Computer Sciences Corporation

May 30, 2008
Letter No. DRS-08-0122

State of North Carolina
Department of Health and Human Services
Office of Procurement & Contracting Services
801 Ruggles Drive, Hoey Building
Raleigh, NC 27603-2001

CSC

Attention: Susan W. Lewis
Subject: Submission of Best and Final Offer -DHHS-1228-08

Dear Ms. Lewis:

In accordance with the instructions set forth in your letter of May 2, 2008, Computer Sciences Corporation (CSC) transmits herewith our Best and Final Offer ("BAFO") in support of our prior bid on the North Carolina Replacement MMIS. Included are the following:

- Ten printed copies of the updated Proposal.
- Thirty CDs containing our Technical Proposal.
- Two original executed copies of cover page of Addendum 3, dated May 2, 2008, to RFP 30-DHHS-1228-08-R, one each for the original signed copies of the Technical Proposal, and copies of these pages for the other copies of the Technical Proposal.
- The "delta" State Requirements Matrix Updated May 1, 2008, immediately after the end of the main State Requirements Matrix (Appendix 50, Attachment C, Exhibit 1).
- The Statement of Objectives (SOO) Requirements Matrix immediately after the end of the delta State Requirements Matrix.
- The Page Limitations Worksheet immediately following the Proposal Submission Requirements Checklist (Section B).
- The attached Changed Pages List immediately following the Page Limitations Worksheet described above.

Please feel free to contact me with any questions regarding this material.

Sincerely,

Dianne R. Sagner
Senior Manager Contracts and Subcontracts

Enc.

North American Public Sector (NPS)
15245 Shady Grove Road
Rockville, MD 20850
301.921.3000

North Carolina Replacement Medicaid Management Information System (MMIS)

RFP Number: 30-DHHS-1228-08

Prepared for:
North Carolina Department of Health and Human Services

Office of Medicaid Management Information System Services

Prepared by:
Computer Sciences Corporation

30 May 2008

Volume I — Technical Proposal

Book 1 of 4
Sections A-D.1.13

Best and Final Offer

Copy

Redacted Version

With Confidential Pages Removed

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List of Exhibits

CSC Compliance Matrix

In our initial submission we included a Compliance Matrix that mapped our proposal outline to RFP Sections 10, 50 and 60. This matrix is a CSC best practice for performance based contracting proposals. For the BAFO submission the State has requested that we remove the Section 60 references and has provided separate matrices for the Statement of Objectives, DDI Requirements, Proposal Submission elements and changes. Because the State's matrices have expanded and are more comprehensive than the CSC Compliance Matrix we have removed it for our BAFO submission. **(Comment CSC9)**

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List of Abbreviations

AARP	American Association of Retired Persons
ABEND	Abnormal Ending
ABTC	Asia Pacific Economic Council Business Travel Card
ACCP	American College of Clinical Pharmacy
ACD	Automatic Call DistributionDistributor
ACH	Automated Clearing House
ACII	Allergy and Clinical Immunology International
ACTS	Automated Collection and Tracking System
ACWP	Actual Cost of Work Performed
ADA	American Dental Association, American Diabetes Association, Americans with Disabilities Act of 1990 (US), American Dietetic Association
ADAO	Adult Developmental Disability Assessment and Outreach
ADC	Application Development Completion
ADCEP	Adult Developmental Disability Community Enhancement Program
ADD	Application Detailed Design
ADP	Application Design and Prototyping
AEDC	After Effective Date of Contract
AFTP	Anonymous File Transfer Protocol
AHF	American Hospital Formulary
AHFS	American Hospital Formulary Service
AHIC	American Health Information Community
AHIMA	American Health Information Management Association
AHIP	America's Health Insurance Plan
AIAN	American Indian Alaskan Native
AIDS	Acquired Immune Deficiency Syndrome
AIM	Application Implementation
AINS	Automated Information Notification System
ALM	Application Life-Cycle Management
AMCP	Academy of Managed Care Pharmacy
ANSI	American National Standards Institute
AP	Area Program, Accounts Payable

AP	Accounts Payable
APC	Application Preliminary Design
APEC	Asia-Pacific Economic Cooperation
API	Application Program Interface
AQT	Application Qualification Testing
AR	Accounts Receivable
ARA	Application Requirements Analysis
ASAO	Adult Substance Abuse Assertive Outreach and Screening
ASC	Accredited Standards Committee, Ambulatory Surgery Center
ASCDR	Adult Substance Abuse IV Drug User/Communicable Disease
ASCP	American Society of Consultant Pharmacists
ASHP	American Society of Health Systems Pharmacists
ASP	Automated Support Package
AV	Actual Value
AVRS	Automated Voice Response System
AVRU	Automatic Automated Voice Response Unit
AWP	Average Wholesale Price
BA	Business Analysis, Business Analyst
BAC	Budget at Completion
BCBS	Blue Cross Blue Shield
BCCM	Breast and Cervical Cancer Medicaid
BCP	Business Continuity Plan
BCWP	Budgeted Cost of Work Performed
BCWS	Budgeted Cost of Work Scheduled
BENDEX	Beneficiary Data Exchange
BI	Business Intelligence
BIA	Business Impact Analysis
BPEL	Business Process Execution Language
BPM	Business Process Management
BPMO	Business Process Management Office
BPMS	Behavioral Pharmacy Management System
BPO	Business Process Outsourcing

BRIDG	Biomedical Research Integrated Domain Group
BSD	Business System Design
BV	Budget Variance
C&A	Certification and Accreditation
C&KM	Collaborative and Knowledge Management
C&SI	Consulting and System Integration
CA	Computer Associates, Control Accounts
CA	Control Accounts
CAFM	Computer-Aided Facilities Management
CAM	Control Account Managers
CAP	Community Alternatives Program, Competitive Acquisition Program, Corrective Action Plan
CAP	Community Alternatives Program
CASE	Computer-Aided Software Engineering
CAT	Contingency Assessment Team
CBT	Computer-Based Training
CCAS	Certified Clinical Addiction Specialist
CCS	Certified Clinical Supervisor
CCB	Change Control Board , Configuration Control Board
CCB	Change Control Board
CCI	Correct Coding Initiative
CCM	Child Case Management
CCNC	Community Care of North Carolina
CCSP	Claims Customer Service Program
CDAO	Child Developmental Disability Assessment and Outreach
CDHP	Consumer Driven Healthcare Plan
CDHS	California Department of Health Services
CDISC	Clinical Data Interchange Standards Consortium
CDR	Critical Design Review
CDRL	Contract Data Requirements List
CDS	Controlled Dangerous Substance
CDSA	Children's Developmental Services Agencies

CDW	Client Data Warehouse
CEO	Chief Executive Officer
CERT	Comprehensive Error Rate Testing, Computer Emergency Readiness Team
CERT	Computer Emergency Readiness Team
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CHECK	NC State Departments of Health and Office of State Controller
CI	Configuration Item
CICS	Customer Information Control System (IBM)
CIO	Chief Information Officer
CISSP	Certified Information Systems Security Professional
CLIA	Clinical Laboratory Improvement Amendments, Clinical Laboratory Improvement Act
CLIN	Contract Line Item Number
CM	Configuration Management
CMM	Capability Maturity Model , Center for Medicare Management
CMM	Capability Maturity Model
CMMI	Capability Maturity Model Integration
CMOS	Configuration Memory Operating System
CMP	Change Management Plan
CMS	Call Management System, Centers for Medicare and Medicaid Services
CMS	Centers for Medicare and Medicaid Services
CNDS	Common Name Data System or Service
CNS	Comprehensive Neuroscience
CO	Contracting Officer
COB	Coordination of Benefit
COCC	Certificates of Creditable Coverage
COCR	County Options Change Request
COE	Center of Excellence
COOP	Continuity of Operations
COR	Contracting Officer's Representative
CORI	Criminal Offender Record Information

COS	Category of Service
COTR	Contracting Officer's Technical Representative
COTS	Commercial Off-the-Shelf
CP	Claims Processor, Communication Plan
CPA	Certified Public Accountant
CP	Claims Processor
CPAF	Cost Plus Award Fee
CPAR	Customer Performance Assessment Review
CPAS	Claims Processing Assessment System
CPE	Current Production Environment
CPFF	Cost Plus Fixed Fee
CPI	Cost Performance Index
CPM	Critical Path Methodology
CPR	Contract Performance Reporting, Cost Performance Report
CPR	Cost Performance Report
CPSW	Claims Processor Switch
CPT	Current Procedural Terminology
CPU	Central Processing Unit
CR	Change Request
CRIS	Clinical Research Information System
CRM	Customer Relationship Management
CRNA	Certified Registered Nurse Anesthetist
CROWD	Center for Research on Women with Disabilities
C-RUP	Catalyst Extended RUP
CRP	Conference Room Pilot
CS	Commercial Service
CSC	Computer Sciences Corporation
CSDW	Client Services Data Warehouse
CSE	Child Support Enforcement
CSIRT	Computer Security Incident Response Team
CSR	Customer Service Representative, Customer Service Request
CSSC	Customer Support and Service Center

CSV	Comma Separated Value
CTI	Computer Telephony Integration
CV	Cost Variance
CWBS	Contract Work Breakdown Structure
CWF	Common Working File
DA	Delivery Assurance
DAL	Data Accession List
DASD	Direct Access Storage Device
DAW	Dispense As Written
DB2	IBM Relational Database Management SsytemSystem
DBA	Database Administrator
DBAR	Disaster Backup and Recovery
DBMS	Database Management System
DCEU	Data Cleansing and Entry Utility
DCMWC	Division of Coal Mine Workers' Compensation
DCN	Document Control Number
DD	Developmental Disabilities
DDC	Drug Discount Card
DDI	Design, Development, and Implementation
DEA	Drug Enforcement AdministrationAgency
DEC	Developmental Evaluation Centers
DED	Data Element Dictionary
DEERS	Defense Enrollment Eligibility Reporting System
DEP	Release Deployment
DERP	Drug Effectiveness Review Project
DESI	Drug Efficacy Study Implementation
DHH	Department of Health and Hospitals
DHHS	Department of Health and Human Services
DHMH	Department of Health and Mental Hygiene
DHSR	Division of Health Service and Regulation
DIACAP	DOD Information Assurance Certification and Accreditation Process
DIRM	Division of Information Resource Management

DLP	Derived Logical Process
DMA	Division of Medical Assistance
DME	Durable Medical Equipment
DMECS	Durable Medical Equipment Coding System
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
DMERC	Durable Medical Equipment Regional Carrier
DMH	Division of Mental Health
DMH/DD/SAS	Division of Mental Health, Developmental Disabilities, and Substance Abuse Services – May be referred to as DMH
DMZ	Demilitarized Zone
DNS	Domain Name Server
DOB	Date of Birth
DoD	Department of Defense
DOH	Department of Health
DOJ	Department of Justice
DOL	Department of Labor
DOORS	Data Object Oriented Repository System
DOR	Department of Revenue
DPH	Division of Public Health
DPM	Deputy Program Manager
DR	Disaster Recovery
DRG	Diagnosis-Related Group
DSD	Detailed System Design
DSH	Disproportionate Share Hospital
DSR	Daily Service Review
DSS	Division of Social Services (organization within NC DHHS)
DSS	Decision Support System, Department of Social Services (as part of county government), Division of Social Services (organization within NC DHHS)
DSS	Decision Support System
DUR	Drug Utilization Review
EA	Enterprise Architecture
EAC	Estimate at Completion
EBM	Evidence-Based Medicine

EBP	Elementary Business Process
ECS	Electronic Claims Submission
EDB	Enrollment Database
EDI	Electronic Data Interchange
EDITPS	Electronic Data Interchange Transaction Processing System
EDMS	Electronic Document Management System
EDP	Electronic Data Processing
EDS	Electronic Data Systems
EEOICP	Energy Employees Occupational Illness Compensation Program
EFT	Electronic Funds Transfer
EHR	Electronic Health Record
EI	External Input , External Inquiry
EI	External Input
EIA	Electronic Industries Alliance
EIN	Employer Identification Number
EIS	Eligibility Information System
ELA	Enterprise License Agreement
EMC	Electronic Media Claim
eMedNY	New York MMIS
EMEVS	Electronic Medicaid Eligibility Verification System
EMR	Electronic Medical Record
ENM	Enterprise Network Management
ENV	Environment
EO	External Output
EOB	Explanation of Benefits
EOMB	Explanation of Medicaid(Medicare)(Medical) Benefits
EPA	Environmental Protection Agency
ePACES	Electronic Provider Automated Claims Entry System
EPAL	Enterprise Privacy Assertion Language
EPC	Evidence-based Practice Center
EPMO	Enterprise Program Management Office
EPMR	Executive Level Project Management Review

EPS	Energy Processing System
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment (Aaka Health Check)
EQ	External Query
ER	Emergency Room
ERA	Electronic Remittance Advisory
ERE	Estate Recovery Evaluation
ESRD	End Stage Renal Disease
ETC	Estimate to Completion
ETIN	Electronic Transmitter Identification Number
ETL	Extract, Transform, Load
ETN	Enrollment Tracking Number
EV	Earned Value
EVMS	Earned Value Management System
EVS	Eligibility Verification System
FA	Fiscal Agent
FADS	Fraud and Abuse Detection System
FAO	Fiscal Agent Operations
FAQ	Frequently Asked Questions
FARO	Finance and Reimbursement OfficerOrganization
FAS	Fiscal Agent Staff
FBI	Federal Bureau of Investigation
FBLP	Federal Black Lung Program
FCA	Functional Configuration Audit
FCAPS	Fault Management, Configuration, Accounting, Performance, and Security Management
FCN	Financial Control Number
FDA	Food and Drug Administration
FDB	First DataBank
FDDI	Fiber Distributed Data Interface
FedEx	Federal Express
FFP	Federal Financial Participation, Firm Fixed Price

FFP	Firm Fixed Price
FFS	Fee-For-Service
FFY	Federal Fiscal Year
FIFO	First-In/First-Out
FIPS	Federal Information Processing Standards
FISMA	Federal Information Security Management Act of 2002
FMAP	Federal Medical Assistance Percentage
FMC	Federal Management Center
FP	Function Point
FTE	Full-Time Equivalent
FTP	File Transfer Protocol
FUL	Federal Upper Limit
FYE	Fiscal Year Ended
GAAP	Generally Accepted Accounting Principles
GAO	General Accounting Office
GC3	Generic Classification Code
GCN	Generic Code Number
GEMNAC	Graduate Medical Education National Advisory Committee
GHS	Government Health Services
GIAC	Global Information Assurance Certification
GIS	Global Infrastructure Services
GUI	Graphical User Interface
GL	General Ledger
GMC	Global Management Center
GME	Graduate Medical Education
GMENAC	Graduate Medical Education National Advisory Committee
GMP	General Management Process
GNN	Generic Name
GSS	Global Security Solutions
GTEDS	GTE Data Services
H.E.A.T.	Hydra Expert Assessment Technology
HCC	Health Check Coordinator

HCCR	Health Check Coordinator Reporting
HCCS	Health Check Coordinator System
HCFA	Health Care Financing Administration (predecessor to CMS)
HCPCS	Healthcare Common Procedure Coding System
HCPR	Health Care Personnel Registry
HCSC	Health Care Service Corporation
HETS	HIPAA Eligibility Transaction System
HFMA	Healthcare Finance Financial Management Association
HHA	Home Health Aide
HIC	Health Insurance Claim
HICL	Health Insurance Contract Language
HIE	Health Information Exchange
HIGLAS	Health Integrated General Ledger and Accounting System
HIM	Health Information Management
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIPDB	Healthcare Integrity and Protection Data Bank
HIPP	Health Insurance Premium Payment
HIS	Health Information System
HIT	Healthcare Information Technology
HIV	Human Immunodeficiency Virus
HL7	Health Level 7 (Format and protocol standard)
HMA	Health Management Academy
HMO	Health Maintenance Organization
HP	Hewlett Packard
HPII	High Performance Image Import
HRSA	Health Resources and Services Administration
HSIS	Health Services Information System
HUB	Historical Underutilized Business
HW	Hardware
I/O	Input/Output
IA	Information Assurance
IAD	Incremental Application Development

