMS via DIRM interface					
40.2.1.48	Provides capability to accept and process updates to the Beneficiary Data Exchange (BENDEX) from the Social Security Administration via a DIRM interface					
40.2.1.49	Provides capability to edit online recipient update transactions for completeness, consistency, and valid values					
40.2.1.50	Provides capability to identify the correct eligibility group and associated premium using information on the recipient's eligibility record					
40.2.1.51	Provides capability to produce and send correspondence related to recipient premiums—including invoices, notices of non-payment, cancellation notices, receipts, and refunds—in the recipient's preferred language					
40.2.1.52	Provides capability to collect recipient premium payments					
40.2.1.53	Provides capability to produce refunds of recipient premiums					



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Requirement #	Requirement Description	A	B	C	D	E
40.2.1.54	Provides capability to process financial accounting records for premium payments and refunds					
40.2.1.55	Provides capability to produce reports for recipient premium payment and cost-sharing processes					
40.2.1.56	Provides capability to apply cost-sharing					
40.2.1.57	Provides capability to ensure cost-sharing does not exceed threshold for the family group					
40.2.1.58	Provides capability to associate multiple cases in a family together to ensure cost-sharing does not exceed threshold					
40.2.1.59	Provides capability to send recipient notices and Explanations of Benefits (EOB) in recipient's preferred language					
40.2.1.60	Provides capability to produce a Certificate of Creditable Coverage (COCC) for each recipient deleted/terminated from specified Medicaid coverage					
40.2.1.61	Provides capability to produce a COCC for a specific period if requested by the recipient/client or by the State					
40.2.1.62	Provides capability for an online request function to allow the State to request a COCC for a specific recipient for a specific period					
40.2.1.63	Provides capability to produce a Monthly Summary Report indicating all COCCs mailed to recipients per month that includes: <ul style="list-style-type: none"> <li>▪ Total number of COCCs mailed</li> <li>▪ Total number of COCCs mailed within five (5) days of date of termination/request</li> <li>▪ Total number of COCCs mailed later than five (5) days from the date of termination/request</li> </ul>					
40.2.1.64	Provides capability to use transfer of assets data on the Medicaid recipient record in					



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Requirement #	Requirement Description	A	B	C	D	E
	claims processing					
40.2.1.65	Provides capability to create a report of recipients with paid claims for targeted services for whom a transfer of assets indicator is not on file					
40.2.1.66	Provides capability to provide DIRM an electronic copy of the report of recipients with paid claims for targeted services for whom a transfer of assets indicator is not on file for publication for county Department of Social Services (DSS) agencies					
40.2.1.67	Provides capability to create a report of individuals with a transfer of assets sanction					
40.2.1.68	Provides capability to provide DIRM an electronic copy of the report of individuals with a transfer of assets sanction for publication for county DSS agencies					
40.2.1.69	Provides capability to create the Medicare Modernization Act (MMA) Enrollment File based on selection criteria provided by the State in the format specified by CMS					
40.2.1.70	Provides capability to include data in the MMA Enrollment File necessary to count the number of enrollees for the phased-down State contribution payment					
40.2.1.71	Provides capability to include records in the MMA Enrollment File for those individuals for whom the State has made an enrollment determination for the Part D low income subsidy					
40.2.1.72	Provides capability to transmit the MMA Enrollment File to DIRM for transmission to CMS					
40.2.1.73	Provides capability to process the MMA Enrollment Response File from CMS transmitted via DIRM interface					
40.2.1.74	Provides capability to produce a report of all records transmitted on the MMA Enrollment File					
40.2.1.75	Provides capability to produce a report of all records received on the MMA Response File, identifying any errors, records unable to be matched to a recipient on the Replacement MMIS, and records unable to be processed					



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Requirement #	Requirement Description	A	B	C	D	E
40.2.1.76	Provides capability for online access to MMA Response File records that were in error or unable to be matched with a recipient on the Replacement MMIS					
40.2.1.77	Provides capability for online access to a summary of the recipient's MMA Enrollment and Response File records					
40.2.1.78	Provides capability for online access to the MMA record selected from the summary					
40.2.1.79	Provides capability for online access to Medicare coverage data from EIS for Parts A, B, C, and D for Medicaid recipients					
40.2.1.80	Provides capability to accept and process Medicaid/Medicare coverage data from EIS and make it available for claims processing					
40.2.1.81**	Provides capability for online access to add, update, and inquire into Medicare data for DMH and DPH recipients					
40.2.1.82	Provides capability to produce eligibility extracts for contractors with whom DMA does business					
40.2.1.83	Provides capability to use CNDS governance rules to determine which demographic data has priority when a recipient is enrolled concurrently in multiple lines of business and benefit plans					
40.2.1.84	Provides capability for multiple types of recipient addresses per line of business (LOB)					
40.2.1.85	Provides capability for a Client Services Data Warehouse (CSDW) extract of recipient data					
40.2.1.86	Provides capability to produce letters/notices to applicants/recipients					
40.2.1.87	Provides capability to send, receive, and update Provider data between DHSR and the Replacement MMIS for placement of eligible recipient					



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Requirement #	Requirement Description	A	B	C	D	E
	<b>DPH Online Enrollment</b>					
40.2.1.88**	Provides capability to accept Web-submitted and hard copy financial eligibility applications (DHHS 3014) for program participation					
40.2.1.89**	Provides capability for enrollment instructions and guidelines for supporting functions by selected enrollment options					
40.2.1.90**	Provides capability to accept Web-submitted and hard copy supporting documentation for financial eligibility applications					
40.2.1.91**	Provides capability to upload attachments electronically and associate attachments with submitted financial eligibility applications					
40.2.1.92**	Provides capability to receive paper and facsimile documentation, scan it so it can be viewed online, and associate documentation with the submitted financial eligibility application					
40.2.1.93**	Provides capability to identify and assign the applicant's CNDS ID and associate/link it to the financial eligibility application in accordance with CNDS Governance Rules					
40.2.1.94**	Provides capability for State DPH staff to enter the status of the application as either complete or incomplete					
40.2.1.95**	Provides capability to place all applications in an online work queue for State DPH eligibility staff to review					
40.2.1.96**	Provides capability for State DPH staff to accept, reject, and/or modify income and deductions provided on the application and provides capability to indicate the reason income and/or deductions are rejected or modified					
40.2.1.97**	Provides capability for State DPH staff to indicate if an application is complete and ready for disposition					



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Requirement #	Requirement Description	A	B	C	D	E
40.2.1.98**	Provides capability to calculate recipient income based on information provided on an application and compare it to program thresholds to determine financial eligibility					
40.2.1.99**	Provides capability to electronically store and maintain DPH eligibility data in the Recipient business area					
40.2.1.100**	Provides capability to electronically store and maintain multiple addresses for one recipient, including correspondence mailing, pharmacy mailing, residence, and alternate and to maintain history of addresses					
40.2.1.101**	Provides capability to electronically store and maintain the name, mailing address, and agency of the application interviewer					
40.2.1.102**	Provides capability to electronically store and maintain the name, mailing address, and relationship of an individual other than the applicant/recipient to receive copies of notices and letters if requested					
40.2.1.103**	Provides capability to produce system-generated letters/notices of approvals or denials					
40.2.1.104**	Provides capability to maintain the necessary data elements to produce reports on demand with date span parameters based on application and/or recipient characteristics					
40.2.1.105**	Provides capability for inquiry selection for one (1) or more applications/records that meet specified criteria, by any of the following: <ul style="list-style-type: none"> <li>▪ Application/case number</li> <li>▪ Applicant name (partial or complete)</li> <li>▪ Applicant name phonetic (partial or complete)</li> <li>▪ CNDS ID,</li> <li>▪ SSN</li> <li>▪ Date of birth</li> </ul>					



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Requirement #	Requirement Description	A	B	C	D	E
40.2.1.106**	Provides capability to store abandoned or incomplete applications indefinitely					
40.2.1.107**	Provides capability to store and maintain all applications for program participation					
40.2.1.108**	Provides capability to maintain an audit trail to document time stamp and user ID information for all applications added to the application file					
40.2.1.109**	Provides capability to maintain an audit trail to document before and after image of changed data, time stamp of the change, and the user ID information for all changes made to the application data					
40.2.1.110**	Provides capability to document date and time of receipt of supporting documentation for applications					
40.2.1.111**	Provides capability to produce a weekly aging report that lists work queue status					
40.2.1.112**	Provides capability to produce identification cards for approved recipients; the card must identify the recipient, provide the recipient's identification number, and not contain eligibility information					
40.2.1.113	Provides capability for recipient lock-in/lock-out to a specific pharmacy and/or primary care provider and/or prescriber					
40.2.1.114	Provides capability for recipient lock-in/lock-out from a specific pharmacy and/or primary care provider and/or prescriber					
40.2.1.115	Provides capability for claims exceptions to process automatically when prior authorized by the lock-in/lock-out primary care provider or prescriber in accordance with State policy					
40.2.1.116	Provides capability for historical begin and end dates for each lock-in and lock-out segment, as well as the reason for lock-in/lock-out					
40.2.1.117	Provides capability for an unlimited number of lock-in/lock-out segments per recipient					



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Requirement #	Requirement Description	A	B	C	D	E
40.2.1.118	Provides capability for multiple concurrent active lock-in/lock-out segments of any type					
40.2.1.119	Provides capability for online inquiry and update into lock-in/lock-out segments					
40.2.1.120	Provides capability to maintain an audit trail of all changes to lock-in/lock-out segments					
40.2.1.121	Provides capability for online inquiry into audit trail					
40.2.1.122**	Provides capability for confidential enrollment (when a potential client is unable or unwilling to identify himself or herself) for DMH  These recipients will require separate tracking to avoid potential duplicate enrollment of applicants when they become clients.					
40.2.1.123	Provides capability to associate an individual with a specific provider, including long-term care and group living arrangements, with a begin and end date for each segment, including sponsoring agency, authorizer, level of care, date certified, date of next certification, and patient share of cost, including deductibles and patient liability					

**40.2.2 Recipient Operational Requirements**

Requirement #	Requirement Description	A	B	C	D	E
40.2.2.1	Fiscal Agent shall reconcile specified CNDS data with the Replacement MMIS each State business day. This reconciliation process will verify that all records and segments received through the CNDS interface are processed or are listed on error reports.					
40.2.2.2	Fiscal Agent shall reconcile specified State-entity DMA eligibility data with EIS each State business day. This reconciliation process will verify that all records and segments received through the EIS interface are processed or are listed on error reports.					
40.2.2.3**	Fiscal Agent shall reconcile specified State-entity DMH eligibility data with ASC X12N 834 transactions each State business day. This reconciliation process will verify that all					





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Requirement #	Requirement Description	A	B	C	D	E
	records and segments received via the 834 transaction are processed or are listed on error reports.					
40.2.2.4	Fiscal Agent shall coordinate with the applicable State entity to resolve Medicare enrollment problems.					
40.2.2.5	Fiscal Agent shall perform buy-in functions for the North Carolina Medicaid Program using automated and manual operating procedures.					
40.2.2.6**	Fiscal Agent shall support training requirements for LMEs, local health departments, Developmental Evaluation Centers/Children’s Developmental Services Agencies (DECs/CDSAs), DPH, and other State-approved local entities.					
40.2.2.7	Fiscal Agent shall communicate with recipients and employers regarding COCCs verbally and in written correspondence.					
40.2.2.8**	Fiscal Agent shall identify and assign the applicant’s CNDS ID and associate/link it to the financial eligibility application in accordance with CNDS Governance Rules.					

**40.2.3 Recipient Operational Performance Standards**

Requirement #	Requirement Description	A	B	C	D	E
40.2.3.1	Fiscal Agent shall provide online access to State entities’ eligibility edit/error reports by 7:00 A.M. Eastern Time each State business day.					
40.2.3.2	Fiscal Agent shall update the Replacement MMIS with batch eligibility data from each State entity by 7:00 A.M. Eastern Time each State business day.					
40.2.3.3	Fiscal Agent shall update each State entity’s Eligibility Data from online processes for State EIS, CNDS, LMEs, and DPH in near-real time.					



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Requirement #	Requirement Description	A	B	C	D	E
40.2.3.4	Fiscal Agent shall generate COCC and log the mail date for each COCC mailed. Fiscal Agent shall provide a monthly report with the number of recipients/clients terminated from each health plan and the number of COCC mailed within one (1) month of the termination.					

### 40.3 Eligibility Verification System Requirements

#### 40.3.1 EVS System Requirements

Requirement #	Requirement Description	A	B	C	D	E
40.3.1.1	Provides capability to receive and process ASC X12N 270/271 eligibility inquiry and response transactions in real-time and batch transactions					
40.3.1.2	Provides capability for inquiry via ASC X12N 270 transactions by recipient identification number, recipient full name and DOB, recipient partial name and DOB, and recipient SSN and DOB					
40.3.1.3	Provides capability for ensuring safeguards in responses via ASC X12N 271 transactions, including: <ul style="list-style-type: none"> <li>▪ Limiting access to eligibility information to authorized medical providers, VANs, and authorized State personnel only; and</li> <li>▪ Protecting the confidentiality of all recipient information</li> </ul>					
40.3.1.4	Provides capability for access to eligibility verification inquiry to inquire for dates of service within the preceding twelve (12) months					
40.3.1.5	Provides capability for an online audit trail of all inquiries and verification responses made, the information conveyed, and to whom the information was conveyed					
40.3.1.6	Provides capability to report all EVS transactions online, segregating transaction data by provider and source of inquiry (Automated Voice Response System [AVRS], Web, EVS,					



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Requirement #	Requirement Description	A	B	C	D	E
	etc.) at a minimum					
40.3.1.7	Provides capability to uniquely identify and track each EVS recipient eligibility verification inquiry and response					
40.3.1.8	Provides capability to issue a reference number to a provider for any Medicaid eligibility inquiry and response issued from the EVS					

**40.3.2 EVS Operational Requirements**

Requirement #	Requirement Description	A	B	C	D	E
40.3.2.1	Fiscal Agent shall obtain State approval and demonstrate acceptable test results to the State prior to implementing each VAN.					
40.3.2.2	Fiscal Agent shall provide necessary file specifications and testing assistance to VANs on how to access EVS.					
40.3.2.3	Fiscal Agent shall provide the necessary instructions to State and VANs in how to use the EVS. <i>Note: The VANS are responsible for training the providers who contract with them.</i>					

**40.3.3 EVS Operational Performance Standards**

Requirement #	Requirement Description	A	B	C	D	E
40.3.3.1	Fiscal Agent shall provide for a response from the EVS in three (3) seconds or less ninety-eight (98) percent of the time, twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year.					



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Requirement #	Requirement Description	A	B	C	D	E
40.3.3.2	Fiscal Agent shall provide applicable documentation and successful test data for State approval within ten (10) State business days prior to VAN Replacement MMIS implementation.					
40.3.3.3	Fiscal Agent shall ensure the EVS is available ninety-nine and nine tenths (99.9) percent of the time, twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year, except for scheduled downtimes.					

## 40.4 Automated Voice Response System Requirements

### 40.4.1 AVRS System Requirements

Requirement #	Requirement Description	A	B	C	D	E
40.4.1.1	Provides AVRS capability and toll-free telephone access for providers and Medicaid recipients to access information from the Replacement MMIS AVRS, twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year except for agreed-upon scheduled down-time for maintenance					
40.4.1.2	Provides capability for an online audit trail of all inquiries and verification responses made, the information conveyed, and to whom the information was conveyed					
40.4.1.3	Provides capability for eligibility verification inquiry by recipient identification number, or SSN and DOB, and date of service					
40.4.1.4	Provides capability for access to eligibility verification for dates of service within the preceding 365 days					
40.4.1.5	Provides capability for access to eligibility verification for dates of service not greater than the current date for Medicaid recipients					
40.4.1.6**	Provides capability for access to eligibility verification for dates of service not greater than					



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Requirement #	Requirement Description	A	B	C	D	E
	the current date plus 365 days for DPH recipients					
40.4.1.7	Provides capability for system-generated monthly reporting of AVRS daily system availability checks					
40.4.1.8	Provides capability for an AVRS menu Help option, accessible at any time during the call, which allows callers a choice of being transferred to the Fiscal Agent call center or being directed to a specific Web site where detailed, written instructions are available					
40.4.1.9	Provides capability for menu options to distinguish between NC DHHS provider and Medicaid recipient callers; designs cascading options appropriate to these two (2) caller types					
40.4.1.10	Provides capability for AVRS to repeat to caller the recipient's full name and spelling of full name exactly as defined in the Recipient business area					
40.4.1.11	Provides capability to process inquiries made by enrolled providers entering either a National Provider Identifier (NPI) or a legacy provider ID number (for atypical providers)					
40.4.1.12	Provides capability to process inquiries made by Medicaid recipients entering the recipient's Medicaid ID number, DOB, and SSN					
40.4.1.13	Provides capability to report all AVRS transactions online, segregating transaction data by caller type (provider or recipient), inquiry type (eligibility, claim status, etc.), and inquiry source (AVRS, Web, EVS, etc.)					
40.4.1.14**	Provides capability to allow access by providers, aides, potential employers, etc. via AVRS to the Division of Health Service Regulation (DHSR) Health Care Personnel Registry (HCPR) and the DHSR Nurse Aide Training & Registry (NATRA) for inquiry on DHSR registry information					
40.4.1.15	Provides capability to allow callers to interact with the AVRS by interactive voice response (IVR) or by touch-tone telephone keypad					
40.4.1.16	Provides capability to retain and transfer all information entered and received when the					



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Requirement #	Requirement Description	A	B	C	D	E
	caller chooses to be transferred to the Fiscal Agent call center					
40.4.1.17	Provides capability to switch from English to other languages for all Medicaid recipient inquiry options					
40.4.1.18	Provides capability to refer or transfer recipient calls for information about additional translator services					
40.4.1.19	Provides capability for providers to enter real-time requests for prior approval adjudication via AVRS					
40.4.1.20	Provides capability to interface with the communication solution that will execute a fax verification (and/or e-mail verification, if no protected health information is involved) of entry, approval, or denial of a prior approval request					
40.4.1.21	Provides capability for providers to request printed copies of their Remittance Advice (RA) statements					
40.4.1.22	Provides capability for call flows for the following provider inquiry types: <ul style="list-style-type: none"> <li>▪ Claim status</li> <li>▪ Checkwrite</li> <li>▪ Drug coverage</li> <li>▪ Procedure code pricing</li> <li>▪ Modifier verification</li> <li>▪ Procedure code and modifier combination</li> <li>▪ Procedure code pricing for Medicaid Community Alternatives Program services</li> <li>▪ Prior approval for procedure code</li> <li>▪ Medicaid dental benefit limitations</li> <li>▪ Medicaid refraction and eyeglass benefits</li> <li>▪ Medicaid prior approval for durable medical equipment (DME), orthotics, and</li> </ul>					



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Requirement #	Requirement Description	A	B	C	D	E
	prosthetics <ul style="list-style-type: none"> <li>▪ Prior Approval for DPH benefits</li> <li>▪ Recipient eligibility, enrollment, and Medicaid service limits</li> <li>▪ Sterilization consent and hysterectomy statement inquiry</li> <li>▪ Referrals</li> <li>▪ Medicaid Carolina ACCESS Emergency Authorization Overrides</li> </ul>					
40.4.1.23	Provides capability to allow the Carolina ACCESS referring provider and the Carolina ACCESS referred-to provider to inquire on the primary care provider referral status					
40.4.1.24	Provides capability for call flows for responses for the following Medicaid recipient inquiry types: <ul style="list-style-type: none"> <li>▪ Medicaid eligibility</li> <li>▪ Managed care enrollment information, including the primary care provider name, address, and daytime and after-hours phone numbers</li> <li>▪ Third party liability</li> <li>▪ Medicare coverage</li> <li>▪ Well child checkup dates</li> <li>▪ Hospice eligibility</li> </ul>					
40.4.1.25	Provides capability to uniquely identify and track each AVRS recipient eligibility verification inquiry and response					
40.4.1.26	Provides capability to return a reference number to a provider for any DMA/Medicaid eligibility verification inquiry and response issued from the AVRS					
40.4.1.27	Provides capability for Web-accessible downloads of AVRS training documentation that will be synchronized with application system updates					



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Requirement #	Requirement Description	A	B	C	D	E
	<b>Web Inquiry</b>					
40.4.1.28	Provides capability for an online, HIPAA-compliant inquiry of all information available via the AVRS					
40.4.1.29	Provides capability to return a reference number to a provider for any DMA/Medicaid eligibility verification inquiry and response issued from the Web					
40.4.1.30	Provides capability for Medicaid recipient access to recipient eligibility and enrollment information, including: <ul style="list-style-type: none"> <li>▪ Medicaid eligibility</li> <li>▪ Carolina ACCESS enrollment information to include the primary care provider name, address, and daytime and after-hours phone numbers</li> <li>▪ Third party liability</li> <li>▪ Medicare coverage</li> <li>▪ Well child checkup dates</li> <li>▪ Hospice eligibility</li> </ul>					
40.4.1.31	Provides capability for the option to switch from English to non-English (Spanish, Russian, Hmong, etc.) static content on each non-secure page that is targeted for consumers/recipients for all Medicaid recipient inquiry options					
40.4.1.32	Provides capability for the option to switch from English to non-English (Spanish, Russian, Hmong, etc.) static content on each secure page targeted for recipients for all Medicaid recipient inquiries and responses					
40.4.1.33	Provides capability for English and non-English (Spanish, Russian, Hmong, etc.) versions of all downloadable written materials targeted for recipients/consumers					
40.4.1.34	Provides capability to report all Web inquiry transactions online, segregating transaction data by provider and recipient inquiry, by inquiry type (eligibility, claim status, etc.), and					





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Requirement #	Requirement Description	A	B	C	D	E
	inquiry source (AVRS, Web, EVS, etc.)					
40.4.1.35	Provides capability to uniquely identify and track each online recipient eligibility verification and nurse aide verification inquiry and response					
40.4.1.36**	Provides capability to provide access to providers, nurse aides, potential employers of nurse aides, etc., via the Web query functionality to the DHSR Health Care Personnel Registry (HCPR) and the DHSR Nurse Aide Training & Registry (NATRA) for inquiry on DHSR registry information					
40.4.1.37	Provides capability to report all Web Inquiry transactions online, segregating transaction data by caller type (provider or recipient), inquiry type (eligibility, claim status, etc.) and inquiry source (AVRS, Web, EVS, etc.)					

**40.4.2 AVRS Operational Requirements**

Requirement #	Requirement Description	A	B	C	D	E
40.4.2.1	Fiscal Agent shall perform daily systems check to ensure that the AVRS electronic interface is working properly and report the findings monthly.					
40.4.2.2	Fiscal Agent shall perform transaction analysis by hour of the day, indicate the number of transactions processed, and report the findings monthly.					
40.4.2.3	Fiscal Agent shall perform telephone analysis by hour of the day, track the number of transactions, number of transactions with less than a ten-second (10-second) response time, and number of transactions with greater than a ten-second (10-second) response time, and report the findings monthly.					
40.4.2.4	Fiscal Agent shall operate and maintain a Web site for providers and recipients, nurse aides, potential employers of nurse aides, etc. twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year, with the exception of State-approved scheduled maintenance.					



### 40.4.3 AVRS Operational Performance Standards

Requirement #	Requirement Description	A	B	C	D	E
40.4.3.1	Fiscal Agent shall provide for a response from the AVRS in three (3) seconds or less ninety-eight (98) percent of the time, twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year, with the exception of State-approved scheduled system maintenance.					
40.4.3.2	Fiscal Agent shall provide system checks to the AVRS daily and log the findings.					
40.4.3.3	Fiscal Agent shall provide monthly AVRS logs within five (5) State business days from the end of the previous month.					
40.4.3.4	Fiscal Agent shall ensure the Web inquiry functionality is available twenty-four (24) a day, seven (7) days a week, three hundred sixty-five (365) days a year, except during State-approved maintenance periods.					

## 40.5 Provider Requirements

### 40.5.1 Provider System Requirements

Requirement #	Requirement Description	A	B	C	D	E
	<b>Provider Enrollment</b>					
40.5.1.1	Provides capability to interactively enroll eligible providers in a multi-payer environment using a single enrollment strategy to eliminate process redundancy					
40.5.1.2	Provides capability to generate and accept electronic and hard copy supporting documentation for enrollment and re-enrollment or verification functions					
40.5.1.3	Provides capability for provider access to online and batch enrollment functionality					



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Requirement #	Requirement Description	A	B	C	D	E
40.5.1.4	Provides capability for secure log-on that allows providers to retrieve and update incomplete application or check status of a submitted application					
40.5.1.5	Provides capability for a provider to download application for paper submission					
40.5.1.6	Provides capability to edit against duplicate provider record during enrollment, addition, or change processes					
40.5.1.7	Provides capability to image, link, and reference all provider correspondence, enrollment applications, contracts, and supporting documentation to be retrieved by the Fiscal Agent or State-authorized staff					
40.5.1.8	Provides capability for a provider to select services that will be provided at a practice location or by the provider entity					
40.5.1.9	Provides capability to capture and maintain demographic information of the LME from which the provider is seeking and/or has received endorsement					
40.5.1.10	Provides capability to capture and maintain Medicare numbers and crossover information					
40.5.1.11	Provides capability for a provider to access enrollment functions, download enrollment package, recall a saved application, submit, and check the status of an application online					
40.5.1.12	Provides capability to receive, image, and link hard copy attachments, executed contracts, and signatory documentation to the provider application					
40.5.1.13	Provides capability to capture and maintain all provider data elements necessary to support the enrollment, credentialing, inquiry, and participation by program					
40.5.1.14	Provides capability to electronically store multiple historic provider identifiers					
40.5.1.15	Provides capability to accept and electronically store multiple occurrences of provider demographic information, including e-mail					



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Requirement #	Requirement Description	A	B	C	D	E
40.5.1.16	Provides capability to capture information on provider billing agents					
40.5.1.17	Provides capability to present customized enrollment application options					
40.5.1.18	Provides capability to edit data during the enrollment process to ensure that all required information is captured based on provider's participation and contractual requirements					
40.5.1.19	Provides capability to present enrollment instructions and guidelines for supporting functions by selected enrollment options					
40.5.1.20	Provides capability to system-generate application attachments based on required criteria and affirmative responses					
40.5.1.21	Provides capability to identify and enroll providers classified as special, atypical, State-funded, or funded by other assistance programs					
40.5.1.22	Provides capability to identify and assign unique identifiers to providers					
40.5.1.23	Provides capability to support a time-limited, abbreviated, or expedited enrollment process that collects a limited amount of information to enroll a provider for a limited period					
40.5.1.24	Provides capability to capture the requestor, sender, and status for all hard copy provider enrollment form requests					
40.5.1.25	Provides capability to capture all enrollment events					
40.5.1.26	Provides capability to accept and electronically store electronic funds transfer (EFT) information					
40.5.1.27	Provides capability to flag provider records to support operational activities					
40.5.1.28	Provides capability to capture and validate nine-digit (9-digit) zip code to geographic location					



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Requirement #	Requirement Description	A	B	C	D	E
40.5.1.29	Provides capability to store abandoned or incomplete applications for ninety (90) days					
40.5.1.30	Provides capability to capture provider eligibility, program eligibility, and participation status codes with associated affiliations, effective dates, and end dates					
40.5.1.31	Provides capability to capture the providers' preference to use electronic submittal of claims, remittance, and/or EFT					
40.5.1.32	Provides capability to capture, link, and reference multiple provider affiliations, specialties, and taxonomies, by program, with associated effective and end dates					
40.5.1.33	Provides capability to capture providers' legal business filing status, including Non-profit, Corporate, State-owned, Federally owned, For Profit, and Tribal-owned					
40.5.1.34	Provides capability to capture, verify, and cross-reference provider ownership information					
40.5.1.35	Provides capability to recognize predefined events requiring State determination or intervention					
40.5.1.36	Provides capability to accommodate NPI and multiple associated taxonomies					
40.5.1.37	Provides capability to validate all NPIs					
40.5.1.38	Provides capability for option selection for a provider to indicate preference to receive a paper RA					
40.5.1.39	Provides capability for the system to capture electronic signatures					
40.5.1.40	Provides capability to use workflow functionality to forward a completed application for credentialing/re-credentialing or verification					
40.5.1.41	Provides capability for batch and/or online real-time access between EIS, Mental Health Eligibility Inquiry, CSDW, Medicaid Quality Control, Online Verification, Automated Collection and Tracking System (ACTS), and Health Information System (HIS) and the					



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Requirement #	Requirement Description	A	B	C	D	E
	Replacement MMIS using API and SOA concepts					
40.5.1.42	Provides capability to send, receive, and update data between DHHS and the Replacement MMIS in support of provider participation for enrollment functionality					
	<b>Provider Credentialing</b>					
40.5.1.43	Provides capability to conduct provider credentialing and source verification of provider participation criteria and requirements					
40.5.1.44	Provides capability for credentialing to include Office of Inspector General (OIG) participation "exclusion" data or capability to receive and employ OIG file interface					
40.5.1.45	Provides capability for credentialing process to include criminal background checks and query of the North Carolina State Provider Penalty Tracking "exclusions" data					
40.5.1.46	Provides capability to restrict or eliminate provider billable services if the service requirements are no longer supported (by endorsement, certification, or licensure) with associated begin and end date by service					
40.5.1.47	Provides capability to send and receive electronic communications to support credentialing data verifications					
40.5.1.48	Provides capability to exclude a provider from licensure requirements based on provider type or category					
40.5.1.49	Provides capability to generate notification to providers of status, changes, enrollment, termination, credentialing, re-verification, penalties, and termination					
40.5.1.50	Provides capability to capture and electronically store critical credentialing data missing from current Legacy MMIS+ to support licensure, credentialing, and verification processes					
40.5.1.51	Provides capability to share licensure, endorsement, and accreditation information with issuing agencies, authorized State entities, and users					



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Requirement #	Requirement Description	A	B	C	D	E
40.5.1.52	Provides capability to send notification to a provider of impending renewal					
40.5.1.53	Provides capability to send notification to providers who failed to respond to renewal information requests					
40.5.1.54	Provides capability to send, receive, and update data between DHHS and the Replacement MMIS in support of provider credentialing functionality					
	<b>Provider Maintenance</b>					
40.5.1.55	Provides capability to present to the provider selected data for verification and update					
40.5.1.56	Provides capability to support different business rule definitions by program and services to be provided					
40.5.1.57	Provides capability to make State-approved forms available online					
40.5.1.58	Provides capability to process online requests for generation and distribution of provider contracts					
40.5.1.59	Provides capability to accept and process online requests for additions and changes to the provider data					
40.5.1.60	Provides capability to capture, identify, and report suspected duplicate provider identification numbers and applicable expiration dates					
40.5.1.61	Provides capability to capture, update, and maintain Clinical Laboratory Improvement Amendments (CLIA) information for providers					
40.5.1.62	Provides capability to track, identify, and provide notification the status of licenses, certifications, endorsements, and State-defined participation requirements or criteria					
40.5.1.63	Provides capability to systematically suspend and notify providers who do not meet enrollment or participation criteria					



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Requirement #	Requirement Description	A	B	C	D	E
40.5.1.64	Provides capability to cross-reference all provider identifiers that correspond to the providers' tax identification/reporting number					
40.5.1.65	Provides capability for online access of providers to training materials, training registrations, and tracking, including audit history of all provider trainings					
40.5.1.66	Provides capability to generate on-demand reports with date span parameters for provider data					
40.5.1.67	Provides capability to enter and maintain tax and financial information, including budget codes for accessing State funds					
40.5.1.68	Provides capability to capture data regarding agency-specific provider incentives, sanctions, withholds, and review processes by issuing agency with beginning and end dates					
40.5.1.69	Provides capability to capture the providers who participate in the Competitive Acquisition Program with begin and end dates by program					
40.5.1.70	Provides capability to suspend, sanction, or terminate providers					
40.5.1.71	Provides capability to identify and report on out-of-state provider claims denied for non-enrollment					
40.5.1.72	Provides capability to maintain 1099 and associated payment summary data					
40.5.1.73	Provides capability to identify and reference ownership across multiple occurrences and entities					
40.5.1.74	Provides capability to generate provider notifications of licensure, certification, accreditation, and endorsement renewals or expirations and monitor all response activity					
40.5.1.75	Provides capability for providers to enter requested updates to data and identify instances that require operational review					





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Requirement #	Requirement Description	A	B	C	D	E
40.5.1.76	Provides capability to identify to the State those providers with issues under review, giving the State equal access to work queue and documents to support the business decision process					
40.5.1.77	Provides capability to identify providers for whom mail has been returned and suppress all printing and claims activity					
40.5.1.78	Provides capability to place the provider on pre-payment, post-payment, payment review, compliance payment withholds, and denial as directed by the State					
40.5.1.79	Provides capability to leverage electronic listserv technology to allow providers to register for notifications and facilitate communications					
40.5.1.80	Provides capability for online access by State-authorized users to view and update information on sanctioned providers by LOB					
40.5.1.81	Provides capability to perform manual and automated updates to provider data					
40.5.1.82	Provides capability for online real-time access to Provider data using API and SOA concepts between EIS and the Replacement MMIS					
40.5.1.83	Provides capability for a daily provider table extract					
40.5.1.84	Provides capability for online, real-time responses to EIS and DIRM applications for all provider data processing transactions					
40.5.1.85	Provides capability to send, receive, and update data between DHHS and the Replacement MMIS in support of provider maintenance functionality					
	<b>Provider Training</b>					
40.5.1.86	Provides capability for online automated provider training and related documentation access					



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Requirement #	Requirement Description	A	B	C	D	E
40.5.1.87	Provides capability to capture and maintain provider-written, verbal, or electronic correspondence requesting an on-site visit or training					
40.5.1.88	Provides capability for automated workflow functionalities to process call center and provider training requests and educational monitoring activities					
40.5.1.89	Provides capability for an online provider training tutorial that can be tailored by selection to facilitate training in a variety of subject matters					
40.5.1.90	Provides capability to image, maintain, and make accessible all (current and historic) course instructional materials					
40.5.1.91	Provides capability to image instructional materials, training evaluations, and other correspondence linked to a site visit to the provider record					
40.5.1.92	Provides capability to track and report on provider requested visits					
40.5.1.93	Provides capability for online and on-site training evaluation questionnaires for providers to complete					
40.5.1.94	Provides capability to develop a State-approved training evaluation process					
40.5.1.95	Provides capability to maintain and submit to the State provider training sessions participants					
40.5.1.96	Provides capability to identify providers with a claims denial rates of twenty (20) percent or higher					
40.5.1.97	Provides capability to maintain State-approved instructional materials for viewing and retrieval					
40.5.1.98	Provides capability for initial and updated State-approved Provider Basic Training Tutorials to be available through Web access					



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Requirement #	Requirement Description	A	B	C	D	E
	<b>Secure, Browser-Based, Web-Enabled Capability To Record and Track All Verbal Communication between State/Fiscal Agent and Providers</b>					
40.5.1.99	Provides capability to record, track, and report on provider and recipient communication					
40.5.1.100	Provides capability to make provider contact data accessible and retrievable					
40.5.1.101	Provides capability to report on queries for call-related data					
40.5.1.102	Provides capability for communication tracking business area to interface with other MMIS functional areas					
40.5.1.103	Provides capability for individual access to query tools					
40.5.1.104	Provides capability to auto-populate Replacement MMIS provider data into the Web-based provider enrollment and maintenance functions					

**40.5.2 Provider Operational Requirements**

Requirement #	Requirement Description	A	B	C	D	E
	<b>General</b>					
40.5.2.1	Fiscal Agent shall provide State-authorized access to the Provider database.					
40.5.2.2	Fiscal Agent shall receive and process provider complaints and summarize this activity in the Status Report.					
40.5.2.3	Fiscal Agent shall respond to and report on activities and outcomes of all inquiries referred by the State.					
40.5.2.4	Fiscal Agent shall perform imaging of all provider documents, contracts, agreements,					



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Requirement #	Requirement Description	A	B	C	D	E
	attachments, training and publication material and forms, and on-site visitation documentation, linking them to the provider for viewing and retrieval by State and Fiscal Agent staff.					
40.5.2.5	Fiscal Agent shall provide the capability to link provider applications in PDF format for retrieval via a document management system.					
40.5.2.6	Fiscal Agent shall initiate and complete re-credentialing procedures on all providers who have not been previously credentialed and on providers whose data indicates expiration of any license, accreditation, certification, or other authorizing agencies. All re-credentialing and credentialing should be completed within twelve (12) months of contract start up.					
40.5.2.7	Fiscal Agent shall generate and distribute provider contract renewals to providers seventy-five (75) days before expiration.					
40.5.2.8**	Fiscal Agent shall accept, process, and maintain DMH attending-only provider records entered by the LME					
	<b>Provider Enrollment, Credentialing, and Verification</b>					
40.5.2.9	Fiscal Agent shall implement at the direction of the State suspension or termination action for providers whose licenses have been revoked or suspended by State licensing or accrediting bodies.					
40.5.2.10	Fiscal Agent shall conduct activities to suspend, terminate, or withhold payments, percentages, and incentives from providers under investigation by State or Federal agencies at the sole discretion of the State.					
40.5.2.11	Fiscal Agent shall implement provider sanctions, as directed by the State.					
40.5.2.12	Fiscal Agent shall initiate recoupment/collection of claims and non-claims payments made subsequent to the effective date of an action or sanction, as directed by the State.					
40.5.2.13	Fiscal Agent shall send enrollment information and instructions to a provider whose					



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Requirement #	Requirement Description	A	B	C	D	E
	claims have denied for non-enrollment.					
40.5.2.14	Fiscal Agent shall retain all active and historical provider documents, contracts, participation agreements, and supporting documentation for control, balance, audit, and State retrieval.					
40.5.2.15	Fiscal Agent shall capture and maintain information on all billing agents, including information necessary to identify and contact billing agents and providers using each billing agent within a specified timeframe.					
40.5.2.16	Fiscal Agent shall test potential Trading Partners to be implemented into MMIS production and maintain signed and State-approved Trading Partner Agreements.					
40.5.2.17	Fiscal Agent shall obtain and maintain all executed EFT Agreements.					
40.5.2.18	Fiscal Agent shall create and distribute to each independent enrolled provider or provider site a New Provider Participation Packet.					
40.5.2.19	Fiscal Agent shall respond to provider requests for participation in a NC DHHS program.					
40.5.2.20	Fiscal Agent shall review applications and contracts for completeness, original signature, and required participation criteria.					
40.5.2.21	Fiscal Agent shall update provider data based on information received during the credentialing, re-credentialing, and subsequent enrollment of the provider.					
40.5.2.22	Fiscal Agent shall initiate communication to providers advising them of the potential for suspension of services.					
40.5.2.23	Fiscal Agent shall route any incomplete credentialing or re-credentialing requests to the State for final disposition as to the provider's initial or ongoing participation.					
	<b>Urgent Reviews</b>					



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Requirement #	Requirement Description	A	B	C	D	E
40.5.2.24	Fiscal Agent shall perform "Urgent Reviews" when the State or Fiscal Agent has become aware of negative provider information that may affect the provider's participation status.					
40.5.2.25	Fiscal Agent shall route imaged data regarding Urgent Review through Workflow to the Quality Review/Appeals Coordinator for assessment.					
40.5.2.26	Fiscal Agent shall send a system-generated letter to the provider advising disposition of the case and appeal process procedures.					
40.5.2.27	Fiscal Agent shall notify the State's Medical Board or other appropriate agencies of its intent to suspend/terminate a provider's participation.					
	<b>Appeals</b>					
40.5.2.28	Fiscal Agent shall receive, image, and link provider appeals correspondence to the provider record.					
40.5.2.29	Fiscal Agent shall system-generate appeal letters advising the provider of the date the appeal request is received and that a written response shall be sent within thirty (30) days.					
40.5.2.30	Fiscal Agent shall ensure the Review/Appeals Coordinator obtains any additional information to provide to the State Review Committee to support an informed decision.					
40.5.2.31	Fiscal Agent shall route appeals and all supporting documentation to the State Review Committee Work Queue for disposition.					
40.5.2.32	Fiscal Agent shall update Provider data with the completed dates and disposition of appeal information.					
	<b>Provider Communications</b>					
40.5.2.33	Fiscal Agent shall staff a separate Provider communications business function area to include toll-free telephone lines that are staffed from 8 A.M. to 5:00 P.M. Eastern Time					



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Requirement #	Requirement Description	A	B	C	D	E
	Monday through Friday, except for State-approved holidays.					
40.5.2.34	Fiscal Agent shall respond to all verbal provider inquiries immediately. If an immediate response is not possible, then a written or verbal response shall be provided within two (2) business days.					
40.5.2.35	Fiscal Agent shall track and report on all State-referred or provider-initiated calls and/or complaints.					
40.5.2.36	Fiscal Agent shall respond in writing to written provider inquiries within five (5) business days of the date of receipt.					
40.5.2.37	Fiscal Agent shall refer questions regarding eligibility and program benefits to the State.					
40.5.2.38	Fiscal Agent shall refer questions regarding rates and budgets to the State.					
40.5.2.39	Fiscal Agent shall respond to all other provider inquiries as referred by the State.					
40.5.2.40	Fiscal Agent shall track and trend the number and nature of inquiries or complaints and status of resolution, referring clarification of policy issues to the State.					
40.5.2.41	Fiscal Agent shall coordinate and conduct all training for new and ongoing State and Fiscal Agent employees on Fiscal Agent MMIS procedures.					
	<b>Provider Publications</b>					
40.5.2.42	Fiscal Agent shall prepare and post provider publications and instructions online.					
40.5.2.43	Fiscal Agent shall publish approved bulletins via e-mail and Web.					
40.5.2.44	Fiscal Agent shall provide the State with current update of MMIS-related forms to be accessible via the State's Web site.					
40.5.2.45	Fiscal Agent shall use the workflow management tools to publish drafts and receive approvals of all provider publications, e.g., bulletins, training materials, standard letters,					



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Requirement #	Requirement Description	A	B	C	D	E
	etc.					
	<b>Provider Training</b>					
40.5.2.46	Fiscal Agent shall present mock training sessions to the State for approval prior to conducting provider training workshops.					
40.5.2.47	Fiscal Agent shall determine topics for workshops by assessing and targeting provider types with special need.					
40.5.2.48	Fiscal Agent shall track and report on provider requested visits.					
40.5.2.49	Fiscal Agent shall implement annual marketing plans for electronic commerce options.					
40.5.2.50	Fiscal Agent shall conduct provider workshops at State-approved locations.					
40.5.2.51	Fiscal Agent shall assist the State with annual meetings of billing providers.					
40.5.2.52	Fiscal Agent shall assist the State with quarterly training conferences.					
40.5.2.53	Fiscal Agent shall distribute on-site training evaluation questionnaires for providers to complete.					
40.5.2.54	Fiscal Agent shall analyze completed evaluation questionnaires and provide the State with a compiled summary report within five (5) business days from the training seminar date.					
40.5.2.55	Fiscal Agent shall maintain and submit to the State lists of provider training session participants.					
40.5.2.56	Fiscal Agent shall prepare State-approved online provider enrollment and billing instructions, ensuring the inclusion of all revisions and policy-related communications, such as special bulletins and/or newsletters, in the format and number specified by the State.					





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Requirement #	Requirement Description	A	B	C	D	E
40.5.2.57	Fiscal Agent shall ensure the accuracy and consistency of initial and ongoing updated State-approved tutorials.					
40.5.2.58	Fiscal Agent shall ensure that whenever changes are made that affect the information available on the tutorials that State-approved changes are made as a part of the CSR change documentation, provider publication/ALERT, or as directed by the State.					
40.5.2.59	Fiscal Agent shall maintain State-approved instructional materials for viewing and retrieval.					
40.5.2.60	Fiscal Agent shall provide training workshop materials and evaluations imaged and electronically available with ninety-nine and nine tenths (99.9) percent accuracy.					
	<b>Imaging Provider Communications</b>					
40.5.2.61	Fiscal Agent shall image all provider written communications.					
	<b>Imaging Provider On-Site Visit Materials and Evaluation</b>					
40.5.2.62	Fiscal Agent shall perform imaging of all materials and the provider on-site evaluation applicable to a provider site visit, linking to the provider identification number for complete profile data retrieval.					
	<b>Imaging Provider Training Workshop Materials and Provider Evaluation Forms</b>					
40.5.2.63	Fiscal Agent shall perform imaging of all Provider Training Workshop materials and Provider Training Evaluations, linking to the provider identification number for complete profile data retrieval.					
40.5.2.64	Fiscal Agent shall provide training to State staff in the use of the Customer Call Center System, initially and on an ongoing basis.					
40.5.2.65	Fiscal Agent shall provide all Customer Service Call Center reports according to State specification.					



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Requirement #	Requirement Description	A	B	C	D	E
40.5.2.66	Fiscal Agent shall maintain up-to-date complete system and user documentation.					
40.5.2.67	Fiscal Agent shall develop workflow processes for customer service support activities.					
	<b>E-mail Communications</b>					
40.5.2.68	Fiscal Agent shall produce listserv lists that are updated as appropriate to new enrollments, disenrollments, and provider change requests for individual or mass communications based on State protocols and approval for types of communications.					
	<b>Recording/Tracking Provider/Recipient Verbal Communications</b>					
40.5.2.69	Fiscal Agent shall ensure recording and tracking verbal communications with provider and recipients are available for use between the hours of 7:00 A.M. to 11:00 P.M. Eastern Time Monday through Friday and from 7:00 A.M. to 6:00 P.M. Saturday and Sunday.					
40.5.2.70	Fiscal Agent shall perform daily system checks to ensure that the recording/tracking business area is functioning as designed and provides system logging of check date, time, operator, comments, and reporting as directed by the State.					
40.5.2.71	Fiscal Agent shall provide State-approved instructional materials and secure, browser-based, Web-enabled tutorial for use of the Recording/Tracking Provider/Recipient Communications function/query tool.					
40.5.2.72	Fiscal Agent shall provide appropriate staff to monitor and support the continuous availability of the recording/tracking query tool.					

**40.5.3 Provider Operational Performance Standards**

Requirement #	Requirement Description	A	B	C	D	E
40.5.3.1	Fiscal Agent shall log and image all hard copy provider applications received within one					



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Requirement #	Requirement Description	A	B	C	D	E
	(1) State business day of receipt.					
40.5.3.2	Fiscal Agent shall initiate credentialing and source verification to ensure participation guidelines are met on all completed applications within three (3) business days.					
40.5.3.3	Fiscal Agent shall complete and approve all providers for participation who have no negative responses to credentialing requirements within two (2) State business days of receipt of all data necessary to adjudicate the application.					
40.5.3.4	Fiscal Agent shall send approval letters and other State-required information within one (1) State business day of provider participation approval.					
40.5.3.5	Fiscal Agent shall send denial letters and other State-required information within one (1) State business day of provider participation denial.					
40.5.3.6	Fiscal Agent shall initiate Urgent Reviews within one (1) State business day of receipt of any adverse provider information.					
40.5.3.7	Fiscal Agent shall acknowledge receipt of provider appeal requests within one (1) State business day of receipt.					
40.5.3.8	Fiscal Agent shall ensure that all appeals are adjudicated within thirty (30) calendar days of receipt unless permission for delay is received from the State.					
40.5.3.9	Fiscal Agent shall provide the State with an extract of the MMIS Provider tables each business night.					
40.5.3.10	Fiscal Agent shall support online real-time access between EIS, Mental Health Eligibility Inquiry, Medicaid Quality Control, Online Verification, ACTS, and HIS and the Replacement MMIS using API and SOA concepts, from 7:00 A.M. until 7:00 P.M. Eastern Time Monday through Friday, including non-State business days when EIS is available for online processing, and from 10:00 A.M. to 5:00 P.M. Eastern Time on weekends when EIS is available for online processing.					
40.5.3.11	Fiscal Agent shall provide online real-time access to provider data for State-designated					



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Requirement #	Requirement Description	A	B	C	D	E
	staff using API and SOA concepts between EIS and the Replacement MMIS 7:00 A.M. until 8:00 p.m. Eastern Time Monday through Friday, including non-State business days when EIS is available for online processing, and from 10:00 A.M. to 5:00 P.M. Eastern Time on weekends and when EIS is available for online processing.					
40.5.3.12	Fiscal Agent shall provide batch access to provider data using API and SOA concepts between EIS and the Replacement MMIS from 5:30 P.M. Eastern Time Monday through Friday until batch processing is completed.					
40.5.3.13	Fiscal Agent shall provide online real-time access to Provider data for State-designated staff using API and SOA concepts between EIS and the Replacement MMIS.					
40.5.3.14	Fiscal Agent shall provide initial and ongoing updated e-mail listservs based on initial and ongoing provider enrollments, disenrollments, and change requests the same day the transaction occurs ninety-nine and nine tenths (99.9) percent of the time.					
40.5.3.15	Fiscal Agent shall provide initial and ongoing capability for recording and tracking communications with providers and recipients during State business days between the hours of 7:00 A.M. to 11:00 P.M. Eastern Time Monday through Friday and from 7:00 A.M. to 6:00 P.M. Saturday and Sunday ninety-nine and nine tenths (99.9) percent of the time.					
40.5.3.16	Fiscal Agent shall provide monthly system check logs in the content, frequency, format, and media as directed by the State.					
40.5.3.17	Fiscal Agent shall produce State-approved initial and ongoing updates to training materials and secure, browser-based, Web-enabled tutorials in the content, frequency, format, and all media as directed by the State.					

## 40.6 Reference Requirements

### 40.6.1 Reference System Requirements

Requirement #	Requirement Description	A	B	C	D	E
40.6.1.1	Provides capability for necessary data to accommodate multiple population groups, their benefit packages, and payment methodologies					
40.6.1.2	Provides capability for online access to all Reference and pricing data					
40.6.1.3	Provides capability to accept online and batch updates, additions, and deletions to all Reference data with the capability to make changes to individual records or mass changes to groups or classes/records					
40.6.1.4	Provides capability to identify all covered and non-covered ICD-9/ICD-10 Diagnosis codes and any field value differences based upon a match of the Replacement MMIS Diagnosis Codes to the Diagnosis Update Tape/data					
40.6.1.5	Provides capability to produce a report that demonstrates the differences of all covered and non-covered ICD-9/ICD-10 Diagnosis codes and any field value differences based upon a match of the Legacy MMIS+ Diagnosis Codes to the Diagnosis Update Tape/Data for State use in determining appropriateness to update ICD-9/ICD-10 data					
40.6.1.6	Provides capability for diagnosis codes to be accessible from the National Council of Prescription Drug Programs (NCPDP) claims and physician drug program					
40.6.1.7	Provides capability to configure maximum rates and algorithms that permit rates to be assigned based on one of the following for all providers: <ul style="list-style-type: none"> <li>▪ Financial payer</li> <li>▪ Billing provider (i.e., single county or multi-county)</li> <li>▪ Population group</li> <li>▪ Procedure code</li> <li>▪ Begin and end date of service</li> </ul>					



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Requirement #	Requirement Description	A	B	C	D	E
	<ul style="list-style-type: none"> <li>▪ Attending provider (i.e., single county or multi-county)</li> <li>▪ Recipient</li> </ul>					
40.6.1.8	Provides capability to allow reformatting of automated files to develop or update fee schedules and/or rate files					
40.6.1.9	Provides capability for system logging of receipt date of each Reference File Maintenance Request, file maintenance initiation completion date, operator completing request, and supervisor validation date					
40.6.1.10	Provides capability for parameter-driven, ad hoc activity logging reports					
40.6.1.11	Provides capability to ensure appropriate tracking, controls, and audit logs are associated with all file updates					
40.6.1.12	Provides capability to link Reference File updates to applicable edits/audits					
40.6.1.13	<p>Provides capability to maintain the diagnosis data set using State-approved number of characters of the ICD-9/ICD-10 coding system that supports relationship between diagnosis code and claim information, including:</p> <ul style="list-style-type: none"> <li>▪ Valid age</li> <li>▪ Valid gender</li> <li>▪ Family planning indicator</li> <li>▪ Health Check indicator</li> <li>▪ Prior approval requirements</li> <li>▪ Reference indicator</li> <li>▪ TPL, emergency, accident trauma diagnosis, and cause code/indicator</li> <li>▪ Inpatient length of stay criteria</li> <li>▪ Description of the diagnosis</li> </ul>					



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Requirement #	Requirement Description	A	B	C	D	E
	<ul style="list-style-type: none"> <li>▪ Attachment required</li> <li>▪ Primary and secondary diagnosis code usage</li> <li>▪ Cross-reference to procedure codes</li> <li>▪ Drug by designated parameters</li> </ul>					
40.6.1.14	<p>Provides capability for online, updateable edit disposition tables and files that contain unlimited edit numbers with:</p> <ul style="list-style-type: none"> <li>▪ Description of edit</li> <li>▪ Description of edit for RA per RA media</li> <li>▪ RA print indicator, exception print detail, or list indicator</li> <li>▪ Disposition, force indicator, deny indicator, location code, prior approval override indicator, location override per claim type, per claim media, per program, per provider</li> <li>▪ Cross-referencing edits/audits</li> <li>▪ Information line</li> </ul>					
40.6.1.15	Provides capability to audit HCPCS codes and associated National Drug Codes (NDCs) against pharmacy NDCs to prevent duplicative services					
40.6.1.16	Provides capability to maintain an online, updateable claims Edit Resolution Manual that reflects correct processes for adjudicating edits and audits					
40.6.1.17	Provides capability to cross-reference new CPT codes and ICD-9/ICD-10 codes to Replacement MMIS edits and audits that support the code's data set within the same or specified range					
40.6.1.18	Provides capability to generate a report of edits/audits associated with codes that will be end-dated					
40.6.1.19	Provides capability to categorize edits/audits					



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Requirement #	Requirement Description	A	B	C	D	E
40.6.1.20	Provides capability to link each procedure code, diagnosis code, revenue code, dental code, etc. to the associated current and reverse (historical) edit					
40.6.1.21	Provides capability to create online Edit Manuals that enables access by edit or specific procedure code, revenue code, diagnosis code, dental code, etc. that displays: <ul style="list-style-type: none"> <li>▪ Edit relationships</li> <li>▪ Other procedure, revenue, diagnosis, dental codes</li> <li>▪ Modifiers related</li> <li>▪ Sex, age indicators (by day, month, year)</li> <li>▪ State Memo effective date with a link to a separate promulgated policy file to obtain policy or related detail information</li> <li>▪ Any other parameters that drive the edit</li> </ul>					
40.6.1.22	Provides capability to upload State-approved HCPCS updates from CMS, including Resource-Based Relative Value Scale (RBRVS)					
40.6.1.23	Provides capability for a procedure code data set that contains the current five-character (5-character) HCPCS/CPT code and can accommodate the future six-character (6-character) HCPCS codes, second-level HCPCS codes, State-specific local Level III codes, and ICD-9 procedure codes and can accommodate the future ICD-10 procedure codes, acceptance of a one-character (1-character) or a two-character (2-character) field for HCPCS pricing modifier(s); and at a minimum, the following elements: <ul style="list-style-type: none"> <li>▪ Valid tooth surface codes and tooth number/quadrant designation</li> <li>▪ Date-specific pricing segments by program code, provider taxonomy, and/or provider type and or specialty</li> <li>▪ Five (5) date-specific pricing segments, including two (2) occurrences of pricing action</li> <li>▪ Five (5) status code segments with effective beginning and end dates for each segment</li> </ul>					





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Requirement #	Requirement Description	A	B	C	D	E
	<ul style="list-style-type: none"> <li>▪ Indicator of covered/not-covered and effective and end dates by program code</li> <li>▪ Allowed amount for each pricing segment</li> <li>▪ Multiple modifiers and the percentage of the allowed price applicable to each modifier or procedure code/modifier combination</li> <li>▪ State-specified restrictions on conditions to be met for a claim to be paid, including, but not limited to:               <ul style="list-style-type: none"> <li>○ Recipient eligibility</li> <li>○ Pricing Action Code</li> <li>○ Category of service</li> <li>○ Specialty</li> <li>○ Lab certification</li> <li>○ Recipient age/sex restrictions</li> <li>○ Allowed diagnosis codes</li> <li>○ Prior approval required</li> <li>○ Medical review required</li> <li>○ Place of service</li> <li>○ Pre- and post-operative days</li> <li>○ Appropriate diagnosis</li> <li>○ Acceptable place of service</li> <li>○ Units of service</li> <li>○ Once-in-a-lifetime indicator</li> <li>○ Attachments required</li> <li>○ Valid provider type/specialty</li> <li>○ NDC codes and units</li> </ul> </li> </ul>					



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Requirement #	Requirement Description	A	B	C	D	E
	<ul style="list-style-type: none"> <li>○ Claim type</li> <li>○ Purge criteria</li> <li>○ Provider subspecialty</li> <li>○ Drug Coverage (effective/term dates)</li> <li>○ Health Check reporting indicator</li> <li>○ Family Planning indicator</li> <li>○ Family Planning Waiver Indicator</li> <li>▪ Narrative language of procedure codes in both short and long description</li> <li>▪ Indication of when or whether claims for the procedure can be archived from online history (such as once-in-a-lifetime procedures)</li> <li>▪ Indication of TPL actions, such as cost avoidance, benefit recovery, or pay and chase by procedure code</li> <li>▪ Indication of third party payers, non-coverage by managed care organizations by managed care organization type</li> <li>▪ Other information, such as accident/trauma indicators for possible TPL, Federal cost-sharing indicators, and Medicare coverage indicator</li> </ul>					
40.6.1.24	<p>Provides capability to maintain Pharmacy Point-of-Sale (POS) reference files that include:</p> <ul style="list-style-type: none"> <li>▪ NDC number</li> <li>▪ Generic Code Number (GCN) or formulation ID</li> <li>▪ Generic Code Number-Sequence (GCN-Sequence) or clinical formulation ID</li> <li>▪ Therapeutic class-specific (TxCL) or Therapeutic class code (General Classification Code 3 [GC3])</li> <li>▪ Ingredient list ID (HICL-S, relational and non-relational)</li> <li>▪ HICL sequence number</li> </ul>					



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Requirement #	Requirement Description	A	B	C	D	E
	<ul style="list-style-type: none"> <li>▪ Med ID</li> <li>▪ Routed DF Med ID</li> <li>▪ Routed MED ID</li> <li>▪ Med Name ID</li> <li>▪ HIC Sequence</li> <li>▪ Generic name (GNN)</li> <li>▪ Ingredient List ID (HICL)</li> <li>▪ Brand name</li> <li>▪ Label name</li> <li>▪ Manufacturer</li> <li>▪ Enhanced Therapeutic Classification (ETC) system</li> <li>▪ American Hospital Formulary (AHF) classification</li> <li>▪ Universal Product Code (UPC)</li> </ul> <p>Search criteria should also include edit description, claim exceptions, explanation of benefits (EOBs), and NCPDP rejects.</p>					
40.6.1.25	Provides capability for the procedure code data set to contain a minimum of five (5) years of data to support claims online history					
40.6.1.26	Provides capability to upload annual Diagnosis Related Group (DRG) and Medicare Code Editors (MCE) software based on a Federal fiscal year no later than October 1 <sup>st</sup> each year and report all errors that occur in processing of the annual DRG code update					
40.6.1.27	Provides capability to receive all weekly, biweekly, or daily drug updates from the drug update service vendor and upload within one (1) business day, including all new modules developed by the Vendor					
40.6.1.28	Provides capability to process updates from the contracted or State-owned drug update service upon receipt without overwriting exact updates previously made by the State or at					



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Requirement #	Requirement Description	A	B	C	D	E
	the request of the State					
40.6.1.29	Provides capability to produce a report that identifies contracted drug updates bypassed identifying the data on the database and the update received from the State-owned or contracted drug update service					
40.6.1.30	Provides capability for State-specified customized updates to the drug file from a contracted or State-owned drug update service					
40.6.1.31	Provides capability for specific “facility rate times DRG weight” as well as appropriate facility disproportionate share information for inpatient reimbursement annually					
40.6.1.32	Provides capability to maintain rate files for all services and institutional rates to support pricing that conforms to program requirements					
40.6.1.33	Provides capability to create NC Title XIX Tables Manual and Edit Resolution Manuals					
40.6.1.34	Provides capability to apply edit criteria across claim types, provider type, and specialty types of service, provider taxonomy, provider type and/or specialty by procedure code and therapeutic class, generic product indicator, generic code, and all other drug codes					
40.6.1.35	Provides capability to electronically store State-assigned EOB and ESC message descriptions					
40.6.1.36	Provides capability to store unlimited policy changes received via State/Fiscal Agent Memo regarding file changes for procedure codes, diagnosis codes, revenue codes, dental codes, etc.					
40.6.1.37	Provides capability to electronically store accommodation rate data					
40.6.1.38	Provides capability to maintain indefinitely procedure codes that have timeframe limitations					
40.6.1.39	Provides capability to electronically store modifier information with appropriate multiple modifier and payment calculations					



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Requirement #	Requirement Description	A	B	C	D	E
40.6.1.40	Provides capability to produce electronic copies of Reference Files					
40.6.1.41	Provides capability to electronically store an unlimited number of pricing files and methodologies by date range that support NC DHHS program requirements					
40.6.1.42	Provides capability to create crosswalk of all claim type/provider type/taxonomy combinations to State, Family Planning, and Federal Categories of Service for all Types of Service					
40.6.1.43	Provides capability to apply State-approved policy to: <ul style="list-style-type: none"> <li>▪ HCPCS, including CPT, American Dental Association (ADA) codes, HCPCS Level II codes, NDCs, State local codes, International Classification of Diseases diagnosis and procedure codes (ICD-9) and future ICD codes</li> <li>▪ Drug codes</li> <li>▪ Edits</li> <li>▪ Rate methodology and calculations</li> <li>▪ Professional services fees</li> </ul>					
40.6.1.44	Provides capability for the Replacement MMIS Reference diagnosis file to interface with pharmacy claims processing to ensure that the diagnosis data is the same in both systems					
40.6.1.45	Provides capability to maintain a Reference Modifier File that contains procedure code and modifier information, including sub-database/matrix that supports State/Fiscal Agent staff-authorized access by procedure code and modifier that displays: <ul style="list-style-type: none"> <li>▪ Narrative of procedure code</li> <li>▪ Narrative of modifier, including effective end dates by either date of service, date of processing, or date of receipt</li> <li>▪ Modifier and narrative applicable to the use of the procedure code/modifier combination</li> </ul>					



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Requirement #	Requirement Description	A	B	C	D	E
	<ul style="list-style-type: none"> <li>▪ Modifier pricing information, including effective end dates by either date of service, date of processing, or date of receipt</li> <li>▪ Applicable modifier combinations</li> <li>▪ Applicable procedure/modifier combinations</li> <li>▪ Applicable providers for each modifier, including effective and end dates</li> </ul>					
40.6.1.46	<p>Provides capability to maintain Reference data with all procedure codes and pricing action codes (PAC) that indicate where pricing occurs based on:</p> <ul style="list-style-type: none"> <li>▪ Procedure code, type of service, and/or modifier</li> <li>▪ Provider type, provider specialty, taxonomy, and procedure code</li> <li>▪ Type of service</li> <li>▪ Place of service</li> <li>▪ Provider and per diem rate</li> <li>▪ Provider, DRG rate, and financial payer</li> <li>▪ Provider accommodation code</li> <li>▪ Provider number, percentage of charges, and financial payer</li> <li>▪ Pharmacy dispensing fee</li> <li>▪ Enhanced pharmacist professional services fee for performing cognitive services and State-approved interventions</li> <li>▪ Revenue code</li> <li>▪ Accommodation code on the Accommodation Rate File</li> <li>▪ Capitation payments and management fees</li> </ul>					
40.6.1.47	Provides capability to indicate whether pricing is performed on the revenue code or the CPT code when a combination of the two is billed					
40.6.1.48	Provides capability to determine if auditing/editing occurs on procedure code or revenue					



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Requirement #	Requirement Description	A	B	C	D	E
	code when a combination of revenue code and procedure code is used					
40.6.1.49	Provides capability to search for drugs using the following search criteria: <ul style="list-style-type: none"> <li>▪ NDC number</li> <li>▪ Generic code number or formulation ID</li> <li>▪ Generic sequence number or clinical formulation ID</li> <li>▪ Therapeutic class specific or Therapeutic class code</li> <li>▪ Ingredient list ID (HICL-S, relational and non-relational)</li> <li>▪ HICL sequence number</li> <li>▪ Med ID</li> <li>▪ Routed DF Med ID</li> <li>▪ Routed Med ID</li> <li>▪ Med Name ID</li> <li>▪ HIC Sequence</li> <li>▪ Generic name (GNN)</li> <li>▪ Ingredient List ID (HICL)</li> <li>▪ Brand name</li> <li>▪ Label name</li> <li>▪ Manufacturer</li> <li>▪ Enhanced Therapeutic Classification (ETC)</li> <li>▪ AHF classification</li> <li>▪ UPC</li> </ul>					
40.6.1.50	Provides capability to search for Drug Utilization Review (DUR) parameter data, drug name, NDC, TxCL, GCN, GCN-Sequence, or State-defined data elements					



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Requirement #	Requirement Description	A	B	C	D	E
40.6.1.51	Provides capability for an online, updateable GCN data set to maintain references and associations of drugs with similar indications/therapeutic benefits					
40.6.1.52	Provides capability for an online, updateable GCN data set to identify acute level and duration of a drug before prior approval is required					
40.6.1.53	Provides capability to electronically store and maintain all State-approved pharmacy pricing methodologies					
40.6.1.54	Provides capability to create a crosswalk of HCPCS Level I and Level II codes in the Physician Drug Program (PDP) to NDC/GC3 codes					
40.6.1.55	Provides capability to create a crosswalk of HCPCS Level I and Level II codes to rebateable NDCs					
40.6.1.56	Provides capability to identify Drug Efficacy Study Implementation (DESI) drugs					
40.6.1.57	Provides capability for State-approved provider maximum reimbursement rates for claims processing to ensure the ability to modify, add, or delete any rates on an individual provider basis or mass provider basis					
40.6.1.58	Provides capability to electronically store maximum reimbursement rates for DME by procedure code priced for rental or purchase (new or used)					
40.6.1.59	Provides capability to electronically store laboratory maximum reimbursement rates for individual and "panel" laboratory procedures					
40.6.1.60	Provides capability to maintain an online audit trail of all updates to Reference data, including PRO-DUR data, identifying source of the change, CSR number, memo number, before and after images, and change dates to assure State and Federal auditing requirements are met					
40.6.1.61	Provides capability to receive memos from the State online and send memos to the State online for approval					





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Requirement #	Requirement Description	A	B	C	D	E
40.6.1.62	Provides capability to electronically store and track State Memos with online status updates					
40.6.1.63	Provides capability to generate an online status report of State Memos					
40.6.1.64	Provides capability for note entry					
40.6.1.65	Provides capability for electronic storage of unlimited policy changes received via State/Fiscal Agent Memos and link to all the memo contents for all record changes					
40.6.1.66	Provides capability to link a State/Fiscal Agent Memo with associated procedure codes					
40.6.1.67**	Provides capability to maintain budget criteria information					
40.6.1.68	Provides capability to replicate rates from one (1) type of provider and service to another like type of provider when the service and rate are equal					
40.6.1.69	Provides capability to supply claims pricing information to the Division of Vocational Rehabilitation and the Division of Services for the Blind					
40.6.1.70	Provides capability to retain MMIS Reference data change requests received from the State in the format received for control, balance, and audit purposes for the life of the Fiscal Agent Contract					
40.6.1.71	Provides capability for a user-controlled method to maintain edit criteria online					
40.6.1.72	Provides capability to access or link with State online policies to facilitate search of policies for changes in CPT and ICD-9/ICD-10 codes					
40.6.1.73	Provides capability for inquiry, entry, and updates to group-level pricing parameters for the determination of pharmacy reimbursement calculations					
40.6.1.74	Provides capability to maintain and electronically store pharmacy pricing methodologies to appropriately price claims according to the appropriate financial payer or population					



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Requirement #	Requirement Description	A	B	C	D	E
	according to State policy and business rules					
40.6.1.75	Provides capability to maintain and electronically store new pricing methodologies, criteria, and/or parameters					
40.6.1.76	Provides capability to search for drug data using as primary search criteria: <ul style="list-style-type: none"> <li>▪ NDC</li> <li>▪ Generic code number</li> <li>▪ Generic sequence number</li> <li>▪ Therapeutic class</li> <li>▪ Drug name</li> <li>▪ Any State-identified First DataBank (FDB) data element</li> </ul>					
40.6.1.77	Provides capability for inquiry, entry, and updates of existing and new drug data for a specific drug					
40.6.1.78	Provides capability to search for claim exception parameter data using primary and/or secondary search criteria					
40.6.1.79	Provides capability to search by phonetic and partial description or user-defined selection criteria					
40.6.1.80	Provides capability to electronically store and update drug rates on a schedule determined by the State that allows drug price indicator to be turned on or off for coverage					
40.6.1.81	Provides capability to restrict pharmacy services according to State policy and business rules					
40.6.1.82	Provides capability to handle recipient opt-in to specified lock-in pharmacies according to State policy and business rules					



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Requirement #	Requirement Description	A	B	C	D	E
40.6.1.83	Provides capability to electronically store and maintain the Prescription Advantage List (PAL) tiers					
40.6.1.84	Provides capability to maintain and use list of Medicare Part D drugs for dual-eligible recipients according to State policy and business rules					
40.6.1.85	Provides capability to search inquiry, entry, and updates for step care data					
40.6.1.86	Provides capability for inquiry, entry, and updates to a list of preferred agents for a specific step care plan					
40.6.1.87	Provides capability to ensure that all prior approval requirements and associated edits and audits are linked					
40.6.1.88	Provides an online separate file in the Prior Approval business area that includes all services that require prior approval with a minimum of code, definition, initial date the prior approval was required, and end date when prior approval is no longer required					
40.6.1.89	Provides capability to create Fee Schedule reports detailed in the bullets below: <ul style="list-style-type: none"> <li>▪ Adult Care Home Personal Care</li> <li>▪ Ambulance</li> <li>▪ Ambulatory Surgical Centers/Birthing Centers</li> <li>▪ Behavioral Health (separate schedules)</li> <li>▪ Certified Clinical Supervisor and Addictions Specialist</li> <li>▪ Children’s Developmental Service Agencies</li> <li>▪ Licensed Clinical Social Worker and Licensed Professional Counselor and Licensed Marriage and Family Therapist</li> <li>▪ Licensed Psychological Associate</li> <li>▪ Mental Health Enhanced Services</li> </ul>					



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Requirement #	Requirement Description	A	B	C	D	E
	<ul style="list-style-type: none"> <li>▪ Mental Health (LME)</li> <li>▪ Mental Health Non-Licensed Clinical Fee Schedule</li> <li>▪ Nurse Practitioner</li> <li>▪ Nurse Specialist</li> <li>▪ Prospective Rates</li> <li>▪ Psychologist</li> <li>▪ Residential Treatment Level III and IV</li> <li>▪ Community Alternatives Program (CAP) Rates (separate rates)</li> <li>▪ CAP/AIDS</li> <li>▪ CAP/Children</li> <li>▪ CAP/DA</li> <li>▪ CAP/Mentally Retarded-Development Disability (MR-DD)</li> <li>▪ DRG Weight Table</li> <li>▪ Dental Services</li> <li>▪ Durable Medical Equipment</li> <li>▪ Federally Qualified Health Center</li> <li>▪ Home Health Agency Services</li> <li>▪ Home Infusion Therapy</li> <li>▪ Hospice</li> <li>▪ Local Education Agency Practitioners</li> <li>▪ Local Health Department</li> <li>▪ Multi-specialty Independent Practitioner</li> <li>▪ Nursing Facility Rates</li> </ul>					



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Requirement #	Requirement Description	A	B	C	D	E
	<ul style="list-style-type: none"> <li>▪ Occupational Therapy</li> <li>▪ Orthotics and Prosthetics</li> <li>▪ Physical Therapy</li> <li>▪ Physician Drug Program</li> <li>▪ Respiratory Therapy</li> <li>▪ Rural Health Center</li> <li>▪ Speech and Audiology Services</li> </ul>					
40.6.1.90	Provides capability to create fee schedules and related rate reports for State users and division Web site, including: <ul style="list-style-type: none"> <li>▪ Dialysis Centers</li> <li>▪ Nurse Midwife</li> <li>▪ Portable X-ray</li> <li>▪ Optical and Visual Aids</li> <li>▪ Private Duty Nursing</li> <li>▪ Targeted Case Management</li> </ul>					
40.6.1.91	Provides capability to create rate reports for internal State use only, including: <ul style="list-style-type: none"> <li>▪ Lower Level NF Rates</li> <li>▪ Outpatient Hospital Pricing, Ratio-Cost-to-Charge</li> <li>▪ Nursing Facility Rates</li> </ul>					
40.6.1.92	Provides capability to electronically store a daily file of county DSS mailing addresses					
<b>New Requirement</b> 40.6.1.93	Provides capability to calculate selected physician fee schedule records based on periodic Resource-Based Relative Value Scale (RBRVS) updates					



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**40.6.2 Reference Operational Requirements**

Requirement #	Requirement Description	A	B	C	D	E
40.6.2.1	Fiscal Agent shall log receipt date of each Reference File maintenance request, file maintenance initiation completion date, operator completing request, and supervisor validation date.					
40.6.2.2	Fiscal Agent shall notify the State in writing when a file maintenance request has not been made in accordance with the State Memo and/or as applicable to the contractual performance criteria.					
40.6.2.3	Fiscal Agent shall maintain procedure code updates and applicable editing data as directed by the State or upon receipt of all pertinent information requested from the State; produce before and after images; and return them to the originator of the State request.					
40.6.2.4	Fiscal Agent shall retain MMIS Reference data change requests received from the State in the format received for control, balance, and audit purposes for the life of the Fiscal Agent Contract.					
40.6.2.5	Fiscal Agent shall verify the accuracy of all file maintenance activities; produce weekly reports that summarize, by operator, file maintenance activities, including timeliness of updates and operator accuracy; reports shall be made available to the Contract Monitoring Unit by 7:00 A.M. Eastern Time each Monday following the update activity.					
40.6.2.6	Fiscal Agent shall perform research and analysis for adjudication and policy issues.					
40.6.2.7	Fiscal Agent shall analyze the appropriateness of the cross-reference of new CPT codes and ICD-9/ICD-10 codes to MMIS edits and audits and make recommendations to the State for incorporation of the codes into the established edit criteria or for additional edits/audits as appropriate.					
40.6.2.8	Fiscal Agent shall update edit criteria and all applicable documentation and notify the State when updates occur.					
40.6.2.9	Fiscal Agent shall provide PAL tiers information for provider inquiries.					



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Requirement #	Requirement Description	A	B	C	D	E
40.6.2.10	Fiscal Agent shall notify providers of DESI drug denials of payment through the Pharmacy Newsletter or other State-approved medium for communication.					

**40.6.3 Reference Operational Performance Standards**

Requirement #	Requirement Description	A	B	C	D	E
40.6.3.1	Fiscal Agent shall initiate all Reference File maintenance requests within one (1) State business day of receipt of a request and complete such maintenance according to State-defined timeframe: <ul style="list-style-type: none"> <li>▪ Online updates within two (2) State business days of receipt</li> <li>▪ Mass adjustments within two (2) claims cycles</li> <li>▪ Other within timeframe, as directed by the State.</li> </ul>					
40.6.3.2	Fiscal Agent shall apply Reference File updates (mass updates and subscription service updates) to the Replacement MMIS according to State-defined schedule.					
40.6.3.3	Fiscal Agent shall notify the State in writing when a file maintenance request has not been completed, as directed by the State.					
40.6.3.4	Fiscal Agent shall produce before and after images and return them to the originator of the State Memo the same day the change is made.					
40.6.3.5	Fiscal Agent shall verify the accuracy of all file maintenance activities, producing weekly reports for the Contract Monitoring Unit by 7:00 A.M. Eastern Time each State business Monday.					