IAVA	Information Assurance Vulnerability Alert
IAW	In Accordance With
Ibis	Integrated Business Information System
IBR	Initial Baseline Review
IBS	Integrated Business Solution
ICD	International Classification of Diseases , Iterative Custom Development
ICD	International Classification of Diseases
ICF-MR	Intermediate Care Facilities for the Mentally Retarded
ICR	Intelligent Character Recognition
ID	Identification
IDS	Intrusion Detection System
IEEE	Institute of Electrical and Electronics Engineers
IFPUG	International Function Point Users Group
IGN	Integrated Global Network
IIHI	Individually Identifiable Health Information
ILM	Information Life-Cycle Management
IM	Information Management
IMP	Integrated Master Plan
IMS	Integrated Master Schedule
Ind HC	Independent Health Care
IOM	Institute of Medicine
IP	Internet Protocol
IPGW	Internet Protocol Gateway
IPL	Initial Program Load
IPMD	Integrated Program Management Database
IPR	In-Progress Review
IPRS	Integrated Payment and Reporting System
IPT	Integrated Product Team
IRS	Internal Revenue Service
ISO	International Standards Organization
ISPTA	International Security, Trust and Privacy Alliance
ISVM	Information Security Vulnerability Management

IT	Information Technology
ITIS	Integrated Taxonomic Information System
ITF	Integrated Test Facility
ITIL	Information Technology Infrastructure Library
ITIS	Integrated Taxonomic Information System
ITS	Information Technology Solutions
IV&V	Independent Verification and Validation
IVR	Interactive Voice Response
JAD	Joint Application Development
JCL	Job Control Language
KE	Knowledge Engineer
KFI	Key From Imaging
KM	Knowledge Management
KPI	Key Performance Indicator
KPP	Key Performance Parameter
LAN	Local Area Network
LDAP	Lightweight Directory Access Protocol
LDSS	Local Department of Social Services
LEP	Limited English Proficiency
LHD	Local Health Department
LME	Local Managing Entity
LMFT	Licensed Marriage and Family Therapist
LOB	Line of Business
LOE	Level of Effort
LPA	Licensed Psychological Associates
LPC	Licensed Professional Counselors
LMFT	Licensed Marriage and Family Therapists
LPN	Licensed Practical Nurse
LST	Legacy Systems Transformation
LTC	Long-Term Care
MA	Medicare Advantage
MAAR	Monthly Accounting of Activities Report

MAC	Maximum Allowable Cost
MAR	Management and Administrative Reporting
MARS	Management and Administrative Reporting Subsystem
MARx	Medicare Advantage Prescription Drug Program
MAS	Medicaid Accounting System
MA-SHARE	Massachusetts — Simplifying Healthcare Among Regional Entities
MCE	Medicare Code Editor
MCHP	Maryland Children's Health Program
MCO	Managed Care Organization
MDCN	Medicare Data Communications Network
MDME	Medicare Durable Medical Equipment
MEQC	Medicaid Eligibility Quality Control
MES	Managed Encryption Service
MEVS	Medicaid Eligibility Verification System
MIME	Multipurpose Internet Mail Extensions
MiMMIS	Multi-Payer Medicaid Management Information System
MIP	Medicare Integrity Program
MIS	Management Information System
MITA	Medicaid Information Technology Architecture
MM	Meeting Minutes
MMA	Medicare Modernization Act
MMCS	Medicare Managed Care System
MMIS	Medicaid Management Information System
MOAS	Medicaid Override Application System
MOF	Meta Object Facility
MPAP	Maryland Pharmacy Assistance Programs , Medical Procedure Audit Policy
MPAP	Maryland Pharmacy Assistance Programs
Mpas	Multi-Payer Administrator System
MPLS	Multi-Protocol Label Switching
MPP	Media Processing Platform
MPW	Medicaid for Pregnant Women

MS	Microsoft
MSIS	Medicaid Statistical Information System
MSMA	Monthly Status Meeting Agenda
MSP	Medicare Secondary Payer
MSR	Monthly Status Report
MT	Management Team
MTBF	Mean Time Between Failures
MTF	Medical Treatment Facility
MTQAP	Master Test and Quality Assurance Plan
MTS	Medicare Transaction System
NAHIT	National Association for Health Information Technology
NAS	Network Authentication Server
NASMD	National Association of State Medicaid Directors
NAT	Network Address Translation
NATRA	Nurse Aide Training and Registry
NC	North Carolina
NCAMES	North Carolina Association for Medical Equipment Services
NCAS	North Carolina Accounting System
NCHA	North Carolina Hospital Association
NCHC	North Carolina Health Choice for Children
NCHCFA	North Carolina Health Care Facilities Association
NCID	North Carolina Identity Service
NCMGMA	North Carolina Medical Group Manager's Association
NCMMIS+	North Carolina Medicaid Management Information System (Legacy system)
NCP	Non-Custodial Parent
NCPDP	National Council for Prescription Drug Programs
NCQA	National Committee on Quality Assurance
NCSC	North Carolina Senior Care
NCSTA	North Carolina Statewide Technical Architecture
NC*Tracks*	North Carolina Transparent Reporting, Accounting, Collaboration, and Knowledge Management System
NDC	National Drug Code

NDM	Network Data Mover
NEDSS	National Electronic Disease Surveillance System
NEHEN	New England Healthcare EDI Network
NGD	Next Generation Desktop
NHA	North Carolina Hospital Association
NHIN	National Health Information Network
NHSCHP	National Health Service Connecting for Health Program
NIACAP	National Information Assurance Certification and Accreditation Process
NIH	National Institutes of Health
NIST	National Institute of Standards and Technology
NNRP	Non-Network Retail Pharmacy
NOC	Network Operations Center
NPDB	National Practitioner Data Bank
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
NPS	North American Public Sector
NSC	National Supplier Clearinghouse
NYeC	New York eHealth CollabortaiveCollaborative
NYS	New York State
O&M	Operations and Maintenance
O&P	Orthotics and Prosthetics
OAC	Office of Actuary
OBRA-90	Omnibus Budget Reconciliation Act of 1990
OBS	Organizational Breakdown Structure
OCI	Organizational Conflict of Interest, Organizational Change Implementation
OCR	Optical Character Recognition
OCSQ	Office of Clinical Standards and Quality
ODS	Operational Data Store
OIG	Office of the Inspector General
OLAP	Online Analytical Processing
OLTP	Online Transaction Processing
OMB	Office of Management and Budget

OMMISS	Office of MMIS Services
ONC	Office of the National Coordinator
ONCHIT	Office of the National Coordinator for Health Information Technology
OP	Operations Management Plan
OPA	Ohio Pharmacists Association
ORDI	Office of Research and Development
ORHCC	Office of Rural Health and Community Care
OS	Operating System
OSC	Office of the State Comptroller
OSCAR	Online, Survey, Certification, and Reporting
OTC	Over the Counter
OWCP	Office of Workers' Compensation Programs
P&L	Profit and Loss
PA	Prior Approval
PAC	Pricing Action Code
PAL	Prescription Advantage List
PASARR	Pre-Admission Screening and Annual Resident Review
PBAC	Policy-Based Access Control
PBC	Performance-Based Contract, Package Design and Prototyping
PBD	Package-Based Development
PBM	Pharmacy Benefits Management
PBX	Private Branch Exchange
PC	Personal Computer
PCA	Physical Configuration Audit
PCCM	Primary Care Case Management
PCP	Primary Care Physician , Primary Care Provider
PCP	Primary Care Physician
PCS	Personal Care Service
PDA	Personal Digital Assistant
PDC	Package Development Completion
PDF	Portable Document Format
PDP	Prescription Drug Plans

PDTS	Pharmacy Data Transaction System or Service
PDTS	Pharmacy Data Transaction Service
PEND	Slang for suspend
PERM	Payment Error Rate Measurement
PES	Package Evaluation and Selection
PHI	Protected Health Information
PHSS	Population Health Summary System
PIHP	Pre-Paid Inpatient Mental Health Plan
PIM	Personal Information Management
PIR	Problem Investigation Review , Process Improvement Request
PIR	Problem Investigation Review
PMB	Performance Measurement Baseline
PMBOK	Project Management Body of Knowledge
PMI	Project Management Institute
PML	Patient Monthly Liability
PMO	Project Management Office
PMP	Project Management Plan, Project Management Professional
PMP	Project Management Professional
PMPM	Per Member Per Month
PMR	Performance Metrics Report, Program Management Review, Project Management Review
PMR	Program Management Review
PMR	Performance Metrics Report
POA&M	Plan of Action and Milestones
POMCS	Purchase of Medical Care Services
POP	Point of Presence
POS	Point of Sale (Pharmacy), Point of Service
POS	Point of Service
PPA	Prior Period Adjustment
PQAS	Prior Quarter Adjustment Statement
PRE	Release Preparation
PreDR	Preliminary Design Review

PREMO	Process Engineering and Management Office
PRIME	Prime Systems Integration Services
PrISMS	Program Information Systems Mission Services
ProDR	Production Readiness Review
ProDUR	Prospective Drug Utilization Review
PRPC	Pega Rules Process Commander
PSC	Program Safeguard Contractor
PSD	Package System Design
PST	Production Simulation Test or Testing
PST	Production Simulation Testing
PV	Planned Value
PVCS	Polytron Version Control System
QA	Quality Assurance
QAP	Quality Assurance Plan
QASP	Quality Assurance Surveillance Plan
QC	Quality Control
QCP	Quality Control Plan
QIC	Qualified Independent Contractor
QMB	Qualified Medicare Beneficiary
QMO	Quality Management Organization
QMP	Quality Management Plan
QMS	Quality Management System
R&A	Reporting and Analytics
RA	Remittance Advice
RACI	Responsibility, Accountability, Coordination, and Informing Requirements
RADD	Rapid Application Development and Deployment
RAID	Redundant Array of Inexpensive Disks
RAM	Responsibility Assignment Matrix
RAS	Remote Access Server
RBM	Release-Based Maintenance
RBRVS	Resource-Based Relative Value Scale
RCA	Root Cause Analysis

RDBMS	Relational Database Management System
REMIS	Renal Management Information System
REOMB	Recipient Explanation of Medicaid Benefits
Retro-DUR	Retroactive Drug Utilization Review
RFI	Request For Information
RFP	Request for Proposals
RHH&H	Regional Home Health and Hospice
RHHI	Regional Home Health and Hospice Intermediaries
RHIO	Regional Health Information Organization
RIA	Rich Internet Application
RICE	Reports, Interfaces, Conversions, and Extensions
RIMP	Risk and Issue Management Plan
RM	Risk Manager
RMP	Risk Management Plan
RN	Registered Nurse
ROI	Return on Investment
ROSI	Reconciliation of State Invoice
RPN	Retail Pharmacy Network
RPO	Recovery Point Objective
RRB	Railroad Retirement Board
RSS	Really Simple Syndication
RTM	Requirements Traceability Matrix
RTO	Recovery Time Objectives
RTP	Return to Provider
SA	System Architect
SADMERC	Statistical Analysis Durable Medical Equipment Carrier
SAN	Storage Area Network
SANS	System Administration, Networking and Security Institute
SAP	Systems Acceptance Plan
SAS	Statement on Auditing Standards, Statistical Analysis Software
SCC	Security Control Center
SCHIP	State Children's Health Insurance Program

SD	Software Development, System Development
SD	Software Development
SDB	Small Disadvantaged Business
SDEP	Service Delivery Excellence Program
SDLC	Software Development Life Cycle
SDM	Service Delivery Manager
SE	Software Engineering, System Engineering
SE	Software Engineering
SEC	IT Security
SEI	Software Engineering Institute
SEPG	Software Engineering Process Group
SFY	State Fiscal Year
SIMS	Security Information Management Systems
SIT	Systems Integration Testing
SIU	Special Investigations Unit
SLA	Service Level Agreement
SMAC	State Maximum Allowable Charge
SME	Subject Matter Expert
SMR	Senior Management Reviews
SMTP	Simple Mail Transfer Protocol
SNIP	Strategic National Implementation Process
SOA	Service-Oriented Architecture
SOAP	Simple Object Access Protocol
SOB	Scope of Benefit
SOC	Security Operations Center
SOCC	Secure One Communications Center
SOO	Statement of Objectives
SP	Security Plan
SPAP	State Pharmacy Assistance Plan
SPI	Schedule Performance Index
SPOE	Service Point of Entry
SRR	System Readiness Review

SRT	Service Restoration Team
SRTM	Security Requirements Traceability Matrix
S*S	Sure*Start
SSA	Social Security Administration
SSL	Secure Socket Layer
SSN	Social Security Number
SSO	System Security Officer
SSP	System Security Plan
STD	Standard
STA	Statewide Technical Architecture
STD	Standard
STest	String Test
STP	Staffing Plan
SURS	Surveillance and Utilization Review Subsystem
SV	Schedule Variance
SW	Software
T&M	Time and Materials
TBD	To Be Determined
TCE	Training Center of Excellence
TCN	Transaction Control Number
TCO	Total Cost of Ownership
TCP	Transmission Control Protocol
TDD	Technical Design Document, Telecommunication Device for the Deaf
TDD	Technical Design Document
TED	TRICARE Encounter Data
TES	Time Entry System
TIA	Technical Infrastructure Acquisition
TMA	TRICARE Management Activity
TMOP	TRICARE Mail Order Pharmacy
TOA	Threshold Override Applications
TP	Turnover Plan
TPA	Third Party Administrator

TPAR	Transactional Performance Assessment Review
TPCI	To Complete Performance Index
TPL	Third-Party Liability
TRR	Test Readiness Review
TRRx	TRICARE Retail Pharmacy
TRScan	Transform Remote Scan
TSN	Transmission Supplier Number
TTY	Text Telephone
TxCL	Therapeutic Class Code
UAT	User Acceptance Test
UBAT	User Build Acceptance Test
UDDI	Universal, Description, Discovery, and Integration
UI	User Interface
UPC	Universal Product Code
UPIN	Unique Provider Identification Number
UPS	Uninterruptible Power Supply, United Parcel Service
UPS	United Parcel Service
UR	Utilization Review
URA	Unit Rebate Amount
USB	Universal Serial Bus
US-CERT	United States Computer Emergency Readiness Team
USD	Unicenter Service Desk
USI	User-System Interface
USPS	United States Postal Service
UT	User Testing
V&V	Verification and Validation
VAC	Variance at Completion
VAF	Value Adjustment Factor
VAN	Value Added Network
VAR	Variance Analysis Report
VAT	Vulnerability Assessment Tools
VoIP	Voice Over Internet Protocol

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Computer Sciences Corporation

May 30, 2008
Letter No. DRS-08-0122

State of North Carolina
Department of Health and Human Services
Office of Procurement & Contracting Services
801 Ruggles Drive, Hoey Building
Raleigh, NC 27603-2001

CSC

Attention: Susan W. Lewis
Subject: Submission of Best and Final Offer -DHHS-1228-08

Dear Ms. Lewis:

In accordance with the instructions set forth in your letter of May 2, 2008, Computer Sciences Corporation (CSC) transmits herewith our Best and Final Offer ("BAFO") in support of our prior bid on the North Carolina Replacement MMIS. Included are the following:

- Ten printed copies of the updated Proposal.
- Thirty CDs containing our Technical Proposal.
- Two original executed copies of cover page of Addendum 3, dated May 2, 2008, to RFP 30-DHHS-1228-08-R, one each for the original signed copies of the Technical Proposal, and copies of these pages for the other copies of the Technical Proposal.
- The "delta" State Requirements Matrix Updated May 1, 2008, immediately after the end of the main State Requirements Matrix (Appendix 50, Attachment C, Exhibit 1).
- The Statement of Objectives (SOO) Requirements Matrix immediately after the end of the delta State Requirements Matrix.
- The Page Limitations Worksheet immediately following the Proposal Submission Requirements Checklist (Section B).
- The attached Changed Pages List immediately following the Page Limitations Worksheet described above.

Please feel free to contact me with any questions regarding this material.

Sincerely,

Dianne R. Sagner
Senior Manager Contracts and Subcontracts

Enc.

North American Public Sector (NPS)
15245 Shady Grove Road
Rockville, MD 20850
301.921.3000

STATE OF NORTH CAROLINA **Department of Health and Human Services**)HHS Office of Procurement and Contracts	**REQUEST FOR PROPOSAL NO. 30-DHHS-1228-08** Proposal Due Date and Time: 2:00 p.m. ET, May 30, 2008 Contract Type: Agency Specific
Refer ALL Inquiries to: 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: **Computer Science Corporation**	FEDERAL ID OR SOCIAL SECURITY NO. **95-2043126**	
STREET ADDRESS: **3170 Fairview Park Dr.**	P.O. BOX:	ZIP: **22042**
CITY & STATE & ZIP: **Falls Church, VA 22042**	TELEPHONE NUMBER: **301-921-3256**	TOLL FREE TEL. NO
Will any work under this contract be performed outside the United States? Where will services be performed:	YES_____ NO__X_____	
TYPE OR PRINT NAME & TITLE OF PERSON SIGNING: **Dianne R. Sagner**	FAX NUMBER: **301-921-9870**	
AUTHORIZED SIGNATURE: Dianne R. Sagner 11/5/08	DATE: 5/23/08	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 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).