## 40.7 Prior Approval Requirements

### 40.7.1 Prior Approval System Requirements

Requirement #	Requirement Description	A	B	C	D	E
40.7.1.1	Provides capability to receive and adjudicate prior approval requests and adjustments					
40.7.1.2	Provides capability to integrate prior approval functionality for all applicable claims and benefit plans (services and drugs)					
40.7.1.3	Provides capability for secure electronic submissions of adjudicated Prior Approval data from State-contracted Prior Approval vendors					
40.7.1.4	Provides capability for receipt and response of prior approval and referral requests and adjustments via a secure electronic transmission medium, such as AVRS/IVR, Web, ASC X12 278 transactions, and/or NCPDP					
40.7.1.5	Provides capability to receive and manage prior approval, override, and referral requests via telephone, mail, and fax					
40.7.1.6	Provides capability to create and maintain electronic copies of all prior approval, override, and referral requests and all supporting documentation, including medical photographs					
40.7.1.7	Provides capability to electronically link supporting documentation to prior approval, override, and referral request for on-demand online retrieval by staff					
40.7.1.8	Provides capability for real-time, online prior approval and referral adjudication and notification of response via secure electronic transmission medium, such as AVRS/IVR, Web, ASC X12 278 transactions, and/or NCPDP					
40.7.1.9	Provides capability to review online claims and stored electronic health information					
40.7.1.10	Provides capability for automated screening of drug claims to ensure that evidenced-based, drug-specific criteria are met for pharmacy claims, medical claims data (ICD-9/ICD-10, revenue, and CPT codes), laboratory data, and eligibility data					





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Requirement #	Requirement Description	A	B	C	D	E
40.7.1.11	Provides capability for entry, inquiry, updates, and reporting for prior approvals, overrides, and referrals					
40.7.1.12**	Provides capability to manage and adjudicate prior approval requests for individuals who are not currently on the Recipient File					
40.7.1.13	Provides capability for entry and adjudication of prior approval request by LOB					
40.7.1.14	Provides capability for online, real-time update and adjudication of prior approval requests by State and State Prior Approval contractors					
40.7.1.15	Provides capability for interface with State-contracted Prior Approval vendors to accept adjudicated prior approvals					
40.7.1.16	Provides capability for interface with the contracted Pre-Admission, Screening, and Annual Resident Review (PASARR) Vendor and retain PASARR number and associated start/end dates					
40.7.1.17	Provides capability to retain the relationship of recipient-based hospice information (recipient, diagnosis, provider, and coverage dates)					
40.7.1.18	Provides capability for a secure online entry of overrides and referrals					
40.7.1.19	Provides capability to enter comments (free-form text) within a prior approval, referral, or override					
40.7.1.20	Provides capability for online inquiry, data entry, and update access for prior approval, referral, and override requests 6:00 A.M. until 11:00 P.M. Eastern Time Monday through Friday and 7:00 A.M. to 7:00 P.M. on Saturday and Sunday					
40.7.1.21	Provides capability for tracking prior approval date of receipt, date of decision, denial/reduction in service reason, and decision notification date					
40.7.1.22	Provides capability for tracking override date and time of receipt and date decision was					



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Requirement #	Requirement Description	A	B	C	D	E
	rendered					
40.7.1.23	Provides capability to generate Prior Approval statistical processing report detailing contracted Prior Approval vendors' submissions that indicates the date and time file received, date and time processed, number of transactions received, number of transactions processed, number of transactions updated, and number of transaction errors, listing each error transaction and error reason					
40.7.1.24	Provides capability to ensure each keyed prior approval, referral, and override by Fiscal Agent, State agency, or vendor has complete audit trail					
40.7.1.25	Provides capability to enter prior approval, referral, and override services and limitations					
40.7.1.26	Provides capability to retain prior approvals for each State program's recipients for five (5) years from last occurrence online and an additional five (5) years near-line; provides capability to maintain all usage by recipient for those benefits that are considered to be periodical or lifetime					
40.7.1.27	Provides capability to retain overrides and referrals for each recipient for five (5) years from last occurrence online and an additional five (5) years near-line					
40.7.1.28	Provides capability to assign system-generated unique prior approval, referral, and override numbers to approved, pending, and denied requests					
40.7.1.29**	Provides capability to encumber funds associated with approved prior approval/authorizations					
40.7.1.30**	Provides capability to establish variable recipient co-pay percentages on a prior approval					
40.7.1.31	Provides capability for incrementing approved units, Prior Approval pricing amounts, and frequencies of authorizations resulting from adjusted claims and voided claims or fully refunded claims back to the Prior Approval data					
40.7.1.32	Provides capability for decrementing approved units, Prior Approval pricing amounts, and frequencies of authorizations of services reimbursed from paid claims, adjusted claims,					



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Requirement #	Requirement Description	A	B	C	D	E
	and fully refunded claims to Prior Approval data until all services are used up or zero units remaining within approved timeframe in which time closure of prior approval should occur					
40.7.1.33	Provides capability to generate letters of notification for approved, denied, reduced, or pending prior approval requests					
40.7.1.34	Provides capability for automated denial of prior approval and referral requests for providers who are determined to be on suspension or under review					
40.7.1.35	Provides capability to request prior approval recipient profiles by name, recipient ID number, specific or range of time from five-year (5-year) Prior Approval history online; near-line five (5) years and lifetime procedures in State-approved format					
40.7.1.36	Provides capability to apply Prior Approval logic by LOB, benefit, and recipient eligibility category					
40.7.1.37	Provides capability for online, updateable letter templates to all prior approval letters with the ability to add free-form text specific to a provider or recipient					
	<b>Prior Approval Customer Service Center</b>					
40.7.1.38	Provides capability to support inquiries regarding prior approval, referrals and overrides from physicians, pharmacists, recipients, and other health care professionals					
40.7.1.39	Provides capability to generate a prior approval to limit drug claims for a specific NDC, GCN, GCN-Sequence, GC3 therapeutic class, American Hospital Formulary Service (AHFS) therapeutic class, or any other State-determined FDB-selected data element					
40.7.1.40	Provides capability to change services authorized and to extend or limit the effective dates of the authorization while maintaining the original and the change data on the prior approval, referral, or override					
40.7.1.41	Provides capability to search prior approval and overrides by service type, name of					



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Requirement #	Requirement Description	A	B	C	D	E
	provider (issuing and authorized), provider number, name of recipient, recipient number, prior approval and override number, category of service, clerk identification, effective dates, prior approval type, diagnosis, HCPCS, or revenue code and any combinations thereof					
40.7.1.42	Provides capability to search referrals by recipient ID, referring provider ID, referred provider ID, and referral number					
40.7.1.43	Provides capability to validate the need for prior approvals based upon NDC, GCN, GCN-Sequence, GC3 therapeutic class, AHFS therapeutic class, or any other State-determined FDB-selected data element					
40.7.1.44	Provides capability to dispense a seventy-two-hour (72-hour) supply of drugs without prior approval in emergency situations					
40.7.1.45	Provides capability to tie in the date of delivery to the Prior Approval logic for Medicaid for Pregnant Women (MPW) (actually requiring prior approval for anything but postpartum care after the date of delivery)					
40.7.1.46	Provides capability for inquiry and update of prior approval, overrides, and referrals reason/exception codes and descriptions					
40.7.1.47	Provides capability to edit DME prior approvals online to include: <ul style="list-style-type: none"> <li>▪ Valid provider identification and eligibility, including other payers and place of residence</li> <li>▪ Valid recipient age for service</li> <li>▪ Duplicate approval check for previously authorized or previously adjudicated services, including the same service over the same timeframe by different providers</li> </ul>					
40.7.1.48	Provides capability to maintain multiple referral types					
40.7.1.49	Provides capability for data validation and duplicate prior approval, referral, and override					



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Requirement #	Requirement Description	A	B	C	D	E
	editing					
40.71.50	Provides capability for authorized users to search for a provider number for purposes of authorizing a referral					
40.7.1.51	Provides capability to make available to a provider, his/her last twenty-five (25) unique referred-to provider IDs and provider names used during the submission of referrals via Web entry					
40.7.1.52	Provides capability to return to the provider, upon successful submission of a referral, a confirmation page in a readable PDF format					
40.7.1.53	Provides capability to allow the referring provider and the referred-to provider to inquire on referrals					
40.7.1.54	Provides capability to produce a report that lists all open referrals not used within a specified period of time					
40.7.1.55	Provides capability for a monthly report that lists the total number of referrals processed within a given month, broken out by referral media type and referral type					
40.7.1.56	Provides capability for workflow imaging application, to enable automated processing and work queue functionality for prior approvals and overrides					
	<b>Searching and Tracking of Therapeutic Leave</b>					
40.7.1.57	Provides capability for online searchable tracking of therapeutic leave in child care facilities, nursing facilities, and intermediate care facilities for the mentally retarded (ICF-MR) by patient identification number and number of days used per calendar year to State staff					
	<b>Pharmacy Benefits Management</b>					
40.7.1.58	Provides capability for workflow imaging and work queue functionality to ensure that prior approval requests are listed in each work queue based on first in, first out					



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Requirement #	Requirement Description	A	B	C	D	E
40.7.1.59	Provides capability to generate adjudicated prior approval appeal letters to recipients and providers when prior approval was denied or reduced					
40.7.1.60	Provides capability to identify and capture recipient drug information where aberrant drug patterns have been identified					
40.7.1.61	Provides capability for providers to link to the DHHS Web site to obtain the current Prescription Advantage List (PAL) and other pharmacy-related information					
40.7.1.62	Provides capability to ensure verification of recipient eligibility, provider program participation, and third party coverage during adjudication of prior approvals					
40.7.1.63	Provides a prior approval Web site (prior approval-enhanced pharmacy program Web site to include: Home page/Welcome page, What's New section, prior approval list/criteria, prior approval forms, authorization via e-mail, provider information, FAQs, Contact Us page, link to NC Medicaid Home page), and PAL, including upgrades to drug list, updates to criteria, EBM prescriber updates to clinical pearls, and updates to information for providers and recipients					
40.7.1.64	Provides for search capability of covered drugs by: <ul style="list-style-type: none"> <li>• Effective, termination, or a range of dates</li> <li>• NDC. Generic name, brand name</li> <li>• HICL, HICL-Sequence, HICL code, GCN, GCN-Sequence, GNN, label name manufacturer, UPC, GC3, TxCL, AHF</li> </ul>					

**40.7.2 Prior Approval Operational Requirements**

Requirement #	Requirement Description	A	B	C	D	E
40.7.2.1	Fiscal Agent shall record telephone pharmacy prior approval requests in the same format					



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Requirement #	Requirement Description	A	B	C	D	E
	as the pharmacy paper/facsimile hard copy version.					
40.7.2.2	Fiscal Agent shall enter each prior approval request online to include the following: receipt date of each prior approval request made to the Fiscal Agent, denial code, decision date, and mailing date of decision.					
40.7.2.3	Fiscal Agent shall adjudicate prior approvals and mail system-generated disposition letters.					
40.7.2.4	Fiscal Agent shall receive and determine resolution (e.g. approval, denial, or pending) of prior approval and override requests, including retroactive requests based on State-approved medical criteria and medical judgment.					
40.7.2.5	Fiscal Agent shall notify the State via a quarterly report of the number of prior approval requests received, number entered into the system within one (1) State business day, and the number entered into the system after more than one (1) State business day.					
40.7.2.6	Fiscal Agent shall provide a weekly batch processing report that indicates the date and time the file was received, date and time processed, number of transactions received, number of transactions processed, number of transactions updated, and number of transactions errored, listing each error transaction and error reason.					
40.7.2.7	Fiscal Agent shall notify the State monthly when it takes more than one (1) business day from receipt to process and render a decision on a non-emergency prior approval and override request that does not require additional research or additional information.					
40.7.2.8	Fiscal Agent shall notify the State monthly when it takes more than one (1) business day from receipt of all required information to process and render a decision on a non-emergency prior approval and override request that required additional information or research.					
40.7.2.9	Fiscal Agent shall notify the State when it takes more than five (5) business days to process, render a decision, and mail a status report on a prior approval request for retrospective and therapeutic days.					



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Requirement #	Requirement Description	A	B	C	D	E
40.7.2.10	Fiscal Agent shall provide the capability for authorized services to be flagged for pre-payment review.					
40.7.2.11	Fiscal Agent shall represent the State throughout the hearing/appeals process for all prior approval decisions made by the Fiscal Agent. Fiscal Agent shall attend Office of Administrative Hearings Representation and must include the Fiscal Agent staff that rendered the final decision of denial.					
40.7.2.12	Fiscal Agent shall perform long-term care facility on-site visits with or without State staff as requested for specific provider problems.					
40.7.2.13	Fiscal Agent shall evaluate and determine prior approval adjudication for: <ul style="list-style-type: none"> <li>▪ Eye exams or refraction</li> <li>▪ Visual aids</li> <li>▪ Hearing aids, accessories, ear molds, FM systems, repairs</li> <li>▪ Dental and orthodontics</li> <li>▪ Hyperbaric oxygenation therapy</li> <li>▪ Blepharoplasty/blepharoptosis eyelid repair</li> <li>▪ Panniculectomy</li> <li>▪ Breast surgery</li> <li>▪ Clinical severe obesity surgery</li> <li>▪ Lingual frenulum surgery</li> <li>▪ Stereotactic pallidotomy</li> <li>▪ Electrical osteogenic stimulators</li> <li>▪ Keloids</li> <li>▪ Craniofacial/facial surgeries</li> <li>▪ Out-of-state ambulance</li> </ul>					





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Requirement #	Requirement Description	A	B	C	D	E
	<ul style="list-style-type: none"> <li>▪ Rhinoplasty</li> <li>▪ Chiropractic and podiatry</li> <li>▪ Durable medical equipment</li> <li>▪ Orthotics and prosthetics</li> <li>▪ Pharmacy</li> <li>▪ All services for DPH payment programs</li> </ul>					
40.7.2.14	Fiscal Agent shall present prior approval, referral, and override information and provide education at provider workshops.					
40.7.2.15	Fiscal Agent shall respond to and resolve all phone inquiries/questions from recipients, providers, Office of Citizen Services, and manufacturers pertaining to pharmacy drug-related issues and concerns.					
40.7.2.16	Fiscal Agent shall ensure that the Pharmacy Prior Approval Customer Service Center is available from 7:00 A.M. until 11:00 P.M. Eastern Time on State business days Monday through Friday, and from 7:00 A.M. until 6:00 P.M. Eastern Time on Saturday and Sunday.					
40.7.2.17	Fiscal Agent shall ensure that the non-pharmacy Customer Service Center is available for prior approval, referral and override requests from 7:00 A.M. until 7:00 P.M. Eastern Time Monday through Friday and from 8:00 A.M. until 5:00 P.M. Eastern Time on Saturday					
40.7.2.18	Fiscal Agent shall ensure that adequate prior approval staff, including a clinical pharmacist, is on-site during all hours of call center operation (including evenings and weekends).					
40.7.2.19	Fiscal Agent shall locate a Prior Approval Customer Service Center within the State-approved Fiscal Agent's local facility unless otherwise approved by the State.					
40.7.2.20	Fiscal Agent shall provide capability to receive prior approval requests for stem cell and bone marrow transplants. If all clinical information is included in the request, then the Fiscal Agent forwards the request to the DMA Hospital Consultant for review. If all clinical					



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Requirement #	Requirement Description	A	B	C	D	E
	information is not included in the request, the Fiscal Agent must contact the requesting provider for additional clinical information before forwarding the request to the DMA Hospital Consultant for review.					
40.7.2.21	Fiscal Agent shall provide training for Prior Approval Vendors and State staff.					
40.7.2.22	Fiscal Agent shall ensure verification of recipient eligibility, provider program participation, and third party coverage during adjudication of prior approvals.					
40.7.2.23	Fiscal Agent shall ensure automated prior approval adjudication is not available when TPL coverage exists for recipient. Manual review and verification of coverage must be conducted to determine prior approval authorization.					
40.7.2.24	Fiscal Agent shall provide for toll-free telephone and fax number access for providers to request prior approvals, referrals, and overrides					
	<b>Pharmacy Benefits Management</b>					
40.7.2.25	Fiscal Agent shall prepare the CMS Annual Report that includes all information, charts, and statistics relating/pertaining to the Prospective and Retrospective DUR Programs in the format and media as directed by the State.					
40.7.2.26	Fiscal Agent shall coordinate with the DUR Contractor to assure functionality of the Pharmacy Point-of-Sale Business Area, including adding edits, PRO-DUR informational alerts and intervention, conflict, and outcome codes (NCPDP 5.1 standards) and shall assist DUR Vendor with the Retrospective DUR Program.					
40.7.2.27	Fiscal Agent shall provide for updating clinical data, dosing limits to DUR alerts, changes in GCN, GCN-Sequence, weekly DUR file updates, and State-selected FDB data elements.					
40.7.2.28	Fiscal Agent shall prepare monthly Pharmacy Newsletter for State approval and distribute as directed by the State.					
40.7.2.29	Fiscal Agent shall ensure daily supervisor signoffs of each Pharmacy Prior Approval					



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Requirement #	Requirement Description	A	B	C	D	E
	Service Representative work queue transferring any prior approvals to the next shift's work queue to ensure performance standards are met.					
40.7.2.30	Fiscal Agent shall coordinate with the State's Drug Utilization Review Vendor or the State to ensure appropriate Pharmacy POS alerts for potential drug therapy problems are identified; shall meet each month; and shall prepare meeting minutes.					
40.7.2.31	Fiscal Agent shall post on the Web site the EBM updates to PAL clinical pearls.					
40.7.2.32	Fiscal Agent shall maintain the Prior Approval Web site that will contain the State Maximum Allowable Cost (SMAC) list and linkage to the Drug Effective Review Process (DERP) reports.					
40.7.2.33	Fiscal Agent shall notify DMA weekly of new drugs with recommended criteria/protocol that become available in the marketplace that are in the same classes as those drugs included in the Prior Approval drug list and PAL.					
40.7.2.34	Fiscal Agent shall develop criteria-driven recommendations for each new drug within an existing Prior Approval therapeutic class category.					
40.7.2.35	Fiscal Agent shall coordinate with the State's Retrospective DUR Vendor or the State to capture claim data specific to aberrant drug patterns; shall meet each month; and shall prepare meeting minutes.					
40.7.2.36	Fiscal Agent shall coordinate with the State's Community Care Program to prevent duplication or fragmentation of effort related to pharmacy benefit coverage; shall meet each month; and shall prepare meeting minutes.					
40.7.2.37	Fiscal Agent shall adjudicate provider appeals.					
40.7.2.38	Fiscal Agent shall prepare monthly Pharmacy Bulletin/Newsletter information for State approval in format, content, and media as directed by the State, including the production, updating of preferred drug lists, prior approvals and lists, and other informational materials for prescribers.					



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Requirement #	Requirement Description	A	B	C	D	E
40.7.2.39	Fiscal Agent shall provide for dispensing and reimbursement of a seventy-two-hour (72-hour) supply of prior approval drug in emergency situations.					
40.7.2.40	Fiscal Agent shall identify pharmacy provider training issues related to prior approvals and shall address at workshops					
40.7.2.41	Fiscal Agent shall make recommendations to the State on drugs for a preferred drug list and drugs for which prior approval and/or step therapy protocols would be appropriate. The list shall be based on utilization patterns and shall take into consideration clinical value, recipient and provider disruption, and cost savings.					
40.7.2.42	Fiscal Agent shall add the new drug(s) to their respective therapeutic Prior Approval categories and to add new Prior Approval categories after final approval and notification from DMA; updates must be included on Web site within forty-eight (48) hours of notification.					

**40.7.3 Prior Approval Operational Performance Standards**

Requirement #	Requirement Description	A	B	C	D	E
40.7.3.1	Fiscal Agent shall update the Prior Approval business area with all prior approval results received from other entities within twenty-four (24) hours of receipt from each entity, except Fridays, when the updates shall be available by 7:00 A.M. Eastern Time on the following Monday.					
40.7.3.2	Fiscal Agent shall render a decision for non-pharmacy prior approval within one (1) State business days of the receipt of all of the required information or research for non-emergency prior approval requests.					
40.7.3.3	Fiscal Agent shall generate and mail prior approval decisions to appropriate designees within two (2) State business days of rendering a decision.					



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Requirement #	Requirement Description	A	B	C	D	E
40.7.3.4	Fiscal Agent shall apply the State Prior Approval Policy with ninety-nine and nine-tenths (99.9) percent accuracy rate based on the information available when rendering a prior approval decision.					
40.7.3.5	Fiscal Agent shall provide online inquiry and data entry to the Prior Approval data to providers, Fiscal Agent staff, and State-designated staff from 6:00 A.M. until 11:00 P.M. Eastern Time Monday through Friday and 7:00 A.M. to 7:00 P.M. on Saturday and Sunday ninety-nine and nine-tenths (99.9) percent of the time.					
40.7.3.6**	Fiscal Agent shall provide online inquiry and data entry to the Prior Approval data to AP/LME staff and State-designated staff from 7:00 A.M. until 7:00 P.M. Eastern Time Monday through Friday ninety-nine and nine-tenths (99.9) percent of the time.					
40.7.3.7	Fiscal Agent shall provide online Prior Approval for Pharmacy Prior Approval from 7:00 A.M. to 11:00 P.M. Eastern Time Monday through Friday and 7:00 A.M. to 6:00 P.M. Eastern Time Saturday and Sunday ninety-nine and nine-tenths (99.9) percent of the time.					
40.7.3.8	Fiscal Agent shall produce system-generated letters to recipients and providers of the status of prior approval requests within twenty-four (24) hours from the time of receipt.					
40.7.3.9	Fiscal Agent shall produce weekly Pharmacy Alerts.					
40.7.3.10	Fiscal Agent shall adjudicate each complete pharmacy prior approval request within one (1) State business day of receipt.					
40.7.3.11	Fiscal Agent shall meet monthly with DUR, the State and/or Retrospective DUR vendors and Community Care Program and include minutes in bi-weekly Project Status Report.					
40.7.3.12	Fiscal Agent shall adjudicate provider pharmacy prior approval request appeals within one (1) State business days of receipt.					
40.7.3.13	Fiscal Agent shall respond to a requesting provider within one (1) hour for a telephone request for an emergency override.					



## 40.8 Claims Processing Requirements

### 40.8.1 Claims Processing System Requirements

Requirement #	Requirement Description	A	B	C	D	E
	<b>Mailroom</b>					
40.8.1.1	Provides capability for mechanized date stamping of all mail					
40.8.1.2	Provides capability to access system for logging receipt of packages and envelopes received from couriers					
40.8.1.3	Provides capability to access system log for entering checks received					
40.8.1.4	Provides capability for system-generated logging of regular mail costs					
40.8.1.5	Provides capability for automated Return to Provider (RTP) letter					
40.8.1.6	Provides capability for automated system log/accounting for mailroom					
	<b>Claim Acquisition</b>					
40.8.1.7	Provides capability to assign a unique number for each claim, adjustment, and financial transaction that contains date of receipt, batch number, and sequence of document within the batch, upon receipt of each claim and adjustment					
40.8.1.8	Provides capability for tracking of all claims, adjustments, and financial transactions from receipt to final disposition					
40.8.1.9	Provides capability for mechanized images of all claims, attachments, adjustment requests, and other claims-related documents and ability to link these documents to the unique claim number they are associated with					
40.8.1.10	Provides capability to maintain batch and online entry controls for all claims, batch audit trails, and all other transactions entered into the system					



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Requirement #	Requirement Description	A	B	C	D	E
40.8.1.11	Provides capability to identify any activated claim batches that fail to balance to control counts					
40.8.1.12	Provides capability for editing to prevent duplicate entry of electronic media claims					
40.8.1.13	Provides capability to perform CLIA editing based on the provider CLIA number and the CLIA number for the service					
40.8.1.14	Provides capability to perform diagnosis editing by line item					
40.8.1.15	Provides capability to adjudicate a claim to the fullest extent possible in order to report all errors					
40.8.1.16	Provides capability to adjudicate claims for Medicare Part D dual-eligible recipients according to State business rules and policies					
40.8.1.17	Provides capability for key re-verification of critical fields, data entry software editing, and supervisor audit verification of keyed claims					
40.8.1.18	Provides capability to maintain extract tables that contain key elements to verify the validity of entered claim information					
40.8.1.19	Provides capability to perform presence and format editing on all entered claims					
40.8.1.20	Provides capability to perform validity editing on all entered claims using current information on Provider, Recipient, Claims History, Prior Approval, and Reference Files or business area/interfaces					
40.8.1.21	Provides capability to support the Medicare Correct Coding Initiative (CCI)					
40.8.1.22	Provides capability for front-end claim, adjustment, or crossover denials when required attachments are not present					
40.8.1.23	Provides capability to generate RTP letters with entry available to denote front-end claim					



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Requirement #	Requirement Description	A	B	C	D	E
	error conditions					
40.8.1.24	Provides capability for individual paper and electronic claim overrides on edits such as presumptive eligibility, Medicare A, B, and C, HMO coverage, TPL, and timely filing limit					
40.8.1.25	Provides capability to override service limitations for Early Periodic Screening, Diagnosis, and Treatment (EPSDT) -eligible recipients					
40.8.1.26	Provides capability to identify and allow online correction to claims suspended as a result of data entry errors					
40.8.1.27	Provides capability to return to submitters an acknowledgement of all electronic submissions and claim status within twenty-four (24) hours of original receipt					
40.8.1.28	Provides capability to pre-screen batch electronic media claims to identify global error conditions and prevent entry of such claims into the system					
40.8.1.29	Provides capability to reject electronic claims at the claim level					
40.8.1.30	Provides capability to process claims and financial transaction adjustments					
40.8.1.31	Provides capability to perform duplicate editing of drugs billed by physicians and pharmacy					
40.8.1.32	Provides capability to use transfer of assets data on the Medicaid recipient record in claims processing					
40.8.1.33	Provides capability to populate each claim detail with appropriate header level EOB					
40.8.1.34	Provides capability to use Medicaid/Medicare coverage data from EIS to adjudicate claims					
40.8.1.35	Provides capability to update the Claims History tables with paid and denied claims from the previous audit run					





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Requirement #	Requirement Description	A	B	C	D	E
40.8.1.36	Provides capability for inquiry on suspended claims, accessible for online inquiry					
40.8.1.37	Provides capability to accept the indicator denoting whether a third party was billed for TPL claims					
40.8.1.38	Provides capability to use EDB and BENDEX information to detect Medicare and Medicare HMO entitlement for use in claims processing					
40.8.1.39**	Provides capability to define parameters and create a file for the negative and positive eligibility quality control sampling for DMH					
40.8.1.40**	Provides capability to produce reports regarding the results of the DMH negative and positive sampling					
40.8.1.41**	Provides capability to accept an MEQC positive sample file from DMA via DIRM					
40.8.1.42	Provides capability to produce claim history reports using the MEQC positive sample file from DMA via DIRM					
40.8.1.43	Provides capability to reflect all premium payments and adjustments on the online paid Claims History files					
40.8.1.44	Provides capability to maintain a complete history of all claims: paid, adjusted, and denied					
40.8.1.45	Provides capability to accrue all appropriate EOBs messages for relevant claim adjudication for each detail line and report on RA					
40.8.1.46	Provides capability to maintain a minimum five-year (5-year) history of previously paid or denied claims to support duplicate checking and utilization review					
40.8.1.47	Provides capability to assign the status of claims in the system to determine course of each action to be taken in the claims adjudication process and completion of appropriate financial processing tasks					



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Requirement #	Requirement Description	A	B	C	D	E
40.8.1.48	Provides capability to adjust paid claims history for State-specified TPL recoveries at the detail level to include duplicate check					
40.8.1.49	Provides capability to allow DME claims to span across calendar months in order to be consistent with Medicare and thus allow appropriate claims payment for Medicaid-covered items					
40.8.1.50	Provides capability for providers to bill ambulance services using multiple claim types					
40.8.1.51**	Provides capability for an extract of DMH claims denied due to insufficient budget					
	<b>Pharmacy Point-of-Sale</b>					
40.8.1.52	Provides capability for an interactive session that accepts submitted pharmacy claims and processes to identify and alert the provider of problems associated with inappropriate drug use prior to dispensing					
40.8.1.53	Provides capability to allow for the submitting provider to respond to alerts by overriding alerts or reversing the claim submitted based on State-determined hierarchy					
40.8.1.54	Provides capability to identify informational alerts for warning on claim denials					
40.8.1.55	Provides capability for an audit trail of all inquiries (event logging), including who made the inquiry, information input, and response provided					
40.8.1.56	Provides capability for alerts for drugs requiring prior approval; provides capability to allow providers to immediately apply for prior approval; provides capability to receive approval if appropriate and complete claim adjudication online					
40.8.1.57	Provides capability to price all pharmacy claims using lesser of logic incorporating all State-approved pricing methodologies					
40.8.1.58	Provides capability for online prospective drug utilization review POS/PRO-DUR) for all pharmacy claims using 5.1 formats or newer, more recent NCPDP format updates					



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Requirement #	Requirement Description	A	B	C	D	E
40.8.1.59	Provides capability for submittal of decimal units on claims up to the maximum allowed by NCPDP standards and calculate payment based on the actual decimal versus rounding to a whole unit					
40.8.1.60	Provides capability to interface with Comprehensive Neuroscience (CNS) Program-Behavioral Pharmacy Management System (BPMS); provides capability to interface with BPMS quality indicator algorithms developed by an outside vendor (CNS)					
40.8.1.61	Provides capability for PRO-DUR and Retroactive DUR					
40.8.1.62	Provides capability to process all pharmacy claims in POS/PRO-DUR inclusive with edits/audits/overrides consistent with current State policy					
40.8.1.63	Provides capability to allow for online pharmacy claim reversal/adjustment within one (1) year of date of service					
40.8.1.64	Provides capability to allow for duplicate editing across lines of business, claim types, including pharmacy against HCPCS (e.g., J codes) or NDC codes to ensure both are not billing for nursing home and inpatient stays or pharmacy claims against DME, physician, or Competitive Acquisition Program (CAP) B claims					
40.8.1.65	Provides capability for an online audit trail of all POS/PRO-DUR transactions					
40.8.1.66	Provides capability for submissions and responses for all Replacement MMIS POS/PRO DUR via the Web Portal					
40.8.1.67	Provides capability to accept multiple NDCs and associated prices to calculate total allowed for compound drugs to price and pay compound drugs that include multiple NDCs, rebateable legend drugs, and selected covered over-the-counter products					
40.8.1.68	Provides capability for flexible State-determined dispensing fees					
40.8.1.69	Provides capability to set edits that cannot be overridden when the potential drug conflict reaches certain State-approved severity or significance levels					



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Requirement #	Requirement Description	A	B	C	D	E
40.8.1.70	Provides capability to exempt a drug or a recipient from the State-specific prescription limit according to policy					
40.8.1.71	Provides capability to maintain an online audit trail of all updates to Reference and POS/PRO-DUR data, identifying the source of the change, before and after, and change dates					
40.8.1.72	Provides capability to allow for the submitting provider to respond to alerts by overriding alerts or reversing the claim submitted					
40.8.1.73	Provides capability to edit for and deny FDA DESI-identified drugs					
40.8.1.74	Provides capability to pay or deny (but not suspend) all pharmacy claims entered through POS devices					
40.8.1.75	Provides capability to edit against lock-in/lock-out recipient data for pharmacy, primary care provider, and/or prescriber					
40.8.1.76	Provides capability to process claims for pharmacist's professional services and to price according to the cognitive service provided					
40.8.1.77	Provides capability for State-specified customized updates from a contracted drug update service and provides the State all clinical and editorial highlights, newsletter, product information, and modules					
40.8.1.78	Provides capability to edit all claims entered into the system to ensure claims for drugs mandated by Federal regulations, the Federal upper limit (FUL) drugs, and the SMAC drugs are processed correctly; provides capability to edit claims entered into the system to ensure claims are not paid for the drugs listed on the Federal DESI list					
40.8.1.79	Provides capability to edit against all State-determined DUR alerts					
40.8.1.80	Provides capability for e-prescribing services, e.g., Rx HUB , and access to formulary and benefit information to enrolled providers using NCPDP Version 1.0 ( or more recent)					



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Requirement #	Requirement Description	A	B	C	D	E
	Formulary and benefit standard					
40.8.1.81	Provides capability to apply edits for coverage of non-legend drugs within compound drugs					
40.8.1.82	Provides capability to ensure use of the appropriate package size in calculating the maximum allowable unit cost for reimbursement					
40.8.1.83	Provides capability to edit for Part D eligibility or suspect and deny appropriately					
40.8.1.84	Provides capability to ensure drugs have not been previously issued within the Physician Drug Program and Pharmacy POS					
	<b>Determination of Financial Payer and Population Group</b>					
40.8.1.85	Provides capability to ensure that financial payer and population group determination is based on the recipient's program, enrollment, and related benefit packages, the enrollment of the provider, the inclusion of services in eligible benefit packages, and the dates services were rendered					
40.8.1.86	Provides capability to determine the most appropriate LOB and benefit plan for each claim (by line detail)					
40.8.1.87	Provides capability to perform Payer Determination process daily after input conversion process to accurately route the claim according to financial payer					
40.8.1.88	Provides capability to re-perform Payer Determination process before the claims processing cycle to incorporate any data corrections made subsequent to the initial Payer Determination process					
40.8.1.89	Provides capability to determine financial payer hierarchy					
40.8.1.90	Provides capability to determine population group hierarchy within a specified financial payer					



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Requirement #	Requirement Description	A	B	C	D	E
40.8.1.91	Provides capability to maintain, report, and view the original claim and associated actions that changed the original makeup of claim details					
40.8.1.92	Provides capability to identify any claim details and track back to the original claim					
40.8.1.93	Provides capability to identify a claim detail line that has been processed independent of the original claim and tie it to the original claim					
40.8.1.94	Provides capability to apply appropriate Replacement MMIS edits to any claim detail that is processed independent of the original claim					
40.8.1.95	Provides capability to require prior approval for recipients covered in the Medicaid for Pregnant Women (MPW) program for services (other than postpartum care) that are provided after date of delivery					
40.8.1.96	Provides capability to format key-entered POS, batch, and electronic claims submission/electronic data interchange (ECS/EDI) claims into common processing formats for each claim type					
40.8.1.97	Provides capability to perform claims processing based on recipient's enrollment and eligibility information					
40.8.1.98	Provides capability to edit claim detail identifying all error codes for claims that fail daily edit processing at initial processing of the claim to minimize the need for multiple re-submissions of claims					
40.8.1.99	Provides capability to identify the processing outcome of claims (suspend, deny, or pay and report) that fail edits, based on the edit disposition					
40.8.1.100	Provides capability for online claims correction and resolution of suspended claims					
40.8.1.101	Provides capability to receive paper/electronic claims for Medicare and Medicare HMO cost sharing					



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Requirement #	Requirement Description	A	B	C	D	E
40.8.1.102	Provides capability for the identification of potential TPL (including Medicare) and suspend, deny, or pay and report the claim					
40.8.1.103	Provides capability to distinguish between a Medicare denial versus private insurance denials					
40.8.1.104	Provides capability for editing to assure that TPL has been satisfied or that a TPL denial attachment is present if required					
40.8.1.105	Provides capability for editing and suspending of claims for pre-payment review based on provider, recipient, procedure code, diagnosis code, third party insurance, and authorized services					
40.8.1.106	Provides capability for editing to assure that the services for which payment is requested are covered by the appropriate State Medical Assistance program					
40.8.1.107	Provides capability for editing to ensure that all required attachments are present					
40.8.1.108	Provides capability to edit for cost-sharing requirements on applicable claims					
40.8.1.109	Provides capability to edit any suspended claims requiring provider or recipient prepayment review					
40.8.1.110	Provides capability to process all claims against the edit criteria					
40.8.1.111	Provides capability for editing to assure that reported diagnosis, procedures, revenue codes, and denial codes are present on Medicare primary claims and all other appropriate claim types					
40.8.1.112	Provides capability to edit for recipient eligibility on date(s) of service					
40.8.1.113	Provides capability to edit for valid recipient identification, using DOB and a minimum of the first two (2) characters of last name and the first character of first name					



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Requirement #	Requirement Description	A	B	C	D	E
40.8.1.114	Provides capability to edit for special eligibility records, indicating recipient participation in special programs where program service limitations or restrictions may vary					
40.8.1.115	Provides capability to edit for recipient living arrangement within the dates of service					
40.8.1.116	Provides capability to edit for Provider program eligibility to perform procedure rendered on date of service					
40.8.1.117	Provides capability to edit for provider participation as a member of the billing group					
40.8.1.118	Provides capability to edit claims for recipients in nursing facilities against recipient approval data, level of care, patient liability, patient deductible, Medicare denial, reserve bed and leave days, and admit/discharge information					
40.8.1.119	Provides capability to edit for prior approval and ensure an active prior approval number is on file					
40.8.1.120	Provides capability to edit for prior approval claims and cut back billed units or dollars					
40.8.1.121	Provides capability to edit for step therapy criteria and protocol for selected drugs					
40.8.1.122	Provides capability to override the thirty-four-day (34-day) supply limit edit for drugs					
40.8.1.123	Provides capability to maintain edit disposition to deny claims for services that require prior approval if no prior approval is identified or active					
40.8.1.124	Provides capability to update the Prior Approval record(s) to reflect the services paid on the claim, including units, amount paid, and the number of services still remaining to be used					
40.8.1.125	Provides capability for automated cross-checks and relationship edits on all claims					
40.8.1.126	Provides capability for automated audit processing against history, suspended, and same cycle claims					





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Requirement #	Requirement Description	A	B	C	D	E
40.8.1.127	Provides capability to apply Medical Procedure Audit Policy (MPAP) to determine audits on a specific claim detail					
40.8.1.128	Provides capability to ensure that auditing supports claim denials, automatic recoupments or cutbacks, suspended for review, or specific pricing					
40.8.1.129	Provides capability for automatic system recoupment and denial of hospital claim when prior approval for surgery was not granted					
40.8.1.130	Provides capability to apply clinical and pricing business rules in claims processing					
40.8.1.131	Provides capability to identify paid and denied claims in Claims History					
40.8.1.132	Provides capability for editing an unlimited number of claim lines					
40.8.1.133	Provides capability to process multiple units of service for a span of dates of service					
40.8.1.134	Provides capability to edit for potential duplicate claims based on a cross-reference of group and rendering provider, multiple provider locations, and across provider and claim types					
40.8.1.135	Provides capability to identify potential and/or exact duplicate claims in the MMIS and POS within and across financial payers					
40.8.1.136	Provides capability to edit using duplicate audit and suspect-duplicate criteria to validate against history, suspended claims, and same-cycle claims					
40.8.1.137	Provides capability for audit trail of all claims that identify timing and suspense status, error codes, and occurrences per claim header and claim detail as processed to final adjudication status					
40.8.1.138	Provides capability for an unlimited number of edits per claim					
40.8.1.139	Provides capability to identify and track all edits and audits posted to the claim from					



**APPENDIX 50, ATTACHMENT C, EXHIBIT 1**



Requirement #	Requirement Description	A	B	C	D	E
	suspense through adjudication					
40.8.1.140	Provides capability for each error code to have a resolution code, an override, force or deny indicator, and the date that the error was resolved, forced, or denied					
40.8.1.141	Provides capability for the acceptance of overrides of claim edits and audits					
40.8.1.142	Provides capability to turn off and on edits/audits for program types as specified by State Memo					
40.8.1.143	Provides capability to identify the claim deposition, based on the edit status or force code with the highest severity specific to each LOB					
40.8.1.144	Provides capability to maintain a record of service codes required for audit processing where the audit criteria covers a period longer than five (5) years (such as once-in-a-lifetime procedures)					
40.8.1.145	Provides capability to modify the disposition of edits by LOB to: <ul style="list-style-type: none"> <li>▪ Suspend for special handling</li> <li>▪ Deny and print an explanatory message on the provider RA</li> <li>▪ Suspend to a specific location unit</li> <li>▪ Pay and report to a specific location/unit</li> <li>▪ Pay</li> </ul>					
40.8.1.146	Provides capability to set claim edits to allow dispositions and exceptions to edits based on claim type submission media, provider type and specialty and subspecialty or taxonomy, recipient Medical Assistance program, or individual provider number					
40.8.1.147	Provides capability to perform edits against claims for limits on dollars, units, and percentages					
40.8.1.148	Provides capability to override the Prior Approval edit to allow for emergency seventy-two-hour (72-hour) supply of a drug and does not count toward service limitations for					