FOR NC DHHS USE ONLY

Offer accepted and contract awarded this ____ day of _____, 2008, as indicated on attached certification, by _____ (Authorized representative of NC DHHS).

BID ADDENDUM

August 09, 2007

State of North Carolina
Department of Health & Human Services
Office of Procurement & Contract Services

FAILURE TO RETURN THIS BID ADDENDUM IN ACCORDANCE WITH INSTRUCTIONS MAY SUBJECT YOUR BID TO REJECTION

BID NUMBER: RFP 30-DHHS-1228-08

SERVICE: "NC Replacement Medicaid Management Information System"

ADDENDUM NUMBER: 1 Part I: Questions and Answers
Part II: Change in Specifications

PURCHASER: Susan W. Lewis

USING AGENCY: NC DHHS

OPENING/TIME: October 29, 2007, 2:00 PM

INSTRUCTIONS:

1. Two (2) properly executed copies of this Addendum are to be included with your proposal.
2. This Addendum contains questions from potential Offerors and DHHS's responses, changes in specifications, and extension of due date.
3. Execute Addendum:

Bidder: Computer Sciences Corporation

Authorized Signature: Mark E. Anderson Date: 12/20/07

Name and Title (Typed or Printed): Mark E. Anderson, Director of Contracts

City/County of Fairfax
Commonwealth of Virginia
Subscribed and sworn to before me, in my presence,
this 17 day of December, 2007
by Christina L. McKenzie
Notary Public
CHRISTINA L. MCKENZIE
My commission expires June 30, 2009

BID ADDENDUM

August 09, 2007

State of North Carolina
Department of Health & Human Services
Office of Procurement & Contract Services

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BID NUMBER: RFP 30-DHHS-1228-08

SERVICE: "NC Replacement Medicaid Management Information System"

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Part II: Change in Specifications

PURCHASER: Susan W. Lewis

USING AGENCY: NC DHHS

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BID ADDENDUM

August 17, 2007

State of North Carolina
Department of Health & Human Services
Office of Procurement & Contract Services

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BID NUMBER: RFP 30-DHHS-1228-08

SERVICE: "NC Replacement Medicaid Management Information System"

ADDENDUM NUMBER: 2 Part I: Questions and Answers
Part II: RFP Changes

PURCHASER: Susan W. Lewis

USING AGENCY: NC DHHS

OPENING/TIME: October 29, 2007, 2:00 PM

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August 17, 2007

State of North Carolina
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BID NUMBER: RFP 30-DHHS-1228-08

SERVICE: "NC Replacement Medicaid Management Information System"

ADDENDUM NUMBER: 2 Part I: Questions and Answers
Part II: RFP Changes

PURCHASER: Susan W. Lewis

USING AGENCY: NC DHHS

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BID ADDENDUM

September 4, 2007

State of North Carolina
Department of Health & Human Services
Office of Procurement & Contract Services

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BID NUMBER: RFP 30-DHHS-1228-08

SERVICE: "NC Replacement Medicaid Management Information System"

ADDENDUM NUMBER: 3

Part I: Questions and Answers
Part II: RFP Changes

PURCHASER: Susan W. Lewis

USING AGENCY: NC DHHS

OPENING/TIME: October 29, 2007, 2:00 PM

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September 4, 2007

State of North Carolina
Department of Health & Human Services
Office of Procurement & Contract Services

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BID NUMBER: RFP 30-DHHS-1228-08

SERVICE: "NC Replacement Medicaid Management Information System"

ADDENDUM NUMBER: 3

Part I: Questions and Answers
Part II: RFP Changes

PURCHASER: Susan W. Lewis

USING AGENCY: NC DHHS

OPENING/TIME: October 29, 2007, 2:00 PM

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BID ADDENDUM

September 11, 2007

State of North Carolina
Department of Health & Human Services
Office of Procurement & Contract Services

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BID NUMBER: RFP 30-DHHS-1228-08

SERVICE: "NC Replacement Medicaid Management Information System"

ADDENDUM NUMBER: 4

Part I: Questions and Answers
Part II: RFP Changes

PURCHASER: Susan W. Lewis

USING AGENCY: NC DHHS

OPENING/TIME: October 29, 2007, 2:00 PM

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September 11, 2007

State of North Carolina
Department of Health & Human Services
Office of Procurement & Contract Services

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BID NUMBER: RFP 30-DHHS-1228-08

SERVICE: "NC Replacement Medicaid Management Information System"

ADDENDUM NUMBER: 4

Part I: Questions and Answers
Part II: RFP Changes

PURCHASER: Susan W. Lewis

USING AGENCY: NC DHHS

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September 17, 2007

State of North Carolina
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BID NUMBER: RFP 30-DHHS-1228-08

SERVICE: "NC Replacement Medicaid Management Information System"

ADDENDUM NUMBER: 5

Part I: Questions and Answers
Part II: RFP Changes

PURCHASER: Susan W. Lewis

USING AGENCY: NC DHHS

OPENING/TIME: October 29, 2007, 2:00 PM

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BID ADDENDUM

September 17, 2007

State of North Carolina
Department of Health & Human Services
Office of Procurement & Contract Services

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BID NUMBER: RFP 30-DHHS-1228-08

SERVICE: "NC Replacement Medicaid Management Information System"

ADDENDUM NUMBER: 5

Part I: Questions and Answers
Part II: RFP Changes

PURCHASER: Susan W. Lewis

USING AGENCY: NC DHHS

OPENING/TIME: October 29, 2007, 2:00 PM

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BID ADDENDUM

September 24, 2007

State of North Carolina
Department of Health & Human Services
Office of Procurement & Contract Services

FAILURE TO RETURN THIS BID ADDENDUM IN ACCORDANCE WITH INSTRUCTIONS MAY SUBJECT YOUR BID TO REJECTION

BID NUMBER: RFP 30-DHHS-1228-08 Management Information System"

SERVICE: "NC Replacement Medicaid

ADDENDUM NUMBER: 6

Part I: Questions and Answers
Part II: RFP Changes

PURCHASER: Susan W. Lewis

USING AGENCY: NC DHHS

OPENING/TIME: October 29, 2007, 2:00 PM

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BID ADDENDUM

September 24, 2007

State of North Carolina
Department of Health & Human Services
Office of Procurement & Contract Services

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BID NUMBER: RFP 30-DHHS-1228-08 Management Information System"

SERVICE: "NC Replacement Medicaid

ADDENDUM NUMBER: 6

Part I: Questions and Answers
Part II: RFP Changes

PURCHASER: Susan W. Lewis

USING AGENCY: NC DHHS

OPENING/TIME: October 29, 2007, 2:00 PM

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BID ADDENDUM

October 26, 2007

State of North Carolina
Department of Health & Human Services
Office of Procurement & Contract Services

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BID NUMBER: RFP 30-DHHS-1228-08

SERVICE: "NC Replacement Medicaid Management Information System"

ADDENDUM NUMBER: 7

Part I: Questions and Answers
Part II: RFP Changes

PURCHASER: Susan W. Lewis

USING AGENCY: NC DHHS

OPENING/TIME: To be determined

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BID ADDENDUM

October 26, 2007

State of North Carolina
Department of Health & Human Services
Office of Procurement & Contract Services

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BID NUMBER: RFP 30-DHHS-1228-08

SERVICE: "NC Replacement Medicaid Management Information System"

ADDENDUM NUMBER: 7

Part I: Questions and Answers
Part II: RFP Changes

PURCHASER: Susan W. Lewis

USING AGENCY: NC DHHS

OPENING/TIME: To be determined

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BID ADDENDUM

October 26, 2007

State of North Carolina
Department of Health & Human Services
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BID NUMBER: RFP 30-DHHS-1228-08

SERVICE: "NC Replacement Medicaid Management Information System"

ADDENDUM NUMBER: 8

Part I: Questions and Answers
Part II: RFP Changes

PURCHASER: Susan W. Lewis

USING AGENCY: NC DHHS

OPENING/TIME: To be determined.

INSTRUCTIONS:

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BID ADDENDUM

October 26, 2007

State of North Carolina
Department of Health & Human Services
Office of Procurement & Contract Services

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BID NUMBER: RFP 30-DHHS-1228-08

SERVICE: "NC Replacement Medicaid Management Information System"

ADDENDUM NUMBER: 8

Part I: Questions and Answers
Part II: RFP Changes

PURCHASER: Susan W. Lewis

USING AGENCY: NC DHHS

OPENING/TIME: To be determined.

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Notary Public
CHRISTINA L. MCKENZIE
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BID ADDENDUM

November 5, 2007

State of North Carolina
Department of Health & Human Services
Office of Procurement & Contract Services

BID NUMBER: RFP 30-DHHS-1228-08 **SERVICE:** "NC Replacement Medicaid Management Information System"

ADDENDUM NUMBER: 9 - Extension of Due Date for Vendor Questions

PURCHASER: Susan W. Lewis **USING AGENCY:** NC DHHS

PURPOSE:

The due date for vendor questions regarding the updated terms and conditions included in Addendum 8 has been extended from November 9th until COB **November 14th, 2007**.

Bidder: Computer Sciences Corporation

Authorized Signature: _____ Date: 12/20/07

Name and Title (Typed or Printed): Mark E. Anderson, Director of Contracts

City/County of Fairfax
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BID ADDENDUM

November 5, 2007

State of North Carolina
Department of Health & Human Services
Office of Procurement & Contract Services

BID NUMBER: RFP 30-DHHS-1228-08 **SERVICE:** "NC Replacement Medicaid Management Information System"

ADDENDUM NUMBER: 9 - Extension of Due Date for Vendor Questions

PURCHASER: Susan W. Lewis **USING AGENCY:** NC DHHS

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BID ADDENDUM

November 28, 2007

State of North Carolina
Department of Health & Human Services
Office of Procurement & Contract Services

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BID NUMBER: RFP 30-DHHS-1228-08

SERVICE: "NC Replacement Medicaid Management Information System"

ADDENDUM NUMBER: 10

Part I: Questions and Answers
Part II: RFP Changes

PURCHASER: Susan W. Lewis

USING AGENCY: NC DHHS

OPENING/TIME: To be determined.

INSTRUCTIONS:

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Notary Public

CHRISTINA L. MCKENZIE
My commission expires June 30, 2009

BID ADDENDUM

November 28, 2007

State of North Carolina
Department of Health & Human Services
Office of Procurement & Contract Services

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BID NUMBER: RFP 30-DHHS-1228-08

SERVICE: "NC Replacement Medicaid Management Information System"

ADDENDUM NUMBER: 10

Part I: Questions and Answers
Part II: RFP Changes

PURCHASER: Susan W. Lewis

USING AGENCY: NC DHHS

OPENING/TIME: To be determined.

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BID ADDENDUM

December 3, 2007

State of North Carolina
Department of Health & Human Services
Office of Procurement & Contract Services

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BID NUMBER: RFP 30-DHHS-1228-08

SERVICE: "NC Replacement Medicaid Management Information System"

ADDENDUM NUMBER: 11

Part I: Questions and Answers
Part II: RFP Changes

PURCHASER: Susan W. Lewis

USING AGENCY: NC DHHS

OPENING/TIME: To be determined.

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BID ADDENDUM

December 3, 2007

State of North Carolina
Department of Health & Human Services
Office of Procurement & Contract Services

FAILURE TO RETURN THIS BID ADDENDUM IN ACCORDANCE WITH INSTRUCTIONS MAY SUBJECT YOUR BID TO REJECTION

BID NUMBER: RFP 30-DHHS-1228-08

SERVICE: "NC Replacement Medicaid Management Information System"

ADDENDUM NUMBER: 11

Part I: Questions and Answers
Part II: RFP Changes

PURCHASER: Susan W. Lewis

USING AGENCY: NC DHHS

OPENING/TIME: To be determined.

INSTRUCTIONS:

1. Two (2) properly executed copies of this Addendum shall be included with your Proposal.
2. This Addendum contains changes in specifications.
3. Execute Addendum:

Bidder: Computer Sciences Corporation

Authorized Signature: _____ Date: 12/20/07

Name and Title (Typed or Printed): Mark E. Anderson, Director of Contracts

City/County of Fairfax
Commonwealth of Virginia
Subscribed and sworn to before me, in my presence,
this 17 day of December, 2007
by Christina L. McKenzie

Notary Public

CHRISTINA L. MCKENZIE
My commission expires June 30, 2009

BID ADDENDUM

December 5, 2007

State of North Carolina
Department of Health & Human Services
Office of Procurement & Contract Services

FAILURE TO RETURN THIS BID ADDENDUM IN ACCORDANCE WITH INSTRUCTIONS MAY SUBJECT YOUR BID TO REJECTION

BID NUMBER: RFP 30-DHHS-1228-08

SERVICE: "NC Replacement Medicaid Management Information System"

ADDENDUM NUMBER: 12

PURCHASER: Susan W. Lewis

USING AGENCY: NC DHHS

OPENING/TIME: To be determined.

INSTRUCTIONS:

1. Two (2) properly executed copies of this Addendum shall be included with your Proposal.
2. **This Addendum replaces Addendum 6.**
3. Execute Addendum:

Bidder: Computer Sciences Corporation

Authorized Signature: _____ Date: 12/20/07

Name and Title (Typed or Printed): Mark E. Anderson, Director of Contracts

City/County of Fairfax
Commonwealth of Virginia
Subscribed and sworn to before me, in my presence,
this 17th day of December, 2007
by _____
_____ Notary Public
CHRISTINA L. MCKENZIE
My commission expires June 30, 2009

BID ADDENDUM

December 5, 2007

State of North Carolina
Department of Health & Human Services
Office of Procurement & Contract Services

FAILURE TO RETURN THIS BID ADDENDUM IN ACCORDANCE WITH INSTRUCTIONS MAY SUBJECT YOUR BID TO REJECTION

BID NUMBER: RFP 30-DHHS-1228-08

SERVICE: "NC Replacement Medicaid Management Information System"

ADDENDUM NUMBER: 12

PURCHASER: Susan W. Lewis

USING AGENCY: NC DHHS

OPENING/TIME: To be determined.

INSTRUCTIONS:

1. Two (2) properly executed copies of this Addendum shall be included with your Proposal.
2. **This Addendum replaces Addendum 6.**
3. Execute Addendum:

Bidder: Computer Sciences Corporation

Authorized Signature: _____ Date: 12/20/07

Name and Title (Typed or Printed): Mark E. Anderson, Director of Contracts

City/County of Fairfax
Commonwealth of Virginia
Subscribed and sworn to before me, in my presence,
this 20th day of December, 2007
by _____
_____ Notary Public
CHRISTINA L. MCKENZIE
My commission expires June 30, 2009

BID ADDENDUM

December 5, 2007

State of North Carolina
Department of Health & Human Services
Office of Procurement & Contract Services

FAILURE TO RETURN THIS BID ADDENDUM IN ACCORDANCE WITH INSTRUCTIONS MAY SUBJECT YOUR BID TO REJECTION

BID NUMBER: RFP 30-DHHS-1228-08

SERVICE: "NC Replacement Medicaid Management Information System"

ADDENDUM NUMBER: 13

Part I: Questions and Answers
Part II: RFP Changes

PURCHASER: Susan W. Lewis

USING AGENCY: NC DHHS

OPENING/TIME: December 20, 2007 / 2:00 PM EST

INSTRUCTIONS:

1. Two (2) properly executed copies of this Addendum shall be included with your Proposal.
2. This Addendum contains changes in specifications.
3. Execute Addendum:

Bidder: Computer Sciences Corporation

Authorized Signature: _____ Date: 12/20/07

Name and Title (Typed or Printed): Mark E. Anderson, Director of Contracts

City/County of Fairfax
Commonwealth of Virginia
Subscribed and sworn to before me, in my presence,
this 17th day of December, 2007
by Christina L. McKenzie

_____ Notary Public
CHRISTINA L. MCKENZIE
My commission expires June 30, 2009

BID ADDENDUM

December 5, 2007

State of North Carolina
Department of Health & Human Services
Office of Procurement & Contract Services

FAILURE TO RETURN THIS BID ADDENDUM IN ACCORDANCE WITH INSTRUCTIONS MAY SUBJECT YOUR BID TO REJECTION

BID NUMBER: RFP 30-DHHS-1228-08

SERVICE: "NC Replacement Medicaid Management Information System"

ADDENDUM NUMBER: 13

Part I: Questions and Answers
Part II: RFP Changes

PURCHASER: Susan W. Lewis

USING AGENCY: NC DHHS

OPENING/TIME: December 20, 2007 / 2:00 PM EST

INSTRUCTIONS:

1. Two (2) properly executed copies of this Addendum shall be included with your Proposal.
2. This Addendum contains changes in specifications.
3. Execute Addendum:

Bidder: Computer Sciences Corporation

Authorized Signature: _____ Date: 12/20/07

Name and Title (Typed or Printed): Mark E. Anderson, Director of Contracts

City/County of Fairfax
Commonwealth of Virginia
Subscribed and sworn to before me, in my presence,
this 17 day of December 2007
by Christina L. McKenzie
Notary Public
CHRISTINA L. MCKENZIE
My commission expires June 30, 2009

BID ADDENDUM

December 6, 2007

State of North Carolina
Department of Health & Human Services
Office of Procurement & Contract Services

FAILURE TO RETURN THIS BID ADDENDUM IN ACCORDANCE WITH INSTRUCTIONS MAY SUBJECT YOUR BID TO REJECTION

BID NUMBER: RFP 30-DHHS-1228-08-R

SERVICE: "NC Replacement Medicaid Management Information System"

ADDENDUM NUMBER: 1

Change to Appendix 50, Attachment A

PURCHASER: Susan W. Lewis

USING AGENCY: NC DHHS

OPENING/TIME: December 20, 2007 / 2:00 PM EST

INSTRUCTIONS:

1. Two (2) properly executed copies of this Addendum shall be included with your Proposal.
2. This Addendum contains changes in specifications.
3. Execute Addendum:

Bidder: Computer Sciences Corporation

Authorized Signature: _____ Date: 12/20/07

Name and Title (Typed or Printed): Mark E. Anderson, Director of Contracts

City/County of Fairfax
Commonwealth of Virginia
Subscribed and sworn to before me, in my presence,
this 17 day of December, 2007
by Christina L. McKenzie
Notary Public
CHRISTINA L. MCKENZIE
My commission expires June 30, 2009

BID ADDENDUM

December 6, 2007

State of North Carolina
Department of Health & Human Services
Office of Procurement & Contract Services

FAILURE TO RETURN THIS BID ADDENDUM IN ACCORDANCE WITH INSTRUCTIONS MAY SUBJECT YOUR BID TO REJECTION

BID NUMBER: RFP 30-DHHS-1228-08-R

SERVICE: "NC Replacement Medicaid Management Information System"

ADDENDUM NUMBER: 1

Change to Appendix 50, Attachment A

PURCHASER: Susan W. Lewis

USING AGENCY: NC DHHS

OPENING/TIME: December 20, 2007 / 2:00 PM EST

INSTRUCTIONS:

1. Two (2) properly executed copies of this Addendum shall be included with your Proposal.
2. This Addendum contains changes in specifications.
3. Execute Addendum:

Bidder: Computer Sciences Corporation

Authorized Signature: _____ Date: 12/20/07

Name and Title (Typed or Printed): Mark E. Anderson, Director of Contracts

City/County of Fairfax
Commonwealth of Virginia
Subscribed and sworn to before me, in my presence,
this 17 day of December, 2007
by Christina L. McKenzie

_____ Notary Public
CHRISTINA L. MCKENZIE
My commission expires June 30, 2009

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF Medical Assistance (DMA)

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.

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.

Director of Contracts

Signature | Title

Computer Sciences Corporation | December 20, 2007

Agency/Organization | Date

Note
Certification signature should be same as Contract signature.

City/County of Fairfax
Commonwealth of Virginia
Subscribed and sworn to before me, in my presence,
this 17 day of December, 2007
by _____
Notary Public

CHRISTINA L. MCKENZIE
My commission expires June 30, 2009

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF Medical Assistance (DMA)

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

(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. 15245 Shady Grove Road

(Street address)

Rockville, MD 20850

(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	Director of Contracts Title
Computer Sciences Corporation Agency/Organization	December 20, 2007 Date

Note

(Certification signature should be same as Contract signature.)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF Medical Assistance (DMA)

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	Director of Contracts Title
Computer Sciences Corporation Agency/Organization	December 20, 2007 Date

Note
Certification signature should be same as Contract signature.

BASELINE REPRESENTATION

Computer Sciences Corporation (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: Mark E. Anderson

Title: Director of Contracts

Date: December 20, 2007

City/County of Fairfax
Commonwealth of Virginia
Subscribed and sworn to before me, in my presence
this 17 day of December, 2007
by Christina L. McKenzie
Notary Public
CHRISTINA L. MCKENZIE
My commission expires June 30, 2009

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF Medical Assistance (DMA)

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 subject to the provisions of 31 USC 1352, particularly the exclusions in subsection (d) thereof:

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

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

Director of Contracts
Title

Computer Sciences Corporation
Agency/Organization

12/20/07
Date

Note
Certification signature should be same as Contract signature.

City/County of Fairfax
Commonwealth of Virginia
Subscribed and sworn to before me, in my presence,
this 27th day of December, 2007
by Christina L. McKenzie
Notary Public
CHRISTINA L. MCKENZIE
My commission expires June 30, 2009

The Disclosure of Lobbying Activities page contains confidential information.

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.

2. Identify the status of the covered Federal action.

3. Identify the appropriate classification of this report. If this is a followup report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.

4. Enter the full name, address, city, State and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.

5. If the organization filing the report in item 4 checks "Subawardee," then enter the full name, address, city, State and zip code of the prime Federal recipient. Include Congressional District, if known.

6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.

7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency). Include prefixes, e.g., "RFP-DE-90-001."

9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.

10. (a) Enter the full name, address, city, State and zip code of the lobbying registrant under the Lobbying Disclosure Act of 1995 engaged by the reporting entity identified in item 4 to influence the covered Federal action.

    (b) Enter the full names of the individual(s) performing services, and include full address if different from 10 (a). Enter Last Name, First Name, and Middle Initial (MI).

11. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Section B.1
Replacement MMIS Proposal Submission Requirements Checklist

This appendix identifies the requirements for the Proposal responding to RFP 30-DHHS-1228-08 and RFP 30-DHHS-1228-08-R. Team CSC has completed the acknowledgement column.

Proposal Submission Requirements	Acknowledgement "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?	Yes	
2. (RFP Section 50.1) Was the Technical Proposal package(s) labeled as indicated in the RFP Cover Letter?	Yes	
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?	Yes	
4. (RFP Section 50.1) Are the originals clearly marked as such?	Yes	
5. (RFP Section 50.1) Did the Offeror include a table of contents in its proposal?	Yes	
6. (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?	Yes	
7. (RFP Section 50.2) Is the Technical Proposal comprised of the following eleven (11) separate sections, individually tabbed, in the following sequence: • Section A—Transmittal Letter and Execution Page (Page 1 of 2 of RFP Cover Page) • Section B—Proposal Submission Requirements Checklist • Section C—Executive Summary • Section D—Proposed Solution Details • Section E—Project Management Plan • Section F—Operations Management Approach • Section G—Contract Data Requirements List (CDRL) • Section H—Security Approach • Section I—Turnover Approach • Section J—Corporate Capabilities • Section K—Oral Presentations and Demonstrations	Yes	
8. (RFP Section 50.2) Did the Offeror provide the Subsection Number preceding its response explaining its fulfillment in the Technical Proposal?	Yes	
9. (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?	Yes	
10. (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?	Yes	
11. (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?	Yes	
12. (RFP Section 50.2.1) Does the Transmittal Letter include the 15 items listed?	Yes	
13. (RFP Section 50.2.2) Was a completed Proposal Submission Requirements Checklist included in the Proposal as Section B?	Yes	
14. (RFP Section 50.2.3) Was an Executive Summary included in the Technical Proposal as Section C?	Yes	
15. (RFP Section 50.2.3) Is the Executive Summary within the limit of fifteen (15) pages?	Yes	
16. (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?	Yes	
17. (RFP Section 50.2.4.1) Is the Proposed System Solution and Solution for DDI included in the Technical Proposal as Section D?	Yes	
18. (RFP Section 50.2.4.1.1) Is the Overview of System Solution and Solution for Design, Development and Installation included in Section D?	Yes	
19. (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?	Yes	

Proposal Submission Requirements	Acknowledgement "Yes" or "No"	For NC DHHS Use Only
20. (RFP Section 50.2.4.1.2) Is the Software Development and Systems Engineering Methodology included in Section D?	Yes	
21. (RFP Section 50.2.4.1.2) Is the Software Development and Systems Engineering Methodology within the limit of 50 pages?	Yes	
22. (RFP Section 50.2.4.1.3) Is the Data Conversion and Migration Approach included in Section D?	Yes	
23. (RFP Section 50.2.4.1.3) Is the Data conversion and Migration Approach within the limit of 20 pages?	Yes	
24. (RFP Section 50.2.4.1.4) Is the Deployment/Rollout Approach included in Section D?	Yes	
25. (RFP Section 50.2.4.1.4) Is the Deployment/Rollout Approach within the limit of 20 pages?	Yes	
26. (RFP Section 50.2.4.1.5) Did the Offeror complete appendix 50, Attachment C, Part I, DDI Requirements Matrix, as required?	Yes	
27. (RFP Section 50.2.4.1.6) Did the Offeror complete Appendix 50, Attachment C, Part II, Adjusted Function Point Count, as required?	Yes	
28. (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?	Yes	
29. (RFP Section 50.2.4.2.1) Is the Proposed Solution for Operations within the limit of 150 pages?	Yes	
30. (RFP Section 50.2.4.3) Is the Offeror's Statement of Work included in Section D?	Yes	
31. (RFP Section 50.2.4.3) Is the Offeror's Statement of Work formatted per Appendix 50, Attachment D?	Yes	
32. (RFP Section 50.2.4.4) Is the Offeror's Training Approach provided in Section D?	Yes	
33. (RFP Section 50.2.4.4) Is the Offeror's Training Approach limited to 20 pages?	Yes	
34. (RFP Section 50.2.5) Did the Offeror include a Project Management Plan?	Yes	
35. (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?	Yes	
36. (RFP Section 50.2.5.1) Did the Offeror submit its Integrated Master Plan?	Yes	
37. (RFP Section 50.2.5.2) Did the Offeror submit its Integrated Master Schedule?	Yes	
38. (RFP Section 50.2.5.3) Did the Offeror describe its Master Test Process and Quality Assurance Approach?	Yes	
39. (RFP Section 50.2.5.3) Is the Master Test Process and Quality Assurance Approach within the limit of 20 pages?	Yes	
40. (RFP Section 50.2.5.4.1) Did the Offeror provide its comprehensive Organizational Chart for DDI and a description of its organization?	Yes	
41. (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?	Yes	
42. (RFP Section 50.2.5.4.1) Did the Offeror limit its Organization Chart for DDI to 2 pages?	Yes	
43. (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?	Yes	
44. (RFP Section 50.2.5.4.2) Did the Offeror provide its comprehensive Organizational Chart for Operations?	Yes	
45. (RFP Section 50.2.5.4.2) Did the Offeror 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?	Yes	
46. (RFP Section 50.2.5.4.2) Did the Offeror limit its Organization Chart for Operations to 2 pages?	Yes	
47. (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?	Yes	
48. (RFP Section 50.2.5.5) Did the Offeror describe its communications approach?	Yes	

Proposal Submission Requirements	Acknowledgement "Yes" or "No"	For NC DHHS Use Only
49. (RFP Section 50.2.5.5) Did the Offeror limit its Communications Approach to 15 pages?	Yes	
50. (RFP Section 50.2.5.6) Did the Offeror submit its Risk and Issue Management Plan?	Yes	
51. (RFP Section 50.2.5.6) Did the Offeror limit its Risk and Issue Management Plan to 30 pages?	Yes	
52. (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?	Yes	
53. (RFP Section 50.2.5.7) Did the Offeror limit its Initial Risk Assessment to no more than 1 page per identified risk?	Yes	
54. (RFP Section 50.2.5.8) Did the Offeror submit its Change Management Approach?	Yes	
55. (RFP Section 50.2.5.8) Did the Offeror limit its Change Management Approach to 20 pages?	Yes	
56. (RFP Section 50.2.6) Did the Offeror provide its Operations Management Approach in Section F?	Yes	
57. (RFP Section 50.2.6) Did the Offeror limit its Operations Management Approach to 30 pages?	Yes	
58. (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)	Yes	
59. (RFP Section 50.2.6.2) Did the Offeror's Risk and Issue Management Plan includes Operations as well as Systems and DDI? (see RFP Section 50.2.5.6)	Yes	
60. (RFP Section 50.2.6.3) Did the Offeror submit its Business Continuity/Disaster Recovery Approach?	Yes	
61. (RFP Section 50.2.6.3) Did the Offeror limit its Business Continuity/Disaster Recovery Approach to 15 pages?	Yes	
62. (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)	Yes	
63. (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)	Yes	
64. (RFP Section 50.2.7) Did the Offeror provide the CDRL, updated with additional data requirements in Section G?	Yes	
65. (RFP Section 50.2.8) Did the Offeror describe its approach to security in Section H of the Technical Proposal?	Yes	
66. (RFP Section 50.2.8) Did the Offeror limit its Security Approach to 30 pages?	Yes	
67. (RFP Section 50.2.9) Did the Offeror describe its Turnover Approach in its Technical Proposal, Section I?	Yes	
68. (RFP Section 50.2.9) Did the Offeror limit its Turnover Approach to 20 pages?	Yes	
69. (RFP Section 50.2.10) Is the response to Corporate Capabilities included in the Proposal as Section J?	Yes	
70. (RFP Section 50.2.10) Is the response to Corporate Capabilities within the limit of 40 pages?	Yes	
71. (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?	Yes	
72. (RFP Section 50.2.11) Did the Offeror acknowledge in Section K that it understands and agrees to perform the requirements of the Oral Presentations and System Demonstrations?	Yes	
73. (RFP Section 50.2.11.2) Did the Offeror identify the state(s) where its "baseline system" is installed?	Yes	
74. (RFP Section 50.2.11.2) Did the Offeror sign the statement in Appendix 50, Attachment I representing that its baseline system for the system demonstration complies with the description of a "baseline" solution as described in this RFP Section?	Yes	

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Cost Proposal Submission Requirements	Acknowledgement "Yes" or "No"	For NC DHHS Use Only
1. (RFP Section 50.3.1) Did the Offeror use the attached Pricing Tables and submit all requested information for the Cost Proposal?	N/A	
2. (RFP Section 50.3.3) Did the Offeror submit all prices as required for Price Table A, including the basis of estimates?	N/A	
3. (RFP Section 50.3.4) Did the Offeror submit all prices as required for Price Table B, including the basis of estimates?	N/A	
4. (RFP Section 50.3.5) Did the Offeror submit all prices as required by Price Table C, including the basis of estimates?	N/A	
5. (RFP Section 50.3.6) Did the Offeror submit all prices as required by Price Table D, including the basis of estimates?	N/A	

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Team CSC has not included this section pending the request for Cost Proposal submission.