**APPENDIX 50, ATTACHMENT C, EXHIBIT 1**



Requirement #	Requirement Description	A	B	C	D	E
	prescriptions					
40.8.1.149	Provides capability for variable limitations of pharmacy prescription benefits, such as number of prescriptions, quantity of drugs, specific drugs, and upper limits					
40.8.1.150	Provides capability to allow for exceptions to pharmacy lock-ins					
40.8.1.151	Provides capability to edit claims with billed amounts that vary by a specified degree above or below allowable amounts					
40.8.1.152	Provides capability to validate provider IDs for billing, attending, referring, and prescribing providers					
40.8.1.153	Provides capability to edit for valid CLIA certification for laboratory procedures					
40.8.1.154	Provides capability to edit claim for tooth numbers for procedures requiring tooth number, surface, or quadrant					
40.8.1.155	Provides capability to edit for procedure to procedure on same date of service					
40.8.1.156	Provides capability to edit for service limitations					
40.8.1.157	Provides capability to edit for the identification of the quadrant based on tooth number for editing					
40.8.1.158	Provides capability to track service limitations online					
40.8.1.159	Provides capability to edit and suspend with procedure codes set to manually price unless there is a prior approval for the procedure code for the recipient with the servicing provider					
40.8.1.160	Provides capability to edit for program and allow for services to ICF-MR adults for procedures limited to those individuals under twenty-one (21) years of age					



**APPENDIX 50, ATTACHMENT C, EXHIBIT 1**



Requirement #	Requirement Description	A	B	C	D	E
40.8.1.161	Provides capability to edit for timely filing					
40.8.1.162	Provides capability to cut back units on claims, retaining the original units billed and units paid					
40.8.1.163	Provides capability to process Medicare cost-sharing charges using the full claim input information and system edit capability					
40.8.1.164	Provides capability to edit across claim types, including the ability to process with a minimum of four (4) modifiers and edit for modifier appropriateness					
40.8.1.165	Provides capability to edit for disproportionate share hospitals					
40.8.1.166	Provides capability for all edits as listed by the State					
40.8.1.167	Provides capability for encounter-specific editing and auditing					
40.8.1.168	Provides capability to edit billed charges for high and low variances					
	<b>Suspended Claims</b>					
40.8.1.169	Provides capability to suspend claims for review, as required by the State					
40.8.1.170	Provides capability for manual review of claims for specific services, such as hysterectomies, abortions, sterilizations, DME claims for external insulin pumps, equipment repairs, miscellaneous pediatric items, miscellaneous drugs, off-labeled drugs, and all PAC "1" codes					
40.8.1.171	Provides capability to process Medicare cost-sharing charges					
40.8.1.172	Provides capability to electronically store and report comparable codes used to price unlisted procedure codes					
40.8.1.173	Provides capability to subject all pharmacy claims to the automated POS PRO-DUR					



**APPENDIX 50, ATTACHMENT C, EXHIBIT 1**



Requirement #	Requirement Description	A	B	C	D	E
	consistently					
40.8.1.174	Provides capability to provide adjudication of the pharmacy POS claim as paid or denied when it passed all edits and audits, sending a response back to the provider via a VAN					
	<b>General Claims Resolution</b>					
40.8.1.175	Provides capability for online claims resolution, edit override capabilities for all claim types, and online adjudication					
40.8.1.176	Provides capability to ensure that all corrected claims are completely re-edited					
40.8.1.177	Provides capability for claims correction process that allows inquiry and update by transaction control number, provider ID, recipient ID, location code, adjustment initiator ID, clerk ID, claim type, date of service, ranges of dates, and prior approval number					
40.8.1.178	Provides capability to sort suspended claims into applicable work queues					
40.8.1.179	Provides capability to forward suspended claims to multiple locations					
40.8.1.180	Provides capability to accept mass adjustments to suspended claims					
40.8.1.181	Provides capability to link free-form notes from all review outcomes and directions to the imaged claim					
40.8.1.182	Provides capability to maintain error codes and messages that clearly identify the reason(s) for the suspension					
40.8.1.183	Provides capability for the methodology to process the adjustment offset in the same payment cycle as the adjusting claim					
40.8.1.184	Provides capability to adjust Claims History only					
40.8.1.185	Provides capability to re-edit, re-price, and re-audit each adjustment, including checking					



**APPENDIX 50, ATTACHMENT C, EXHIBIT 1**



Requirement #	Requirement Description	A	B	C	D	E
	for duplication against other regular and adjustment claims, in history, and in process					
40.8.1.186	Provides capability to allow online changes to the adjustment claim record to reflect corrections or changes to information during the claim correction (suspense resolution) process					
40.8.1.187	Provides capability to maintain primary and secondary adjustment reason codes that indicate who initiated the adjustment, the reason for the adjustment, and the disposition of the claim for use in reporting the adjustment					
40.8.1.188	Provides capability for the methodology to allow online changes to the adjustment claim record to reflect corrections or changes to information during the claim correction (suspense resolution) process					
<b>Requirement Deleted</b> 40.8.1.189	<del>Provides capability to generate exception sheets online</del>					
40.8.1.190	Provides capability to capture and maintain the medical reviewer ID and claims resolution worker ID by date and by error/edit for each suspended claim					
40.8.1.191	Provides capability to identify and access the status of any related limitations for which the recipient has had services					
40.8.1.192	Provides capability to enter multiple error codes for a claim to appear on the RA					
40.8.1.193	Provides capability to assign a unique status to corrected claims					
40.8.1.194	Provides capability of entering multiple error codes for a claim to appear on the RA					
40.8.1.195	Provides capability to maintain all claims on the suspense file until corrected, automatically recycled, or automatically denied					
40.8.1.196	Provides capability to adjudicate special batches of claims					



**APPENDIX 50, ATTACHMENT C, EXHIBIT 1**

Requirement #	Requirement Description	A	B	C	D	E
40.8.1.197	Provides capability to force release of claims					
40.8.1.198	Provides capability to adjudicate and track non-covered service claims for EPSDT recipients					
40.8.1.199	Provides capability to capture rebateable NDCs for all administered drugs in the Physician Drug Program, including drugs administered with HCPCS codes					
	<b>Retrospective Drug Utilization Review</b>					
40.8.1.200	Provides capability to generate a file of paid drug claims to the Retrospective DUR Vendor					
40.8.1.201	Provides capability to generate a file of physician, clinic, hospital, and pharmacy Provider data to the Retrospective DUR Vendor					
40.8.1.202	Provides capability to generate a file of the recipient data to the Retrospective DUR Vendor					
40.8.1.203	Provides capability to produce the CMS Annual Drug Utilization Review Report					
	<b>Adjustment Processing</b>					
40.8.1.204	Provides capability for online search inquiry for pharmacy claims via any available FDB data element/module, including, but not limited to: <ul style="list-style-type: none"> <li>▪ Recipient identifier</li> <li>▪ Provider identifier</li> <li>▪ Pharmacy number</li> <li>▪ Internal control number (ICN)</li> <li>▪ Prescription number</li> <li>▪ Therapeutic class</li> </ul>					



## APPENDIX 50, ATTACHMENT C, EXHIBIT 1

Requirement #	Requirement Description	A	B	C	D	E
	<ul style="list-style-type: none"> <li>▪ Drug codes</li> <li>▪ GCN</li> <li>▪ GCN-Sequence</li> <li>▪ NDC</li> </ul>					
40.8.1.205	Provides capability to update provider payment history and recipient claims history with all appropriate financial records and reflect adjustments in subsequent reporting, including claim-specific and non-claim-specific recoveries					
40.8.1.206	Provides capability to link an original claim with all adjustment transactions					
40.8.1.207	Provides capability for an online mass-adjustment function to re-price claims, within the same adjudication cycle, for retroactive pricing changes					
40.8.1.208	Provides capability to correct the tooth surface on dental claims and process as an adjustment					
40.8.1.209	Provides capability to process unit dose credits					
40.8.1.210	Provides capability to input transactions to Drug Rebate and TPL of all collected dollars					
40.8.1.211	Provides capability to capture pharmacy/drug rebates on professional and institutional claims					
40.8.1.212	Provides capability to capture and electronically store the clerk ID of the individual who initially entered the adjustment and the clerk ID who worked the suspended adjustment					
	<b>General Payment Processing</b>					
40.8.1.213	Provides capability to process all claims and adjustments in accordance with Replacement MMIS policy and procedure					
40.8.1.214	Provides capability to assign the status of claims in the system to determine the course of					





**APPENDIX 50, ATTACHMENT C, EXHIBIT 1**



Requirement #	Requirement Description	A	B	C	D	E
	each action to be taken in the claims adjudication process and completion of appropriate financial processing tasks					
40.8.1.215	Provides capability to apply payments to open accounts receivables when the provider has a positive balance, apply third party collections, create Adjudication Claims File for checkwrite period, and update Provider Earnings file					
40.8.1.216	Provides capability to generate Health Insurance Premium Payments (HIPP)					
40.8.1.217	Provides capability for claims exceptions to process automatically when prior authorized by the lock-in primary care provider or prescriber in accordance with State policy					
	<b>Financial and Related Processing</b>					
40.8.1.218	Provides capability to maintain complete audit trails of adjustment processing activities					
40.8.1.219	Provides capability to assign the status of claims in the system to determine course of each action to be taken in the claims adjudication process and completion of appropriate financial processing tasks					
40.8.1.220	Provides capability to calculate claims payments by payer source, balancing payments due from adjudicated claims with any increase/decrease for adjustments or other financial transactions					
40.8.1.221	Provides capability to apply payments to open accounts receivables when the provider has a positive balance, apply third party collections, create Adjudication Claims File for checkwrite period, and update Provider Earnings file					
40.8.1.222	Provides capability to produce system-generated check registers, provider checks, and RAs and update control totals by LOB					
40.8.1.223	Provides capability to print provider voucher statements and checks by LOB					
40.8.1.224	Provides capability to validate a provider's status prior to issuing payments or processing refund checks and voided checks					



**APPENDIX 50, ATTACHMENT C, EXHIBIT 1**

Requirement #	Requirement Description	A	B	C	D	E
40.8.1.225	Provides capability to produce a monthly file of all adjudicated claims and other financial transactions by LOB					
40.8.1.226	Provides capability to track the status of all financial transactions by payer source					
40.8.1.227	Provides capability to run separate payment cycles by each LOB					
40.8.1.228	Provides capability to override the system date used for the payment cycle through a system parameter					
40.8.1.229	Provide the capability to use the same system date for all outputs of a claims payment cycle					
40.8.1.230	Provides capability to create a single check or EFT per payment cycle for each provider by LOB					
40.8.1.231	Provides capability to generate beneficiary Recipient Explanation of Medicaid Benefits (REOMBs)					
40.8.1.232**	Provides capability to generate beneficiary Recipient Explanation of Benefits (REOBs) by LOB					
40.8.1.233	Provides capability to produce and distribute paper RAs formatted separately for individual provider types					
40.8.1.234	Provides capability to produce ANSI 835 and 820 transactions					
40.8.1.235	Provides capability for EFT by LOB					
40.8.1.236	Provides capability to update historical files with information from RAs/835s and checks					
40.8.1.237	Provides capability to ensure RAs contain State-approved EOB messages by LOB					
40.8.1.238	Provides capability for producing statistically valid sampling reports for use in provider					



**APPENDIX 50, ATTACHMENT C, EXHIBIT 1**



Requirement #	Requirement Description	A	B	C	D	E
	audits by LOB					
40.8.1.239	Provides capability to rerun a payment cycle by LOB before the next regularly scheduled cycle and within eight (8) clock hours of State notification, when the original cycle is considered unacceptable					
40.8.1.240	Provides capability to produce EFT register and ANSI 835					
40.8.1.241	Provides capability for balancing process associated with financial month-end reporting					
40.8.1.242	Provides capability to modify payment cycle schedule					
40.8.1.243	Provides capabilities to provide independent and separate banking					
40.8.1.244	Provides capability to combine claims from MMIS and POS for payment processing					
40.8.1.245	Provides capability to withhold adjudicated claims from the payment cycle by payer source					
40.8.1.246	Provides capability to retrieve budget and available balance data from North Carolina Accounting System (NCAS)					
40.8.1.247**	Provides capability to accept and process budget data from a DMH file					
40.8.1.248	Provides capability to use approved budget data for expenditure allotment and control					
40.8.1.249**	Provides capability to process and pay claims, based on the applicable budget hierarchy, from the first eligible benefit plan where money is available and the service is covered, within the same payment cycle					
40.8.1.250**	Provides capability to deny claims for services for lack of available funds					
40.8.1.251	Provides capability to hold payment of a claim for a specified period of time					



## APPENDIX 50, ATTACHMENT C, EXHIBIT 1

Requirement #	Requirement Description	A	B	C	D	E
40.8.1.252	Provides capability to exclude “to be paid” claims for payment processing when the provider is in hold status					
40.8.1.253	Provides capability to accumulate by LOB the reimbursement amounts of all original claims, voids, adjustments, and financial transactions in a “to-be-paid” status to determine an initial net payment amount for a provider					
40.8.1.254	Provides capability to create a receipt for individual claims that were overpaid or paid in error and produce a void or adjustment claim showing the transaction					
40.8.1.255	Provides capability to create a financial transaction to correct overpayments, link to original transaction, and apply to offset future payments					
40.8.1.256	Provides capability to apply all or a portion of the provider’s initial payment amount, if it is positive, to recoup monies against any outstanding accounts receivable balances present for the provider					
40.8.1.257	Provides capability to use the Thursday following the processing date as the last payment cycle of the month					
40.8.1.258	Provides capability to process adjustment claims and credit the appropriate budgets before processing any new day claims					
40.8.1.259	Provides capability to apply Patient Monthly Liability (PML) to specific types of claims and post liability amounts used					
40.8.1.260	Provides capability to apply recipient deductible balance to specified types of claims					
40.8.1.261	Provides the capability for positive pay processing					
40.8.1.262	Provides the capability for provider payment data					
40.8.1.263	Provides capability to apply withholds to capitation payments					



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Requirement #	Requirement Description	A	B	C	D	E
40.8.1.264	Provides capability to release withholds to capitation payments					
40.8.1.265	Provides capability to apply provider sanctions by rate or percentage					
40.8.1.266	Provides capability to apply provider incentives to management fee claims					
40.8.1.267	Provides all payments, adjustments, and other financial transactions to enrolled providers for approved services					
40.8.1.268	Provides the capability to associate all drug rebates to the claim detail					
	<b>Financial Management and Accounting Business Area</b>					
40.8.1.269	Provides capability to establish accounts receivable in the format of withholds, liens, levy data, and advance payment/recovery of advance payment					
40.8.1.270	Provides capability for claims that have passed all edit and pricing processing or that have been denied to be documented on the RA by LOB					
40.8.1.271	Provides capability to create financial transactions					
40.8.1.272	Provides capability to create receivables generated from other MMIS functions					
40.8.1.273	Provides capability to create provider, recipient, reference, and account receivable/payout data					
40.8.1.274	Provides capability to make retroactive changes to deductibles					
40.8.1.275	Provides capability to create transactions for corrections to receivables entered into the Replacement MMIS					
40.8.1.276	Provides capability to create transactions for manual checks					
40.8.1.277	Provides capability to create transactions for paper checks					



**APPENDIX 50, ATTACHMENT C, EXHIBIT 1**



Requirement #	Requirement Description	A	B	C	D	E
40.8.1.278	Provides capability to validate new and updated EFT provider information					
40.8.1.279	Provides capability to requests an override EFT and create paper checks for a date range and check pulls for void and replacement					
40.8.1.280	Provides capability to create transactions of check voucher status from the State Controller's Office					
40.8.1.281	Provides capability for notes tracking to accommodate tracking of calls					
40.8.1.282	Provides capability for online access to all recipient, provider, encounter (shadow claims), and reference data related to Financial Management and Accounting by LOB					
40.8.1.283	Provides capability for Financial Management and Accounting functions with system update capability					
40.8.1.284	Provides capability to maintain a consolidated accounting function, by program, type, and provider					
40.8.1.285	Provides capability to process capitation payments					
40.8.1.286	Provides capability to withhold a percentage of capitation payments					
40.8.1.287	Provides capability to process Managed Care management fees					
40.8.1.288	Provides capability to process management fees for Health Check					
40.8.1.289	Provides capability to process capitation and/or management fee adjustments					
40.8.1.290	Provides capability to process management fees for APs/LMEs					
40.8.1.291	Provides capability to process encounter claims through the payment cycle, updating the final status of the claims to "paid" or "denied" but not producing an associated payment					



**APPENDIX 50, ATTACHMENT C, EXHIBIT 1**



Requirement #	Requirement Description	A	B	C	D	E
40.8.1.292	Provides capability to produce an output extract of encounters (an Encounter RA)					
40.8.1.293	Provides capability to produce an output extract of enhanced Pharmacist Professional fee (on a Pharmacy RA)					
40.8.1.294	Provides capability for system-generated log and tracking of receipt date of request for changes					
40.8.1.295	Provides capability to ensure that provider payments are generated by the processing of claims for eligible recipients and provides capability for adjustments					
40.8.1.296	Provides capability to carry the provider's selection of receiving checks or EFT form of payment					
40.8.1.297	Provides capability to carry the provider's selection of receiving hard copy, electronic RAs, or both					
40.8.1.298	Provides capability to accept pended and adjudicated claims against Provider Earnings file					
40.8.1.299	<p>Provides capability to generate or reproduce provider RAs, to include:</p> <ul style="list-style-type: none"> <li>▪ An itemization of submitted claims that were paid, denied, or adjusted, and any financial transactions that were processed for that provider, including subtotals and totals by LOB</li> <li>▪ An itemization of suspended claims, including dates of receipt and suspense and dollar amount billed by LOB</li> <li>▪ Adjusted claim information showing the original claim information and the adjusted information, with an explanation of the adjustment reason code and credits pending by LOB</li> <li>▪ Reason for recoupment or adjustment by LOB</li> <li>▪ Indication that a claim has been rejected due to TPL coverage on file for the recipient; include available relevant TPL data on the RA by LOB</li> </ul>					



**APPENDIX 50, ATTACHMENT C, EXHIBIT 1**



Requirement #	Requirement Description	A	B	C	D	E
	<ul style="list-style-type: none"> <li>▪ Tooth number and surface</li> <li>▪ Explanatory messages relating to the claim payment cutback, denial, or suspension</li> <li>▪ Summary section containing earnings information, by program, regarding the number of claims paid, denied, suspended, adjusted, in process, and financial transactions for the current payment period, month-to-date, and year-to-date</li> <li>▪ Listing of all relevant error messages per claim header and claim detail that would cause a claim to be denied by LOB</li> </ul>					
40.8.1.300	Provides capability to print global informational messages on RAs by LOB; provides capability to make multiple messages available on an online, updateable, user-maintainable message text table; provides capability for unlimited free-form text messages; provides capability for parameters such as provider category of service, provider type, provider specialty, program enrollment, claim type, individual provider number, or pay cycle to control the printing of RA messages					
40.8.1.301	Provides capability to suppress the generation of (both zero-pay and pay) check requests for any provider or provider type but generates associated RAs					
40.8.1.302	Provides capability to update provider payment data					
40.8.1.303	Provides capability to maintain a process of fiscal pends					
40.8.1.304	Provides capability to not accumulate claims in a "to be paid" status that have been excluded from payment					
40.8.1.305	Provides capability to suppress the print of a RA when the only thing that is being printed is related to a credit balance					
40.8.1.306	Provides capability to maintain all data items received on all incoming claims, including the tooth number and tooth surface(s)					
40.8.1.307	Provides capability to update Claims History and online financial files with the date of					





**APPENDIX 50, ATTACHMENT C, EXHIBIT 1**



Requirement #	Requirement Description	A	B	C	D	E
	payment and amount paid					
40.8.1.308	Provides capability for summary-level provider accounts receivable and payable data and pending recoupment amounts that are automatically updated after each claims processing payment cycle					
40.8.1.309	Provides capability to adjust claim money fields to net out					
40.8.1.310	Provides capability to automatically establish new accounts receivables					
40.8.1.311	Provides identification of providers with credit balances and no claim activity, by program, during a State-specified number of months					
40.8.1.312	Provides capability for the issuance of provider checks and/or EFTs for all claims in the current checkwrite cycle					
40.8.1.313	Provides capability to ensure accurate balances for each checkwrite in accordance with State-approved policy and procedures					
40.8.1.314	Provides capability to process transactions for manually written checks generating a Claims History record					
40.8.1.315	Provides capability to process EFT provider information, updating provider records to reflect their status with EFT					
40.8.1.316	Provides capability to accept requests to override EFT payment to a provider					
40.8.1.317	Provides capability to process check voucher information from the State Controller's Office					
40.8.1.318	Provides capability to update Claims History with RA number and RA issued date from the State Controller's Register file					
40.8.1.319	Provides capability to ensure that the weekly budget reporting is consistent with the costs					



**APPENDIX 50, ATTACHMENT C, EXHIBIT 1**

Requirement #	Requirement Description	A	B	C	D	E
	allocated during the checkwrite by LOB					
40.8.1.320	Provides capability to produce reports and RAs within the financial processing function of the checkwrite cycle by LOB					
40.8.1.321	Provides capability to process and/or set up a recoupment against a provider without specifying a credit balance by LOB					
40.8.1.322	Provides capability to use a hierarchy table when a provider has multiple recoupment accounts					
40.8.1.323	Provides capability to identify and recoup payments from the provider made for services after a recipient's date of death					
40.8.1.324	Provides capability to apply claims payments recoupments to more than one (1) account receivable at a time					
40.8.1.325	Provides capability to support a methodology that allows the portion of payments made against each account receivable to be controlled by State staff					
40.8.1.326	Provides capability to validate provider tax identification numbers and associated tax names					
40.8.1.327	Provides capability to process any change transactions received for corrections to checks by LOB					
40.8.1.328	Provides capability to ensure that all financial reports can be tied into the basic financial activity recorded in Provider histories by LOB					
40.8.1.329	Provides capability to generate weekly, monthly, quarterly, and annual financial reports after checkwrites					
40.8.1.330	Provides capability for Advance Provider payments by LOB					



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Requirement #	Requirement Description	A	B	C	D	E
40.8.1.331	Provides capability to receive online requests from authorized users to retrieve paid claims data to produce Recipient Profiles by LOB and return the data in a printable electronic format					
40.8.1.332	Provides capability to include all buy-in premium payments and adjustments in the online paid Claims History files and in Recipient Profile Reports					
40.8.1.333	Provides the capability to obtain approval from NC DHHS for the amount to be applied for payment prior to each checkwrite					
40.8.1.334	Provides the capability to check remaining balance as each payment amount is calculated to verify that the budgeted amount is not exceeded					
40.8.1.335	Provides capability to identify and calculate pricing amounts according to the fee schedules, per diems, rates, and business rules					
40.8.1.336	Provides capability to apply pricing and reimbursement methodologies to appropriately price claims according to NC DHHS pricing standards					
40.8.1.337	Provides capability to price using any combination of procedure code, population group, billing provider, attending provider, and client					
40.8.1.338	Provides capability to establish fee schedules based on procedures, procedure/modifier, or procedure/type of service, including provider specific rates, DRGs, anesthesia base units, and global surgery days					
40.8.1.339	Provides capability to apply percentages for dual-eligible recipients					
40.8.1.340	Provides capability for pricing of pharmacy claims and reimbursement methodologies to appropriately price claims according to the appropriate financial payer or population group in accordance with State policy, including a dispensing fee and pricing actions					
40.8.1.341	Provides capability to determine calculations for the PAL tiers					



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Requirement #	Requirement Description	A	B	C	D	E
40.8.1.342	Provides capability to process and reimburse pharmacy-enhanced professional service fees as defined by State policy and business rules					
40.8.1.343	Provides capability to price pharmacy claims using lesser of logic incorporating all State-approved pricing methodologies					
40.8.1.344	Provides capability to price using State-specific services from the Prior Approval File					
40.8.1.345	Provides capability to apply recipient liability and co-pay rules, including varying co-pay amounts					
40.8.1.346	Provides capability to identify and calculate payment amounts for Health Check procedures when higher rate applies					
40.8.1.347	Provides capability to deduct either the provider reported or recipient database deductible amount					
40.8.1.348	Provides capability to use non-Medicaid charges first and apply the remainder to allowed charges based on first bill received for processing for the deductible for recipients classed as medically needy					
40.8.1.349	Provides capability to allow the deductible amount to be assigned to specific providers for recipients classed as medically needy					
40.8.1.350	Provides capability to invoke State-approved "Medicare Suspect" procedures					
40.8.1.351	Provides capability to deduct or otherwise apply TPL amounts when pricing claims					
40.8.1.352	Provides capability to price procedure codes, allowing for multiple modifiers that enable reimbursement by program at varying percentages of allowable amounts					
40.8.1.353	Provides capability to price units for procedures based on the cutback units					
40.8.1.354	Provides capability to price encounter claims at equivalent fee for service payment less					



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Requirement #	Requirement Description	A	B	C	D	E
	deductions, such as TPL or co-payments					
40.8.1.355	Provides capability to maintain multiple date-specific prices for each applicable provider, procedure code, revenue code, and DRG					
40.8.1.356	Provides capability to maintain multiple date-specific rates for each procedure code, population group, billing provider, attending provider, and/or client specific combination					
40.8.1.357	Provides capability to ensure that NC DHHS programs are payers of last resort with respect to private insurance					
40.8.1.358	Provides capability to ensure that claims with known TPL are reduced by the liability in accordance with NC DHHS standards					
40.8.1.359	Provides capability to support application of State-specific services for claims processing					
40.8.1.360	Provides capability to pay only out-of-plan services for capitated program enrollees as fee-for-service and deny in-plan services					
40.8.1.361	Provides capability to automate the calculation for Ambulatory Surgical Centers					
40.8.1.362	Provides capability to apply Graduate Medical Education (GME), both direct and indirect, to inpatient claims					
40.8.1.363	Provides capability to price NDC codes					
40.8.1.364	Provides capability to price or deny claims with Medicare participation, including Medicare HMOs Part C, according to program pricing rules					
40.8.1.365	Provides capability to calculate a DRG per diem for undocumented alien's claims					
40.8.1.366	Provides capability to apply a percentage of an existing fee schedule rate for a different provider specialty					



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Requirement #	Requirement Description	A	B	C	D	E
40.8.1.367	Provides capability to apply variable recipient co-pay percentages to a claim from a prior approval					
40.8.1.368	Provides capability to prorate monthly rate for days billed according to State business rules					
40.8.1.369	Provides capability to calculate provider reimbursement according to business rules					
40.8.1.370	Provides capability to price pharmacy claims up to a maximum level allowed by current NCPDP and FDB					
40.8.1.371	Provides capability to price a claim at the lower of the maximum applicable rate, the provider's billed amount, applicable manual pricing, or invoice pricing					
40.8.1.372	Provides capability to accommodate and provide for claims sampling specific to Payment Error Rate Measurement (PERM) Program requirements mandated by CMS and/or their Federal contract agent within designated timeframes  Refer to <i>2007 PERM Data Submission Instructions–Jan 2007[1].pdf</i> for current PERM data submission requirements.					
40.8.1.373	Provides capability to process HIPPA payments					
40.8.1.374	Provides capability to produce and send correspondence related to recipient premiums in the recipient's preferred language, including invoices, notices of non-payment, cancellation notices, receipts, and refunds					
40.8.1.375	Provides capability to collect recipient premium payments					
40.8.1.376	Provides capability to produce refunds of recipient premiums					
40.8.1.377	Provides capability to process financial accounting records for premium payments and refunds					



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Requirement #	Requirement Description	A	B	C	D	E
40.8.1.378	Provides capability to produce reports for recipient premium payment and cost-sharing (e.g., recipient co-insurance, deductibles, co-payments, etc.) processes					
40.8.1.379	Provides capability to apply cost-sharing, e.g., recipient co-insurance, deductibles, co-payments					
40.8.1.380	Provides capability to ensure cost-sharing does not exceed threshold for the family group					
40.8.1.381	Provides capability to produce and send recipient letters/notices and Explanations of Benefits (EOB) in the recipient's preferred language					

**40.8.2 Claims Processing Operational Requirements**

Requirement #	Requirement Description	A	B	C	D	E
	<b>General Responsibilities</b>					
40.8.2.1	Fiscal Agent shall perform all claims processing operations functions to support Claims Processing Business Area requirements specified in the Replacement MMIS and user documentation and operating procedures, including, but not limited to: <ul style="list-style-type: none"> <li>▪ Pickup and delivery of mail</li> <li>▪ Sorting and screening of documents</li> <li>▪ Scanning and batching of documents</li> <li>▪ Batch control</li> <li>▪ Data entry</li> <li>▪ Pharmacy Point-of-Sale</li> <li>▪ Payer determination processing</li> <li>▪ Edit processing</li> </ul>					



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Requirement #	Requirement Description	A	B	C	D	E
	<ul style="list-style-type: none"> <li>▪ Suspense resolution</li> <li>▪ Medical review</li> <li>▪ Claims pricing</li> <li>▪ Adjudication processing</li> <li>▪ Adjustment processing</li> <li>▪ Payment processing</li> <li>▪ Financial processing</li> <li>▪ Encounter processing</li> </ul>					
40.8.2.2	Fiscal Agent shall maintain and update the current State-approved Medical Procedure Audit Policy (MPAP).					
40.8.2.3	Fiscal Agent shall create test, process, and review claims in a duplicate region (test region) to assure that State-requested changes to the system adjudicate as anticipated and make changes or receive approval according to contractual agreements.					
	<b>Mailroom</b>					
40.8.2.4	Fiscal Agent shall prepare and process all incoming and outgoing mail.					
40.8.2.5	Fiscal Agent shall pick up and deliver mail to the State once in the morning, once in the afternoon of each State business day, and at the request of the State.					
40.8.2.6	Fiscal Agent shall control hand-delivered mail at the Fiscal Agent's main entrance for security and management of routing to appropriate personnel or functional unit.					
40.8.2.7	Fiscal Agent shall ensure no mail, claims, tapes, diskettes, cash, or checks are misplaced after receipt by the Fiscal Agent.					
40.8.2.8	Fiscal Agent shall ensure all mail is date-stamped with date of receipt and within one (1) business day of receipt.					





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Requirement #	Requirement Description	A	B	C	D	E
40.8.2.9	Fiscal Agent shall maintain system logging for packages/envelopes mailed via USPS or any other mailing service.					
40.8.2.10	Fiscal Agent shall prepare RTP letters, REOMBs, notice of service approval or denial, and appeal rights TPL letters, drug recovery invoices, estate letters, COCC, and small packages for First Class Mail delivery.					
40.8.2.11	Fiscal Agent shall print and mail/deliver electronically Replacement MMIS State-approved forms.					
40.8.2.12	Fiscal Agent shall log postage costs daily and report to the State a reconciliation of all postage costs to types of articles mailed and distributed					
40.8.2.13	Fiscal Agent shall prepare RAs for mailing and/or transmitting, EFTs for transmitting, and checks for release and mailing.					
	<b>Claims Acquisition</b>					
40.8.2.14	Fiscal Agent shall scan hard copy claims and accompanying documentation.					
40.8.2.15	Fiscal Agent shall pre-screen hard copy claims before entering claims into the system and return those not meeting certain criteria to providers under the RTP letter, indicating missing or incorrect information and log returned claims daily.					
	<b>Adjustments</b>					
40.8.2.16	Fiscal Agent shall sort, log, and batch adjustment requests and supporting documentation.					
40.8.2.17	Fiscal Agent shall assign adjustment internal control numbers that can associate back with the original claim or previous adjustment.					
40.8.2.18	Fiscal Agent shall return adjustment requests with RTP letter to provider, indicating missing or other required information needs.					



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Requirement #	Requirement Description	A	B	C	D	E
40.8.2.19	Fiscal Agent shall scan adjustments and supporting documentation.					
40.8.2.20	Fiscal Agent shall verify the quality and readability of scanned adjustment documents.					
40.8.2.21	Fiscal Agent shall reconcile all adjustments (hard copy) entered into the system to batch processing cycle input and output figures.					
	<b>Claims Entry</b>					
40.8.2.22	Fiscal Agent shall perform data entry of all hard copy claims.					
40.8.2.23	Fiscal Agent shall determine if front-end denials are required (such as claims that do not have required sterilization forms or Medicare voucher attached for Medicaid Claims).					
40.8.2.24	Fiscal Agent shall perform individual paper and electronic claim overrides on edits, such as presumptive eligibility, Medicare A, B, and C, HMO coverage, TPL, and timely filing limit					
	<b>Specific to Adjustments</b>					
40.8.2.25	Fiscal Agent shall perform data entry of adjustments.					
	<b>Specific to Electronic Claims Submission/Electronic Data Interchange</b>					
40.8.2.26	Fiscal Agent shall distribute provider claim submission software.					
40.8.2.27	Fiscal Agent shall develop and implement procedures to ensure the integrity of claims submitted by providers via ECS/EDI.					
40.8.2.28	Fiscal Agent shall ensure that all providers submitting via ECS/EDI have signed and returned State-approved ECS/EDI agreements prior to accepting any "production" claim data.					
40.8.2.29	Fiscal Agent shall maintain the original imaged provider-signed ECS/EDI agreements					



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Requirement #	Requirement Description	A	B	C	D	E
	linked to the provider's file data.					
40.8.2.30	Fiscal Agent shall accept tape-to-tape billing from defined sources.					
40.8.2.31	Fiscal Agent shall staff ECS/EDI Help Desk to respond to provider support requirements from 8:00 A.M. to 5:00 P.M. Eastern Time on State business days.					
40.8.2.32	Fiscal Agent shall perform ECS/EDI Trading Partner acceptance testing and send memo to the State for signoff and approval of Trading Partner claims submission once testing is successful.					
40.8.2.33	Fiscal Agent shall perform provider ECS/EDI acceptance testing.					
40.8.2.34	Fiscal Agent shall assign provider ECS/EDI security identification number during testing and add to the production security file when provider is ECS/EDI-approved.					
40.8.2.35	Fiscal Agent shall log tapes and diskettes upon receipt and assigns batch number.					
40.8.2.36	Fiscal Agent shall perform acceptance testing of VANs for Pharmacy POS claim submission.					
40.8.2.37	Fiscal Agent shall obtain and maintain signed Pharmacy POS Trading Partner Agreements prior to accepting any "production" POS claim data.					
40.8.2.38	Fiscal Agent shall perform pharmacy worksheet resolutions to resolve pending front-end edits for pharmacy claims and submits resolved worksheets to data entry for processing.					
	<b>Drug Utilization Review</b>					
40.8.2.39	Fiscal Agent shall produce information to support the State in completing the CMS Annual Drug Utilization Review Report.					
40.8.2.40	Fiscal Agent shall attend the DUR board meetings, supply copies of the annual DUR Report, and apply all board recommendations to POS once approved by the State.					



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Requirement #	Requirement Description	A	B	C	D	E
	<b>Retrospective Drug Utilization Review</b>					
40.8.2.41	Fiscal Agent shall submit quarterly extract files to the DUR Vendor within five (5) State business days of the month following the quarter's end.					
	<b>Manual Review</b>					
40.8.2.42	Fiscal Agent shall conduct manual reviews of claims for specific services.					
40.8.2.43	Fiscal Agent shall perform manual review on claims according to the manual review procedure manual that identifies claim error information and State-approval criteria.					
40.8.2.44	Fiscal Agent shall refer claims requiring policy decisions to the State.					
40.8.2.45	Fiscal Agent shall perform manual review when claim for EPSDT eligible recipient is denied for "non-covered" services.					
	<b>Adjustments</b>					
40.8.2.46	Fiscal Agent shall return adjustment requests not acceptable due to individual invalid information.					
40.8.2.47	Fiscal Agent shall review adjustment requests.					
40.8.2.48	Fiscal Agent shall process claim-specific retroactive rate adjustments as specified by the State.					
	<b>State-Authorized Claim Overrides</b>					
40.8.2.49	Fiscal Agent shall refer denied claims to the State for review when special circumstances require override designation.					
40.8.2.50	Fiscal Agent shall provide a method to process payments for any specific claim and maintain an audit trail.					



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Requirement #	Requirement Description	A	B	C	D	E
	<b>General Claims Resolution</b>					
40.8.2.51	Fiscal Agent shall add functionality to management fee payments to allow for enhanced/reduced fees for individual providers and shall provide interactive updates when entering the revisions into the system.					
40.8.2.52	Fiscal Agent shall complete a report of identified claims with the potential for TPL, including Medicare, based on the previous mentioned elements.					
40.8.2.53	Fiscal Agent shall use claims consultants to serve as technical supervisors to staff performing claims processing. These individuals shall: <ul style="list-style-type: none"> <li>▪ Research and analyze problem areas at the request of the State</li> <li>▪ Provide consultation on complex cases and advise when to refer to the Fiscal Agent's medical consultant and/or the State</li> <li>▪ Review, analyze, and recommend suggestions affecting State operations.</li> </ul>					
40.8.2.54	Fiscal Agent shall obtain approval from NC DHHS for the amount to be applied for payment.					
40.8.2.55	Fiscal Agent shall check remaining balance as each payment amount is calculated to verify that the budgeted amount is not exceeded.					
40.8.2.56	Fiscal Agent shall manually price claims as designated by State policy.					

**40.8.3 Claims Processing Operational Performance Standards**

Requirement #	Requirement Description	A	B	C	D	E
40.8.3.1	Fiscal Agent shall date-stamp all mail with actual date of receipt within one (1) business day of receipt at Fiscal Agent site.					