Additional Proposal Pages Used for Best and Final Technical Proposal			
Proposal Section		**Mandatory Page Limit**	**Additional Pages Used**
50.2.1	Section A—Transmittal Letter and Execution Page	3	**0**
50.2.3	Section C—Executive Summary	15	**1**
50.2.4.1.1	Overview of System Solution and Solution for Design, Development, and Installation	500	**0**
50.2.4.1.2	Software Development and Systems Engineering Methodology	50	**0**
50.2.4.1.3	Data Conversion and Migration Approach	20	**0**
50.2.4.1.4	Deployment/Rollout Approach	20	**1**
50.2.4.2.1	Proposed Solution for Operations	150	**3**
50.2.4.4	Training Approach	20	**0**
50.2.5	Section E—Project Management Plan	50	**5**
50.2.5.3	Master Test Process and Quality Assurance Approach	20	**0**
50.2.5.4.1	Staffing Approach—DDI—Organization Chart	2	**0**
50.2.5.4.1	Staffing Approach—DDI—Position Descriptions	1 page per position	**0**
50.2.5.4.1	Staffing Approach—DDI—Resumes	3 pages per resume	**0**

Additional Proposal Pages Used for Best and Final Technical Proposal			
Proposal Section		**Mandatory Page Limit**	**Additional Pages Used**
50.2.5.4.2	Staffing Approach—Operations—Organization Chart	2	**0**
50.2.5.4.2	Staffing Approach—Operations—Position Descriptions	1 page per position	**0**
50.2.5.4.2	Staffing Approach—Operations—Resumes	3 pages per resume	**0**
50.2.5.5	Communications Approach	15	**0**
50.2.5.6	Risk and Issue Management Plan	30	**0**
50.2.5.7	Initial Risk Assessment (Risk Profile)	1 page per risk	**0**
50.2.5.8	Change Management Approach	20	**0**
50.2.6	Section F—Operations Management Approach	30	**0**

Additional Proposal Pages Used for Best and Final Technical Proposal			
Proposal Section		**Mandatory Page Limit**	**Additional Pages Used**
50.2.6.3	Business Continuity/Disaster Recovery Approach	15	**0**
50.2.8	Section H—Security Approach	30	**0**
50.2.9	Section I—Turnover Approach	20	**0**
50.2.10	Section J—Corporate Capabilities	40	**7**
Total Additional Pages Used			**17**

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Section B.3
Pages Changed – Best and Final Technical Proposal

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CSC9	D.1.18-6
CSC12	D.1.4.2-18
CSC13	E.3-8
CSC14	D.1.4.2-19 D.1.17-51
CSC19	D.1.17-151 E.4-18
CSC20	D.1.4.8-50
CSC24	D.1.4.2-12 D.1.4.2-13 D.2.1.1-6
CSC25	D.1.4.9-13
CSC27	D.1.4.11-9
CSC29	D.2.1.3-35
CSC30	D.1.4.11-14
CSC42	D.1.15-2 D.1.15-6 D.1.15-7 D.1.15-8
CSC45	D.1.4.11-15
CSC46	D.1.4.11-15
CSC47	D.1.4.11-12
CSC48	D.1.4.11-13
CSC52	D.2.1.2-16
CSC53	D.2.1.2-16

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CSC60	D.2.1.4-24 D.2.1.30
CSC61	D.1.4.8-23 D.1.4.14-9
CSC74	D.1.4.6-6
CSC75	E.3-8
CSC82	D.1.17-47
CSC84	D.1.4.6-14
CSC86	D.1.4.5-10
CSC88	D.1.17-95
CSC89	D.2.1.3-12 D.1.17-201
CSC91	D.1.4.5-14
CSC94	D.1.4.5-25 D.2.1.3-6
CSC95	D.1.4.5-27 D.2.1.3-12
CSC97	D.1.4.5-18
CSC106	D.1.4.6-13
CSC107	D.1.4.6-15
CSC108	D.1.4.8-81
CSC109	D.1.4.1-14
CSC116	D.1.17-2 D.1.17-151
CSC119	D.1.4.3-8 D.1.4.4-7 D.1.4.4-11
CSC122	D.1.4.8-50
CSC126	D.1.17-216 D.2.1.2-21 D.3-83
CSC130	D.1.4.5-18
CSC134	D.1.4.14-36

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CSC140	D.1.4.8-29
CSC144	D.1.14-8 E.3-8
CSC146	E.3-8
CSC147	D.1.4.14-11
CSC148	D.1.14-13 D.1.14-22
CSC149	D.1.4.14-11
CSC150	E.7-12 E.8-16
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CSC169	D.2.1.4-7
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CSC176	D.1.4.12-10
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CSC219	C.1-7
CSC225	D.1.4.6-15
CSC229	D.1.4.5-25
CSC232	D.1.17-77 D.2.1.3-6
CSC233	D.1.8-3
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CSC252	D.1.4.1-12
CSC261	J.1-28
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CSC266	D.1.4.6-6
CSC267	D.1.4.14-34
CSC268	D.1.4.14-38

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CSC297	D.1.14-26 D.1.14-28
CSC298	G-1 G-13
CSC301	D.1.4.2-8
CSC303	D.1.8-8
CSC308	D.1.6-2 D.1.6-3
CSC318	D.1.4.11-3 D.1.4.11-4

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CSC379	G-41 G-42 G-43 G-44
CSC532	E.3-8 E.8-3
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CSC618	G-11
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CSC637	E.9-16
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CSC654	D.1.8-8 D.1.8-9 D.3-47 E.2-26 E.3-5
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CSC728	G-29 G-30
CSC729	D.1.1-3 D.1.14-36
CSC731	D.1.14-6 D.3-16 E.3-8
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CSC737	E.5 Job Descriptions-7 E.5 Job Descriptions-13 E.5 Job Descriptions-16 E.5 Job Descriptions-18 E.5 Job Descriptions-20 E.5-26
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CSC746	E.3-8
CSC752	D.1.4.5-18

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CSC772	E.3-8
CSC774	D.1.11-2

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C.2 – High Level Functionality Matrix	2-11
D.1.1 – Fulfilling North Carolina's Objectives	1-7
D.1.2 – Overview of Our Proposed Solution	1-7
D.1.3 – Baseline System Functionality	1-3, 5-8, 10, 13
D.1.4.1 – General System Requirements	1-33, 35-38, 40-47
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D.1.4.6 – Reference Subsystem	1, 4-7, 9-15, 19, 22
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D.1.11 – Licensing and Software/Hardware Support Relationships	1, 2
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D.1.13 – Warranty After Delivery of Final System	1-3
D.1.14 – Software Development and Systems Engineering Methodology	1-8, 12-14, 16, 18-23, 26-29, 31, 36-37, 43-45, 47-49
D.1.15 – Data Conversion and Migration Approach	2, 4-8, 10-13, 15
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D.2.2 – Operations Facilities	1-3, 5
D.3 – Statement of Work	1-4, 10, 14, 16-18, 27, 32-33, 36, 43-45, 47, 52, 54-56, 59, 65, 67, 69-73, 75, 83-84, 92, 97, 99, 102-104
D.4 – Training Approach	1, 3-4, 6-9, 11-16, 18-19
E.1 – Project Management Plan	1, 5-6, 8, 11, 16, 19, 23-29, 31-32, Appendix A: 1-69
E.2 – Integrated Master Plan	1-2, 5-10, 6-26 (All of the events, milestones, and CDRLs chart was changed)
E.3 – Integrated Master Schedule	1-19, 20-145 (All pages of the IMS MS Project file printed

Section	Associated Page Number(s) Changed
	changed)
E.4 – Master Test Process/QA Approach	1-4, 6-8, 10, 15-19
E.5 – Staffing Approach	1, 3-5, 7, 9, 11-13, 15-20, 22, 24-26, 35-46, 55, 57-58, 65, 67, 73-74. Job descriptions: 7, 9, 11-13, 16, 18, 20
E.6 – Communications Approach	2-3, 8, 12, 14. Resumes: 5, 9-14, 16, 18-19, 25, 27-31, 35
E.7 – Risk and Issue Management Plan	1-3, 9, 11-13, 15, 20-21
E.8 – Initial Risk Assessment	1-20
E.9 – Change Management Approach	1, 7, 10, 12, 14-16, 20
F.1 – Operations Management Overview	1-4, 6-8, 10-17
F.2 – Change and Configuration Management	None, single page document
F.3 – Risk and Issue Management	None, single page document
F.4 – Business Continuity & Disaster Recovery Approach	1, 4-5, 7-8, 11
F.5 – Ongoing Training	None, single page document
F.6 – Communications Process/Procedures	1
G – Contract Data Requirements List	1-6, 9, 11-46
H – Security Approach	2-7, 9, 11-15, 17-18, 21-22
I – Turnover Approach	1-9, 11-12
J.1 – Relevant Experience	4, 6, 12, 17, 19, 25, 27-29, 31
J.2 – Summary Information – Offeror's Corporate Relevant Experience	3, 4, 27, 31, 35, 40, 44, 47, 51, 55
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J.5 – Damages and Penalties Assessed	1
K – Oral Presentations and Demonstration	1, 2

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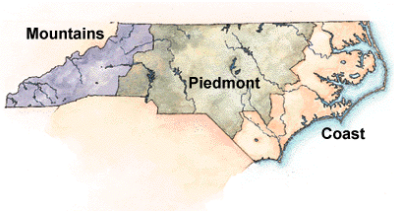
Faced with high growth, limited resources, and demands from new and expanding programs, the Department of Health and Human Services (DHHS) requires a reliable multi-payer platform to help meet today's business needs and tomorrow's challenges. Team CSC brings a proven, highly reliable, CMS-certified business solution focused on improving the Department's service outcomes. We bring a singular driven focus on DHHS, software engineering discipline, and quality assurance practices that will lower implementation risks for North Carolina.

C.1 PROJECT UNDERSTANDING (50.2.3)

The State of North Carolina is the sixth fastest growing state in the country, a trend that brings both opportunities and challenges for its citizens, providers, and those that serve in the North Carolina Department of Health and Human Services (NC DHHS). Recognizing this challenge, NC DHHS and its 30 programmatic and business support divisions and offices have developed a Business Plan that addresses the Department's mission and vision in this rapidly changing environment. The Business Plan, supported by the objectives presented in the RFP makes it clear how the Replacement MMIS Project will contribute to meeting the challenges and opportunities facing the Department.

The procurement sets a direction for the Replacement MMIS to function as much more than the current legacy system. We recognize that the legacy MMIS serves as a multi-payer application for the Division of Medical Assistance (DMA), the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS). The Replacement MMIS must offer more capabilities as a multi-payer MMIS and also have the functionality to create new healthcare payer benefit plans with new business and processing rules. Through capabilities such as user-defined configurable features, the Replacement MMIS will also deliver MIS services for the separate and unique needs of the Division of Public Health (DPH) and the Office of Rural Health and Community Care (ORHCC). We further recognize the implications of Section 10.40D(a) of the Current Operations and Capital Improvements Appropriations Act of 2007, which directs NC DHHS to make development and implementation of the Replacement MMIS a top priority. We believe that our design for the new Replacement MMIS will enable the rapid implementation required in this Act. With the Replacement MMIS' configurable features, Team CSC delivers a solution prepared to meet these requirements. *At this point, the Replacement MMIS truly becomes an enterprise-wide solution for NC DHHS.* **(SOO 10.2-2, SOO 10.7-1)**



NC DHHS is the largest department in the State and contains diverse divisions and offices delivering services to nearly every citizen in North Carolina. Our evaluation of the NC DHHS Business Plan and associated materials establishes a set of requirements and identifies the following needs and conditions common to all NC DHHS divisions:

- Need for staff training, retention, and development
- Adoption of an enterprise approach to technology and business applications
- Knowledge sharing and collaboration across the NC DHHS enterprise
- Continuous quality improvement
- Insight rather than oversight of programs, vendors, and contracts
- Budget predictability and control; ability to manage the growth in programs
- Customer service experience with NC DHHS to meet expectations

- Limited resources (funding, technology, staff resources)
- IT solutions aligned with business goals and strategies
- Technology that facilitates and enables service delivery
- Increased access and capacity to deliver services and products
- Striving for flexibility, innovation, and continual improvement
- Continuous quality improvement

Our goal is to provide services and solutions aligned with the priorities of NC DHHS and each division, as you address your Business Plan's critical success factors. We recognize the diverse needs of each division and office. Our Replacement MMIS provides NC DHHS with an information technology (IT) platform that meets each division's needs and also promotes efficient information sharing across the enterprise.

As illustrated in **Exhibit C.1-1**, Team CSC understands these challenges. Our approach to the Replacement MMIS project addresses NC DHHS business drivers and our commitment to your efforts to fulfill the NC DHHS Business Plan. We will deliver a flexible, configurable Replacement MMIS that gives the Department and divisions the agility to rapidly respond to new challenges. Components of the Replacement MMIS, such as our business process automation solution, offer NC DHHS an expandable platform and an IT solution enabling process improvements, automation, and information access. NC DHHS business rules can be implemented through a user-friendly rules engine, configurable tables and criteria that enable NC DHHS staff to deliver more service more rapidly with fewer resources. **(50.2.3, SOO 10.1-1, SOO 10.1-2, SOO10.2-1, SOO 10.3.1-1)**

C.1.1 Understanding the NC DHHS Enterprise

The Department has expanded the nationally recognized Community Care of North Carolina (CCNC) program statewide and continues to invest in its evolution. Acting as a model for the rest of the country, the NC DHHS will seek to expand the program's capabilities to improve care management for its members. In 2001, the Legislature mandated significant reform of public mental health, DD, and SAS in North Carolina.

Through the efforts of DMH/DD/SAS to implement this reform, the largest division in NC DHHS has improved mental health services and recognized necessary significant changes in systems and services capabilities. The DPH has

DHHS Business Drivers	Team CSC Contribution
Employ an enterprise-wide approach.	• A CMS certified baseline enterprise-wide solution that processes 450M claims a year without ever missing a program cycle, is being enhanced with top rated COTS products and cost-effective custom code to meet State objectives to " Acquire systems that can be transferred and maintained by the State…for a long period" at a good ROI.
Sustain a culture of continuous improvement	• A dedicated QA/QC Team in our NC office augmented by independent Corporate Delivery Assurance Teams performing audits at no cost to NC DHHS, making sure we comply with contract terms and performance metrics. • A multi-disciplined Operations Excellence (OPEX) committee of NC and CSC focused on improving DDI and FA Operations to improve the amount and quality of service to stakeholders at the lowest TCO. • A personal performance evaluation methodology that ties personal promotions and merit raises to a persons success in meeting personal improvement and team and program performance goals and metrics.
Enable business needs to drive operational decisions and resource allocation	• A SAS Business Intelligence capability that leverages the power of our simplified Data Service Layer to surface insights the State and CSC Staff need to collaboratively set priorities, refine processes and change operations • Team assets such as the UNC Sheps Center and CSC Innovation Laboratories who, when directed, will quickly study issues and calculate ROI options to support NC DHHS decision making. • A Configuration Management/Change Planning process helping NC stakeholders understand all NC CSRs to make decisions as a team.
Achieve operational efficiencies	• A dashboard, scorecard, alerts and reports based performance metrics program to enable NC and CSC Staffs to work cooperatively to achieve TCO reduction similar to the 20% reduction CSC was able to achieve for the NY DPH.
Enhance internal and external communication; focus on customer service	• Our NC*Tracks* multi-media portal that, based on NC Security Policies, gives rolls based, self-service, stakeholder access to metrics, current/historical knowledge bases, training centers, and communication /collaboration tools including Customer Satisfaction Surveys that make stakeholders more productive and encourage feedback to us.

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Exhibit C.1-1. NC DHHS Business Drivers

faced enormous challenges in fulfilling its mission since 9/11 changed our country. Despite the IT improvements over the last few years, more remains to be done. Integration of systems, data sharing and interoperability with the new Replacement MMIS is critical to continued advancement.

CSC's eMedNY Performance

Today, CSC's CMS-certified eMedNY MMIS efficiently supports more than 4 million recipients, processes over 450 million claims per year, and pays providers $40 billion annually. Over the last 3 years, eMedNY has achieved a 99.9995% uptime record — close to perfection.

In order to increase access to care and advance community-based care systems, ORHCC seeks to encourage the collaboration of its constituencies - from providers and hospitals - to community organizations and the local or county Department of Health and the Department of Social Services, and DMH/DD/SAS' Local Management Entities. Achieving quality patient care and cost-effectiveness are goals common to all of NC DHHS. Team CSC's proposed Replacement MMIS offers the NC DHHS enterprise the required flexibility, maintainability, and quality of services and products.

North Carolina's rapid population growth poses many challenges for NC DHHS. This is especially true for DMH/DD/SAS, as they seek to reform services and build a community service capacity, for the Division of Public Health as it meets the challenges of a changing and migratory population, and the Office of Rural Health as it works to deliver and manage access to healthcare for many in this growing population. DMA also faces challenges resulting from rapid growth in Medicaid consumers and services utilization. Since 1995, the State's Medicaid expenditures have increased by more than 250%. Today, DMA serves more than 1.6 million recipients a year, and the number continues to grow. As reported in the 2006 DMA Annual Report, the claims error rate has risen from 0.8% in 2000 to more than 4% today. The Replacement MMIS plays a significant role enabling each Division to address its future needs. **(10.2-1, SOO 10.2-2, SOO 10.3.1-1)**

Team CSC Will Deliver Added Value

Strong Complementary Team Members. **Because we are committed to delivering the best resources to NC DHHS,** CSC has assembled a core team of outstanding companies with the expertise and flexibility to grow as the State's needs grow. For example, MemberHealth is nationally recognized for its pharmacy benefits management and prior-approval programs. North Carolina-based PhyAmerica is an industry leader in provider credentialing, and North Carolina's SAS Institute produces software that has become a national and international standard. **Exhibit C.1-2** presents our team partners.

The Right Management Team. Team CSC leaders for this project are seasoned MMIS experienced professionals who **are committed 100% full time to this program** and to its total success. We propose eight key staff with over 225 years of combined experience directly related to their specialty for this program.

- ✓ **John Singleton.** Our Executive Account Director brings more than 30 years of experience in Medicaid, Medicare, and multi-payer systems. A native of North Carolina, he led the North Carolina MMIS software development and implementation project in 1980–1981. He has conducted 10 healthcare implementations across the country in Medicaid, Medicare, and managed care. His strong personal commitment to North Carolina brings NC DHHS a leader focused on project success.
- ✓ **Ellen Charlebois.** Our Deputy Account Director brings more than 29 years of Fiscal

Company	Role	Key Value
CSC	Prime Contractor – program manager, integrator, replacement, operations, and turnover phases.	• DDI, FA, and DSS Prime for NY MMIS contract, the largest FFS in the United States. We are now processing more than 450 million claims and disbursing over $40 billion annually • Lead architect for CMS MITA
MemberHealth	Pharmacy prior authorization	• Expertise in pharmacy authorization system expertise • Ready to complete early implementation if approved by State
PhyAmerica Government Services	Provider credentialing	• Perform credentialing services today in NC • Ready to complete early implementation if approved by State
SAS	Business intelligence (BI) and data conversion	• SAS has an extensive installed base of BI and data conversion products and services in NC
UNC Sheps Center	Focused consulting to improve healthcare operations at lower TCO	• North Carolina state organization to analyze the efficacy of use of Medicaid dollars
Cansler-Fuquay Solutions, Inc.	Focused consulting to improve productivity in Replacement and Operations Phase	• Deep knowledge of DHHS goals, policies, procedures, and working cultures
BizLogic, Inc.	Requirements validation; Architecture; and legacy MMIS analysis	• Extensive knowledge of NC MMIS requirements and decomposition/extraction of business rules from legacy MMIS
S2 Technologies	SMEs NC MMIS and eMedNY SMEs for DDI	• Involved in eMedNY DDI; Specialty teams working on eight states' MMIS projects, including NPI for Washington, DC

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Exhibit C.1-2. Team CSC. *We have the expertise and flexibility to grow as the State's needs grow.*

Agent account management and operations experience. Her diverse hands-on approach gives NC DHHS a leader with the attention to details of a large Medicaid Fiscal Agent operation.

- ✓ **Nelson Kennedy.** Our Implementation Director has more than 33 years of experience in leading major MMIS development projects. He has led or worked on 10 large healthcare MIS implementations. With experience in working on the baseline MMIS, eMedNY, he fully understands the capabilities of our solution and how we will develop the Replacement MMIS as an enterprise-wide solution for NC DHHS.
- ✓ **Frank Terrell.** Our Program Management Office Director has 25 years of experience in information technology and management of information technology projects.
- ✓ **Tom Canine.** Our Claims Processing Manager has 25 years of experience in Medicaid FA Operations, including OCHAMPUS expertise.
- ✓ **Dr. Robert Harris**. Our Medical Director has 25 years of experience in Healthcare Policy and is also a North Carolina Board certified, licensed Physician.
- ✓ **Dr. Ted Mayer**. Our Dental Director has 25 years of experience in Dental policy and is also a North Carolina licensed Dentist.
- ✓ **David Moody RPh.** Our Pharmacy Director has 33 years of Pharmacy policy experience and is also a North Carolina licensed Pharmacist.

Each of these individuals brings significant relevant experience to this Project minimizing the risks associated with an implementation of this scope and complexity.

Stakeholder Focus. We know there are many interested parties and stakeholders we must satisfy to create a successful Replacement MMIS. Our North Carolina-based team has identified these individuals and groups and created a communication and outreach plan that focuses on their needs and on how best to empower them.

We will build the Replacement MMIS on a foundation of partnership, results, and capability. Together we will achieve success, meet the demands imposed by North Carolina's rapidly growing population, and prepare for tomorrow's challenges. **Our success will be measured by the strength of our partnership with you.**

Partnership, Flexibility, Reliability, and Collaboration

Team CSC understands the importance of this project and NC DHHS' need for a Replacement MMIS that delivers the technology, platform, and applications to carry NC DHHS into the future. Our solution enables the Department and the Divisions to accomplish enterprise-wide objectives without sacrificing individual needs. We will build a Replacement MMIS that serves the NC DHHS as an enterprise and also enables the Divisions, individually or in partnership as necessary, to succeed in their missions.

Our solution reduces risk. It is based upon the CMS-certified eMedNY MMIS that we built in New York State. It is designed for a 100% uptime environment, large transaction volumes, and a multi-tiered, service oriented architecture (SOA). In the initial phase, we will validate our gap analysis of the baseline eMedNY MMIS and our understanding of the Replacement MMIS' requirements. Our design solution will achieve all seven NC DHHS objectives, as summarized in **Exhibit C.1-3.**

C.1.2 Team CSC Commitment

Team CSC has spent a year developing our proposed solution and preparing for its implementation. In New York, since 1986 we have successfully operated and managed the largest single fee-for-service Fiscal Agent operation in the nation. CSC's NY MMIS system, eMedNY, has achieved the following:

- Successfully and accurately processes more Medicaid claims than any other system in the nation (approximately 450 million processed annually)
- Annually disburses more provider payments (over $40 billion) than any other Fiscal Agent contract in the nation
- Successfully reduced paper claims processing to only 3% of the total workload

High Level NC Objectives and Team CSC Solutions

NC Program Objectives

- A baseline system CMS certified in 60 days
- A baseline SW architecture systematically improved over time so that the same sized CSR Team now completes about 5 times more CSRs a year
- A baseline server and network architecture continually upgraded to reliably handle very large loads
- A Replacement MMIS solution with innovative, cost-effective COTS additions to our baseline system improving project metrics, security & privacy, productivity, collaboration, & training. It is ready to accept more multi-payer programs than is currently predicted in NC documents

NC Financial Objectives

- Use of tools and methods to give the state transparency of the basis of our work and pricing
- A SOW and IMS with clearly defined deliverables as a basis for invoicing

NC Schedule Objectives

- Our low-risk DDI scheduling approach was proven in NY. We are also offering several options we used successfully in NY to further shorten our proposed NC schedules

NC SW and SE Objectives

- Use of the CSC Catalyst and SOA methods, both highly rated by independent industry analysts, for MMIS DDI and operations support planning & control
- Compliance with the STA, DHHS IT standards and best industry practices to produce a MITA aligned solution that will provide the state with a good ROI
- Integration of COTS rules and table driven change capabilities to speed changes and reduce TCO
- A CM/Change planning process enabling the state to make sound decisions on priorities, schedules and ROI
- An integrated test and auto-documentation update capability that increases IT productivity and quality at low risk
- Security, privacy and data protection experts who will prevent unintended "leaks" and assist the State in any audits or investigations

NC DDI PM Objectives

- A dashboard, scorecard, alerts, and reports system delivering timely info to the right CSC and state people
- Web enabled collaboration tools enabling state and CSC personnel to review status and agree on work priorities & action plans

NC Early Implementation Objectives

- A realist approach for early transfer of credentialing work, and pharmacy PA if also approved by NC

NC Life-Cycle Support Objectives

- A proven organization, staffed with a balanced team of experts in the most current MMIS methods and with a deep understanding of NC goals, procedures and working styles
- A multi-media **NC***Tracks* portal that pushes the right info to the right people at the right time: metrics and reports, communications, knowledge bases, training programs, and collaboration tool sets

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Exhibit C.1-3. NC DHHS Objectives. *We meet all of your objectives.*

- Provides quality and consistent customer service to more than 50,000 active providers each year
- Has never missed a payment cycle, making all provider payments as scheduled
- Ensures system reliability, with only 7 minutes of downtime in the past 4 years

We bring a proven MMIS baseline for North Carolina reducing the risks associated with the project.

Replacement MMIS and MITA Alignment.

The single most important deliverable for this project is a new certifiable Replacement MMIS. Team CSC commits to delivering a new Replacement MMIS that not only meets screen time and sometimes exceeds the RFP Section 40 requirements but also lays the groundwork for future needs and enhancements. We also commit to achieving CMS certification and delivering a SOA-based MMIS aligned with the MITA principles.

In partnership with NC DHHS and its divisions, we are dedicated to your success in delivering a new Replacement MMIS and efficient, quality-focused Fiscal Agent operations. Today, CSC is recognized as a world leader in providing advanced IT solutions. Our diverse experience in healthcare positions us to help solve the ever-increasing challenges facing state Medicaid agencies, Federal health departments, and private health organizations. Our leading-edge engineering and software development support and our operational focus on quality, efficiency, and continuous improvements drive the operational efficiencies that formed the framework of CSC's baseline MMIS.

Our healthcare achievements illustrate CSC's diversity, currency, and achievements in the healthcare field. We will use this experience and expertise to inform the Department of new developments, impacts, and solutions. Our breadth and depth in the market will be to your advantage. **We commit to keeping you informed of these advancements in technology and services. (SOO 10.3.1-2)**

We are Your Trusted Partner

Team CSC understands that NC DHHS has partnered with community physicians, health departments, hospitals, mental health agencies, and other community health organizations to build a highly respected community network system to improve the care and care outcomes of Medicaid recipients. We recognize that the community care system, which relies substantially on Medicaid to pay the claims for services delivered, also relies on the MMIS

system to provide the utilization and cost information it needs for managing patient care. Team CSC will work closely with NC DHHS and Community Care of North Carolina leadership to provide support the programs need to operate and expand their capabilities in managing enrollee care. We also recognize that the DPH, DMH/DD/SAS, and ORHCC support community agencies and organizations that deliver and manage the care of Medicaid and other low-income and under-served North Carolina residents. We understand that these agencies are challenged to increase access and also to improve quality of care and cost-effectiveness. **Team CSC is committed to working with these NC DHHS divisions in achieving strategic goals and management objectives**.

Team CSC expresses it interest in serving as the NCMMIS+ Systems Integrator. As the State's partner we will provide support for these future solicitations for the R&A and DHSR. Team CSC will collaborate with DHSR during the DDI and Operations Phases supporting the integration of business needs. Team CSC will not extend the Replacement MMIS DDI schedule solely due to its role as the NCMMIS+ System Integrator and we will not unreasonably refuse to enter into amendments to the Contract due to our role as your system integrator for the NCMMIS+ Program. **(30.38, SOO 10.8-19, SOO 10.8-20, SOO 10.3.2-1, SOO 10.3.3-2, SOO 10.12.1-17, Comment CSC219)**

Total Transparency. **Team CSC will make our efforts under the contract totally transparent.** NC DHHS will have access to management and program information for sharing information and monitoring status. **NC***Tracks*, the **T**ransparent **R**eporting, **A**ccounting, **C**ollaboration, and **K**nowledge management **S**ystem, is our delivery mechanism for this transparency. Team CSC's user-friendly Web 2.0 functionality will give each Replacement MMIS user community a baseline of menus of helpful information, which each user can personalize for their own needs with self-service features. The public and secure features of the **NC***Tracks* portal will improve productivity, decrease learning time, increase user retention, and build a self-service, self-sustaining knowledge base. **NC***Tracks* will also contain a dashboard area that can be customized to display performance standards and key performance measures at a summary level or by functional area, with information available to DHHS at all times. **(SOO 10.8-12, SOO 10.8-11)**

Meaningful, Visible Performance Measures. In addition to the RFP's performance requirements, Team CSC will work with you to develop important qualitative and quantitative measurements and metrics tied to NC DHHS goals and objectives. **Team CSC is committed to Department visibility into our day-to-day performance measurements.** We will also work with NC DHHS to develop performance metrics for the **NC***Tracks* portal, so that all authorized parties can monitor quality and progress throughout the project phases.

For the DDI Phase of the project, our measurement system begins with an Integrated Master Plan and Integrated Master Schedule. **NC***Tracks* enables the user community to view the details and status of our deliverables. **NC***Tracks* also provides access to our Earned Value Management System (EVMS). **Exhibit C.1-4** on the following page shows our approach to EVMS. Maintenance of these deliverables continues through the life of the contract and is

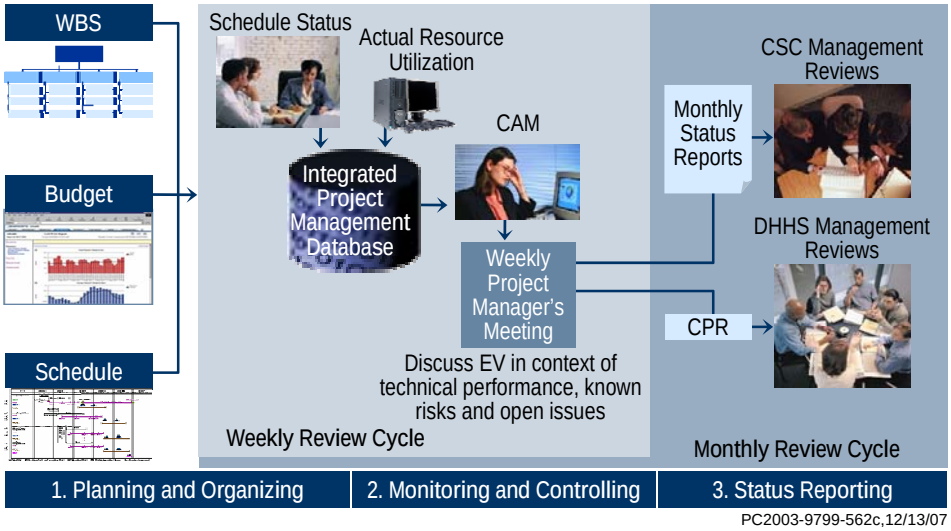

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Exhibit C.1-4. CSC's Comprehensive EVMS Workflow

always available to NC DHHS. *We make it easy for you to review our work.*

When the project moves into the Operations Phase, Team CSC will apply new performance metrics and indicators that focus on day-to-day Fiscal Agent operations. All operational units track and monitor key performance indicators, covering inventories, production, and quality metrics.

All metrics are posted as dashboard elements for the appropriate **NC***Tracks* user community. Establishing solid operational metrics with appropriate thresholds allows NC DHHS and Team CSC to proactively monitor the status of all operational units via meaningful thresholds and color-coded performance indicators. **(SOO 10.8-1, SOO 10.8-2, SOO 10.8-3, SOO 10.8-5)**

Improved Customer Service. In New York State, provider satisfaction increased dramatically as we applied new process improvements in provider training, call center operations, and the provider Web portal. **We will bring these approaches and focus to North Carolina to improve service to the stakeholder communities, particularly providers and recipients.**

With NC DHHS permission, **NC***Tracks* will enable the provider community to perform a number of self-service functions, such as the following:

- Direct web portal claims submission into the Replacement MMIS
- Electronic adjusting of previously adjudicated claims
- Electronic submission and claims prior authorization requests with editing
- Electronic submission of enrollment applications for new providers, which features:
  - Automated workflow documents tool to process new applicants
  - Image capture of signed hard copy documents and automated link to the electronic form and work object
  - Significant improvement in the quality and timeliness of provider enrollment process

Our Replacement MMIS solution enables process automation across the enterprise driving down NC DHHS' total cost of ownership.

NC is Our Primary Focus. The success of the Replacement MMIS project is Team CSC's primary focus, unencumbered by competing MMIS implementation projects. Team CSC selectively pursues the Medicaid Fiscal Agent market and has chosen North Carolina as a strategic opportunity. *We understand that a state facing the challenges of a rapidly growing population and service delivery challenges must have a proven system capable of meeting its current and future needs. We believe our experience, modern proven system, and successful track record in the State of New York represent a perfect fit for North Carolina. The success of this project will be as important for Team CSC as it is for NC DHHS.*

The North Carolina project reports directly to the CSC President of Government Health Services, Ray Henry. As **Exhibit C.1-5** illustrates, Jim Sheaffer, President of the North America Public Sector, closely monitors this project. The Business Process Management Office (BPMO) will frequently and independently review this project through monthly business reviews and direct contact with Ray Henry and John Singleton. CSC senior management will monitor progress on the project ensuring the team has all resources needed when they are needed.