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Requirement #	Requirement Description	A	B	C	D	E
40.8.3.2	Fiscal Agent shall print and mail Replacement MMIS State-approved forms to providers within two (2) business days of receipt of the provider request (at no cost to the provider).					
40.8.3.3	Fiscal Agent shall provide ECS/EDI Help Desk staff from 8:00 A.M. to 5:00 P.M. Eastern Time on State business days.					
40.8.3.4	Fiscal Agent shall electronically acknowledge back to the submitter, within twenty-four (24) hours of processing, a notice of all teleprocessed electronic claims files received as either accepted or rejected, along with the number of claims.					
40.8.3.5	Fiscal Agent shall assign an ICN to every claim, attachment, and adjustment within twenty-four (24) hours of receipt.					
40.8.3.6	Fiscal Agent shall maintain data entry-field accuracy rates above ninety-eight (98) percent.					
40.8.3.7	Fiscal Agent shall scan every claim and attachment within one (1) State business day.					
40.8.3.8	Fiscal Agent shall return hard copy claims missing State-specified required data within two (2) State business days of receipt.					
40.8.3.9	Fiscal Agent shall process all provider-initiated adjustments within forty-five (45) calendar days of receipt; however, if the claim requires a review by the State, the forty-five (45) calendar days shall suspend until the claim is returned to the Fiscal Agent.					
40.8.3.10	Fiscal Agent shall adjudicate: <ul style="list-style-type: none"> <li>▪ Ninety (90) percent of all clean claims for payment or denial within thirty (30) calendar days of receipt</li> <li>▪ Ninety-nine (99) percent of all clean claims for payment or denial within ninety (90) calendar days of receipt</li> <li>▪ All non-clean claims within thirty (30) calendar days of the date of correction of the condition that caused the claim to be unclear.</li> </ul>					



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Requirement #	Requirement Description	A	B	C	D	E
40.8.3.11	Fiscal Agent shall provide correct claims disposition and post to the appropriate account or when appropriate, request additional information within one (1) State business day of receipt.					
40.8.3.12	Fiscal Agent shall notify the State of any delays in the checkwrite process by 8:00 A.M. Eastern Time the next State business day following the checkwrite cycle.					
40.8.3.13	Fiscal Agent shall notify the State immediately upon discovery of any erroneous payments, irrespective of cause, and prior to initiating appropriate recovery action. Fiscal Agent shall use the change request process to notify the State of any system errors that result in a potential provider erroneous payment.					
40.8.3.14	Fiscal Agent shall provide financial month-end reporting to the State within three (3) days from the last checkwrite of each month.					
40.8.3.15	Fiscal Agent shall provide specified quarterly extract files to the DUR Vendor within five (5) State business days of the start of the month following the quarter's end.					
40.8.3.16**	Fiscal Agent shall adjudicate for payment all claims with date of service in previous fiscal year July through April claims by the last checkwrite in May for payment, and shall adjudicate all claims for May and June by the last checkwrite in October of the current fiscal year August for payment due to State fiscal year processing of the State monies.					
40.8.3.17	Fiscal Agent shall ensure that all payments, adjustments, and other financial transactions made through the Replacement MMIS shall be made on behalf of eligible clients to enrolled providers for approved services in accordance with the payment rules and other policies of the State.					
40.8.3.18	Fiscal Agent shall timely process all claims to assure that the average time from receipt to payment is within the schedule of allowable times. In addition, payments shall be made in compliance with Federal regulations, and the Fiscal Agent shall pay any penalties, interest, and/or court cost and attorney's fees arising from any claim made by a provider against the Fiscal Agent or the State where the Fiscal Agent's actions resulted in a claim payment that was late.					



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Requirement #	Requirement Description	A	B	C	D	E
40.8.3.19	Fiscal Agent shall successfully complete each checkwrite by the date on the State-approved Checkwrite Schedule.					

## 40.9 Managed Care Requirements

### 40.9.1 Managed Care System Requirements

Requirement #	Requirement Description	A	B	C	D	E
40.9.1.1	Provides capability for notes tracking for managed care provider complaints					
40.9.1.2	Provides capability for online access to all recipient, provider, claims, and reference data related to Managed Care					
40.9.1.3	Provides capability to support multiple Managed Care programs, including those currently in existence: <ul style="list-style-type: none"> <li>▪ Primary Care Case Management (PCCM)</li> <li>▪ Pre-Paid Inpatient Mental Health Plan (PIHP)</li> </ul>					
40.9.1.4	Provides capability to maintain Managed Care capitation rates for specific groups of recipients					
40.9.1.5	Provides capability to apply edits/audits that prevent claims from being paid when Managed Care program recipients receive program-covered services from sources other than the capitated plans in which they are enrolled					
40.9.1.6	Provides capability to apply edits/audits that prevent claims from being paid when a recipient has not received a referral or override approval when required by the Managed Care program or primary care provider with whom they are enrolled					
40.9.1.7	Provides capability to track the utilization rates and costs for program enrollees and to					





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Requirement #	Requirement Description	A	B	C	D	E
	compare such utilization rates and costs to comparable groups of non-Managed Care recipients and across different Managed Care plans to assure sufficient savings are achieved					
40.9.1.8	Provides capability to auto-assign recipients into a Managed Care program(s) See Auto Assignment Business Rules in the Managed Care DSD Exhibits in the Procurement Library.					
40.9.1.9	Provides capability to automatically and on demand produce notices and letters to recipients about their eligibility, enrollment/disenrollment, unavailability of chosen plan, and Managed Care program changes					
40.9.1.10	Provides capability to calculate member months per Managed Care program by age groups and/or by aid categories					
40.9.1.11	Provides capability to maintain an online audit trail of all updates to Managed Care data					
40.9.1.12	Provides capability for online, updateable letter templates for Managed Care recipient and provider letters with the ability to add free-form text and allow for online template changes					
40.9.1.13	Provides capability to apply primary care provider sanctions by entering a provider-specific dollar amount or percentage that results in withholding, or repaying, suppressing, and releasing of all or part of the provider's monthly management/coordination fee up to one hundred (100) percent and notify the State of completed transaction					
40.9.1.14	Provides capability for online logging and tracking of changes to capitation fees or administrative entity provider numbers, file maintenance initiation date, receipt date, file maintenance completion date, operator completing respective changes, name of supervisor, validation, and date					
40.9.1.15	Provides capability to support encounter processing data and costing for the following functions for generation of reports: <ul style="list-style-type: none"> <li>▪ State History File</li> </ul>					



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Requirement #	Requirement Description	A	B	C	D	E
	<ul style="list-style-type: none"> <li>▪ Finalized Claim Activity File</li> <li>▪ Storage of encounter fee for service equivalent cost</li> </ul>					
40.9.1.16	Provides capability to produce monthly Managed Care enrollment reports					
40.9.1.17	Provides capability to produce a file to DIRM/EIS on a weekly basis to report auto-assignment results					
40.9.1.18	Provides capability to produce county-specific Managed Care Provider Directory and transmit electronically to DIRM nightly					
40.9.1.19	Provides capability to produce a county-specific Provider Availability Report and transmit electronically to DIRM nightly					
40.9.1.20	Provides capability to create an extract file containing North Carolina Health Choice recipients linked with a provider/administrative entity and send to the North Carolina State Health Plan by the third business day of each month					
40.9.1.21	Provides capability to generate management fees monthly					
40.9.1.22	Provides capability to generate capitation payments monthly and retroactively for one (1) year					
40.9.1.23	Provides capability to generate prorated capitation payments for a partial month of eligibility					
40.9.1.24	Provides capability to access Managed Care data by recipient identification number, recipient name, provider identification number, provider name, procedure code, procedure description, prior approval number, clerk identification, and any combinations thereof					
40.9.1.25	Provides capability to generate a monthly Federal report of auto-assigned Medicaid recipients					



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Requirement #	Requirement Description	A	B	C	D	E
40.9.1.26	Provides capability to produce PAL scorecard for Managed Care providers					
40.9.1.27	Provides capability to adjust base management fees by percentage resulting in enhanced/reduced fees for all individual providers or administrative entities					
40.9.1.28	Provides capability to create notification letters to the provider/administrative entity regarding the adjustment to management fee rates and the reason for the adjustment					
40.9.1.29	Provides capability to produce a monthly report of all adjusted management fees					
40.9.1.30	<p>Provides capability to produce quarterly utilization reports based on paid claims for all Community Care of North Carolina (CCNC) providers, comparing each provider's service rates and per member per month (PMPM) costs to other primary care provider types within their peer group(s)</p> <p>This will include the ability to automate these reports and to produce the report(s) with varying parameters, including, but not limited to, date spans, provider, provider specialties, provider network, service categories, diagnosis codes, CPT codes, and DRG diagnostic-related groupings. This report shall also include the average total enrollment, adult enrollment, and child enrollment for each CCNC provider.</p>					
40.9.1.31	<p>Provides capability to calculate utilization outlier data for the purpose of provider education, utilization management, and quality improvement</p> <p>This data shall be produced in conjunction with the Utilization Review Report.</p>					
40.9.1.32	Provides capability to revise the Quarterly Utilization Report format to allow for more flexibility to revise the report parameters and data and to include, but not be limited to, disease management and system of care groupings, drug utilization, and other group comparisons, as well as the current peer group comparisons					
40.9.1.33	Provides capability to produce recipient letters based on age, sex, and/or clinical data/medical services based on claim data					
40.9.1.34	Provides capability to generate a report of mailed letters					



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**40.9.2 Managed Care Operational Requirements**

Requirement #	Requirement Description	A	B	C	D	E
40.9.2.1	Fiscal Agent shall resolve all errors, discrepancies, and/or issues related to capitated payments or management fees.					
40.9.2.2	Fiscal Agent shall monitor encounter processing to ensure no payments are generated as a result of encounter processing.					
40.9.2.3	Fiscal Agent shall compile, update, and distribute the Data Submission Manual for encounter data processing.					
40.9.2.4	Fiscal Agent shall serve as first point of contact for questions regarding encounter-related issues.					
40.9.2.5	Fiscal Agent shall conduct training seminars with providers and State staff regarding the encounter claim submission process.					
40.9.2.6	Fiscal Agent shall serve as point of contact for Medicaid providers requesting Managed Care override approvals, make a determination regarding issuance of override, and enter the override approval into the system.					
40.9.2.7	Fiscal Agent shall support toll-free telephone access and be the point of contact for Managed Care providers between 8:00 A.M. and 5:00 P.M. Eastern Time each State business day.					
40.9.2.8	Fiscal Agent shall log receipt of Managed Care provider telephone messages, including brief description of reason for the call, date received, date and who responded to the call, action taken, and any necessary follow-up actions, and ensure follow-up actions are completed.					



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**40.9.3 Managed Care Operational Performance Standards**

Requirement #	Requirement Description	A	B	C	D	E
40.9.3.1	Fiscal Agent shall provide the Withhold and Penalty Log within five (5) State business days of the end of the previous month.					
40.9.3.2	Fiscal Agent shall provide the file maintenance log for Managed Care-related transactions within five (5) State business days of the end of the previous month.					
40.9.3.3	Fiscal Agent shall complete requests for changes to capitation payments/management fees within two (2) State business days from date of request.					
40.9.3.4	Fiscal Agent shall enter all written override approval requests into the system within two (2) State business days from receipt of the request and provide a decision to the requesting providers within five (5) State business days from receipt of request.					
40.9.3.5	Fiscal Agent shall respond to a requesting provider within one (1) hour for a telephone request for an emergency override.					
40.9.3.6	Fiscal Agent shall compile, update, and distribute the Data Submission Manual for encounter data processing to providers within five (5) State business days from State date of approval of change.					
40.9.3.7	Fiscal Agent shall provide toll-free access and a point of contact for Managed Care providers between 8:00 A.M. and 5:00 P.M. Eastern Time each State business day.					
40.9.3.8	Fiscal Agent shall respond to Managed Care provider telephone messages within one (1) State business day of receipt of the message.					
40.9.3.9	Fiscal Agent shall produce Managed Care provider enrollment reports and make them available to providers no later than the first day of each month.					
40.9.3.10	Fiscal Agent shall conduct weekly searches for all “exempt” numbers that are linked to the mandatory program category for a system-generated letter advising the eligible of the potential of primary care provider selection from five (5) providers within a thirty-mile (30-					



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Requirement #	Requirement Description	A	B	C	D	E
	mile) range.					
40.9.3.11	Fiscal Agent shall send the Health Choice file to the North Carolina State Health Plan by the third business day of each month.					

## 40.10 Health Check Requirements

### 40.10.1 Health Check System Requirements

Requirement #	Requirement Description	A	B	C	D	E
40.10.1.1	Provides capability to maintain the Health Check periodicity schedule					
40.10.1.2	Provides capability for online inquiry to all Health Check data with access by recipient ID and provider number					
40.10.1.3	Provides capability to maintain each Health Check-eligible recipient, the current and historical screening results, referral, diagnosis and treatment, and immunizations, including the provider numbers and dates					
40.10.1.4	Provides capability to identify paid and denied screening claims					
40.10.1.5	Provides capability to identify abnormal conditions by screening date and whether the condition was treated or referred for treatment					
40.10.1.6	Provides capability to update recipient Health Check data with screening results and dates and referral information					
40.10.1.7	Provides capability for online, updateable letter templates for Health Check monthly notifications, standardized letters, and inserts					
40.10.1.8	Provides capability for automatic generation of monthly notifications to case heads for next screenings, screenings missed, and abnormal conditions not treated based on State					



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Requirement #	Requirement Description	A	B	C	D	E
	criteria					
40.10.1.9	Provides capability to maintain all notices sent, identifying case and recipient and date the notice was sent					
40.10.1.10	Provides capability to maintain an online audit trail of all updates to Health Check data					
40.10.1.11	Provides capability for Web-based Health Check functionality that allows for the creation, update, and management of: <ul style="list-style-type: none"> <li>▪ Health Check Information Notifications</li> <li>▪ Monthly Accounting of Activities Report (MAAR) Information</li> <li>▪ County Options Change Request (COCR) Information</li> <li>▪ Full-Time Equivalency (FTE) Information</li> <li>▪ Health Check Recipient Data</li> </ul>					
40.10.1.12	Provides capability for the following Web-based functionality: <ul style="list-style-type: none"> <li>▪ Search recipient data</li> <li>▪ Enter comments</li> <li>▪ Update notification suppression</li> <li>▪ Send standardized notifications</li> </ul>					
40.10.1.13	Provides capability to calculate and system-generate Health Check Coordinator management fees					
40.10.1.14	Provides capability to generate a monthly FTE report based on information received on the MAAR and COCR					
40.10.1.15	Provides capability to capture and electronically store all Health Check county staff information					
40.10.1.16	Provides Web-based access to current Health Check data to include new eligibles, new health check screenings, referral, etc.; provides access to each Health Check Coordinator (HCC) to their specific county information and provides ad hoc query					



**APPENDIX 50, ATTACHMENT C, EXHIBIT 1**



Requirement #	Requirement Description	A	B	C	D	E
	capability for extraction of data to the desktop					
40.10.1.17	Provides capability to produce the Health Check Activity Report					
40.10.1.18	Provides capability to convert HCC comments from legacy FoxPro Data Shell application into the Replacement MMIS					
40.10.1.19	Provides capability to generate EPSDT report for primary care providers and administrative entities monthly no later than the fifth day of the month for the preceding month's data  This information should be available on the Web for providers to download for their practice only.					
40.10.1.20	Provides capability to produce monthly MAAR Summary reports					
40.10.1.21	Provides capability to generate reports of recipients who have been in a particular practice for defined time periods, which includes the county and Statewide participation rates					

**40.10.2 Health Check Operational Requirements**

Requirement #	Requirement Description	A	B	C	D	E
40.10.2.1	Fiscal Agent shall produce and update Health Check User Manual(s).					
40.10.2.2	Fiscal Agent shall provide telephone and on-site technical support and training for Health Check Coordinators.					
40.10.2.3	Fiscal Agent shall participate in Health Check Coordinator Training Sessions in Raleigh, NC.					
40.10.2.4	Fiscal Agent shall update Health Check Billing Guide.					





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Requirement #	Requirement Description	A	B	C	D	E
40.10.2.5	Fiscal Agent shall conduct agenda planning meetings with State Health Check staff prior to Provider Training Workshops and conduct mock workshops for State approval.					
40.10.2.6	Fiscal Agent shall conduct annual regional Health Check workshops for participating providers in six (6) separate sites throughout the State.					
40.10.2.7	Fiscal Agent shall monitor the Denied Claims Report for Health Check denials and contact providers by telephone to educate and schedule provider visits if denial rate is above ten (10) percent.					
40.10.2.8	Fiscal Agent shall review the Health Check County Option File Master Report monthly to ensure that all participating counties received Automated Information Notification System (AINS) (or Fiscal Agent equivalent) data and all Health Check reports.					
40.10.2.9	Fiscal Agent shall review the Health Check Management Fee Option File Master Report monthly to ensure that Health Check management fee claims were generated correctly.					
40.10.2.10	Fiscal Agent shall submit the monthly FTE Report to the State for approval.					
40.10.2.11	Fiscal Agent shall respond to questions from Health Check County staff related to Health Check management fees and provides written responses to the State.					
40.10.2.12	Fiscal Agent shall provide telephone support and on-site provider visits to educate providers on the Health Check program, policies, and billing requirements.					
40.10.2.13	Fiscal Agent shall coordinate rewrite of the Health Check Billing Guide.					

**40.10.3 Health Check Operational Performance Standards**

Requirement #	Requirement Description	A	B	C	D	E
40.10.3.1	Fiscal Agent shall maintain and update Health Check User Manual(s) within thirty (30)					



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Requirement #	Requirement Description	A	B	C	D	E
	days of a change in policy/procedures and shall notify HCCS within two (2) days after posting.					
40.10.3.2	Fiscal Agent shall produce CMS Statistical Database updates and required reports one (1) month prior to CMS deadline and shall make all appropriate corrections to reports within forty-eight (48) hours of notification of problem.					
40.10.3.3	Fiscal Agent shall produce a monthly FTE Report by the second Friday from the end of each month.					
40.10.3.4	Fiscal Agent shall provide training for use of the Health Check functionality to HCCS, in their respective counties, within three (3) weeks of notification by the State.					
40.10.3.5	Fiscal Agent shall review claim denials and contact providers with denial rate greater than ten (10) percent within fourteen (14) days of claim denial.					
40.10.3.6	Fiscal Agent shall respond to questions from Health Check county staff related to Health Check management fees within twenty-four (24) hours of receipt and shall notify State Health Check staff in writing of inquiry and resolution within forty-eight (48) hours of receipt.					
40.10.3.7	Fiscal Agent shall update addresses in the Health Check County Option File within twenty-four (24) hours of receipt.					
40.10.3.8	Fiscal Agent shall coordinate with the State for the annual revisions to the Health Check Billing Guide.					



## 40.11 Third Party Liability Requirements

### 40.11.1 TPL System Requirements

Requirement #	Requirement Description	A	B	C	D	E
40.11.1.1	Provides capability to search TPL database by recipient name, recipient number, policy number, policy holder name, policy holder ID number, SSN of the policy holder, by either the whole name or number or any part of the last name or number, or combination thereof					
40.11.1.2	Provides capability to ensure that claims for preventive pediatric services and prenatal care for pregnant women are paid to providers and not cost-avoided if TPL is available					
40.11.1.3	Provides capability to ensure that claims for inpatient hospital stays for pregnant women are cost avoided					
40.11.1.4	Provides capability for updating of insurance carrier information					
40.11.1.5	<p>Provides capability to retrieve/search third party resource information by the following:</p> <ul style="list-style-type: none"> <li>▪ Name (by any part of last name), ID number (by any part of ID number), date of birth, SSN (by any part of number) of eligible recipient, and relationship of covered individual to policy holder, or combination thereof</li> <li>▪ Insurance carrier</li> <li>▪ Policy number (by any part of number), Medicare Health Insurance Claim (HIC) number (by any part of number), or railroad number</li> <li>▪ Group name and number</li> <li>▪ Source code indicating source of suspect TPL information</li> <li>▪ Name, SSN, and/or ID number of policy holder (by any part of number)</li> <li>▪ Prescription number, whole number, or any part of number</li> <li>▪ Therapeutic code</li> <li>▪ Therapeutic class</li> </ul>					



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Requirement #	Requirement Description	A	B	C	D	E
	<ul style="list-style-type: none"> <li>▪ User ID of individual entering or updating TPL record</li> </ul>					
40.11.1.6	Provides capability to electronically store multiple, date-specific TPL resources for each recipient					
<b>Requirement Deleted</b> 40.11.1.7	<del>Provides capability to electronically store multiple, date-specific TPL resources for each Medicare recipient</del>					
40.11.1.8	Provides capability to electronically store all third party resource information by recipient					
40.11.1.9	Provides capability to electronically store third party carrier information					
40.11.1.10	Provides capability to identify all cost-avoided payments due to established TPL					
40.11.1.11	Provides capability to bill carriers for “pay and chase” claims and automatically create a “case” once claims have accumulated to defined threshold amount					
40.11.1.12	Provides capability to automatically identify previously paid claims for recovery when TPL resources are identified or verified retroactively and automatically creates a recovery “case” to initiate recovery within a period specified by the State					
40.11.1.13	Provides capability to identify claims and support recovery actions on paid claims when Medicare coverage is identified or verified after claims have been paid.					
40.11.1.14	Provides capability to track and post recoveries to individual claim histories					
40.11.1.15	Provides capability for archival and retrieval of closed TPL recovery cases					
40.11.1.16	Provides capability to identify accident/trauma claims and automatically generate questionnaire/reports					
40.11.1.17	Provides capability to approve or cancel trauma questionnaires					



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Requirement #	Requirement Description	A	B	C	D	E
40.11.1.18	Provides capability to retrieve paid claims from history to assist in TPL recovery					
40.11.1.19	Provides capability to maintain an online audit trail of all updates to TPL data					
40.11.1.20	Provides capability to generate carrier update transactions to the State					
40.11.1.21	Provides capability to provide online inquiry, add, and update to TPL data					
40.11.1.22	Provides capability to enter or update recovery cases from recoveries received					
40.11.1.23	Provides capability to ensure that if the recipient has a pharmacy policy on the date of service that the pharmacy policy is billed or displayed at point of sale rather than any medical policy					
40.11.1.24	Provides capability to identify previously paid claims from the past three (3) years of claims history when TPL resources are identified or verified retroactively					
40.11.1.25	Provides capability to identify previously paid claims from Claims History for the allowed Medicare time limit for filing when Medicare resources are identified or verified after Medicaid payment has occurred					
40.11.1.26	Provides capability to produce and bill drug invoices for insurance carriers					
40.11.1.27	Provides capability to produce accident inquiry letters for identified recipients					
40.11.1.28	Provides capability to maintain recipient health insurance data for TPL through updates from EIS and ACTS to assist in claims processing					
40.11.1.29	Provides capability to capture and maintain Estate Recovery Data, including claims, invoice data, and recovery data on each individual that meets defined criteria					
40.11.1.30	Provides capability to flag and maintain Estate Recovery claims for a lifetime					
40.11.1.31	Provides capability to produce claims/invoices in order to bill for Estate Recovery					



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Requirement #	Requirement Description	A	B	C	D	E
40.11.1.32	Provides capability to track and report on invoices					
40.11.1.33**	Provides capability to route specific DME claims to Medicaid after Children's Special Health Services (CSHS) has paid					
40.11.1.34	Provides capability for online updating and reporting function for cases to track open cases, type of case, amount of liens, amount of recoveries					
40.11.1.35	Provides capability to view the invoices for prescription drugs generated by Fiscal Agent, by carrier, or by recipient					
40.11.1.36	Provides capability for online updating, payment, and reporting for the HIPPA Program					
40.11.1.37	Provides capability to systematically build recovery cases, allowing users to inquire, add, and update recovery case records					
40.11.1.38	Provides capability to search recovery case records by unique recovery case identification number, case type, policy number, policy holder name, policy holder SSN, claim number, recipient name or number, carrier name, carrier number, provider name or number, attorney name, accident number, or a combination of these data elements					
40.11.1.39	Provides capability to include attorney name, attention line, address, and telephone number in a recovery case record					
40.11.1.40	Provides capability to view all TPL receivables online in determining which claim details have not be completed and the total amount not posted					
40.11.1.41	Provides capability to add or delete claims that are included in any recovery case					
40.11.1.42	Provides capability to add and update the TPL threshold amount online					
40.11.1.43	Provides capability to enter free-form text in a recovery case					
40.11.1.44	Provides capability to maintain all open recovery cases online until closed by authorized					



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Requirement #	Requirement Description	A	B	C	D	E
	user					
40.11.1.45	Provides capability to maintain and flag claims that are part of a TPL recovery/cost avoidance case online for three (3) years after the case is closed before archiving					
40.11.1.46	Provides capability to flag a recipient for which a TPL recovery case has been created					
40.11.1.47	Provides capability to generate unique Case Identification Numbers					
40.11.1.48	Provides capability to close a case without full recovery					
40.11.1.49	Provides capability to reproduce a claim and send either by fax, mail or electronically					
40.11.1.50	Provides the capability to flag claims for recipients who have reached a defined threshold					
40.11.1.51	Provides capability for online access and update to TPL data by State-designated staff					
40.11.1.52	Provides capability for batch and/or online real-time access to TPL data between EIS, Mental Health Eligibility Inquiry, CSDW, Medicaid Quality Control, Online Verification, ACTS, and HIS and the Replacement MMIS using API and SOA concepts					
40.11.1.53	Provides capability for daily (next business day) transmission logs showing successful transmission of TPL data to DIRM for CSDW, ACTS, and EIS					
40.11.1.54	Provides capability to exclude third party insurance from claims processing on a per-person/per-policy basis, for a set period; provides capability to support multiple exclusions per person/per policy					
40.11.1.55	Provides capability to process and pay claims when policy limits are exhausted for individuals related to a specific service either annual or lifetime benefits					
40.11.1.56	Provides capability to associate and track Non-Custodial Parent (NCP) policy holder information to covered individuals					



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Requirement #	Requirement Description	A	B	C	D	E
40.11.1.57	Provides capability to pend updates to TPL resource data received from Child Support for Medicaid recipients					
40.11.1.58	Provides the capability to pend TPL updates for recipients who are covered by Breast and Cervical Cancer Medicaid (BCCM) or Health Choice programs and display a notification message that the recipient has BCCM or Health Choice					
40.11.1.59	Provides capability to produce a report of TPL segments that have been updated more than once in thirty (30) days					
40.11.1.60	Provides capability to produce a Health Choice Recipient Activity Report in addition to the reports listed in the Design documentation					
40.11.1.61	Provides capability to provide TPL edit/error report(s) for ACTS for State staff access					
40.11.1.62	Provides capability to extract and process TPL data transmitted by ACTS from the DIRM electronic File Cabinet					
40.11.1.63	Provides capability to produce a daily extract of TPL carrier and recipient resource data for ACTS, CSDW, and EIS					
40.11.1.64	Provides capability to produce an extract of updates to TPL recipient resource data for ACTS for Medicaid recipients referred to Child Support					
40.11.1.65	Provides capability for batch access to TPL data using API and SOA concepts between EIS, ACTS, and the Replacement MMIS					
<b>New Requirement</b> 40.11.1.66	Provides capability to produce system-generated letters to providers, recipients, and county offices					





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**40.11.2 TPL Operational Requirements**

Requirement #	Requirement Description	A	B	C	D	E
<b>New Requirement</b> 40.11.2.1	Fiscal Agent shall identify claims and support recovery actions when Medicare resources are identified or verified after claims have been paid.					
<b>New Requirement</b> 40.11.2.2	Fiscal Agent shall process and track recoveries and collections					
<b>New Requirement</b> 40.11.2.3	Fiscal Agent shall track and post recoveries to individual claim histories.					
<b>New Requirement</b> 40.11.2.4	Fiscal Agent shall enter or update recovery cases from recoveries received					
<b>New Requirement</b> 40.11.2.5	Fiscal Agent shall generate carrier update transactions to the State					
<b>New Requirement</b> 40.11.2.6	Fiscal Agent shall extract and process TPL data transmitted by ACTS from the DIRM electronic File Cabinet					
<b>New Requirement</b> 40.11.2.7	Fiscal Agent shall produce a daily extract of TPL carrier and recipient resource data for ACTS, CSDW, and EIS					
<b>New Requirement</b> 40.11.2.8	Fiscal Agent shall produce an extract of updates to TPL recipient resource data for ACTS for Medicaid recipients referred to Child Support					



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**40.11.3 TPL Operational Performance Standards**

Requirement #	Requirement Description	A	B	C	D	E
<b>Requirement Deleted</b> 40.11.3.1	<del>Fiscal Agent shall produce system-generated letters to providers, recipients, and county offices.</del>					
40.11.3.2	Fiscal Agent shall adjust paid Claims History for State-specified TPL recoveries and provider/recipient collections within five (5) State business days from end of the previous month.					
40.11.3.3	Fiscal Agent shall disposition the recoveries/collections accurately and consistently ninety-nine and eight tenths (99.8) percent of the time.					
40.11.3.4	Fiscal Agent shall produce and bill drug invoices for insurance carriers within five (5) State business days of TPL entry.					
40.11.3.5	Fiscal Agent shall mail the accident inquiry letters to the identified recipients within five (5) State business days from end of the previous month.					
40.11.3.6	Fiscal Agent shall generate an Estate Recovery invoice within 2 business days after a recipient meets the defined criteria.					
40.11.3.7	Fiscal Agent shall provide TPL edit/error report(s) for ACTS for State staff access each State business day.					
40.11.3.8	Fiscal Agent shall provide daily (next business day) transmission logs showing successful transmission of TPL data to CSDW and to and from ACTS available for State staff access each State business day.					
40.11.3.9	The Fiscal Agent shall extract and process recipient TPL data transmitted by ACTS from the electronic DIRM File Cabinet by 7:00 A.M.					
40.11.3.10	The Fiscal Agent shall produce a daily extract of TPL carrier and recipient resource data to DIRM for ACTS, CSDW, and EIS					



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Requirement #	Requirement Description	A	B	C	D	E
40.11.3.11	The Fiscal Agent shall produce a daily extract of updates to TPL recipient resource data to DIRM for ACTS for Medicaid recipients referred to Child Support.					

## 40.12 Drug Rebate Requirements

### 40.12.1 Drug Rebate System Requirements

Requirement #	Requirement Description	A	B	C	D	E
40.12.1.1	Provides capability to maintain and update data on manufacturers with whom rebate agreements exist, including: <ul style="list-style-type: none"> <li>▪ Manufacturer ID numbers and labeler codes</li> <li>▪ Indication of collection media</li> <li>▪ Indication of invoicing media</li> <li>▪ Contact name, mailing and e-mail address, phone and fax numbers</li> <li>▪ Manufacturer (labeler) enrollment, termination and reinstatement dates</li> <li>▪ Manufacturer Unit Rebate Amount (URA)</li> <li>▪ Manufacturer units of measure</li> </ul>					
40.12.1.2	Provides capability to capture CMS drug unit rebate amount and units of measure and provides capability to capture T-bill rates for interest calculation					
40.12.1.3	Provides capability to validate units of measure from CMS file to Replacement MMIS drug file for consistency and reporting on exceptions					
40.12.1.4	Provides capability to calculate and generate rebate adjustments by program and/or labeler based on retroactively corrected CMS and North Carolina rebate data					



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Requirement #	Requirement Description	A	B	C	D	E
40.12.1.5	Provides capability to determine the amount of rebates due by NDC and UPC, using paid claim data and eligible data from both the pharmacy program and NDCs from the physician drug program procedure codes					
40.12.1.6	Provides capability to generate invoices and regenerate invoices that separately identify rebate amounts and interest amounts by program, labeler, and rebate quarter					
40.12.1.7	Provides capability to maintain identification of the original drug rebate quarter for the claim throughout any adjustments made to the claim					
40.12.1.8	Provides capability for system determination of the rebate amounts and adjustments overdue, calculates interest, and generates new invoices, separately identifying rebate amounts and interest by program, labeler, and rebate quarter					
40.12.1.9	Provides capability for system generation of invoice details and post-payment details that are consistent with the State's reconciliation of invoices and prior quarter adjustment statement					
40.12.1.10	Provides capability to generate invoice cover letters, collection letters, and follow-up collection letters					
40.12.1.11	Provides capability for online, updateable letter templates, including templates for invoice letters, collection letters, follow-up collection letters, allowing for a free-form comments section					
40.12.1.12	Provides capability to maintain and retrieve history of letters sent to manufacturers					
40.12.1.13	Provides capability to update payment details and adjustments to the Replacement MMIS accounting system					
40.12.1.14	Provides capability to maintain and retrieve drug rebate invoice and payment data indefinitely, including CMS drug data, claim data, and operational comments					
40.12.1.15	Provides capability for system identification and exclusion of claims for drugs not eligible					



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Requirement #	Requirement Description	A	B	C	D	E
	for drug rebate program					
40.12.1.16	Provides capability for system identification and exclusion of claims from dispensing pharmacies that are not eligible for drug rebate program (340B providers)					
40.12.1.17	Provides capability for online access by the State to quarterly manufacturer drug rebate invoice detail and balances					
40.12.1.18	Provides capability for online access to five (5) years of historical drug rebate invoices, including supporting claims-level detail with selection criteria by labeler, quarter, NDC, or any combination of criteria					
40.12.1.19	Provides capability for online posting of accounts receivables labeler, NDC for each quarter, rebates receivable, and interest receivable					
40.12.1.20	Provides capability for unit conversion of units paid per claim to CMS units billed and CMS units billed to units paid per claim					
40.12.1.21	Provides capability to maintain units paid (as used to calculate claims pricing) and CMS units billed for drug rebate on Claims History					
40.12.1.22	Provides capability for online access to accounts receivable data, invoice history, payment history, adjustment history, and the audit trail at the labeler, quarter, and NDC level					
40.12.1.23	Provides capability to adjust accounts receivable balances for: <ul style="list-style-type: none"> <li>▪ Rebates only at labeler/quarter level</li> <li>▪ Interest only at labeler/quarter level</li> <li>▪ Rebates and units at NDC level, which would also update labeler/quarter balances</li> <li>▪ Adjustments and State approved write-offs</li> <li>▪ Interest only at the drug detail level</li> </ul>					



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Requirement #	Requirement Description	A	B	C	D	E
40.12.1.24	Provides capability for online maintenance of comprehensive dispute tracking, including an automated tickler file to flag, track, and/or report quarterly on responding and non-responding manufacturers and disputes					
40.12.1.25	Provides capability for logging and tracking all telephone conversations, letters, inquiries, and other correspondence and actions taken by manufacturers, the State, and others related to drug rebate processing					
40.12.1.26	Provides capability for generation of manufacturer mailing labels on request					
40.12.1.27	Provides capability for an online audit trail of all activities and updates to drug rebate data					
40.12.1.28	Provides capability for online update for Drug Rebate accounts receivable via the NDC with data such as labeler check number and check receipt date to monitor all Drug Rebate accounts receivable activity					
40.12.1.29	Provides capability to make available to the State the total Medicaid expenditures for multiple source drugs (annually) as well as other drugs (every three [3] years); provides capability to include mathematical or statistical computations, comparisons, and any other pertinent records to support pricing changes as they occur					
40.12.1.30	Provides capability for adjustment and State-approved write-off records					
40.12.1.31	Provides capability for system interest calculation on outstanding Drug Rebate balances and applies results to DRS Accounts Receivable File					
40.12.1.32	Provides capability to perform end-of-month balancing process					
40.12.1.33	Provides capability to load all pharmacy claims to the Drug Rebate business area weekly, regardless of where they are paid					
40.12.1.34	Provides capability to maintain the Drug Rebate Labeler Data, facilitating automatic updating with information from CMS and the State					



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Requirement #	Requirement Description	A	B	C	D	E
40.12.1.35	Provides capability to maintain online Drug Rebate Claims Detail generated from the Drug Rebate History File of paid claims and adjustment activity that balances to each Labeler invoice by State entity					
40.12.1.36	Provides capability for audits that ensure consistency of data from detail level to summary level					
40.12.1.37	Provides capability to ensure automated electronic transfer of invoice data and detail history to CMS and the State in their respectively approved formats					
40.12.1.38	Provides capability to freeze invoices so they can no longer be recalculated					
40.12.1.39	Provides capability to create a report showing a list of all invoices for a specified rebate program and quarter; provides capability to allow users to view invoices before or after being frozen and allow user determination of whether to include under-threshold invoices					
40.12.1.40	Provides capability to create a report showing quarterly changes to amounts due in the format required for inclusion in the CMS 64 Report					
40.12.1.41	Provides capability to produce Payment Summary Report to display payments received during a specified date range and balances due by quarter within manufacturer					
40.12.1.42	Provides capability to produce Rebate Summary Report to display payments received, invoiced amounts, and disputed amounts by quarter or by year					
40.12.1.43	Provides capability to produce Quarterly Payment Report to give summary of payments received versus the original and current invoiced amounts per manufacturer					
40.12.1.44	Provides capability to produce the NDC Detail Report to give summary data by quarter for selected NDCs					
40.12.1.45	Provides capability to produce the NDC History Report to display all the activities that have occurred for a selected drug by quarter					



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Requirement #	Requirement Description	A	B	C	D	E
40.12.1.46	Provides capability to produce the Manufacturer Summary Report to display information by quarter, including amounts invoiced, paid, and disputed					
40.12.1.47	Provides capability to produce the Reconciliation of State Invoice (ROSI)/Prior Quarter Adjustment Report to display the amounts allocated for a selected manufacturer or NDC					
40.12.1.48	Provides capability to produce the Unallocated Balance Report to display unallocated balances selected according to user-supplied criteria					
40.12.1.49	Provides capability to produce the Adjusted Claims Report to display claims where the number of units considered for invoicing differed from those originally supplied by the claims processing system					
40.12.1.50	Provides capability to produce a Drug Rebate Distribution Report, listing Drug Rebate Collections by county, with Federal, State, and county share specified					
40.12.1.51	Provides capability to produce an Excluded Provider Report, listing those providers whose claims will not be included in Drug Rebate invoices					
40.12.1.52	Provides capability to produce Excluded Provider Listing, displaying the claims paid for providers not subject to rebate					
40.12.1.53	Provides capability to produce a XIX-CMS Utilization Mismatch Report, showing drugs where the Unit Type from CMS does not match that on the Drug File					
40.12.1.54	Provides capability to produce an Invoice Billing for Quarter Report, showing a summary of drug utilization billed to manufacturers for the quarter					
40.12.1.55	Provides capability to produce a Balance Due Report listing the top ten (10) credit balances at run time					
40.12.1.56	Provides capability to produce a Balance Due Report listing the top twenty (20) debit balances at run time					





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Requirement #	Requirement Description	A	B	C	D	E
40.12.1.57	Provides capability to produce a Check/Deposit Comparison Report for reconciliation with deposit slips					
40.12.1.58	Provides capability to produce a Check/Voucher Comparison Report, comparing the Check Voucher Total and the Interest Voucher Total and the Interest Voucher Total with the Check Table Total					
40.12.1.59	Provides capability to produce a Disputes Activity Report to display disputes by Unassigned, Assigned, and Resolved dispute types					
40.12.1.60	Provides capability to produce an Interest Activity Report to display all interest overrides					
40.12.1.61	Provides capability to produce an Interest Detail Report to display all interest for a labeler and quarter					
40.12.1.62	Provides capability to produce a report of invoiced amounts greater than the sum of claim reimbursement amounts					
40.12.1.63	Provides capability to produce an Invoice not Paid Report, showing all invoices for which no payment has been received					
40.12.1.64	Provides capability to produce a report that will list all codes (HCPCS) from medical claims, including J codes, M codes, Q codes, and others that have been converted to NDCs					
40.12.1.65	Provides capability to produce a Monthly Balance Report to summarize the balance due per labeler per quarter and across all labelers					
40.12.1.66	Provides capability to produce a report of payments received for drugs with CMS URA of zero					
40.12.1.67	Provides capability to produce a Recapitulation Report that notifies manufacturers of corrected balances after dispute resolution procedures have been completed for one (1) or more quarters.					