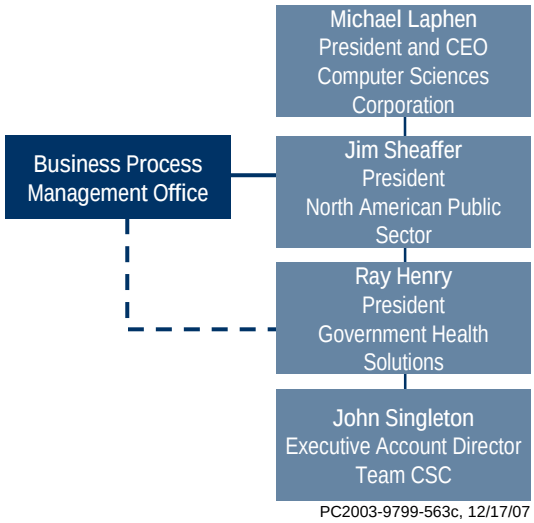

Exhibit C.1-5. MMIS Placement in CSC's Corporate Structure. *The North Carolina Replacement MMIS project is a corporate priority.*

We Will Deliver Meaningful, Measurable Results Today and Tomorrow

NC DHHS' success in this project is vitally important to fulfilling its vision and mission, and our success in delivering the Replacement MMIS on time is critical to that meeting that objective. **Team CSC's commitment is to deliver success early and with concrete results. We will accomplish this through innovation and employing a focus on quality services and the implementation of best practices.**

Improving health outcomes, reducing costs, and extending the Department's ability to manage multiple programs require a focus on people and processes as well as technology. We have built many innovative elements into our solution to automate business functions, reduce paper, measure how well we are doing, automate policy, and provide more proactive business intelligence. These innovations will help the State and its Fiscal Agent to continuously improve their practices and keep up with changing conditions. For example, our Innovations Council is designed to bringing new ideas, technology, and best practices to North Carolina. **We are committed to being your innovative partner,**

delivering lower-cost services through the implementation of process improvement and automation that will lower the levels of staff resources required to deliver more service. Innovations that Team CSC will introduce include the following:

- MITA aligned SOA n-Tier Architecture
- Single MMIS Relational DBMS
- Rules-engine and an MiMMIS Rules Builder
- Workflow BPM
- Team CSC Innovation Council
- Team CSC Advisory Council
- UNC Cecil G. Sheps Center for Health Services Research
- CSC Health Care Center of Excellence (CoE)
- CSC Training Center of Excellence
- Operations Excellence Committee
- Independent Quality Assurance organization
- Communications Portal – **NC***Tracks*
- Management Dashboards
- Full integration of all solution services
- Integrated Call Center
- Multi-media Training

Team CSC is committed to supporting the Department through the Innovation Council and the Health Care COE as a part of day-to-day operations.
In addition, we will move beyond best practices to "next practices," that is, innovative approaches, such as self-documenting workflow and personalized portals. *These practices will save the Department time and money*.

Team CSC will engage staff from NC DHHS to discuss, evaluate, and analyze new ideas and innovations, whether through technology, process improvement, or policy development. As your partner, we will continually bring new ideas to the State for consideration. As an example, a possible solution to pending bipartisan legislation in the United States Senate requiring physicians to use e-Prescriptions by 2011 could be delivered through our secure portal – **NC***Tracks* to any Medicaid approved e-prescribing application enabling a single location for a Medicaid physician to verify recipient eligibility, obtain script prior approval, and validate the number of scripts a patient has used in the month.

Our commitment to an efficient Fiscal Agent operation with a focus on the total cost of ownership and superior quality in the operation of the Replacement MMIS brings a new era of partnership for the Department. Fresh ideas, open, honest communication, and daily visibility into our operation reflect that commitment. (SOO 10.8-14)

Right Resources and Capabilities for Today and Tomorrow

Outstanding Healthcare Credentials. No matter how your goals and objectives change over time, Team CSC is prepared to support your needs. CSC's innovative healthcare solutions and 4,800 healthcare professionals caused Gartner to rank us as the second leading healthcare development and integration contractor in North America. **Team CSC is committed to continuing to bring new ideas, solutions, and processes to the NC DHHS.** We believe it is our responsibility to monitor the changing healthcare environment nationally, from federal regulations to new technologies, and provide information for NC DHHS to consider.

Quality-Focused Approach. Our success in New York reinforces the value of "doing it right the first time," and we have incorporated that principle into our Fiscal Agent operations and software development culture. In New York, we are faced with a contract requirement for 100% uptime for eMedNY, our baseline MMIS. **To meet that requirement requires a strict commitment to quality procedures and sound development methodology.** NC DHHS will benefit from our quality-driven engineering procedures, proven in New York, as we design, develop and implement a new Replacement MMIS that delivers each day. **(SOO 10.9-19)**

According to Forrester Research

CSC has the largest installed base of health plan customers and can provide clients with robust IT along with BPO solutions…. CSC's strongest attributes are its IT outsourcing and BPO services that can help plans get the most out of their claims platform investment. Buyers should look to CSC if they want to focus on process improvements or if they are looking to outsource their claims operation.

— Healthcare Claims Platform Scorecard Summary: CSC, March 24, 2005

Features of the CSC Baseline System

- Unsurpassed reliability – less than 7 minutes of downtime in the last 4 years while operating 24/7
- CMS certified our system in 60 days
- Online, real-time adjudication of claims, eligibility, and other transactions
- Call center integrated into application
- Never missed or delayed a payment cycle
- More than 220 Service Level Agreements (SLA) met since December 2006
- First State to implement the full complement of HIPAA transactions
- Average of less than 0.5 second response time for all transactions since implementation
- Maintenance development work improved 500% over the legacy system without increasing the number of developers
- Only MMIS to have a working, on-line Electronic Medical Record pilot

Exhibit C.1-6 shows how Team CSC integrates quality into all levels.

C.1.3 Replacement MMIS

A Replacement MMIS is necessary for the State to meet a growing population and programmatic and legislative changes. It will yield access to better information for planning and control of fraud, waste, and abuse. Our Replacement MMIS will include maintainability features, such as the configurable table-driven logic and externalized business rules managed by the rules engine components, which will enable rapid response to a changing business environment. Our change

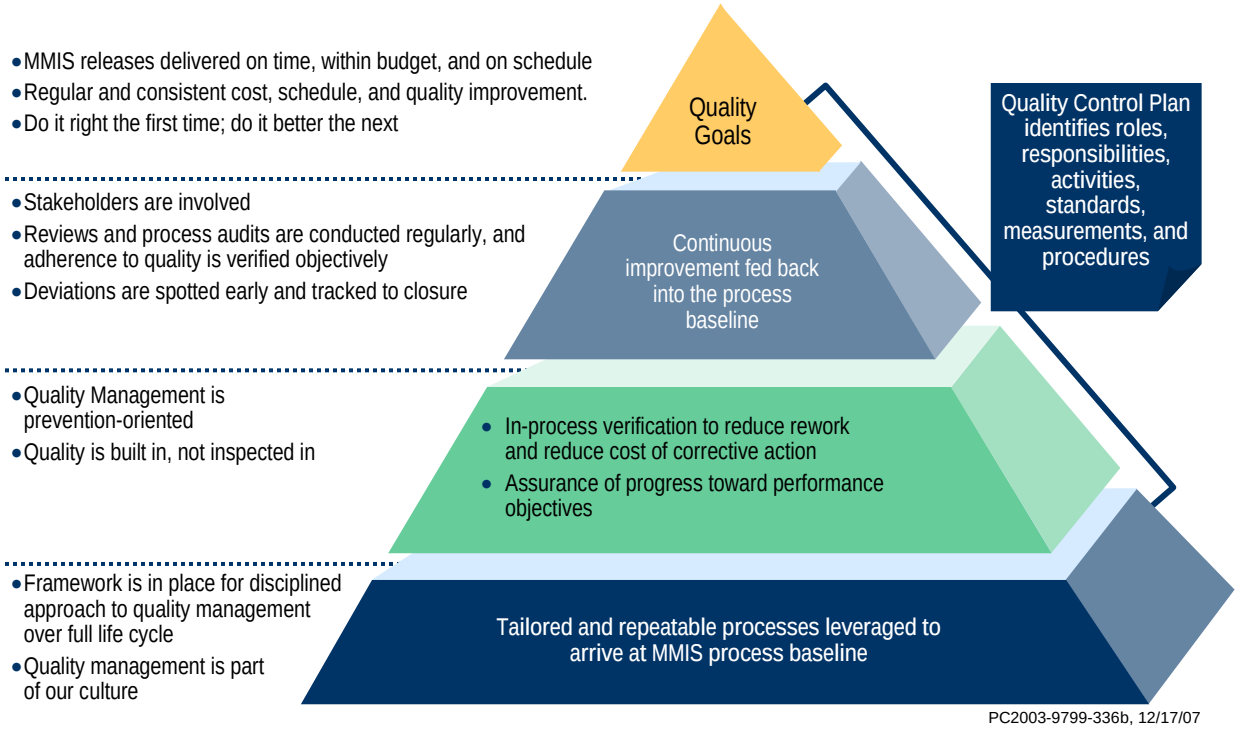

Exhibit C.1-6. Dimensions of Quality

management also ensures quality in each step, ensuring NC DHHS can reliably implement change. Additionally, throughout the project, we will incrementally deliver each system component for State review and testing throughout the system life cycle, providing access to the Replacement MMIS as it is developed. **(SOO 10.9-7)**

But a system is only as good as its ability to support required goals and objectives. ***We offer North Carolina an approach to meeting your evolving business needs, not just a technology solution***. The key elements of our approach are transparent, disciplined software engineering for implementation and system functions that support achieving improved service outcomes and proven high performance. **Exhibit C.1-7** illustrates the components of the new Replacement MMIS.

Team CSC's Replacement MMIS will deliver a solution built upon a service-oriented architecture with fully integrated business processes. Our Replacement MMIS design offers an easily maintained multi-payer application meeting NC DHHS' requirements for an agile enterprise responsive to North Carolina's changing environment**.** Each of these components or layers is described in the following paragraphs.

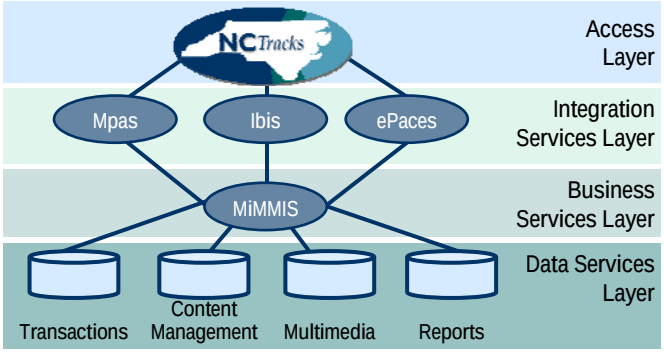

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Exhibit C.1-7. Replacement MMIS Overview

Access Layer

- ✓ **NC***Tracks*, is a web portal based on Microsoft SharePoint technology that offers an access window into the MMIS applications, MMIS and Fiscal Agent information, communication resources, training materials, dashboards, business intelligence services, and stakeholder community web pages. It is the sole on-line entry point for all users to the Replacement MMIS. The web portal will use a role-based authorization scheme integrated with the North Carolina Identity Service (NCID). Access is tailored to specific user communities. **(SOO 10.12.1-10)**

Integration Services Layer

- ✓ **ePACES** is the electronic provider automated claims entry system that provides HIPAA-compliant services allowing authorized providers to submit transactions, such as claims and eligibility verification and prior authorization requests, through an online interactive interface.
- ✓ **Mpas**, the multi-payer administrator system, is the access point for queries to Replacement MMIS online applications or business services, such as provider maintenance, prior authorization, claims inquiry, and claims adjudication. MPAS is a Java-based application that administers the MMIS online applications used by the NC DHHS and Team CSC staff.
- ✓ **Ibis** is a business process management (BPM), workflow, and rules engine. This component is built upon Pegasystems SMART BPM Suite and its healthcare framework technology. Team CSC uses this application framework to deliver many work automation capabilities. Ibis supports the customer relationship management (CRM) system and manages workflow for correspondence tracking, enrollment, and case management.

Business Services Layer

- ✓ **MiMMIS,** is the integrated multi-payer MMIS application that provides the business services transaction processing for all Replacement MMIS functional areas. MiMMIS represents the high-volume core transaction processing engine.

Data Services Layer

- ✓ **Transactions** is a relational database for all types of MMIS transactions data. Unlike other designs, where pharmacy, medical, and financial data are separate, our solution utilizes a single relational database designed for high volume processing capacity, data integrity and consistency.
- ✓ **Content Management** is a database for information such as web content, training, other documents or artifacts.
- ✓ **Multimedia** is a repository that includes the EDMS (imaging and other documentation to support operations). This data store can be further expanded to support other data media such as web casts, training videos and pod casts, etc.
- ✓ **Reports** database represents a repository of report and business intelligence. This data repository supports items such as reports, dashboards information and program metrics, etc.

MITA Alignment

As a key participant in the development of MITA, CSC brings an in-depth understanding of the MITA technology vision. Aligning with MITA, our SOA philosophy focuses on sharing, decoupling business processes from technology, and making possible an agile enterprise that can transform and transform rapidly. Because the architecture is designed to align with CMS' goals and objectives for MITA, NC DHSS is in a better position to ensure that CMS system certification requirements are met.

The Replacement MMIS design establishes a high performance, easily maintained platform for today and tomorrow serving as a key enabler for NC DHHS business processes. **(SOO 10.2-1, SOO 10.3.1-2, SOO 10.3.1-1, SOO 10.3.1-3, SOO 10.3.1-4, SOO 10.9-10)**

C.1.4 Approach to Implementation

We understand the difficulties you faced with the 2004 MMIS contract and have designed a low-risk approach that also takes advantage of the useful work from the previous contract to best meet your goals and objectives. The North Carolina Replacement MMIS project is large and complex. Given the more than 1,800 individual RFP requirements covering the MMIS and Fiscal Agent operations, Team CSC has employed our Catalyst™ methodology to ensure that all aspects of the project are accounted and planned for. **Exhibit C.1-8** illustrates the interactions of the components of our Project Management Plan (PMP) following our Catalyst methodology.

Through our research, we have sought to understand issues and lessons learned from the previous Replacement MMIS project. These efforts enable us to minimize the associated risk, if not eliminate it. Our leadership team has engaged former North Carolina DHHS staff, reviewed Procurement Library materials, and interviewed several of the prior contractor's staff and contractor resources in seeking to understand any lessons learned. Our approach to

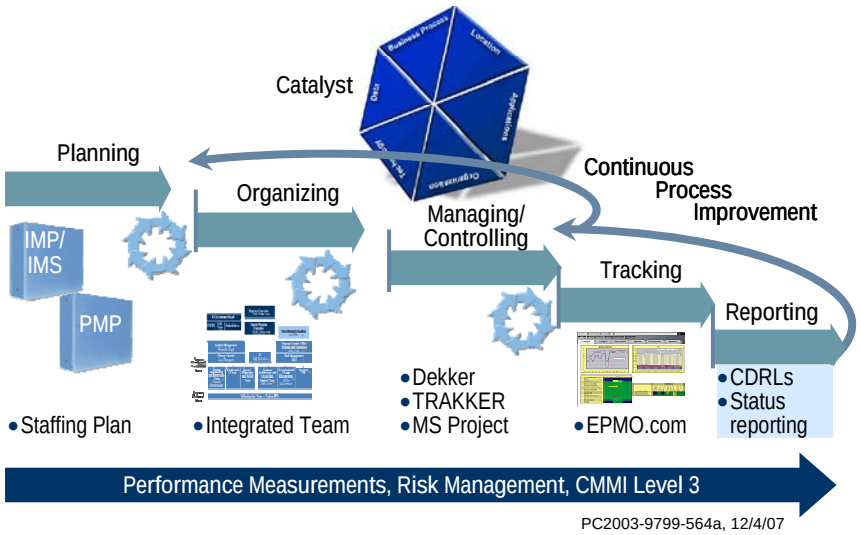

Exhibit C.1-8. CSC's Catalyst Methodology Reduces Risk

development and implementation reflects our proven methodology and our commitment to success. From our extensive analysis of the Section 40 requirements, the Detailed System Design documents, and the Procurement Library materials, we developed our proposed Integrated Master Plan (IMP), the associated Integrated Master Schedule (IMS), and the plans outlined in our methodology, all of which constitute our implementation approach. **(SOO 10.8-3, SOO 10.8-4, SOO 10.8-22)**

Throughout this process, in addition to MMIS or operational requirements, we have emphasized the following:

- Integration of quality processes, ensuring that each deliverable meets RFP requirements
- Alignment with MITA
- Risk analysis and mitigation
- Total cost of ownership and operation of the Replacement MMIS
- Continuous process improvement through feedback and lesson learned activities

Team CSC will follow an iterative build approach to the design, construction, testing, and deployment of the Replacement MMIS. Team CSC will begin with the immediate installation of the applications that constitute the baseline MMIS.

Team CSC will maintain a Replacement MMIS lab at our Raleigh site throughout the DDI Phase, supporting staff from NC DHHS and Team CSC. Our ability in the DDI Phase to use the baseline MMIS augmented through each Build, offers early visibility to your staff and enhances design, build, test, acceptance, and training activities.

Our Replacement MMIS Build Structure is organized around the major components (subsystems) of the MMIS requirements. Breaking the project into iterations or Builds allows us to keep deliverables to a manageable size and efficiently use NC DHHS and Team CSC staff. Our collaborative build approach also features:

- Business System Document Review within each Build
- UBAT for early system test
- 90 business days UAT
- Early CMS certification planning and preparation
- Feedback/lessons learned loop after each build to continually improve the approach.