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Requirement #	Requirement Description	A	B	C	D	E
40.12.1.68	Provides capability to produce a Generic/Non-Generic Report that lists drug rebate amounts invoiced by brand, generic, and multi-source, further divided into brand and generic, plus total for a selected period, and percentages					
40.12.1.69	Provides capability to produce ad hoc reports, including, but not limited to, ad hoc reporting on utilization detail by GCN, GC3 (therapeutic class), and GCN-Sequence					
40.12.1.70	Provides capability to access current and historical URA amounts for all rebateable drugs					

**40.12.2 Drug Rebate Operational Requirements**

Requirement #	Requirement Description	A	B	C	D	E
40.12.2.1	Fiscal Agent shall update online Drug Rebate accounts receivable via the NDC with data such as labeler check number and check receipt date to monitor all Drug Rebate accounts receivable activity.					
40.12.2.2	Fiscal Agent shall make available to the State the total Medicaid expenditures for multiple source drugs (annually) as well as other drugs (every three [3] years); the record keeping for this requirement should include data such as mathematical or statistical computations, comparisons, and any other pertinent records to support pricing changes as they occur.					
40.12.2.3	Fiscal Agent shall receive and process rebate checks from labelers.					
40.12.2.4	Fiscal Agent shall deposit labeler checks.					
40.12.2.5	Fiscal Agent shall allow for adjustment and write-off records.					
40.12.2.6	Fiscal Agent shall perform interest calculation on outstanding Drug Rebate balances and apply results to Drug Rebate accounts receivable file.					
40.12.2.7	Fiscal Agent shall perform end-of-month balancing process.					



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Requirement #	Requirement Description	A	B	C	D	E
40.12.2.8	Fiscal Agent shall maintain Drug Rebate history data with online accessibility by extracting claims data monthly from Claims History and moving the data to the Drug Rebate history on a quarterly basis.					
40.12.2.9	Fiscal Agent shall perform check and voucher entry for update to the accounts receivable records.					
40.12.2.10	Fiscal Agent shall receive, log, and process labeler disputes.					
40.12.2.11	Fiscal Agent shall maintain data for each quarter that a labeler disputes a particular NDC.					
40.12.2.12	Fiscal Agent shall research and resolve discrepancies, including calling providers about questionable claims.					
40.12.2.13	Fiscal Agent shall initiate any necessary adjustments to change units of NDC.					
40.12.2.14	Fiscal Agent shall produce a Recapitulation Report.					
40.12.2.15	Fiscal Agent shall send Recapitulation Report to NC DHHS Auditor(s) for review and approval.					
40.12.2.16	Fiscal Agent shall send Recapitulation Report to labeler with copy of current summary balance once report is approved.					
40.12.2.17	Fiscal Agent shall create and send quarterly invoices for each labeler that has a rebate agreement signed with CMS or the State as division-appropriate.					
40.12.2.18	Fiscal Agent shall update DRS Labeler Data with information from CMS and the State.					
40.12.2.19	Fiscal Agent shall ensure automated electronic transfer process to deliver invoice data and detail history to CMS and the State.					
40.12.2.20	Fiscal Agent shall attend CMS-sponsored Drug Rebate Labeler Dispute meetings as required by the State and based on relevance of agenda.					



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**40.12.3 Drug Rebate Operational Performance Standards**

Requirement #	Requirement Description	A	B	C	D	E
40.12.3.1	Fiscal Agent shall maintain an outstanding rebate balance percentage (i.e., over forty-five [45] days) of less than ten (10) percent of total rebates due for each quarter excluding the outstanding balance of Manufacturers' Disputes Accounts Receivable.					
40.12.3.2	Fiscal Agent shall make available to the State the total Medicaid expenditure for multiple source drugs (annually) as well as other drugs (every three years) accurately and consistently ninety-nine and nine tenths (99.9) percent of the time.					
40.12.3.3	Fiscal Agent shall log all labeler checks received by labeler, check number, amount, date received, date entered into DRS Accounts Receivable file, and date of deposit. Fiscal Agent shall forward the logs to the State within five (5) business days from the end of the previous month.					
40.12.3.4	Fiscal Agent shall update the Drug Rebate accounts receivable within two (2) State business days of receipt.					
40.12.3.5	Fiscal Agent shall deposit all labeler checks within one (1) State business day of receipt.					
40.12.3.6	Fiscal Agent shall perform interest calculation on outstanding Drug Rebate balances and apply results to Drug Rebate accounts receivable ninety-nine and nine tenths (99.9) percent of the time, as directed by the State.					
40.12.3.7	Fiscal Agent shall perform end-of-month Drug Rebate balancing processes and forward to the State for review within five (5) State business days of the end of the previous month.					
40.12.3.8	Fiscal Agent shall extract Drug Rebate history data monthly, moving it to the quarterly file within two (2) State business days from the end of the previous month.					
40.12.3.9	Fiscal Agent shall receive and log all labeler disputes on the date of receipt, including data such as labeler, date of call, caller name/telephone number, issue, processor of call, resolution, follow-up requirements, and a tickler to ensure any follow-up requirements are completed. Fiscal Agent shall forward the log to the State within five (5) business days					



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Requirement #	Requirement Description	A	B	C	D	E
	from the end of the previous month.					
40.12.3.10	Fiscal Agent shall process all labeler disputes within ten (10) State business days from the date of receipt.					
40.12.3.11	Fiscal Agent shall produce a Recapitulation Report, which is a revised invoice, for the labeler one (1) State business day after the completion of the dispute resolution.					
40.12.3.12	Fiscal Agent shall send the Recapitulation Report to NC DHHS Auditor(s) for review and approval by close of business the same day the Recapitulation Report is produced.					
40.12.3.13	Fiscal Agent shall send the Recapitulation Report to the labeler with a copy of the current summary balance the same day the Fiscal Agent has received the NC DHHS Auditor's approval.					
40.12.3.14	Fiscal Agent shall create and forward quarterly invoices for each labeler that has a rebate agreement signed with CMS or the State, as division appropriate, within five (5) State business days from receipt of CMS tape.					
40.12.3.15	Fiscal Agent shall maintain an outstanding rebate balance percentage (i.e., forty-five [45] days or more) of less than ten (10) percent of total rebates due for each quarter excluding the Labeler Disputes Outstanding Accounts Receivable balance accurately and ninety-nine and nine tenths (99.9) percent of the time.					
40.12.3.16	Fiscal Agent shall electronically transfer required data to CMS and the State as applicable to the Drug Rebate requirements within five (5) State business days from invoicing.					
40.12.3.17	Fiscal Agent shall attend CMS-sponsored Drug Rebate Labeler Dispute meetings, as directed by the State.					
40.12.3.18	Fiscal Agent shall provide online access to five (5) years of historical drug rebate invoices based on criteria provided by the State accurately and consistently ninety-nine and nine tenths (99.9) percent of the time.					



## 40.13 Management Administrative and Reporting System Requirements

### 40.13.1 MARS Requirements

Requirement #	Requirement Description	A	B	C	D	E
40.13.1.1	Provides capability to maintain source data from all other functions of the Replacement MMIS to create State and Federal reports at frequencies defined by the State					
40.13.1.2	Provides capability for compiling subtotals, totals, averages, variances, and percents of items and dollars on all reports, as appropriate					
40.13.1.3	Provides capability to generate user-identified reports on a State-specified schedule					
40.13.1.4	Provides capability to generate reports to include the results of all State-initiated financial transactions, by State-specified categories, whether claim-specific or non-claim-specific					
40.13.1.5	Provides capability to identify, separately or in combination as requested by the State, the various types of recoupments and collections					
<b>Requirement Deleted</b> 40.13.1.6	<del>Provides capability to meet all enhanced requirements for the Replacement MMIS</del>					
40.13.1.7	Provides capability for uniformity, comparability, and balancing of data through the MARS reports and between these and other functions' reports, including reconciliation of all financial reports with claims processing reports					
40.13.1.8	Provides capability for detailed and summary-level counts of services by service, program, and eligibility category, based on State-specified units (days, visits, prescriptions, or other); provides capability for counts of claims, counts of unduplicated paid participating and eligible recipients, and counts of providers by State-specified categories					
40.13.1.9	Provides capability for a statistically valid trend methodology approved by the State for generating MARS reports					



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Requirement #	Requirement Description	A	B	C	D	E
40.13.1.10	Provides capability for charge, expenditure, program, recipient eligibility, and utilization data to support State and Federal budget forecasts, tracking, and modeling, to include: <ul style="list-style-type: none"> <li>▪ Participating and non-participating eligible recipient counts and trends by program and category of eligibility</li> <li>▪ Utilization patterns by program, recipient medical coverage groups, provider type, and summary and detailed category of service</li> <li>▪ Charges, expenditures, and trends by program and summary and detailed category of service</li> <li>▪ Lag factors between date of service and date of payment to determine billing and cash flow trends</li> <li>▪ Any combination of the above</li> </ul>					
40.13.1.11	Provides capability to describe codes and values to be included on reports					
40.13.1.12	Provides capability for users to specify selection, summarization, and un-duplication criteria when requesting claim detail reports from Claims History					
40.13.1.13	Provides capability to capture and maintain online at least four (4) years of MARS reports and five (5) years of annual reports, with reports over four (4) years archived and available to NC DHHS within twenty-four (24) hours of the request					
40.13.1.14	Provides capability to generate all MARS reports that will be sent to CMS in the format specified by Federal requirements					
40.13.1.15	Provides capability for the maintenance of the integrity of data element sources used by the MARS reporting function and integrates the necessary data elements to produce MARS reports and analysis					
40.13.1.16	Provides capability for system checkpoints that ensure changes made to programs, category of service, etc. are accurately reflected in MARS reports					
40.13.1.17	Provides capability for consistent transaction processing cutoff points to ensure the					



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Requirement #	Requirement Description	A	B	C	D	E
	consistency and comparability of all reports					
40.13.1.18	Provides capability to ensure all MARS report data supports accurate balancing, uniformity, and comparability of data to ensure internal validity and to non-MARS reports to ensure external validity (including reconciliation between comparable reports and all financial reports)					
40.13.1.19	Provides capability for an audit trail for balanced reporting					
40.13.1.20	Provides capability for a standard date of service/date of procedure cutoff for cost audit data with the capability to report prior year data separately from current year data, as well as summary data for all claims					
40.13.1.21	Provides capability for the MARS database to include the following types of data: <ul style="list-style-type: none"> <li>▪ Adjudicated claims data</li> <li>▪ Adjustment/void data</li> <li>▪ Financial transactions for the reporting period</li> <li>▪ Reference data for the reporting period</li> <li>▪ Provider data for the reporting period</li> <li>▪ Recipient data (including LTC, EPSDT, cost of care, co-pays, benefits used, and insurance information) for the reporting period</li> <li>▪ Budget data from the NCAS</li> <li>▪ Financial data, for the reporting period</li> <li>▪ Other, such as Medco and Health Check, inputs not available from or through the Replacement MMIS claims financial function</li> </ul>					
40.13.1.22	Provides capability to capture and maintain the necessary data to meet all Federal and State requirements for MARS, with the Vendor identifying and providing all Federal MARS reports required to meet and maintain CMS certification					





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Requirement #	Requirement Description	A	B	C	D	E
40.13.1.23	Provides capability to generate reports at monthly, quarterly, semiannual, annual, and bi-annual intervals, as specified by the State and Federal requirements					
40.13.1.24	Provides capability to create all required MMA file and MMA State Response File reports					
40.13.1.25	Provides capability to produce MARS reports by program, plan, county, and population group; reports for other State programs in addition to the standard MARS reports will need to be developed					

### 40.13.2 MARS Operational Requirements

Requirement #	Requirement Description	A	B	C	D	E
40.13.2.1	Fiscal Agent shall review the system audit trail for balanced reporting and deliver the balanced report to the State with each MARS production run.					
40.13.2.2	Fiscal Agent shall respond to State requests for information concerning the reports.					

### 40.13.3 MARS Operational Performance Standards

Not applicable



## 40.14 Financial Management and Accounting Requirements

### 40.14.1 Financial Management and Accounting System Requirements

Requirement #	Requirement Description	A	B	C	D	E
40.14.1.1	Provides capability to create and update Financial Participation Rate Tables					
40.14.1.2	Provides capability to create withholds, advance payments, and recovery of advance payments					
40.14.1.3	Provides capability to record liens and levy data					
40.14.1.4	Provides capability to process retroactive changes to deductible, TPL retroactive changes, and retroactive changes to program codes (from State-funded to Title XIX)					
40.14.1.5	Provides capability to process transactions containing total amount of dollars, per check, received by the State for TPL recoveries, drug rebates, medical refunds, Fraud and Abuse Detection System (FADS) recoveries, and any cash receipts that should be applied to the Replacement MMIS					
40.14.1.6	Provides capability to accept and process Fiscal Agent bank transactions of check and EFT statuses, such as paid, void, and stop payment transactions					
40.14.1.7	Provides capability for fully integrated financial operations, including general ledger, accounts receivable, claims payment/accounts payable, cash receiving, receipts dispositioning, and apportionment functions					
40.14.1.8	Provides capability to automatically compute financial participation (State, Federal, county, and other)					
40.14.1.9	Provides capability for the accounting of all program financial transactions in a manner that provides timely and accurate production of State and CMS reporting requirements					
40.14.1.10	Provides capability to deduct or add appropriate amounts and/or percentages from processed payments, regardless of origin of the transaction in accordance with GAAP via					



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Requirement #	Requirement Description	A	B	C	D	E
	system financial management and accounting functions with online update and inquiry capability					
40.14.1.11	Provides capability for transactions that use existing State accounting and financial reason codes and descriptions (including division, LOB, benefit plan, NCAS Cost Accounting Code [CAC], Period code, Reason Code, Category of Service Code (COS) Code, County Code, type, and provider) that supports production of required financial reports without the need for maintenance of conversion tables					
40.14.1.12	Provides capability to meet CMS requirement to reduce program expenditures for provider accounts receivable that are not collected within sixty (60) days of the date they are discovered					
40.14.1.13	Provides capability to produce NCAS interface file weekly to support checkwrite activity					
40.14.1.14	Provides capability to apply special "timely filing" edits at the end of the State fiscal year					
40.14.1.15	Provides capability for tracking calls regarding Fiscal Agent-related issues, claims, and complaints; provides capability for easy access to the call information by all users					
40.14.1.16	Provides capability to identify and update payment data with each payment cycle					
40.14.1.17	Provides capability to interface with NCAS for accounts receivable and accounts payable functions					
40.14.1.18**	Provides capability for a Client Data Warehouse extract of DMH data					
	<b>MMIS Accounts Payable Processes</b>					
40.14.1.19	Provides capability for accounts payable functionality for all programs					
40.14.1.20	Provides capability to identify providers with credit balances and no claim activity, by program, during a State-specified number of months					



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Requirement #	Requirement Description	A	B	C	D	E
40.14.1.21	Provides capability to process transactions for checks from outside systems, generating a Claims History record					
40.14.1.22	Provides capability for online access to check voucher reconciliation information by provider number or check voucher number and/or issue date, displaying the following information: <ul style="list-style-type: none"> <li>▪ Provider number</li> <li>▪ Issue date</li> <li>▪ Check voucher number</li> <li>▪ Amount</li> <li>▪ Disposition</li> <li>▪ Disposition date</li> </ul>					
40.14.1.23	Provides capability for online inquiry access and update ability on selected individual fields					
40.14.1.24	Provides capability to generate a stop payment or cancel transaction					
40.14.1.25	Provides capability to process the check voucher returned file for failed EFTs					
40.14.1.26	Provides capability to update funding sources and criteria lists based on financial participation rate information received from the State					
40.14.1.27	Provides capability to ensure that weekly budget reporting is consistent with the costs allocated during the checkwrite					
40.14.1.28	Provides capability to produce a provider voucher account payable upon receipt of a State Payout Authorization Form signed by an authorized State Official; provides capability to schedule payment of the voucher by the system in a future checkwrite cycle					
40.14.1.29	Provides capability to support Cost Settlement transaction, which includes disburse payments upon request, recoup receivables, deposit receipts, set up and post the					



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Requirement #	Requirement Description	A	B	C	D	E
	associated accounts receivable/accounts payable transactions, and produce MMIS reports by provider that are required by the DMA Audit Section to support the cost settlement process					
<b>Requirement Deleted</b> 40.14.1.30	<del>Provides capability to support an uncompensated services payment process and pay disproportionate share hospitals for uncompensated services in four (4) quarterly payments, with payments made updated and available for online inquiry</del>					
40.14.1.31	Provides capability to set up an accounts payable for non-provider-specific payments, issue payment, and adjust the financial reporting					
	<b>MMIS Accounts Receivable Process</b>					
40.14.1.32	Provides capability to ensure accurate collection and management of account receivables					
40.14.1.33	Provides capability for summary-level provider accounts receivable and payable data and pending recoupment amounts that are automatically updated after each claims processing payment cycle, with summary-level data consisting of calendar week-to-date, month-to-date, year-to-date, State, and Federal fiscal year-to-date totals					
40.14.1.34	Provides capability to maintain an accounts receivable detail and summary section for each account					
40.14.1.35	Provides capability for automated and manual establishment of accounts receivable for a provider and to alert the other Financial Processing portion of this function if the net transaction of claims and financial transactions results in a negative amount (balance due)					
40.14.1.36	Provides capability to monitor the status of each account receivable and report weekly and monthly to the State in aggregate and/or individual accounts, on paper and online					
40.14.1.37	Provides capability to produce collection letters within the financial processing function of the checkwrite cycle					
40.14.1.38	Provides capability to establish systematic payment plans or recoupments for provider					



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Requirement #	Requirement Description	A	B	C	D	E
	receivable balances, as directed by the State					
40.14.1.39	Provides capability to "write off" outstanding account receivables when approved by the State					
40.14.1.40	Provides capability to set up multiple open accounts receivable items for recoupment against provider claims payable in the financial system, subject to a hierarchy table; provides capability for the system to withhold the money from provider claims payable for all receivable items meeting recoupment criteria until the provider payable balance for all receivables have been fully recouped or the payable balance is equal zero					
40.14.1.41	Provides capability to perform the cash control processing cycle, updating master files for bank reconciliation, cash receipts, and accounts receivables and producing applicable cash control reports, including the cash receipts and accounts receivable detail from the checkwrite cycle					
40.14.1.42	Provides capability to accept claim-specific and gross recoveries, regardless of submitter (provider, carrier, recipient, drug manufacturer); provides capability to apply gross recoveries to providers and/or recipients as identifiable					
40.14.1.43	Provides capability to set up receivables and recoup payments to the provider for services after a recipient's date of death					
40.14.1.44	Provides capability for an online hierarchy table by fund code or recoupment type for the recovery of monies from claims payable to a provider, such as: <ul style="list-style-type: none"> <li>▪ Claims paid in error</li> <li>▪ Cost settlements receivables</li> <li>▪ Program integrity receivables</li> <li>▪ Provider advances tax withholding</li> <li>▪ Tax levies</li> </ul>					
40.14.1.45	Provides capability for an online accounts receivable process with the ability to request recoupments by the following portions of the receivable amount during one (1) payment					



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Requirement #	Requirement Description	A	B	C	D	E
	cycle: <ul style="list-style-type: none"> <li>▪ Percent</li> <li>▪ Dollar amount</li> <li>▪ Total amount</li> </ul>					
40.14.1.46	Provides capability to automatically recoup accounts receivables by either deductions from claims payments or through direct payment by the provider or combinations of both					
40.14.1.47	Provides capability to apply cash received and recoupments to the accounts receivable, including a history of the RA date, number, and amount and have related information available online					
40.14.1.48	Provides capability to apply claims payments recoupments to more than one (1) account receivable at a time					
40.14.1.49	Provides capability to allow the portion of payments made against each account receivable to be controlled by State staff					
40.14.1.50	Provides capability to remove accounts and produce reports on a monthly basis when a provider record has been inactive for one (1) year					
40.14.1.51	Provides capability to generate transactions to the system for each accounts receivable item created and invoiced, accounts receivable adjustments, payments received and, recouped and write-offs					
40.14.1.52	Provides capability for online daily receipts and recoupment information to the unit responsible for dispositioning the detail, for example TPL, drug rebate, medical refund, FADS recoveries, and any other cash receipts received by the State					
40.14.1.53	Provides capability to produce and send correspondence related to recipient premiums in the recipient's preferred language, including invoices, notices of non-payment, cancellation notices, receipts, and refunds					



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Requirement #	Requirement Description	A	B	C	D	E
40.14.1.54	Provides capability to collect recipient premium payments					
40.14.1.55	Provides capability to produce refunds of recipient premiums					
40.14.1.56	Provides capability to process financial accounting records for premium payments and refunds					
40.14.1.57	Provides capability to produce reports for recipient premium payment and cost-sharing (e.g., recipient co-insurance, deductibles, co-payments, etc.) processes					
40.14.1.58	Provides capability to apply cost-sharing, e.g., recipient co-insurance, deductibles, co-payments					
40.14.1.59	Provides capability to ensure cost-sharing does not exceed threshold for the family group					
40.14.1.60	Provides capability to produce and send recipient letters/notices and Explanations of Benefits (EOB) in the recipient's preferred language					
	<b>Financial Accounting and Reporting Processes</b>					
40.14.1.61	Provides capability to perform financial cycles upon completion of each checkwrite and at month-end, summarize paid claims and financial transactions, update account balances and transaction files, and produce interface files and reports					
40.14.1.62	Provides capability to account for and report to the State all program funds paid out and recovered in accordance with State-accounting codes and report specifications					
40.14.1.63	Provides capability for a process to designate which Federal fiscal year claim adjustments and other financial transactions are to be reported					
40.14.1.64	Provides capability to prepare fiduciary statements in accordance with GAAP to account for all program funds received and disbursed under the Fiscal Agent contract					
40.14.1.65	Provides capability to produce general ledger to correspond to the checkwrites over the					





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Requirement #	Requirement Description	A	B	C	D	E
	State's fiscal year; adjusts the general ledger account balances on June 30 <sup>th</sup> to reflect activity between the last June checkwrite and June 30 <sup>th</sup>					
40.14.1.66	Provides capability to summarize checkwrite activity in the Financial Participation Report and general expenditure reports on a year-to-date basis and within ten (10) days of the State's fiscal year's end on June 30 <sup>th</sup> ; provides capability to generate these reports in accordance with State-approved format, media, distribution, and frequency					
40.14.1.67	Provides capability to summarize financial data to meet reporting requirements on a State and Federal fiscal-year basis					
40.14.1.68	Provides capability to ensure all reporting cross-checks and balances to other reports using the same data					
40.14.1.69	Provides capability to produce reporting on providers required by the Federal False Claims Act					
40.14.1.70	Provides capability to maintain all records and reports of administrative expenses permitting the State to verify that the Fiscal Agent bills are accurate and appropriate to enable the State to claim Federal financial participation (FFP) on the Fiscal Agent fees at the appropriate rate					
40.14.1.71	Provides capability to ensure that all financial reports can be tied into the basic financial activity recorded in Provider History					
40.14.1.72	Provides capability to generate weekly, monthly, quarterly, and annual Medicaid and other EOB financial reports after checkwrites in accordance with State approved specifications, basis of accounting, and reporting deadlines					
40.14.1.73	Provides capability to balance details posted to each receivable transaction and update Claims History and Provider paid claims summary information					
40.14.1.74	Provides capability to incorporate data from State-approved automated systems to satisfy accounting and record keeping objectives					



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Requirement #	Requirement Description	A	B	C	D	E
40.14.1.75	Provides capability for system-generated letters to providers requesting updated W-9s or a special IRS form depending on whether they are a first or second B-Notice					
40.14.1.76	Provides capability for system logging and tracking of receipt date of each withholding and penalty request and completion date of withholding or penalty					
40.14.1.77	Provides capability to provide the State with confirmation and validation for each completed date of withholding or penalty					
40.14.1.78	Provides capability to implement backup withholding from all providers who do not respond to the notices within the required timeframes					
40.14.1.79	Provides capability for mechanized copies of documentation to support compliance with IRS procedures and efforts to obtain information from providers in order to abate penalties assessed					
40.14.1.80	Provides capability to report year-to-date provider 1099 earnings					
40.14.1.81	Provides capability to create end-of-year 1099 for providers whose earnings exceed \$600 on a calendar year basis and meet IRS criteria for issuance					
40.14.1.82	Provides capability to generate provider 1099 file and reports annually that indicate LOB, the total paid claims, plus or minus any appropriate adjustments and financial transactions					
40.14.1.83	Provides capability to issue corrected 1099s to providers prior to March 31 <sup>st</sup> each year; provides capability to ensure that corrections are incorporated into the IRS file to report earnings for the prior year					
	<b>Cash Control and Bank Accounts</b>					
40.14.1.84	Provides capability to automate and apply NC DHHS Cash Management Plan business rules and procedures to receive all program receipts in a State Treasurer designated bank Refer to <i>DHHS Cash Management Plan</i> in the Procurement Library.					



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Requirement #	Requirement Description	A	B	C	D	E
40.14.1.85	Provides capability for automated application of cash receipts and provide for online posting of the detail of receipts received to the system with simultaneous notice to for TPL recovery, Drug Rebates, FADS recoveries business areas					
40.14.1.86	Provides capability for indexed images of checks and all written correspondence from or to the provider for audit purposes throughout the life of the Contract					
40.14.1.87	Provides capability to process and post transactions for all program cash receipts received in Fiscal Agent/bank managed lock-boxes					
40.14.1.88	Provides capability to assign and retain a unique transaction control number, the date of receipt, the remitter's name, the remitter's bank name, purpose or reason code, the check/money order number, the transaction amount, and the unit to which the receipt is directed for dispositioning when there is no matching account receivable					
40.14.1.89	Provides capability to account for disposition of all program cash receipts and adjustments within the month of receipt					
40.14.1.90	Provides capability for an audit trail of corrections to posted transactions					
	<b>Budget Checking Prior To Payment of Claims</b>					
40.14.1.91	Provides capability to link the detail financial transaction to the claim detail level activity					
40.14.1.92**	Provides capability to produce balancing reports available online at detail and summary levels on budget availability					
40.14.1.93	Provides capability to produce exception reports on un-reconciled balances or undefined chart of accounts shall be available online					
	<b>Accounting Processes</b>					
40.14.1.94	Provides capability for integration of all Medicaid Accounting System (MAS) legacy system functionality, processes, data, reports and interfaces					



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Requirement #	Requirement Description	A	B	C	D	E
	Refer to <i>Approved MAS Requirements &amp; Business Rules—Updated 12-06-06</i> and attachments in the Procurement Library.					
	<b>General Account Receivable/Accounts Payable Requirements</b>					
40.14.1.95	Provides capability for accounts receivable and accounts payable functionality that is integrated with case management and billing using the open item method to support collection of program overpayments from providers and amounts determined to be due from third parties  Refer to <i>Approved AR-AP Requirements &amp; Business Rules—Updated 12-19-06</i> in the Procurement Library.					

**40.14.2 Financial Management and Accounting Operational Requirements**

Requirement #	Requirement Description	A	B	C	D	E
	<b>General Financial Management and Accounting</b>					
40.14.2.1	Fiscal Agent shall maintain the Replacement MMIS consolidated accounting function by program, type, and provider. Fiscal Agent shall deduct/add appropriate amounts from provider payments for past due receivables and other required withholding.					
40.14.2.2	Fiscal Agent shall provide the State with confirmation and validation for each completed file maintenance request (receipt date of file maintenance request, file maintenance initiation date, file maintenance completion date, and supervisor validation date) related to Financial Management and Accounting.					
40.14.2.3	Fiscal Agent shall ensure provider payments are generated by the processing of claims for eligible recipients, adjustments, or by State authorizations, such as payouts for court orders, open/shut cases, dropped eligibility, and policy changes.					
40.14.2.4**	Fiscal Agent shall provide nightly interface to NCAS to validate availability of funds for					



**APPENDIX 50, ATTACHMENT C, EXHIBIT 1**

Requirement #	Requirement Description	A	B	C	D	E
	claim-specific reimbursement.					
40.14.2.5	Fiscal Agent shall establish systematic payment plans or recoupments for provider receivable balances, collect the payments, apply the payments, monitor the process, and report on the payment activity at a provider and summary level on a weekly basis. Once a provider becomes delinquent in the payment schedule, the recoupment process shall be implemented until the debt is resolved.					
40.14.2.6	Fiscal Agent shall ensure that correct Federal Medical Assistance Percentage (FMAP) is applied to receivables and payables within the monthly financial processing cycles. (Certain receivables and payables may be subject to prior period FMAP.)					
40.14.2.7	Fiscal Agent shall issue provider checks in the number of cycles required by the State each year on State-designated business days, dating the checks and reports for the checkwrite date except for the final checkwrite of the month, which is dated, as directed by the State.					
40.14.2.8	Fiscal Agent shall balance each checkwrite in accordance with State-approved policy and procedures to ensure report accuracy and the completion of a final audit for that checkwrite.					
40.14.2.9	Fiscal Agent shall accept requests to override EFT payment to a provider and create the check voucher as a paper check request.					
40.14.2.10	Fiscal Agent shall accept and process all check voucher reconciliation.					
40.14.2.11	Fiscal Agent shall execute Positive Pay processing.					
40.14.2.12	Fiscal Agent shall ensure weekly budget reporting is consistent with the costs allocated during the checkwrite.					
40.14.2.13	Fiscal Agent shall submit a draft annual checkwrite schedule by the last State business day in September each year.					
40.14.2.14	Fiscal Agent shall perform checkwrites per the State-approved checkwrite schedules.					



**APPENDIX 50, ATTACHMENT C, EXHIBIT 1**

Requirement #	Requirement Description	A	B	C	D	E
40.14.2.15	Fiscal Agent shall notify the State of the total checkwrite expenditure on the first day following the cycle.					
40.14.2.16	Fiscal Agent shall notify the State by close of business of notification from the State Controller's Office that funds are in place each day following any delays in check mailings and EFTs.					
40.14.2.17	Fiscal Agent shall notify the State the next State business day following the checkwrite cycle of any delays in the checkwrite process.					
40.14.2.18	Fiscal Agent shall respond to State Memos as appropriate for canceling or delaying checkwrites or release of system-generated checks or EFTs.					
40.14.2.19	Fiscal Agent shall balance each checkwrite in accordance with State-approved policy and procedures to ensure report accuracy and the completion of a final audit for that checkwrite.					
40.14.2.20	Fiscal Agent shall process check voucher information from the State Controller's Office, updating payment information.					
40.14.2.21	Fiscal Agent shall ensure that the weekly budget reporting is consistent with the costs allocated during the checkwrite.					
40.14.2.22	Fiscal Agent shall produce third party letters within the financial processing function of the checkwrite cycle.					
<b>Requirement Deleted</b> 40.14.2.23	<del>Fiscal Agent shall produce reports and State claims within the financial processing function of the checkwrite cycle.</del>					
40.14.2.24	Fiscal Agent shall process State Payout Authorization Forms in accordance with State-approved guidelines to adjudicate claims that fail to process through the Replacement MMIS under normal circumstances.					



## APPENDIX 50, ATTACHMENT C, EXHIBIT 1

Requirement #	Requirement Description	A	B	C	D	E
40.14.2.25	Fiscal Agent shall execute, manage, maintain, and update financial operations, including claims payment, accounts receivable, accounts payable, cash management, transaction data entry, and financial participation calculations while maintaining detail accounting records in accordance with GAAP for all program financial transactions.					
40.14.2.26	Fiscal Agent shall enter and summarize all Replacement MMIS financial accounting transactions in accordance with GAAP prior to month-end closing deadlines specified by the NC DHHS Controller.					
40.14.2.27	Fiscal Agent shall maintain the MMIS Financial System operations in compliance with applicable State and Federal laws, regulations, reporting requirements, policies, business rules, and procedures as published and referenced in the Contract and the Procurement Library.					
40.14.2.28	Fiscal Agent shall implement and maintain effective internal controls over financial operations, accounting, physical access, system backup and recovery, and security for all Replacement MMIS financial operations, data, records, and assets.					
40.14.2.29	Fiscal Agent shall complete the Office of State Controller Internal Control Self Assessment upon request by the NC DHHS Controller and provide a signed original to the NC DHHS Controller.					
	<b>MMIS Program Account Payable</b>					
40.14.2.30	Fiscal Agent shall record provider claims payable less any overpayment recoupments and required withholding and produce all program cash disbursements in accordance with procedures and a schedule approved by the State for each checkwrite cycle, including State-authorized payments.					
40.14.2.31	Fiscal Agent shall determine daily cash requirements and draw program cash from a special State disbursing account as needed.					
40.14.2.32	Fiscal Agent shall collect recipient premium payments.					



**APPENDIX 50, ATTACHMENT C, EXHIBIT 1**



Requirement #	Requirement Description	A	B	C	D	E
40.14.2.33	Fiscal Agent shall produce refunds of recipient premiums.					
	<b>Replacement MMIS Accounts Receivable Process</b>					
40.14.2.34	Fiscal Agent shall monitor the status of each accounts receivable and reports weekly and monthly to the State in aggregate and/or individual accounts, both on paper and online.					
40.14.2.35	Fiscal Agent shall monitor compliance with written procedures to meet State and Federal guidelines for collecting outstanding provider and recipient account receivables in accordance with State-approved policy and procedures to ensure report accuracy and the completion of a final audit for that checkwrite.					
40.14.2.36	Fiscal Agent shall monitor compliance with written procedures to meet State and Federal guidelines for collecting outstanding provider accounts receivable.					
40.14.2.37	Fiscal Agent shall “write off” outstanding accounts receivable, when directed by the State.					
40.14.2.38	Fiscal Agent shall ensure accurate collection and management of accounts receivables.					
40.14.2.39	Fiscal Agent shall ensure that correct FMAP is applied to receivables and payables within the monthly financial processing cycles. (Certain receivables and payables may be subject to prior period FMAP.)					
40.14.2.40	Fiscal Agent shall maintain claim specific and gross level accounts receivable records for amounts due the program, recoup past due items based on a hierarchy table approved by the State, apply all payments, and produce and distribute invoices, collection letters and accounts receivable reports.					
	<b>Financial Accounting and Reporting Process</b>					
40.14.2.41	Fiscal Agent shall produce general ledger to correspond to the checkwrite over the State’s fiscal year and adjust the general ledger account balances on June 30 <sup>th</sup> to reflect activity between the last June checkwrite and June 30 <sup>th</sup> .					





**APPENDIX 50, ATTACHMENT C, EXHIBIT 1**

Requirement #	Requirement Description	A	B	C	D	E
40.14.2.42**	Fiscal Agent shall make details of the general ledger, including all entries and balances, available to authorized State staff.					
40.14.2.43	Fiscal Agent shall summarize checkwrite activity in the Checkwrite Financial Summary, Financial Participation Report, and general expenditure reports on a year-to-date basis and within ten (10) days of the State's fiscal year end on June 30 <sup>th</sup> and provide these reports in accordance with State-approved format, media, distribution, and frequency.					
40.14.2.44	Fiscal Agent shall change financial participation rates in the Replacement MMIS to correspond with the Federal fiscal year.					
40.14.2.45	Fiscal Agent shall ensure cross-checks and balances to other reporting is using the same data and is categorized in such a manner as to facilitate informed program administration and supporting the State's receipt of maximum.					
40.14.2.46**	Fiscal Agent shall refer questions regarding rates and budgets to the State.					
40.14.2.47	Fiscal Agent shall ensure adherence to NC DHHS Cash Management Plan and Procedures.					
40.14.2.48	Fiscal Agent shall incorporate State-approved automated and manual systems to satisfy accounting and record-keeping objectives.					
40.14.2.49	Fiscal Agent shall notify the State immediately upon discovery of any erroneous payments, irrespective of cause, and prior to initiating appropriate recovery action.					
40.14.2.50**	Fiscal Agent shall produce an extract of DMH claims data for the Client Data Warehouse (CDW) with each checkwrite.					
	<b>IRS Reporting and Compliance</b>					
40.14.2.51	Fiscal Agent shall summarize each provider's NC DHHS earnings by LOB for the previous calendar year no later than January 15 <sup>th</sup> of the succeeding year, providing the summary to the Internal Revenue Service and North Carolina Department of Revenue (NC DOR) by sending a file using File Transfer Protocol (FTP) media. Fiscal Agent shall					



## APPENDIX 50, ATTACHMENT C, EXHIBIT 1

Requirement #	Requirement Description	A	B	C	D	E
	provide this same information on each provider's last RA for the calendar year.					
40.14.2.52	Fiscal Agent shall send system-generated letters to providers requesting updated W-9s or a special IRS form depending on whether they are a first or second B-Notice.					
40.14.2.53	Fiscal Agent shall record receipt date of each withholding and penalty request and completion date of withholding or penalty.					
40.14.2.54	Fiscal Agent shall provide the State with confirmation and validation for each completed date of withholding or penalty.					
40.14.2.55	Fiscal Agent shall comply with all IRS regulations.					
40.14.2.56	Fiscal Agent shall issue corrected 1099s to providers prior to March 31 <sup>st</sup> each year and shall ensure that corrections are incorporated into the IRS file to report earnings for the prior year.					
40.14.2.57	Fiscal Agent shall ensure accuracy of tax identification numbers and tax names reported.					
	<b>Cash Control and Bank Accounts</b>					
40.14.2.58	Fiscal Agent shall ensure returned or refund receipts are received at the Fiscal Agent lock box for security and are accessed only by designated Fiscal Agent or bank personnel; receipts received are to be logged each State business day with disposition denoted, date, time, and individual processing the check.					
40.14.2.59	Fiscal Agent shall deposit program cash receipts into the State-designated State Treasurer's Account on a daily basis; checks received that are missing information are photocopied and deposited into the State's designated account daily regardless of whether they are missing information. Checks received that are missing information result in a system-generated form letter denoting the required corrective action. (Letters are to be maintained in an online report for follow-up actions.)					
40.14.2.60	Fiscal Agent shall retain copies of checks and all written correspondence from or to the provider for audit purposes throughout the life of the Contract.					



**APPENDIX 50, ATTACHMENT C, EXHIBIT 1**



Requirement #	Requirement Description	A	B	C	D	E
40.14.2.61	Fiscal Agent shall process other non-provider checks received, such as TPL and Drug Rebate receipts, in accordance with State-approved policies and procedures; deposits these funds daily into the designated State Treasurer's Account.					
40.14.2.62	Fiscal Agent shall contract and maintain State-approved banking services for, remittance lock box operations, and Fiscal Agent Disbursing Accounts.					
40.14.2.63	Fiscal Agent shall perform daily transfer of funds out of the State's Disbursing Account as appropriate to cover "presentments" on the Fiscal Agent Disbursing Account.					
40.14.2.64	Fiscal Agent shall provide the bank with instructions to transfer funds from the State Disbursing Account to the Fiscal Agent Disbursing Account to cover the "presentments."					
40.14.2.65	Fiscal Agent shall accept responsibility for and bear the cost of any overdraft penalties on Fiscal Agent-controlled checking accounts.					
40.14.2.66	Fiscal Agent shall monitor security of checks during matching, stuffing, and mailing process.					
40.14.2.67	Fiscal Agent shall perform monthly account reconciliation and submit State-approved reports within ten (10) business days of each calendar month, unless the Fiscal Agent notifies the State the reports have not been received from the banking institution in a timely manner.					
	<b>MMIS Program Cash Receiving</b>					
40.14.2.68	Fiscal Agent shall receive all program receipts in State-approved Fiscal Agent lock boxes established for each payer source, log each deposit item, scan or copy all deposit items and information received with the remittance, deposit all receipts daily, accurately record cash, and correctly apply receipts to the correct accounts in accounts receivable.					
40.14.2.69	Fiscal Agent shall report the daily deposit totals to the NC DHHS Controller by 1:30 P.M. for all program cash receipts, including TPL, Drug Rebates, FADS, audit recoveries, cost settlements, refunds, and any other program receipts in accounts receivable while maintaining complete, accurate and detailed accounting records for all program funds					



**APPENDIX 50, ATTACHMENT C, EXHIBIT 1**



Requirement #	Requirement Description	A	B	C	D	E
	received.					
	<b>Production and Distribution of Management and Financial Reports</b>					
40.14.2.70	Fiscal Agent shall produce and distribute all financial reports and interface files accurately and in the media, format, basis of accounting, and according to a schedule approved by the State.					
40.14.2.71	Fiscal Agent shall ensure that all financial reports and files meet State cutoff dates and can be balanced with underlying transactions for the applicable accounting period.					

**40.14.3 Financial Management and Accounting Operational Performance Standards**

Requirement #	Requirement Description	A	B	C	D	E
40.14.3.1	Fiscal Agent shall provide the State with confirmation and validation of accurate file maintenance request transactions ninety-nine and nine tenths (99.9) percent of the time.					
40.14.3.2	Fiscal Agent shall process accurate capitation and/or management fee adjustments ninety-nine and nine tenths (99.9) percent of the time.					
40.14.3.3	Fiscal Agent shall provide deposit of returned monies the same State business day of receipt.					
40.14.3.4	Fiscal Agent shall provide for processing of accurate capitation payments and management fees in the month-end claims cycle and payment in the first checkwrite of the next month.					
40.14.3.5	Fiscal Agent shall accurately complete processing of all HMO withholds and penalties and primary care provider penalties in the next claim cycle after receipt of withholding and penalty requests ninety-nine and nine tenths (99.9) percent of the time.					



**APPENDIX 50, ATTACHMENT C, EXHIBIT 1**



Requirement #	Requirement Description	A	B	C	D	E
40.14.3.6	Fiscal Agent shall publish the planned annual checkwrite schedule sixty (60) days prior to the start of the next calendar year.					
40.14.3.7	Fiscal Agent shall notify the State by 9:30 A.M. Eastern Time on the first State business day following checkwrite of funds required.					
40.14.3.8	Fiscal Agent shall notify the State by close of the business day of notification from the Controller's Office that funds are in place each day following any delays in check mailings and EFTs.					
40.14.3.9	Fiscal Agent shall notify the State of any delays and reasons in the checkwrite process by 8:00 A.M. Eastern Time the next business day following the checkwrite cycle and estimated timeframe for completion.					
40.14.3.10	Fiscal Agent shall balance each checkwrite accurately ninety-nine and nine tenths (99.9) percent of the time. Any discrepancies shall be reported to the State immediately via Operations Incident Reporting procedures.					
40.14.3.11	Fiscal Agent shall process check voucher information from the State Controller's Office accurately ninety-nine and nine tenths (99.9) percent of the time and within one (1) State business day of receipt.					
40.14.3.12	Fiscal Agent shall ensure that weekly budget reporting is accurate and consistent ninety-nine and nine tenths (99.9) percent of the time with the costs allocated during the checkwrite.					
40.14.3.13	Fiscal Agent shall accurately complete processing of all HMO withholds and penalties and primary care provider penalties in the next claim cycle after receipt of withholding and penalty requests.					
40.14.3.14	Fiscal Agent shall perform cost settlement activities accurately and consistently ninety-nine and nine tenths (99.9) percent of the time, as directed by the State.					
40.14.3.15	Fiscal Agent shall ensure that correct FMAP is applied to receivables and payables accurately and consistently ninety-nine and nine tenths (99.9) percent of the time within					



**APPENDIX 50, ATTACHMENT C, EXHIBIT 1**

Requirement #	Requirement Description	A	B	C	D	E
	the monthly financial processing cycles (certain receivables and payables may be subject to prior period FMAP).					
40.14.3.16	Fiscal Agent shall ensure accurate collection and management of accounts receivable/payable ninety-nine and nine tenths (99.9) percent of the time.					
40.14.3.17	Fiscal Agent shall produce and mail out 1099/W9 earnings reports no later than January 31 <sup>st</sup> each year and report to the IRS no later than March 1 <sup>st</sup> .					
40.14.3.18	Fiscal Agent shall maintain the capability to remove accounts receivable on a monthly basis when a provider record has been terminated for one (1) year. Fiscal Agent shall generate a report of remove accounts receivables on a monthly basis.					
40.14.3.19	Fiscal Agent shall account for and report accurately and consistently ninety-nine and nine tenths (99.9) percent of the time to the State all program funds paid out and recovered in accordance with State-approved guidelines.					
40.14.3.20	Fiscal Agent shall summarize each provider's NC DHHS for the previous calendar year no later than January 15 <sup>th</sup> of the succeeding year, providing the summary to the Internal Revenue Service and NC DOR by sending a file using FTP media. Fiscal Agent shall provide this same information on each provider's last RA for the calendar year accurately ninety-nine and nine tenths (99.9) percent of the time.					
40.14.3.21	Fiscal Agent shall log receipt date of each withholding and penalty request and completion date of withholding or penalty within one (1) State business day of receipt accurately ninety-nine and nine tenths (99.9) percent of the time.					
40.14.3.22	Fiscal Agent shall provide the State with confirmation and validation for each completed date of withholding or penalty on the State business day that the transaction is completed.					
40.14.3.23	Fiscal Agent shall comply with all IRS regulations ninety-nine and nine tenths (99.9) percent of the time.					
40.14.3.24	Fiscal Agent shall issue corrected 1099s to providers prior to March 31 <sup>st</sup> each year. Fiscal					



## APPENDIX 50, ATTACHMENT C, EXHIBIT 1

Requirement #	Requirement Description	A	B	C	D	E
	Agent shall ensure that corrections are incorporated into the IRS file to report earnings for the prior year accurately ninety-nine and nine tenths (99.9) percent of the time.					
40.14.3.25	Fiscal Agent shall ensure accuracy of tax identification numbers and tax names reported ninety-nine and nine tenths (99.9) percent of the time.					
40.14.3.26	Fiscal Agent shall ensure that returned or refund checks are received at the Fiscal Agent lock box for security and are accessed only by designated Fiscal Agent personnel. Checks received shall be logged each State business day with disposition denoted, date, time, and individual processing the check accurately ninety-nine and nine tenths (99.9) percent of the time.					
40.14.3.27	Fiscal Agent shall deposit all program cash receipts received into the State-designated State Treasurer's Account each State business day by 1:00 P.M. and certify the amount deposited to the NC DHHS Controller by 1:30 P.M.					
40.14.3.28	Fiscal Agent shall process other non-provider checks received, such as TPL and Drug Rebate receipts, in accordance with State-approved policies and procedures. Fiscal Agent shall deposit these funds daily into the State-designated State Treasurer's Account ninety-nine and nine tenths (99.9) percent of the time.					
40.14.3.29	Fiscal Agent shall perform monthly bank account reconciliation and submit State-approved reports within ten (10) State business days of each calendar month unless the Fiscal Agent notifies the State the reports have not been received from the banking institution in a timely manner.					
40.14.3.30	Fiscal Agent shall receive NCAS account data weekly to support checkwrite activity accurately and consistently ninety-nine and nine tenths (99.9) percent of the time.					
40.14.3.31**	<p>Fiscal Agent shall apply special "timely filing" edits at the end of the State fiscal year:</p> <ul style="list-style-type: none"> <li>▪ AP/LMEs shall file all services rendered prior to May 1<sup>st</sup> no later than the cutoff for the last payment cycle in June.</li> <li>▪ May and June services shall be presented to the Fiscal Agent by a date established by the State. Timely filing allows budgeted services to be allocated to</li> </ul>					



**APPENDIX 50, ATTACHMENT C, EXHIBIT 1**



Requirement #	Requirement Description	A	B	C	D	E
	the appropriate fiscal year accurately and consistently ninety-nine and nine tenths (99.9) percent of the time.					
<b>Requirement Deleted</b> 40.14.3.32	<del>Fiscal Agent shall notify the State by close of business of the day of notification from the State Controller's Office that funds are in place for the checkwrite.</del>					
40.14.3.33	Fiscal Agent shall summarize checkwrite activity in the Checkwrite Financial Summary, Financial Participation Report, and general expenditure reports on a year-to-date basis and within ten (10) days of the State's fiscal year end on June 30 <sup>th</sup>					
40.14.3.34	Fiscal Agent shall assure that Checkwrite Financial Summary and FPR Reports are completed the day after each checkwrite.					
40.14.3.35	Fiscal Agent shall ensure month-end processing and financial reports are completed, balanced and distributed no later than the fifth business day of the following month.					
40.14.3.36	Fiscal Agent shall produce and maintain accounts receivable reports.					
40.14.3.37	Fiscal Agent shall produce and maintain MMIS Medicaid Accounting System Reporting.					
40.14.3.38	Fiscal Agent shall produce and maintain Maximum Allowable Cost (MAC) Transactions and Reporting.					
40.14.3.39	Fiscal Agent shall produce and maintain Medicaid Adjustments Register Reporting.					
40.14.3.40	Fiscal Agent shall produce and maintain listing of paid claims for Indians on reservations.					
40.14.3.41	Fiscal Agent shall produce and maintain the listing of buy-in premiums paid for Indians on reservations.					
40.14.3.42	Fiscal Agent shall produce and maintain the listing and file containing Indian financial adjustment transactions.					





**APPENDIX 50, ATTACHMENT C, EXHIBIT 1**

Requirement #	Requirement Description	A	B	C	D	E
40.14.3.43	Fiscal Agent shall produce and maintain the Medicaid Cost Calculation Reporting.					
40.14.3.44	Fiscal Agent shall produce and maintain NCAS Program Cost Interface.					
40.14.3.45	Fiscal Agent shall produce and maintain the Monthly County Bank Draft File.					
40.14.3.46	Fiscal Agent shall produce and maintain MMIS Summary of Paid Claims.					
40.14.3.47	Fiscal Agent shall provide system logging for all program cash receipts received each State business day in Fiscal Agent/bank-managed lock boxes designated by the State with disposition denoted, date, time, and individual processing the receipt.					
40.14.3.48	Fiscal Agent shall index images of checks and all written correspondence from or to the provider for audit purposes throughout the life of the Contract.					
40.14.3.49	Fiscal Agent shall provide verification of daily deposit total to receipt logs by an employee who is independent of the lock box remittance and bank deposit process.					
40.14.3.50	Fiscal Agent shall process and post transactions for all program cash receipts received in Fiscal Agent/bank-managed lock boxes designated by the State.					
40.14.3.51	Fiscal Agent shall disposition all program cash receipts and adjustments within the month of receipt to the applicable program division, benefit plan, NCAS CAC code and period code, reason code, service, and county code.					
40.14.3.52	The Fiscal Agent shall produce an extract of DMH claims data for CDW with each checkwrite.					



**EXHIBIT 2: ADJUSTED FUNCTION POINT (FP) COUNT**

<b>Business/Functional Area</b>	<b>Baseline Adjusted FP</b>	<b>Enhancement Adjusted FP</b>	<b>New Capabilities Adjusted FP</b>	<b>Notes</b>
Recipient				
EVS				
AVRS				
Provider				
Reference				
Prior Approval				
Claims				
Managed Care				
Health Check				
TPL				
Drug Rebate				
MARS				



APPENDIX 50, ATTACHMENT C, EXHIBIT 2



Business/Functional Area	Baseline Adjusted FP	Enhancement Adjusted FP	New Capabilities Adjusted FP	Notes
Financial				
Multi-Payer Requirements				
Data Transfer and Conversion				
Interfaces				
Architecture				
System Software Controls				
User Interface and Navigation				
Document Management and Correspondence Tracking				
Audit Trail				
Online Help				
Search and Query				
Correspondence and Letters				
Reports				



**APPENDIX 50, ATTACHMENT C, EXHIBIT 2**



<b>Business/Functional Area</b>	<b>Baseline Adjusted FP</b>	<b>Enhancement Adjusted FP</b>	<b>New Capabilities Adjusted FP</b>	<b>Notes</b>
Workflow Management				
Rules Engine				
Integrated Test Facility				
Training				
Call Center Services				
System Availability				
Customer Service Request Tracking System				
Web Portal				
Fiscal Agent Data Center and Offices				
Regulatory Compliance				
Data Protection Assurance				
Enterprise Security Approach				
Facility Access				



APPENDIX 50, ATTACHMENT C, EXHIBIT 2



Business/Functional Area	Baseline Adjusted FP	Enhancement Adjusted FP	New Capabilities Adjusted FP	Notes
Application Systems Change Control				
Logging and Reporting				
Service Continuity Controls				
Data Backup and Recovery				
Records Retention				
LAN/WAN Management Operational Requirements				
System/Software Maintenance				
System Modifications				
Other (specify)				



**APPENDIX 50, ATTACHMENT D**

**STATEMENT OF WORK FORMAT**

<b>DDI Section</b>			
<b>XYZ Subsection</b>			
SOW Number	Work Statement Description	Performance Standard	RFP References

<b>Operations Section</b>			
<b>ABC Subsection</b>			
SOW Number	Work Statement Description	Performance Standard	RFP References



## APPENDIX 50, ATTACHMENT D



<b>Turnover Section</b>			
<b>DEF Subsection</b>			
<b>SOW Number</b>	<b>Work Statement Description</b>	<b>Performance Standard</b>	<b>RFP References</b>

<b>Early Implementation Section</b>			
<b>GHI Subsection</b>			
<b>SOW Number</b>	<b>Work Statement Description</b>	<b>Performance Standard</b>	<b>RFP References</b>



**LISTING OF OFFEROR'S CORPORATE RELEVANT EXPERIENCE**

**Name of the Customer** \_\_\_\_\_

**Name of the Project** \_\_\_\_\_

Did the project involve claims processing specifically for either or all of the following?

- Medicaid
- Medicare
- Mental Health
- Other health care entity

Did the Offeror perform any of the following tasks on the contract?

- Claim processing (include whether fee for service, capitation, and/or encounters)
- Provider relations services
- Prior approval services
- Drug rebate services
- Point of sale processing and support services
- Electronic eligibility verification system processing and services
- Provider payment issuance and financial management
- Other





## APPENDIX 50, ATTACHMENT E



Indicate whether the role Offeror had on the referenced contract was as a prime or a subcontractor

- Prime
- Subcontractor

Time period of the project during which the Offeror participated

\_\_\_\_\_

Program size (number of beneficiaries and dollar amount of claims paid per year)

Total number of providers served by program \_\_\_\_\_

\_\_\_\_\_

Did the Offeror's overall responsibilities on the referenced contract include:

- Design, development, and implementation of a system with COTS?
- Design, development, and implementation of a system with COTS with modifications?
- Design, development, and implementation of a system with ground-up development?
- Design, development, and implementation of a system with a transferred system?
- Design, development, and implementation of a system with a transferred system with modifications?
- Design, development, and implementation of a system requiring CMS certification?
- Operations of a system?
- Maintenance and modification of a system?



## APPENDIX 50, ATTACHMENT E

- Any responsibilities for system turnover at the end of the contract?
- Any responsibilities serving as the systems integrator?

Did the referenced contract involve health care claims processing in a multi-payer environment?

- Yes
- No

Platform the system operates on

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Key technologies used in the implementation and/or operation of the system

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Have damages or penalties been assessed during the last 5 years?

- Yes
- No

Customer reference (including name, address, and current telephone number of the responsible project administrator or manager who is familiar with the Offeror's performance)



## APPENDIX 50, ATTACHMENT E

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Name

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Address

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Telephone

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**APPENDIX 50, ATTACHMENT G**



**DESCRIPTION OF ACCOUNT CODES FOR REPLACEMENT MMIS PROCUREMENT**

Line Item	Account	Description
1	<b>Full-Time Equivalents (FTEs)</b>	Provisions for the number of positions equivalent to full-time employment
2	<b>Hourly</b>	Provisions for labor charged by the hour
3	<b>Labor Subtotal</b>	In general, labor includes wages for employees needed to manage administrative and technical aspects of replacement/maintenance efforts. Costs should include Social Security contributions, straight-time and over-time pay, Medicare contributions, and worker's compensation.
4	<b>Contractual Services (Non-Telecom)</b>	Charge for any services obtained by contract, other than services related to controlling or supporting a telecommunications network.
5	<b>Contractual Services (Telecom)</b>	Charge for services obtained by contract that relate to controlling or supporting a telecommunications network.
6	<b>Electrical and Janitorial</b>	Charge for building operations related to energy and upkeep. May also include other utility costs such as water and gas, as applicable.
7	<b>Lodging</b>	Charge for temporary quarters during in-state, out-of-state, in-US, or out-of-US travel
8	<b>Meals</b>	Charge for food served and eaten during in-state, out-of-state, in-US, or out-of-US travel
9	<b>Phone/Voice Mail</b>	Fee to enable communications by voice. Examples include charges for long distance telephone calls; voice mail services; and voice-over-IP services. Charges should not include wireless phone charges.
10	<b>Printing</b>	Fee to produce printed material; may also include charge for binding printed material
11	<b>Rent/Lease Office Space</b>	Fee to use a facility or space
12	<b>Software and Hardware Maintenance</b>	Fee to keep software and hardware in proper working condition



**APPENDIX 50, ATTACHMENT G**



Line Item	Account	Description
13	<b>Transportation</b>	Charge for transporting persons from one location to another location in the state, out of the state, in the US, or out of the US. May include charges for air or ground transportation, such as airfare, rented vehicles, or train transportation. May also include anticipated reimbursement for mileage.
14	<b>Other</b>	Charge for any other purchased service not expressly defined by items 4 through 13. May include performance bonds (refer to description for 14A below.)
14a	<b>Other, Performance Bonds</b>	Charge for protection against potential losses to the State as a result of defaulting actions by the Fiscal Agent.
15	<b>Purchased Services Subtotal</b>	In general, purchased services include subcontractor agreements; software and hardware maintenance; energy, utilities and maintenance related to facility or office space; third-party agreements for CPU usage, disk storage, transaction charges for testing, equipment rental space; and expenses related to travel.
16	<b>Office Supplies</b>	Charge for general office supplies, data processing supplies, janitorial supplies, and gasoline.
17	<b>Other</b>	Charge for any other supplies not expressly defined by item 16.
18	<b>Supplies Subtotal</b>	In general, supplies include items such as paper, writing instruments, staples, notepads, cleaning supplies, gasoline, and other materials or provisions stored and dispensed when needed.
19	<b>Hardware (Non-storage and Non-Telecom)</b>	Charge for computers and the associated physical equipment directly involved in the performance of data-processing, but not related to physical media used specifically for storing and organizing data. Should also not be related to physical devices that are used specifically to transfer data from one physical location to another. Examples include printers, monitors, keyboards, and pointing devices.
20	<b>Software (Non-storage and Non-Telecom)</b>	Charge for programs that manage development and operations, but not related to software designed specifically to control and support the activities of a telecommunications network. Examples include system software and third-party commercial packages for end-users, such as e-mail and calendaring.
21	<b>Telecommunications Software</b>	Charge for special software for controlling and supporting the activities of a telecommunications network. Examples include Novell Netware and Windows NT for servers.



## APPENDIX 50, ATTACHMENT G



Line Item	Account	Description
22	<b>Storage Technology</b>	Charge for physical media and software governing the storage and organization of data for use in information systems. Examples include direct access storage devices, optical disks, and magnetic tapes.
23	<b>Telecommunications Technology</b>	Charge for physical devices and software that link various computer hardware components and transfer data from one physical location to another. Examples include routers, switches, and hubs.
24	<b>Other</b>	Charge for any other depreciable property, plant, or equipment item not expressly defined by items 19 through 23. May include office equipment and furniture (refer to description for 24A below).
24a	<b>Other, Office Furniture</b>	Charge for office furniture. Examples include desks, chairs, and file cabinets.
25	<b>Property, Plant and Equipment Subtotal</b>	In general, property, plant and equipment includes items that are depreciable and not easily dispensed when needed.
26	<b>Total Fixed-Price</b>	



**BASELINE REPRESENTATION**

\_\_\_\_\_ (Offeror) hereby represents to the North Carolina Department of Health and Human Services (NC DHHS) that the Medicaid Management Information System (MMIS) software that Offeror proposes to demonstrate to NC DHHS in response to RFP 30-DHHS-1228-08-R is a baseline software solution within the description set forth in Section 50 of RFP 30-DHHS-1228-08-R.

Signature: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_



APPENDIX 50, ATTACHMENT I



PERSONNEL STAFFING QUALIFICATION MATRIX

With the exception of the positions the State has mandated as being key, these positions and qualifications are being provided as guidelines.

Title	Key Personnel	Degree Certification	Experience
Account Manager		B.A./B.S. or equivalent combination of education and additional years of directly relevant experience	Any combination of 5 years of experience as any of the following for a Medicaid Fiscal Agent or other large healthcare claims processing organization as an:  Account/Site Manager or Deputy Account/Site Manager
Deputy Account Manager		B.A./B.S. or equivalent combination of education and additional years of directly relevant experience	Any combination of 5 years of progressive responsibility and experience as any of the following for a Medicaid Fiscal Agent or other large healthcare claims processing organization:  Account/Site Manager or Deputy Account/Site Manager or Claims Processing Manager or Systems Manager
Implementation Manager		B.A./B.S. B.S./MIS or DP Preferred; or equivalent combination of education and additional years of directly relevant experience	Minimum of 5 years of experience in managing an MMIS system design, development, and implementation effort; and technical training in the Offeror's proposed design methodologies and technologies.
Operations/Claims Processing Manager	Yes	B.A./B.S. preferred; or equivalent combination of education and additional years of directly relevant experience	Minimum of 5 years of experience working with an operational claims processing component of a Medicaid Fiscal Agent or other large healthcare claims processing organization including the processing of EMC claims; and a minimum of 3 years of the above experience must have been progressively responsible supervisory or management experience.





## APPENDIX 50, ATTACHMENT I

Title	Key Personnel	Degree Certification	Experience
Operations Quality Control Manager		B.A./B.S. degree in preferred accounting, business administration, statistics; or equivalent combination of education and additional years of directly relevant experience	Minimum 4 years experience in developing and maintaining vigorous ongoing quality control function that encompasses data entry, verification of system outputs, balancing of jobs, validating the integrity of the data, controlling and accounting for system inputs, provider communications, finance and accounting, and ensuring adequate internal controls and quality checks throughout all Replacement MMIS operations tasks.
Technical Director/Systems Programming Manager		B.A./B.S. degree preferred in Computer Sciences, Information Systems, or related field; or equivalent combination of education and additional years of directly relevant experience	Minimum of 10 years experience managing or performing software engineering activities, of which at least 8 years must be specialized and 3 of which shall be within the last 5 years. Specialized experience includes: demonstrated experience working with SQL, and third/fourth generation languages in the design and implementation of systems and using database management systems. General experience includes increasing responsibilities in software engineering activities. Knowledgeable of applicable standards.
Senior Systems Architect		B.A./B.S. degree preferred in Computer Sciences, Information Systems, or related field; or equivalent combination of education and additional years of directly relevant experience	Minimum 8 years experience as a principle systems architect working with software development teams to create a systems architecture that most efficiently delivers technology solutions that are comparable to the NC Medicaid and IRMC Standards. Develops sound architecture and distribution strategies, taking into account total system requirements, advanced principles, theories and concepts to develop plans, strategies, and tools to resolve issues.
Project Manager		B.A./B.S. degree preferred in Computer Sciences, Information Systems, or related field; or equivalent combination of education and additional years of directly relevant experience	Minimum 8 years experience, 3 of which shall be within the last 5 years in project development from inception to deployment, and management and control of funds and resources, demonstrated ability in managing multi-payer projects and related sub-projects.



## APPENDIX 50, ATTACHMENT I

Title	Key Personnel	Degree Certification	Experience
Project Management Office Director		B.A./B.S. degree preferred in Computer Sciences, Information Systems, or related field;  Required: certification for project manager	Minimum of 10 years experience directing Project Managers in the development of project plans, schedules, and resource requirements specified in statements of work, task orders, and benefit/value propositions. Such direction includes the maintenance of a time-reporting system for collecting the expenditure of effort at the lowest level of detail in each project plan. Manages project performance by using “earned value” or comparable processes. Maintains a standard project workbook for each project that provides a means for the efficient collection, storage, and dissemination of project information, reports, and official communications. Manages multi-agency, multi-payer projects individually and across multiple agencies.
Systems Quality Control Manager		B.A./B.S. or equivalent combination of education and additional years of directly relevant experience	Minimum 4 years experience in developing and maintaining vigorous ongoing quality control function that encompasses verification of system testing and production outputs, balancing of jobs, validating the integrity of the data, controlling and accounting for system inputs and ensuring adequate internal controls and quality checks throughout all Replacement MMIS related tasks. Responsible for certifying system changes as bug-free and stable, and works to develop, apply, and maintain quality requirements that include the creation and execution of methods and procedures for testing and debugging programs.
Privacy Officer		B.A./B.S. preferred; or equivalent combination of education and additional years of directly relevant experience	Minimum of 3 years experience managing a HIPAA Privacy program. Manages HIPAA-directed privacy program in compliance with federal and state laws and applicable regulatory and accreditation standards. Responsible for development and implementation of policies and procedures for the privacy of patients’ health information development and coordination of initial and annual training on privacy policies and



## APPENDIX 50, ATTACHMENT I



Title	Key Personnel	Degree Certification	Experience
			<p>procedures; working with legal team, ensures contracts or other legal agreements with Business Associates or other types of organizations including grant funding organizations meet the standards for HIPAA compliance and applicable State laws; establish processes to identify, investigate, and mitigate the effects of actual or potential inappropriate uses or disclosure of protected health information; supports the State as a liaison for HIPAA privacy issues. Required membership and participation in Standards Organizations including but not limited to X12, HL7, and NCPDP.</p>
Security Officer		<p>B.A./B.S. in Management, Information Security, or Computer Sciences preferred; or the equivalent combination of education and additional years of directly relevant experience</p> <p>Required: One or more security certifications (e.g., CISSP, CISM, CPP, CISA, CBCP)</p>	<p>Minimum of 5 years experience managing a security program in compliance with federal and state laws. Knowledge of healthcare, HIPAA, or CMS security requirements. Responsible for: Operations Security – the implementation of security policies, processes, and procedures; Performing Risk Management – making assessments of the technical infrastructure; Providing Security Awareness Training; Investigating and Reporting Security Incidents; Developing, Testing, and Maintaining Business Continuity Plans.</p>
Documentation Specialists		<p>B.A./B.S. degree preferred; or equivalent combination of education and additional years of directly relevant experience</p>	<p>Minimum of 2 years experience in the creation and production of technical and/or user documentation; at least 1 year experience in the management of documentation version control procedures and web-based documentation experience. Projects may involve preparing individual sections of the Replacement MMIS manuals or other technical documents, or organizing the complete production of a basic manual.</p>
Sr. Technical Analyst – Subject Matter Expert (SME) – MMIS		<p>B.A./B.S. degree preferred in Computer Sciences, Information Systems, or related field; or equivalent combination of education and additional years of directly</p>	<p>Minimum of 5 years experience in the designing of complex Medicaid Management Information Systems (MMIS): Position requires in-depth knowledge of Medicaid General Systems Design components/requirements, and Medicaid Technical</p>



**APPENDIX 50, ATTACHMENT I**



Title	Key Personnel	Degree Certification	Experience
		relevant experience	Systems Design components/ requirements. Detailed understanding of the complexities associated with designing, developing, and implementing Medicaid claims processing systems ranging from Mainframe to N-Tier systems. Will assist other staff in the analysis and design of MMIS maintenance and modifications.
Sr. Technical Analyst – Subject Matter Expert – HIPAA		B.A./B.S. degree preferred in Computer Sciences, Information Systems, or related field; or equivalent combination of education and additional years of directly relevant experience	Minimum of 5 years experience in the designing of complex MMIS: Position requires in-depth knowledge of HIPAA Transactions and Code Set knowledge. Position will provide ongoing HIPAA expert level advice, planning, and recommendations to the State on the impact of HIPAA changes as Federal changes are initiated. Will provide detailed input for the Fiscal Agent and State regarding the impact of HIPAA initiatives on current and future General Systems Design components/ requirements and Technical Systems Design components/requirements. Will be the HIPAA resource for both the Fiscal Agent and the State on HIPAA Transactions and Codes Sets change requirements to meet Federal standards and guidelines.
Sr. Technical Analyst – Subject Matter Expert – Multi-Payer		B.A./B.S. degree preferred in Computer Sciences, Information Systems, or related field; or equivalent combination of education and additional years of directly relevant experience	Minimum of 5 years experience in the designing of complex MMIS with multi-payer/multi-agency capabilities: Position requires in-depth knowledge of Medicaid General Systems Design components/requirements and Medicaid Technical Systems Design components/ requirements. Detailed understanding of the complexities associated with designing, developing, and implementing Medicaid claims processing systems ranging from Mainframe to N-Tier systems. Will assist other staff in the analysis and design of MMIS maintenance and modifications with Multi-Payer considerations.
Sr. State Business Liaison		B.A./B.S. degree preferred; or equivalent combination of education	Minimum of 5 years experience in MMIS analysis, programming, and operations interface to support the



## APPENDIX 50, ATTACHMENT I



Title	Key Personnel	Degree Certification	Experience
		and additional years of directly relevant experience	State in the preparation of Customer Service Requests. Research system problems, validating system changes, user training, helping customer develop and articulate CSR requests, provide high level Replacement MMIS and process flow to State.
LAN/WAN Manager		B.A./B.S. degree preferred; or equivalent combination of education and additional years of directly relevant experience	Three years lead experience in planning, engineering, implementing, and supporting the organization's computer network. Provides technical support and training to users. Administers security procedures. Investigates, evaluates, recommends, and upgrades hardware and software to meet Replacement MMIS requirements. Prepares and maintains documentation for current network platform, backup, and printing procedures.
Database Administrator		B.A./B.S.; or equivalent combination of education and additional years of directly relevant experience	Minimum 5 years experience in the administration, planning, coordinating, implementation, and maintenance of computerized databases and develops policies and procedures for ensuring the security and integrity of the database. Designs data models, performs imports, creates and maintains database scheme, performance tuning and capacity planning, monitors the database for potential problems and creates end user reports. Confers with other systems and operations business units to maximize the value of the data and determine impact of changes on other systems. Establishes and maintains policies, procedures, and standards relating to database management; Preferred Health Care claims processing experience.
Network Specialist		B.A./B.S. degree preferred; or equivalent combination of education and additional years of directly relevant experience	Minimum 5 years experience in monitoring, testing, and troubleshooting network hardware and software problems. Recommends and schedules repairs to maintain network integrity. Understands commonly used concepts, practices, and procedures.



## APPENDIX 50, ATTACHMENT I



Title	Key Personnel	Degree Certification	Experience
Provider Relations Manager		B.A./B.S. degree preferred; or equivalent combination of education and additional years of directly relevant experience	Minimum of 4 years experience with a Medicaid Fiscal Agent or other large healthcare claims processing organization in management of provider services and relation activities; e.g., developing and implementing training, communications, outreach programs.
Prior Approval Manager		B.A./B.S., MIS, DP, or similar degree preferred; or equivalent combination of education and additional years of directly relevant experience. Tara: clinical degree or master's level	Minimum of 4 years experience with a Medicaid Fiscal Agent or other large healthcare claims processing organization performing prior approval and/or related activities.
Medical Director	Yes	Medical Doctor degree; North Carolina licensed	Minimum of 5 years experience in medical practice; minimum of 3 years experience in supporting policy and claims resolution services in commercial or government health insurance programs. NC medical license with board certification within their specialty.
Pharmacy Director	Yes	Pharmacy degree; North Carolina licensed	Minimum of 5 years experience in pharmaceutical practice; minimum of two years experience in supporting policy and claims resolution services in commercial or government health insurance programs. Current license to practice as a registered pharmacist in NC by the NC Board of Pharmacy.
Dental Director	Yes	Dental degree; North Carolina licensed	Minimum of 5 years experience in dental practice; minimum of 2 years experience in supporting policy and claims resolution services in commercial or government health insurance programs. Licensed to practice dentistry in North Carolina.
Financial Manager		B.A./B.S. degree preferred in accounting, business administration	Minimum of 5 years management experience in accounting for commercial or government projects; preferred MMIS financial management and accounting experience.
Turnover Account Manager		B.A./B.S. or equivalent combination of education and additional years of	Minimum of 4 years MMIS management at a Deputy Account Management level with a broad understanding



## APPENDIX 50, ATTACHMENT I

Title	Key Personnel	Degree Certification	Experience
		directly relevant experience	of Replacement MMIS and operational requirements.
Turnover Technical Director/Systems Programming Manager		B.A./B.S. degree preferred in Computer Sciences, Information Systems, or related field	Minimum of 5 years experience managing or performing software engineering activities, of which at least 8 years must be specialized and 2 of which shall be within the last 4 years. Specialized experience includes: demonstrated experience working with SQL, and third/fourth generation languages in the design and implementation of systems and using database management systems. General experience includes increasing responsibilities in software engineering activities. Knowledgeable of applicable standards.
Registered Nurse		Registered Nurse	Must be licensed in the state of North Carolina with a minimum of 3 years experience in medical practice.



**North Carolina  
Department of  
Health and Human Services**

# **REPLACEMENT MMIS ACRONYM AND GLOSSARY LIST**

**for the North Carolina Medicaid Management Information System  
(NCMMIS+) Program**





## NCMMIS+ ACRONYM AND GLOSSARY LIST

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**NCMMIS+ GLOSSARY AND ACRONYM LIST**

**Note**

Some glossary entries include alternative definitions that shall apply as the context requires.

Acronym or Term	Description
<p>ACTS Automated Collection and Tracking System</p>	<p>In North Carolina, this statewide computer system for Child Support Enforcement (CSE) tracks participant and case activities, stores participant and case information, and performs automated activities to assist CSE caseworkers. ACTS receives data from and shares data with more than 30 State, Federal, and private agencies. This system assists in the location of non-custodial parents, establishing child support orders, and collecting child support.</p>
<p>ADA American Dental Association</p>	<p>The professional “membership” of dentists</p>
<p>AHFS American Hospital Formulary Service</p>	<p>Pharmacy Point-of-Sale (POS) Classification file or code; a data element available from First DataBank as a component for the North Carolina drug file</p>
<p>AINS Automated Information Notification System</p>	<p>A Health Check computerized system used by the Legacy MMIS+ for identifying and following Medicaid eligible children birth through 20 years of age with regard to their activities in the health care system</p>
<p>ARR Annual Resident Review</p>	<p>Annual Review that is federally mandated under Pre-Admission Screening and Annual Resident Review (PASARR) to determine the continuation of a nursing facility placement and need for continued specialized services</p>
<p>ASC Accredited Standard Committee</p>	<p>An organization accredited by the American National Standards Institute for the development of American National Standards such as the following health care transactions:</p> <ul style="list-style-type: none"> <li>➤ ASC X12N 270</li> <li>➤ ASC X12N 271</li> <li>➤ ASC X12N 276</li> <li>➤ ASC X12N 277</li> <li>➤ ASC X12N 834</li> </ul>



## NCMMIS+ ACRONYM AND GLOSSARY LIST



Acronym or Term	Description
	<ul style="list-style-type: none"> <li>➤ ASC X12N 835</li> <li>➤ ASC X12N 837</li> </ul>
ATP or AT Assistive Technology Program or Assistive Technology	The North Carolina Division of Public Health (DPH) program that pays for equipment for children with developmental delays participating in the Infant Toddler Program of North Carolina
AVRS Automated Voice Response System	A telephone system that providers or recipients may use to access MMIS information and receive real-time voice responses AVRS is a business area of the Legacy MMIS+ and Replacement MMIS.
AWP Average Wholesale Price	A drug pricing methodology based on a survey of wholesale prices for a specific drug
Adaptability	Ability to meet the needs of a rapidly changing business environment through the proper separation of application concerns (i.e., user interface, business rules, data access objects) using a 3/N-tier or Service-Oriented Architecture approach to application development
Adjustment by System	A transaction that changes the payment amount and/or units of services of a previously paid claim
Administrative Entity	In North Carolina, any legal entity or organization that operates as a governing body on behalf of the State in administering a program(s); e.g., Community Care of North Carolina (CCNC), Local Managing Entities (LME), Children's Developmental Services Agencies (CDSA), etc.
Adult Care Facility	Assisted living residence that provides 24 scheduled and unscheduled personal care services for 2 or more residents
Adult Cystic Fibrosis Program (CF Program)	The North Carolina DPH program available to persons 19 years and older diagnosed with Cystic Fibrosis
Assumption Notice	In accordance with RFP Section 30.23(b)(i), the means through which Vendor notifies the State in writing that Vendor shall assume control of the defense and settlement of a Third Party Claim.
Atypical Provider	A provider who provides non-health care services
Availability	Ability to meet business objectives at a sustained level of availability based on cost justifications, expressed in measurable terms (e.g., Two 9s, Three 9s, Mean-Time between Failures [MTBF]) Single point(s) of failure are to be identified and eliminated to the fullest extent possible. Robust hardware and software that provides fault tolerance and high availability functionality can be leveraged to provide the specified level of availability.



## NCMMIS+ ACRONYM AND GLOSSARY LIST

Acronym or Term	Description
BAFO Best and Final Offer	In a competitive Request for Proposal process, a BAFO is a bid that is submitted as a follow up to one or more prior bids by the same bidder, which is the “best and final” technical and/or cost proposal that the bidder can offer. Subject to procurement procedures, laws and regulation—a bidder may submit a BAFO following clarifications of the RFP or proposals, or following changes initiated by the requestor. A BAFO may or may not be requested at the sole discretion of the requesting entity.
BENDEX Beneficiary Data Exchange	An electronic file from the Social Security Administration providing information on Medicare benefits for Medicaid recipients
Business Procurement Card	A payment card issued by the State to an individual State employee for that employee’s use purchasing goods on behalf of the State.
Buy-In	The process supporting payment of Medicare premiums for Medicaid recipients
CAC Cost Accounting Code	The accounting string required to appropriately code financial transactions for entry into North Carolina Accounting System (NCAS)
CAP Community Alternatives Program	A Medicaid waiver program designed to enable persons to remain at home rather than enter a Skilled Nursing Facility or Intermediate Care Facility
CAP Competitive Acquisition Program	Elective program for Physicians and DME suppliers to purchase medications and supplies through a CMS-approved CAP vendor for Medicare Part B drugs and biologicals not paid on a cost or prospective payment system basis
CBU Contractor Billable Units	Adjudicated claims—whether fee-for-service, system-generated, or paper—that can be paid by the Fiscal Agent
CCI Correct Coding Initiative	Medicare’s Correct Coding Initiative edits
CCME The Carolinas Center for Medical Excellence	The agency that provides claim pre-approvals and contracts with North Carolina to operate Medicaid’s pre-admission certification program for elective inpatient hospital care; formerly called the Medical Review of North Carolina
CCNC Community Care of North Carolina	North Carolina’s managed health care plan that joins Carolina ACCESS and ACCESS II under one umbrella



## NCMMIS+ ACRONYM AND GLOSSARY LIST



Acronym or Term	Description
CDRL - Contract Data Requirements List	A descriptive list of data (including documents) to be delivered by the Vendor to the State pursuant to the Contract.
CDSA Children's Developmental Services Agencies	In North Carolina, the CDSAs (formerly called the Developmental Evaluation Centers) are the local lead agencies for the North Carolina Infant-Toddler program under Part C of the Individuals with Disabilities Education Act
CDW Client Data Warehouse	The data repository for demographic, clinical, outcomes, and satisfaction data about clients served by DMH The data stored in the CDW is the primary source of information for Mental Health Block Grant (MHBG) and Substance Abuse Block Grant (SABG) reporting as well as Legislative requests. Additionally, the CDW provides a rich source of information for planning and evaluation of the DMH provided to the citizens of North Carolina.
CHOW Change of Ownership	A term used when discussing change in ownership of facilities; also a form used for Facilities Management in Division of Health Service Regulation (DHSR) (formerly Division of Facility Services [DFS])
CLIA Clinical Laboratory Improvement Amendments	CLIA program ensures quality laboratory testing and all clinical laboratories are properly certified to receive Medicare or Medicaid payments CLIA passed by Congress in 1988, establishing quality standards for all laboratory testing to ensure the accuracy, reliability, and timeliness of patient test results regardless of where the test was performed. A laboratory is defined as any facility which performs laboratory testing on specimens derived from humans for the purpose of providing information for the diagnosis, prevention, treatment of disease, or impairment of, or assessment of health.
CNDS Common Name Data System	A system administered by Division of Resource Management (DIRM) for the NC Department of Health and Human Services (DHHS) for assignment, maintenance and tracking of individual IDs assigned to participants in DHHS programs
COCC Certificate of Creditable Coverage	The document that serves as evidence of health care coverage for the period of time noted on the certificate
COS Category of Service	A Medicaid Management Information System code identifying the nature of the service provided
CSDW Client Services Data	In North Carolina, the data warehouse used by various divisions



## NCMMIS+ ACRONYM AND GLOSSARY LIST



Acronym or Term	Description
Warehouse	
CSHS Children's Special Health Services	A North Carolina DPH program that is available to Medicaid-eligible children up to the age of 21 with special health care needs if the child has a disease or chronic condition supported by the program
CSR Customer Service Request	The document and procedure through which the State requests a contractor or support entity to make system updates, changes, or modifications to the Legacy MMIS+ or the Replacement MMIS.
Cancer Program	A North Carolina DPH program that covers medical care related to the diagnosis and treatment of cancer
Carolina ACCESS	A primary care case management managed care plan that began in 1991 that seeks to increase access to primary care and contain Medicaid expenditures  Patient care is coordinated by linking recipients with medical homes. Along with ACCESS II/III, it forms Community Care of North Carolina. ACCESS II/III is a physician-led, community-based managed care plan that began in 1996 to enhance the Carolina ACCESS program. As of the Request for Proposal (RFP) release date, there are 14 networks composed of medical providers and service agencies that operate to improve quality, utilization, and cost.
Certification Date	The effective date of certification by CMS of the Replacement MMIS
Change in Control	A term having the meaning set forth for it in RFP Section 30.46.7 and only for the purposed of that section.
Contract	Consists of the following elements: <ol style="list-style-type: none"> <li>1. Amendments to the Contract in reverse numerical order;</li> <li>2. The Contract signed by all Parties and approved by the United States Department of Health and Human Services (US DHHS), Centers for Medicare &amp; Medicaid Services (CMS);</li> <li>3. Any addenda to the RFP (including without limitation the formal Questions and Answers);</li> <li>4. The RFP, inclusive of appendices, exhibits, documents, and other materials incorporated therein by reference, but excluding the Statement of Objectives (SOO), which is superseded by the Vendor's Statement of Work (SOW);</li> <li>5. The Vendor's Best and Final Offer (BAFO), if a BAFO is solicited;</li> <li>6. The Vendor's Technical Proposal (including the SOW, Integrated Master Plan [IMP], and Integrated Master Schedule [IMS]) and any amendments thereto, as well as any written clarifications or representations regarding Vendor's Technical Proposal that are incorporated as part of the procurement process; and</li> <li>7. The Vendor's Cost Proposal and any amendments to thereto, as well as any written clarifications or representations regarding Vendor's Cost Proposal that are incorporated as part of the procurement process.</li> </ol>
Contract Manager	A designee of the Vendor with the authority to enter into any Contract modifications on behalf of the Vendor and otherwise commit the Vendor to any course of action, undertaking, obligation, or responsibility in connection with the Vendor's performance of the Contract.



## NCMMIS+ ACRONYM AND GLOSSARY LIST



Acronym or Term	Description
Contract Requirements	The Content of Section 30 of the Replacement MMIS RFP.
Control	A term having the meaning set forth for it in RFP Section 30.46.7 and only for the purposed of that section.
Cost Avoidance and Cost Avoided Payment	The payment methodology of avoiding part or all of Medicaid's payment when a third party resource is available to pay a claim
Cost Proposal	The separate portion of a proposal that includes the price to complete the work specified in the Request for Proposal and proposed by the Vendor. In NC, Step 2 of the Replacement MMIS Proposal.
COTS Software	<p>(1) Any software that is of a type customarily used by the general public or by non-governmental entities for purposes other than governmental purposes, and:</p> <ul style="list-style-type: none"> <li>(i) Has been sold, leased, or licensed to the general public; or,</li> <li>(ii) Has been offered for sale, lease, or license to the general public;</li> </ul> <p>(2) Any software that evolved from software described in paragraph (1) of this definition through advances in technology or performance and that is not yet available in the commercial marketplace, but will be available in the commercial marketplace in time to satisfy the delivery requirements under the Contract;</p> <p>(3) Any software that would satisfy a criterion expressed in paragraphs (1) or (2) of this definition, but for modifications of a type customarily available in the commercial marketplace; or</p> <p>(4) Any combination of software meeting the requirements of paragraphs (1), (2), or (3) of this definition that are of a type customarily combined and sold in combination to the general public;</p> <p>(5) Software to be provided by the Vendor pursuant to the Contract, but which is not to be developed pursuant to the Contract, if the software is or was developed exclusively at private expense and sold in substantial quantities, on a competitive basis, to multiple State or local governments.</p>
County DSS County Department of Social Services	Local agencies that administer the North Carolina Medicaid program as well as a number of social services programs
County Option Change Request	A form used by the Division of Medical Assistance (DMA) for maintaining a current directory of administrative and supervisory staff for each Health Check Outreach Project
Crossover Claims	Claims that are billed to Medicare first, with the balance of the claim being automatically transmitted to the Medicaid payer for those individuals eligible for Medicaid
DD Developmental Disability	A disability due to a delayed development or a slow maturation rate



## NCMMIS+ ACRONYM AND GLOSSARY LIST



Acronym or Term	Description
DEERS Defense Enrollment Eligibility Reporting System	Joint medical/personnel benefit central depository database of record implemented to provide portability to government/civil service employees and their dependents
DERP Drug Effectiveness Review Project	Part of the Oregon Health and Science Evidenced-Based Center(s) consortium, of which NC is a paying-member State
DESI Drug Efficacy Study Implementation	The term used by the United States Food and Drug Administration (FDA) to identify drug products found to be less than effective or not proven to be as effective as indicated
DME Durable Medical Equipment	A category of service involving medical equipment and supplies for home or institutional use
DRIVE Data Retrieval and Information Validation Engine	In North Carolina, DMA's data warehouse
DSH Disproportionate Share Hospital	A hospital(s) that serves a disproportionate share of low-income patients and qualifies under one of two CMS statutory formulas  Qualified hospitals meeting federal criteria, that treat a high-percentage of low-income patients, may receive a percentage add-on payment applied to the Diagnosis Related Group (DRG)-adjusted base payment rate. This add-on is known as the disproportionate share hospital (DSH) adjustment.
DUR Program Drug Utilization Review Program	In North Carolina, the DUR program is a program that ensures that outpatient drugs dispensed to Medicaid recipients are appropriate. The DUR program is characterized by the following four major components: <ul style="list-style-type: none"> <li>➤ DUR Board</li> <li>➤ Prospective DUR</li> <li>➤ Retrospective DUR</li> <li>➤ Education</li> </ul>
Data Accession List	A list of all State Material then in existence and held by or on behalf of the Vendor, other than State Material that is identified in the Contract Data Requirements List (CDRL) or that is created and stored in the ordinary course of





## NCMMIS+ ACRONYM AND GLOSSARY LIST



Acronym or Term	Description
	day-to-day operation of the Replacement MMIS (such as claims data and the like).
Deliverable	Any unique and verifiable product or other tangible material that must be delivered to the State to complete a process, phase, or project
Denied Claim	The denial status of all services within a claim at final adjudication when it has been determined non-payable
ECBU Encounter Contractor Billable Unit	A claim shadowing the claim definition for FCBU with the exception of Pharmacy claims submitted by a HMO for reporting purposes only.
EIS Eligibility Information System	The State system supporting eligibility for NC Medicaid, NC Health Choice for Children, and financial benefit programs
EPSDT Early Periodic Screening, Diagnosis, and Treatment	A Federal Medicaid requirement that the State's Medicaid agency cover services, products, or procedures for Medicaid recipients under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical, or mental illness, or a condition (health problem) identified through a screening examination (which includes any evaluation by a physician or other licensed clinician)
ERE Estate Recovery Evaluation	The evaluation by State third party recovery staff to determine whether to recoup Medicaid claims payments for the Medicaid program from the estates of deceased Medicaid recipients
ETC Enhanced Therapeutic Classification System	Pharmacy POS Reference File or code
Effective Date	The date on which the State fully executes its acceptance of the Offeror's bid.
Endorsement	In North Carolina, a verification and quality assurance process using statewide criteria and procedures as applied to providers of MH/DD/SA services funded by Medicaid
Escrow Agent	A person or entity that provides software escrow services in accordance with Section 30.13 of the Replacement MMIS RFP.
Escrow Agreement	An agreement that pursuant to Section 30.13 of the Replacement MMIS RFP provides for the regular deposit into escrow of all source code, object code, and documentation with respect to all Public Material and Proprietary Vendor Material (and cumulative updates thereof), together with (a) continually updated instructions as to the compilation, installation, configuration, deployment and use of the Source Code, and (b) a list of all non-deposited third party software used in conjunction with the Source Code to provide the full functionality of the deposited materials.



## NCMMIS+ ACRONYM AND GLOSSARY LIST



Acronym or Term	Description
Extensibility	In systems architecture, extensibility means that the system has been o architected that the design includes all of the hooks and mechanisms for expanding/enhancing the system with new capabilities without having to make major changes to the system infrastructure. This can mean that capabilities and mechanisms must be built into the final delivery which will not be used in that delivery. These excess capabilities are not frills but are necessary for maintainability and for avoiding early obsolescence.
FA Fiscal Agent	An entity that acts on behalf of the State Medicaid agency in respect to claims processing, provider enrollment and relations, utilization review, and other functions; synonymous with Fiscal Intermediary
FADS Fraud and Abuse Detection System	FADS currently serves as NC's Surveillance and Utilization Review (SUR) system. FADS software assists the Program Integrity Section in fraud and abuse activities by detecting outliers in provider practices and recipient usage of Medicaid services and pharmaceuticals.
FARO Financial and Reimbursement Officer	In the Division of Mental Health/Developmental Disabilities, and Substance Abuse Services (DMH), an organization of the finance officers and systems staff in the Local Managing Entities that meet twice a year (spring and fall) for training and updates related to budgets and systems for DMH
FCBU Fee-For-Service Contractor Billable Unit	A fully adjudicated fee-for-service claim (whether submitted as a paper claim or an electronic transaction) that is adjudicated to pay status
FDB First DataBank	A drug database that combines drug and pricing information with clinical decision-support modules
FFP Federal Financial Participation	The Federal Government's share of a State's expenditures under the Medicaid program Under §1903 of the Act, 90 and 75 percent FFP is provided as enhanced funding for MMIS expenditures, and 50 percent FFP for all general administrative expenditures.
FMAC Federal Maximum Allowable Cost	See Federal Upper Limit (FUL), the term that replaced FMAC
FMAP Federal Medical Assistance Percentage	The Federal matching rate for states for service costs incurred by the Medicaid program The FMAP is calculated by taking into account the average per capita income in a given state in relation to the national average; the FMAP ranged from 50 to 76 percent in 2002, with higher matching allocated to states with lower per capita income.
FPW	The Family Planning Waiver, implemented on October 1, 2005, is a Medicaid program designed to reduce unintended pregnancies and improve the well-being of children and families in North Carolina by extending limited family planning



## NCMMIS+ ACRONYM AND GLOSSARY LIST



Acronym or Term	Description
Family Planning Waiver	services to eligible recipients.
FQHC Federally Qualified Health Center	A community health center, public housing center, or outpatient health program (funded by the Indian Health Service) that meets one of CMS qualifications to bill as an FQHC for services rendered to migrant and homeless populations
FTE Full-Time Equivalent	Hours needed to fund a position equivalent to a full-time staff person The business standard is 2,080 hours a year (52 weeks X 40 hours), unless otherwise specified.
FUL Federal Upper Limit	Regulations that limit the amount that Medicaid will reimburse for drugs with available generic alternatives
GC3 General Classification Code 3	A pharmacy POS Reference File or therapeutic class code
GCN Generic Code Number/Sequence	A pharmacy POS Reference File code or generic sequence number or clinical formulation
Governmental Authority	Any nation or government, any federal, state, province, territory, city, town, municipality, county, local or other political subdivision thereof or thereto, any quasi-governmental authority, and any court, tribunal, arbitral body, department, commission, board, bureau, agency, instrumentality thereof or thereto or otherwise which exercises executive, legislative, judicial, regulatory or administrative functions of or pertaining to government.
HCC Health Check Coordinator	County representative responsible for monitoring and managing the Health Check program
HCPCS Healthcare Common Procedure Coding System	A uniform five-digit health care procedural coding system approved by CMS that summarizes billing information The HCPCS is divided into subsystems. Level I of the HCPCS is comprised of Current Procedural Terminology (CPT), a numeric coding system maintained by the American Medical Association (AMA). Level II is a standardized alphanumeric coding system maintained by CMS to identify products, supplies, and services not included in the CPT. Prior to December 31, 2003, Level III HCPCS were developed and used by Medicaid State agencies, Medicare contractors, and private insurers as local codes when there was no equivalent Level I or Level II codes. These are now used for internal use due to standardization by HIPAA.
HIPP Health Insurance	State payments for commercial insurance premiums



## NCMMIS+ ACRONYM AND GLOSSARY LIST



Acronym or Term	Description
Premium Payment	
HIS Health Information System	In North Carolina, the new Care Management System for DPH that will replace the existing Health Services Information System
HIT Home Infusion Therapy	The Home Infusion Therapy program covers self-administered infusion therapy and external supplies provided to a Medicaid recipient residing in a private residence or an adult care home.
HIV Medications Program	A North Carolina DPH program that covers medications for persons with human immunodeficiency virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) who are not covered by Medicaid or insurance
HSIS Health Services Information System	The DPH system used to exchange data with local health departments, including data collection, reporting, and grant justification, and to bill electronic claims to Medicaid The new HIS will replace HSIS.
Health Check	Health Check is an outreach program in North Carolina developed to ensure availability and accessibility of comprehensive and continuous preventive health services throughout childhood.
ICF Intermediate Care Facility	A health care facility for individuals who are disabled, elderly, or non-acutely ill, usually providing less intensive care than that offered at a hospital or skilled nursing facility
ICF-MR Intermediate Care Facility-Mentally Retarded	A health care facility for individuals who are diagnosed with a mental illness, usually providing less intensive care than that offered at a hospital or skilled nursing facility
ICN Internal Control Number	The unique internal control number assigned to a claim by the Fiscal Agent
IPRS Integrated Payment and Reporting System	The part of the Legacy MMIS+ used to process and report claims specific to DMH services
IPS Interactive Purchasing System	In North Carolina, the Web site used by the State for purchasing services and for providing information to prospective Offerors
ITF	A production-like system, logically separate from the production system, used to dynamically process test transactions–



## NCMMIS+ ACRONYM AND GLOSSARY LIST



Acronym or Term	Description
Integrated Testing Facility	without affecting production—for the purposes of testing transactions and outcomes in a production-simulated environment
ITP Infant Toddler Program	A DPH program that provides early intervention services to children with developmental needs
IVR Interactive Voice Response	A phone technology that allows a computer to detect voice and touch tones using a typical phone The IVR system can respond with prerecorded or dynamically generated audio.
Intellectual Property Rights	<ol style="list-style-type: none"> <li>1. Any patent, patent application, trademark (whether registered or unregistered), trademark application, trade name, service mark (whether registered or unregistered), service mark application, copyright (whether registered or unregistered, or derivative work), copyright application, trade secret, know-how, process, technology, development tool, ideas, concepts, design right, moral right, data base right, methodology, algorithm or invention,</li> <li>2. Any right to use or exploit any of the foregoing, and</li> <li>3. Any other proprietary right or intangible asset (including software).</li> </ol>
Interoperability	Application software must be standards-based and facilitate integration with other technologies and systems. Well-defined interface contracts must be available for consumption by interfacing applications. Usage of Web Services and Service-Oriented Architecture development techniques that rely on standards such as SOAP, WSDL, HTTP, and XML should be utilized. Conformance to industry and de facto standards is critical (e.g., IEEE, NIST, OASIS, W3C, etc.).
Kidney Program	A DPH program that covers persons with End Stage Renal Disease who require dialysis or transplantation
LEA Local Education Agency	A public board of education or other public authority within a state that maintains administrative control of public elementary or secondary schools in a city, county, township, school district, or other political subdivision of a state In North Carolina, LEA is the name of the local public school system.
Legacy MMIS+ Legacy Medicaid Management Information System +	Such as it exists on the Replacement MMIS RFP release date and as it thereafter may be modified for continued operation until its replacement, the claims processing and information retrieval system through which the State of North Carolina (1) reimburses providers of medical assistance to individuals found eligible under Title XIX and various other titles of the Social Security Act and (2) provides the Integrated Payment and Reporting System and other multi-payer functionality to DMH.
LHD Local Health Department	Providers of DPH public health services at the local level As of the issuance of the Replacement MMIS RFP, there are 84 local health departments in North Carolina.
LME Local Managing Entity	An area authority, county program, or consolidated human services agency This is a collective term that refers to the functional responsibilities rather than governance structure.



## NCMMIS+ ACRONYM AND GLOSSARY LIST



Acronym or Term	Description
LOB Line of Business	In NC DHHS, the term used to describe the service(s) provided by a functional group(s) and/or an agency or agencies
Laws	All laws, (including those under common law) statutes, codes, rules, regulations, reporting or licensing requirements, ordinances, and other pronouncements having the effect of law of the United States or any state, county, city, or other political subdivision, including those promulgated, interpreted or enforced by any government or regulatory authority, presently or hereinafter in effect
Level III file	A list of every procedure code by procedure/modifier or procedure/type of service containing pricing action code (PAC) indicators for all procedures. Also known as the Procedure Code Pricing file
Lock-in	A process to control Medicaid payments for care by restricting the recipient to a specific primary care provider and/or pharmacy and/or prescriber The MMIS Recipient record will contain the lock-in information. Only claims from the specified providers shall be paid, except as otherwise authorized by Medicaid.
Lock-out	A process to control Medicaid payments for care by restricting the recipient from a specific primary care provider and/or pharmacy and/or prescriber The MMIS Recipient record will contain the lock-out information. Claims from the specified providers shall not be paid, except as otherwise authorized by Medicaid.
Losses	Losses, claims, obligations, demands, actions, causes of action, assessments, fines and penalties (whether civil or criminal), liabilities, expenses, judgments, awards, and costs (including reasonable fees and disbursements of legal counsel, accountants and other advisors or consultants) of every kind and nature.
MAAR Monthly Accounting of Activities Report	A report that is used to calculate management fees
MAC Maximum Allowable Cost	The highest cost that the State will pay for a given medication
MAS Medicaid Accounting System	The Medicaid Accounting System (MAS), managed and operated by NC DHHS, accumulates all financial transactions generated by the Medicaid Program paid claims, collections and refunds, and any special adjustments into a monthly closing report to determine the respective amounts to be billed to each county for their share and the amount of Federal funds earned through the provision of Medicaid-eligible services approved under the NC State Medicaid Plan.
MDS	A component of the Resident Assessment Instrument (RAI), part of the U.S. federally mandated process for



## NCMMIS+ ACRONYM AND GLOSSARY LIST



Acronym or Term	Description
Minimum Data Set	standardized clinical assessment of all residents in Medicare- or Medicaid-certified nursing homes This process provides a comprehensive assessment of each resident's functional capabilities to prepare individualized care plans and classify residents into the Resource Utilization Groupings (RUG) to determine reimbursement.
MID Medicaid Identification Number	The unique individual recipient client ID in the North Carolina Title XIX program
MMA Medicare Modernization Act	The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, which includes prescription drug coverage, more choices, and better benefits under Medicare
Maintainability	Ability to test and implement software patches as well as new releases and/or versions of the operating system and application software and in an effective and efficient manner on all necessary platforms (i.e., desktops, laptops, PDAs, smartphones, servers) Software versioning and releases should be made available by the vendor in an orderly and preannounced fashion so as to facilitate planning. Customizations must be limited and if allowed must be included in future versions of the software.
Manual Pricing	The process of bypassing system logic to manually generate a price for a claim or detail line
Mass Adjustment	Adjustments made en masse to multiple claims or services to alter data according to a common set of criteria
Migrant Health Program	A DPH program in the Office of Research, Demonstrations and Rural Health Development that provides coverage for basic preventive health services and primary care to migrant farm workers and their dependents
Milestone	A significant point, event, or achievement that reflects progress toward completion of a process, phase, or project.
NC Health Choice for Children	North Carolina's name for the Federal Children's Health Insurance Program or State Children's Health Insurance Program, a program that provides medical care to children of the working poor who do not qualify for Medicaid
NCAS North Carolina Accounting System	The system used by the Controller's Office to control and monitor State funds
NCHC North Carolina Health Choice for Children	North Carolina's name for the State Children's Health Insurance Program, which provides medical care to children who do not qualify for Medicaid due to income



## NCMMIS+ ACRONYM AND GLOSSARY LIST



Acronym or Term	Description
NCID North Carolina Identity	NCID is the Office of Information Technology Services' (ITS') enterprise approach for application access authorization and account management.
NCMMIS+ Program North Carolina Medicaid Management Information System + Program	A set of projects adopted and administered by the State of North Carolina in support of replacing the Legacy MMIS+
NCMMIS+ Steering Committee	A committee composed at the discretion of the State to guide execution of the NCMMIS+ Program
NCP Non-Custodial Parent	The parent who does not have physical custody of a particular child
NCPDP National Council for Prescription Drug Program	A not-for-profit American National Standards Institute (ANSI)-Accredited Standards Development Organization consisting of over 1,300 members representing virtually every sector of the pharmacy services industry
NDC	National Drug Code
New Day Claim	A claim is considered new day when it is submitted to the claims processing system for the first time and issued a new internal control number.
Notification Related Costs	All costs incurred by the State arising out of or in connection with any Security Breach due to Vendor acts or omissions other than in accordance with the terms of the Contract resulting in a requirement for legally required notifications. "Notification Related Costs" include the State's internal and external costs associated with addressing and responding to the Security Breach, including but not limited to: (i) preparation and mailing or other transmission of legally required notifications; (ii) preparation and mailing or other transmission of such other communications to customers, agents or others as the State deems reasonably appropriate; (iii) establishment of a call center or other communications procedures in response to such Security Breach (e.g., customer service FAQs, talking points and training); (iv) public relations and other similar crisis management services; (v) legal and accounting fees and expenses associated with the State's investigation of and response to such event; and (vi) costs for credit reporting services that are associated with legally required notifications or are advisable, in the State's opinion, under the circumstances.
OMMISS Office of Medicaid Management	The NC DHHS office established to manage the processes for the procurement, selection, contract management, and monitoring of the activities in the NCMMIS+ Program





## NCMMIS+ ACRONYM AND GLOSSARY LIST



Acronym or Term	Description
Information System Services	
Offeror	A vendor that submits a Proposal in response to the Replacement MMIS RFP
Operational Start Date	The date on which the State determines in its sole but reasonable discretion that the Replacement MMIS has become operational substantially as a whole and has begun generating official data of record with the approval of the State.
Operations Phase	The Contract phase that begins on the Operational Start Data and continues until expiration or termination of the Contract.
Operations Phase Modification Pool	A pool of Vendor labor hours available for performing modifications to the Replacement MMIS during the Operations Phase
PAC Pricing Action Code	Code that directs the system to a pricing file or to a particular pricing logic
PASARR Pre-Admission Screening and Annual Resident Review	The federally mandated program to determine medical necessity for nursing facility placement and need for specialized services
PBM Pharmacy Benefits Manager or Management (Drug)	Administrator of a prescription drug program(s)
PERM Payment Error Rate Measurement	A Federal protocol from CMS; previously called Payment Accuracy Measurement
POMCS Purchase of Medical Care Services	The NC DHHS Office that handles eligibility determination, prior authorization and claims payment for DPH payment programs and for the Migrant Health Program in the Office of Research, Demonstrations and Rural Health Development DPH programs that provide medical services to people who do not qualify for other public assistance POMCS payment programs include Children's Special Health Services (CSHS); Assistive Technology; Infant Toddler; Adult Cystic Fibrosis; Cancer; Kidney; Sickle Cell; HIV Medications; and Migrant Health.
Paid Claim	A status of a claim that has been adjudicated to its final disposition and contains at least one paid line item if a positive amount was not sent out to satisfy the paid status
Parties	As a capitalized term in the context of the MMIS Replacement Contract, collectively the Vendor and NC DHHS



## NCMMIS+ ACRONYM AND GLOSSARY LIST



Acronym or Term	Description
Party	As a capitalized term in the context of the MMIS Replacement Contract, interchangeably the Vendor or NC DHHS
Pay and Chase	The practice of paying a claim on behalf of a recipient with third party resources and then recovering from the responsible parties
Payer Source	A detailed breakdown of line of business that includes the program fund, account, and budget-level information (account string) needed to pay a claim or update the North Carolina Accounting System budget accounts
Physical Security	Physical security at any site or other location housing systems maintained by Vendor or its agents or subcontractors in connection with the Services.
Physician Drug Program	The listing of and the policies related to the injectable drugs that physicians can bill for in their office settings
Population Group	In North Carolina, the legacy term used to identify a particular segment of the recipient population
Positive Pay Processing	The process by which NCAS provides a daily file to the North Carolina Department of the State Treasurer (NCDST) containing its issued State warrants, thereby allowing the NCDST to match presented warrants (serial number and amount) with the warrants presented for payment through the Federal Reserve Bank (FRB)
Presentments	All checks and electronic fund transfers that are presented through the banking system each business day for payment from the Fiscal Agent's controlled claims-clearing checking account
Processing	For the purposes of Section 30.26 of the Replacement MMIS RFP, any operation or set of operations performed upon the State Data or State confidential information, whether or not by automatic means, such as creating, collecting, procuring, obtaining, accessing, recording, organizing, storing, adapting, altering, retrieving, consulting, using, disclosing or destroying.
Proprietary Vendor Material	<ol style="list-style-type: none"> <li>1. Data, information, material, proposals, manuals, designs, training documents, other documentation (including working papers), software, software modifications, and customizations               <ol style="list-style-type: none"> <li>a. that                   <ol style="list-style-type: none"> <li>(1) existed prior to the Effective Date, or</li> <li>(2) are developed by Vendor after the Effective Date without the use of State Material and that are not based upon all or any portion of the State Material (such as a translation, enhancement, extension, modification, correction, extension, upgrade, improvement, adaptation, abridgement, recasting, transformation or elaboration), and</li> </ol> </li> <li>b. that are incorporated into the Replacement MMIS or otherwise utilized by the Vendor in its performance of the Services with respect to the Replacement MMIS, and</li> </ol> </li> <li>2. Any modifications to the materials listed in 1(a) above created by the Vendor or its subcontractors during the Term</li> </ol>



## NCMMIS+ ACRONYM AND GLOSSARY LIST



Acronym or Term	Description
Provider Disputes	Instances in which a provider disagrees with a payment, finding, or other matter asserted or determined by the State or Vendor
Provider Specialty	A three-digit code used with Provider Type in the Legacy MMIS+ to further identify providers and the services for which they may receive reimbursement
Provider Type	A three-digit code used in the Legacy MMIS+ to identify DHHS providers and to price services on claims
Public Material	Materials that are in the public domain or that are available for use by or on behalf of the State after being developed with public funds for a Federal, state or other governmental entity.
R&A Reporting and Analytics Project	One of the OMMISS projects that will address query reporting and analysis needed for the Medicaid program in North Carolina Reporting and Analytics functionality will be procured through a separate RFP.
R2W Report2Web	A legacy Web-based reporting repository tool
RBRVS Resource Based Relative Value Scale	Established as part of Omnibus Budget Reconciliation Act (OBRA), 1989, Medicare payment rules for physician services that give weight to procedures based upon resources needed to effectively deliver the service or perform a procedure.
REOB Recipient Explanation of Benefits	Notification sent to recipients explaining benefits and denials
REOMB Recipient Explanation of Medicaid Benefits	Notification sent to Medicaid recipients explaining benefits and denial
ROSI Reconciliation of State Invoice	Used by drug manufacturers to explain adjusted rebate payments to the State for the current quarter
RPO Recovery Point Objective	The point in time to which data must be restored to be acceptable to the business owner(s) of the processes supported by that data
RR	In the Drug Rebate business area, a report that is a revised invoice for the labeler



## NCMMIS+ ACRONYM AND GLOSSARY LIST



Acronym or Term	Description
Recapitulation Report	
RSS Really Simple Syndication	A family of Web-feed formats used to publish frequently updated content, such as blog entries, news headlines, or podcasts An RSS document—which is called a "feed," "Web feed," or "channel"—contains either a summary of content from an associated Web site or the full text. RSS makes it possible to keep up with specified Web sites in an automated manner that is easier than checking them manually.
RTO Recovery Time Objectives	The part of a Business Continuity Plan that defines reasonable recovery times for critical assets for the resumption of business
Regulatory Requirements	For the purposes of RFP Section 30, a term with the meaning set forth in Section 30.31(a)
RTP Return to Provider	Notification sent to provider when a claim must be returned for additional information
Replacement MMIS Replacement Medicaid Management Information System	The new replacement multi-payer system for North Carolina that will provide claims processing functionality for Medicaid, Mental Health, and Public Health pursuant to the Contract that results from this RFP
Replacement MMIS Contract Administrator	The member of its personnel whom the State has given the duty of administering the Replacement MMIS Contract.
Replacement Phase	The contract phase during which Replacement MMIS DDI occurs until, but not including, the Operational Start Date.
Replacement Phase Additional Functionality Pool	A pool of labor hours available to add functionality to the Replacement MMIS beyond that set forth in the RFP and the Vendor's Technical Proposal.
SAS 70 Audit Statement on Auditing Standards 70	A standardized audit criterion used to assess computer systems The SAS 70 Audit defines professional standards used by a service organization, such as an insurance company or a medical claims processor, to assess the internal controls of that organization. The Statement on Auditing Standards No. 70 is the statement issued by the Auditing Standards Board of the American Institute of Certified Public Accountants.
SCHIP State Children's Health	The Federal program offered through the North Carolina Health Choice program



## NCMMIS+ ACRONYM AND GLOSSARY LIST



Acronym or Term	Description
Insurance Program	
SFY State Fiscal Year	In North Carolina, July 1 through June 30
SI Systems Integrator	An individual or company that specializes in building complete computer systems by putting together components from different vendors  Unlike software developers, systems integrators typically do not produce any original code. Instead they enable a company to use off-the-shelf hardware and software packages to meet the company's computing needs.
SMAC State Maximum Allowable Cost	The North Carolina Medicaid program uses a SMAC list for generic and multi-source brand drug products. The SMAC list contains products with A-rated equivalents and, in the great majority of cases, products marketed by at least two labelers.
STA Statewide Technical Architecture	In North Carolina, the principles defined by the Office of Information Technology Services (ITS) that describe the characteristics associated with a high-quality software system
SURS Surveillance and Utilization Review Subsystem	A mandatory component of MMIS  The State's SURS is used to identify beneficiary over- or under-utilization and aberrant provider practices for education and potential sanction purposes. Each state also has a unit of the same name. The principal purpose of the SURS unit, utilizing the subsystem, is to safeguard against inappropriate payments for Medicaid services. This is done by analyzing and evaluating provider service utilization to identify patterns of fraudulent, abusive, unnecessary and/or inappropriate utilization.
Scalability	Ability to support the required total number of customers for all business processes and processing periods
Secureability	Proper separation of security controls (e.g., identity management, authentication, and authorization); ability to meet any regulatory or industry security requirements (i.e., HIPAA, FERPA, PCI); ability to secure data in storage and in transit using coarse and fine grained access controls; utilization of proven, industry recognized encryption technologies (e.g., SSL, AES), ability to properly log any activity performed (successfully and/or unsuccessfully) against the data as well as any activities performed by system administrators
Security Breach	<ol style="list-style-type: none"> <li>1) Any circumstance pursuant to which applicable Law (as defined in RFP Section 30.31(a)) requires notification of such breach to be given to affected parties or other activity in response to such circumstance; or</li> <li>2) any actual, attempted, suspected, threatened, or reasonably foreseeable circumstance that compromises, or could reasonably be expected to compromise, either Physical Security or Systems Security in a fashion that either does or could reasonably be expected to permit unauthorized Processing, use, disclosure or acquisition of or access to any the State Data or state confidential information.</li> </ol>



## NCMMIS+ ACRONYM AND GLOSSARY LIST



Acronym or Term	Description
Services	The services and Deliverables (including, without limitation, the hardware, software, tangibles, and intangibles required under the Contract) to be delivered by Vendor pursuant to the Contract, including, without limitation, the inherent services described in Section 30.9 of the Replacement MMIS RFP.
Sickle Cell Program	A DPH program that covers persons of any age with Sickle Cell Syndrome or Sickle Cell Disease
Simplified Sign-on	Allows all State users, including recipient and providers, to sign on to the system for access to the services that they need with one login ID and password, as much as practical
Solution	The Services, Deliverables, functions and responsibilities required to be delivered under the Contract.
Source Code	Computer source code, including without limitation all make files, configurational files, data tables upon which execution is dependent, and the like.
Specifications	For the purposes of RFP Section 30.30, all specifications and requirements set forth in the Contract (including, without limitation, the SOW, IMP and IMS) and any other requirements agreed to in writing by the Parties as pertinent to determining that a Deliverable has been completed or a Milestone has been attained.
State Data	<ol style="list-style-type: none"> <li>1. All information and data (copyrighted or otherwise) developed, derived, documented, stored, by the State under the Contract;</li> <li>2. All data that is provided by or on behalf of the State to Vendor in order for Vendor to provide the Services, including keyed input and electronic capture of information by the Services;</li> <li>3. All records, files, reports and other data provided to Vendor by or on behalf of the State, or otherwise collected or obtained by Vendor, in connection with the Services; and</li> <li>4. All data that is produced by means of the Services as an intermediate step in using or producing any of the State Data, including databases and files containing the State Data; including but not limited to:               <ol style="list-style-type: none"> <li>a. transaction and history files relating to claims;</li> <li>b. provider and recipient demographics and eligibility, code sets, fee schedules, other pricing components;</li> <li>c. prior approval, utilization criteria, and service limit data;</li> <li>d. names, addresses and social security numbers; and</li> <li>e. any information derived from the data described in (i) through (iv).</li> </ol> </li> </ol>
State Indemnities	The State, and its directors, officers, employees, subcontractors, and agents.
State Material	All data, material, proposals, manuals, designs, training documents, other documentation (including working papers), software, and software modifications (including object code, source code, and documentation) upon its creation by the Vendor or its subcontractors for the State pursuant to the Contract, including all Intellectual Property Rights therein, but excluding any Proprietary Vendor Material.
State Plan	A comprehensive statement submitted by the State agency describing the nature and scope of its program and giving



## NCMMIS+ ACRONYM AND GLOSSARY LIST



Acronym or Term	Description
	<p>assurance that it will be administered in conformity with the specific requirements stipulated in the pertinent title of the Act, and other applicable official issuances of DHHS</p> <p>The State Plan contains all information necessary for the Department to determine whether the plan can be approved, as a basis for Federal financial participation in the State program.</p>
State-Provided Material	Goods, software, specifications, drawings, records, documentation, know-how, methodologies, processes, technologies, State Data, or derivative works thereof, or other materials or information provided by the State to the Vendor in connection with the Contract.
Suspended Claim	The status used on claims that cannot complete the normal adjudication process without additional action
Systems Security	Security of computer, electronic or telecommunications systems of any variety (including data bases, hardware, software, storage, switching and interconnection devices and mechanisms), and networks of which such systems are a part or communicate with, used directly or indirectly by Vendor or its agents or subcontractors in connection with the Services.
TCO Total Cost of Ownership	A form of cost accounting that is intended to provide a financial estimate to assist customers and managers in organizations to assess direct and indirect cost relate to software and hardware
TxCL Therapeutic Classification	A pharmacy POS Reference File or code
Targeted Operational Start Date	The date specified by the Vendor in its Technical Proposal that is planned to be the Operational Start Date, as date may be modified in State-approved updates to the Integrated Master Schedule.
Technical Proposal	The competitive bid document in which an Offeror proposes how its system will meet the processing requirements for the North Carolina programs and agencies
Term	The term of the Replacement MMIS RFP, commencing on the Effective Date and continuing until the later of the end of the Turnover Phase or the fourth (4th) anniversary of the date on which the State determines in its sole but reasonable discretion that the Replacement MMIS has become operational substantially as a whole and has begun generating official data of record with the approval of the State, and continuing thereafter as it may be extended pursuant to Section 30.2 of the Replacement MMIS RFP.
Third Party Material	A non-governmental third party's software code, data compilations, or audio/visual/print materials, including without limitation proprietary materials of the Vendor's subcontractors that existed prior to the Effective Date, if any.
Turnover	The process through which an incumbent Fiscal Agent transfers operation of specified systems from itself to the State or a successor Fiscal Agent; to undertake that process



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Acronym or Term	Description
Turnover Phase	The period during the term of the Replacement MMIS Contract when Turnover occurs
VAN Value-Added Network	In North Carolina, switch vendors that provide the Eligibility Verification Services (EVS) and Pharmacy POS services to North Carolina providers
Vendor	When capitalized in the text of the Contract or as the context may otherwise require, the Offeror that is awarded the Replacement MMIS Contract
Vendor Account Manager	The Vendor designee with day to day responsibility for supervising the performance of the Vendor's obligations under the Contract.