As **Exhibit C.1-9** illustrates, Team CSC has constructed the Integrated Master Schedule around 18 Builds, or iterations, of software delivery over the 32-month DDI Phase. **(SOO 10.9-5, SOO 10.9-6, SOO 10.9-7)**

Throughout the DDI Phase, Team CSC is committed to transparency and visibility for the NC DHHS staff into the design and development of the Replacement MMIS. **Exhibit C.1-10** lists the activities for each Build. Managing the documents or artifacts for this project requires automation and utilization of effective, user-

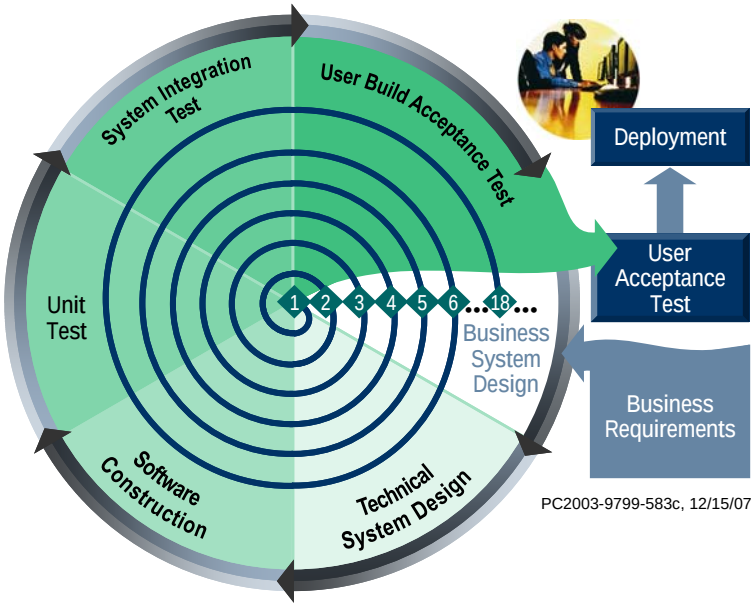

Exhibit C.1-9. Iterative Build Approach Delivers High Quality Software – The First Time!

friendly software engineering tools. We use software engineering support tools such as the Borland suite to assemble these components in a user-friendly repository.

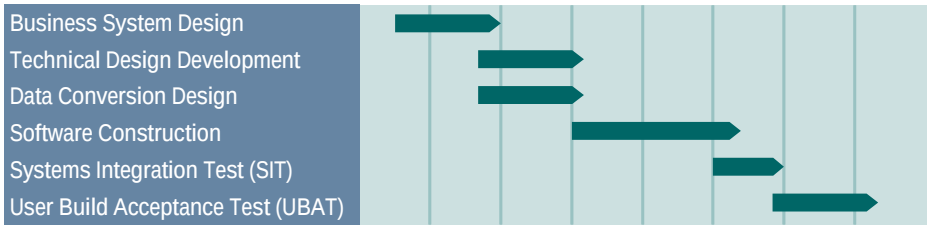

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Exhibit C.1-10. Components of a Build

The Borland suite provides the necessary tools, cross-reference capabilities, and data dictionary to support requirements traceability and maintenance and also gives the NC DHHS and Team CSC staff easy access to the design materials and technical documents, beginning in the DDI Phase and continuing throughout the Operations Phase. **(SOO 10.8-11)**

Team CSC's Technical Proposal

Team CSC's technical proposal follows the guidance in RFP Section 50. A compliance matrix is also provided to map proposal content to RFP and SOW requirements. RFP sections are referenced throughout the Technical Proposal which provides a convenient cross-reference index to assist NC DHHS in evaluating our response to RFP requirements. These references are also noted in the margins of the proposal. As a way of demonstrating our understanding and support of the Statement of Objectives (SOO) in Section 10 of the RFP, we have placed a series of icons throughout the proposal indicating specific information we have provided to support the NC DHHS SOO.

Summary — Why CSC?

Team CSC fully appreciates the challenges facing the NC DHHS and recognizes how important the Replacement MMIS is to your success. Partnering with North Carolina is fundamental to how we will proceed. Delivering a new Replacement MMIS that meets the enterprise-wide needs of NC DHHS while enabling DMA, DMH/DD/SAS, DPH, and ORHCC to individually manage their programs is our goal. Our proposed solution offers a new Replacement MMIS that will meet and exceed your expectations, while enabling the Department to address the challenges of the future by working through the new solution, not around it. The new Replacement MMIS will be a key enabler to the NC DHHS to meet business drivers and achieve success. ***We at Team CSC are equally committed to our mutual success.***

Why CSC?

1. World Class Competency	We successfully completed DDI for the NY MMIS, meeting very strict performance standards, and working with NY to help achieve CMS certification. We are delivering FA services for NY processing the highest claims volume in the US while never missing a check run date. For NC we will add innovative ideas derived from the broad base of government and commercial health services experience that earned us high ratings from independent industry analysts.
2. World Class Efficiency	We reduced our NY TCO by approximately 20% while increasing customer satisfaction. For NC we will partner with DHHS to repeat this level of achievement in any priority order set by NC.
3. World Class Focus	We focus on Customers to whom we can deliver the most value. For NC we will adapt our "best practices" from working in the NY structure, with "next practices" from our other CMS successes to systematically improve the productivity of NC stakeholders with innovative automation.
4. World Class Solution	Our Architecture provides NC with a SOA-based, MITA-aligned, STA compliant Solution that we made much better than most MMIS Solutions by integrating highly ranked COTS workflow, collaboration and knowledge management functionality and a comprehensive training programs.
5. World Class People	The success of any program ultimately lies with the people. Our Management staff is seasoned, dedicated, and eager to deliver. They will deliver clean traceability and transparency of all our work to communicate candidly and collaboratively with the NC DHHS staff. You are getting an A-Team
6. World Class Partners	We are easy to work with. We always partner with our customers. You will recognize the names of many of the Staff members we are proposing because they have supported DHHS before in important areas such as multi-payer policy, IV&V, configuration management decision making.
7. World Class HC Qualifications	CSC is a healthcare systems integrator. Our depth and breadth of healthcare experience will be invaluable, as your MMIS enterprise takes on a greater role for the State.
8. World Class Quality	We integrated quality across our technical, management, and operations solutions. The dedicated QA/QC staff on our Team and the independent CSC corporate Audit teams will keep quality high, lower risk, and clearly report our status to our leaders and yours.
9. World Class Delivery	You have our commitment to deliver on time and on budget. Ask our other satisfied customers!

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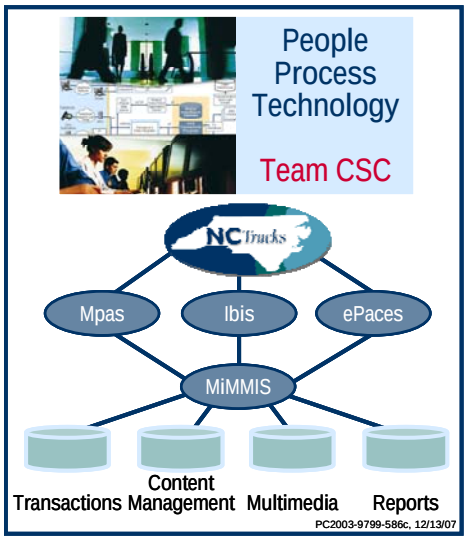
Pages C.2-1 through C.2-12 contain confidential information.

D.1.1 FULFILLING NORTH CAROLINA'S OBJECTIVES

Team CSC focused its efforts to deliver a proposal to the State that meets all the stated and implied goals and objectives in the RFP, related State documents such as the DHHS Business Plan and the Legislative budget language requiring DHHS to report progress on this contract while simultaneously accepting new multi-payer missions. We will work with you as a full partner providing you with the traceability and transparency you need to approve our Statement of Work, and oversee our progress and success based on our schedules and performance metrics. We believe your replacement MMIS and associated Fiscal Agent operation will achieve award winning results and we commit ourselves to help make that belief a reality.



Team CSC understands the DHHS program objectives and proposes a business-driven solution that combines people, process and technology to meet those objectives. We apply the knowledge gained from over 30 years of experience in designing, developing and operating Medicaid management information systems. Our most recent experience in New York is distinguished by a high performance solution coupled with a culture of continuous improvement that has **driven operational costs down by 20% over the last three years**. Team CSC will utilize the first Web-based CMS-certified MMIS solution, eMedNY, as the baseline for the Replacement MMIS. The CSC eMedNY solution provides a baseline MMIS that already meets and exceeds the service level requirements for the Replacement MMIS. The flexible service oriented architecture of the transfer system has enabled Team CSC to easily support healthcare IT initiatives such as the Primary Care Information Project (PCIP), a public and private Collaborative Health IT Adoption association whose mission is to improve population health through appropriate technology and health information exchange such as the adoption and use of Electronic Health Records (EHRs) among primary care providers in New York City's underserved communities. The base MMIS solution provides architecture and technology design supporting service levels requiring 100% system availability, high volume transaction processing, and 0.5 second response times for a recipient and claim volume far exceeding those in the North Carolina multi-payer programs.

Team CSC's proposed North Carolina solution expands upon the current base system strengths by providing **personalized views (portals) that support internal and external stakeholders** in meeting their specific program objectives and by providing innovative policy-driven workflow that will strengthen the culture of continuous improvement. The full integration of business services, such as claims payment, with support for stakeholders and the tools for continuous improvement, will empower DHHS and its Fiscal Agent to meet the challenges of 21st Century healthcare. As instructed by the General Assembly, the new Replacement MMIS must be capable of

supporting the processing for the NC Health Choice and NC Kids Care programs. The new solution is designed to enable the Department to implement multiple programs (payers) within the single MMIS and to operate those programs individually within the enterprise. The new Replacement MMIS delivers an enterprise-wide architecture with the easily maintained business rules unique to the delivery of each program separately. Our solution empowers the Department to take advantage of the multi-payer capabilities and globally manage all public funded healthcare programs. (**SOO 10.1-2, SOO 10.2-1, SOO 10.2-2)**

(10.1-2, 10.2-1, 10.2-2)

Our goal and a primary focus in the development of the proposed Replacement MMIS is to meet or exceed the statement of objectives contained in Section 10 of the Request for Proposal (RFP). Throughout this section of our proposal, Team CSC has linked every aspect of our solution, approach and operation to fulfilling the State's RFP objectives. We understand and appreciate the nature of the work and the technical challenges presented by the development, implementation, and operation of the Replacement System. **Team CSC is a national leader in developing solutions and an experienced integrator of Medicaid Management Information Systems, experienced at establishing and managing the supporting business process operations.**

The Replacement Phase is a critical phase of the North Carolina Replacement MMIS project. We are committed to the successful development and deployment of a new MMIS meeting the needs NC DHHS has detailed in the RFP. During the Replacement Phase, Team CSC will perform the activities necessary to verify that our Replacement MMIS solution meets or exceeds the objectives of the North Carolina Department of Health and Human Services (DHHS) programs. **(50.4.2.1, 10.2)**

D.1.1.1 Replacement MMIS Program Objectives (10.2)

In developing our proposal, Team CSC has evaluated the Replacement MMIS Program Objectives and carefully considered their meaning and intent as we formulated our solution. The following sections illustrate how the Team CSC solution is designed to meet those objectives related to the Replacement MMIS. The following information provides insight into the important connection between the Team CSC Replacement MMIS and the NCMMIS+ Program Objectives contained in the RFP. **Our baseline MMIS, eMedNY, is a CMS-certified MMIS.**

"Team CSC will deliver a multi-payer Replacement MMIS that is certifiable by the Centers for Medicare & Medicaid Services (CMS)"

Team CSC understands the enterprise perspective that DHHS brings to its Replacement MMIS solution. An enterprise view of Providers, Recipients and claims processing allows North Carolina to more efficiently administer its varied programs to enhance the quality of life of North Carolina individuals and families with the opportunity for healthier and safer lives. The new Replacement MMIS provides real-time (timely) access to validated and verified (accurate) information enabling enterprise-wide (multi-payer) measurements of recipient services and outcomes. Building on baseline capability, Team CSC commits to a flexible, table-driven multi-payer system that will incorporate the current Medicaid, Public Health, Mental

(10.2-1, 10.3.1-2, 10.3.1.3, 10.3.1-4)

Health, Rural Health programs and be easily extended to any future programs. **(SOO 10.2-1, SOO 10.3.1-2, SOO 10.3.1-3, SOO 10.3.1-4)**

Team CSC recognizes that CMS Certification is the critical factor in achieving success on this project. CSC is CMM Level 3 certified across many of our programs, and certified to Level 4 and 5 on some programs. We recognize that successful and certifiable implementations are due to enforcing rigorous software engineering discipline and solid, repeatable management and engineering processes. Our successful certifications are based on software engineering discipline and strong management practices. Team CSC will conduct annual internal SEI CMM reviews of our Software engineering and development processes. Team CSC will report the results of this internal review to DHHS. (**Comment CSC729)**

The North Carolina implementation will use an incremental, iterative 'build' process. Each build will focus on a set of functionality, carrying it from requirements verification through systems integration test. The State will then perform a User Based Acceptance Test (UBAT) to allow the State to evaluate progress incrementally. Team CSC provides remote access to the current (latest) version of the Replacement MMIS. Each build will also be put through a quality assurance process to identify opportunities for improvement of subsequent builds. The State will be given full access to the same management tools as Team CSC. **A flexible, adaptable baseline and strong management processes are the basis for Team CSC confidence in a successful implementation. (SOO 10.9-5, SOO 10.9-6, SOO 10.9-7)**

(10.9-5, 10.9-6, 10.9-7)

Team CSC recognizes that the Department of Health Service and Regulation (DHSR) implementation will be released as a separate RFP. Team CSC also recognizes that DHSR is one of many potential systems that could exchange and share data and functionality. The replacement MMIS will employ industry standards-based ways of interfacing such as Web Services that will facilitate data exchange. The DHSR and Replacement Interface will support the enterprise view of Provider. Team CSC will work closely with DHSR to implement a secure data exchange capability. We understand that data interoperability is fundamental to the CMS Medicaid Information Technology Architecture (MITA) and will be incorporated into the new Replacement MMIS. As required in RFP Section 40.4.1.14, Team CSC facilitates providers access via the Automated Voice Response System (AVRS) to DHSR information such as the Health Care Personnel Registry. (**SOO 10.3.3-1, SOO 10.3.3-2, SOO 10.8-20)**

"Team CSC has engineered an IT system to perform services provided by the DHSR."

(10.3.3-1, 10.3.3-2, 10.8-20)

Team CSC provides unparalleled experience and industry-leading Information Assurance (IA) expertise. We specialize in enterprise-wide, full life-cycle and federally compliant approaches to information security that ensures a constant and consistent level of information protection in proper balance with the operating environment. Our IA and Systems Architecture staffs have conducted a review of the NC DHHS Security Policies, ensuring our solution meets or exceeds the North Carolina requirements. **Our New York Medicaid operation meets HIPAA security and privacy requirements.** During DDI, we will incorporate

"Team CSC system, policies, and procedures provides a level of security that will ensure compliance with NC DHHS' Security Policies and Standards."

Federal, State, and DHHS security policies and privacy requirements into the Security Plan. Our global security services capabilities meet or exceed the rigorous requirements of national security agencies, the Department of Defense (DoD), and some of the largest financial institutions in the world. Team CSC draws upon our extensive experience in the Federal community to manage the DDI and operations phases in a secure manner and incorporates application security design principles into our software engineering processes. Team CSC's approach to information security is a combination of risk governance, risk management, and security administration encompassing the entire infrastructure. **(SOO 10.9-14)**

(10.9-14)

A key element of the Team CSC's security management solution is a cohesive communication flow to and from the NC DHHS Secure One Communications Center (SOCC). To meet this requirement, Team CSC will centralize Replacement MMIS physical, personnel and cyber security services under the control of a single Security Manager. **Our base MMIS, eMedNY, already provides the user level role-based security for MMIS application access. Our solution provides the State with the ability to control, view, and update access down to the data element level. (SOO 10.12.1-26)**

(10.12.1-26)

"We have leveraged advances in health care IT to improve NC DHHS' capabilities and operations (e.g., e-prescriptions, electronic health records, and electronic x-rays)."

Team CSC brings practical experience in many of the new technologies positively impacting the health care industry. **As an example, CSC was awarded one of the four Nationwide Health Information Network Prototype Architectures by DHHS, Massachusetts — Simplifying Healthcare among Regional Entities (MA-SHARE)**. CSC serves as the systems integration partner for MA-SHARE, a RHIO, providing Project Management Office (PMO), system development and integration services. Through our efforts on this project, CSC has gained expertise in the inter-organizational exchange of health care data using information technology, standards and administrative simplification design. We also bring unique corporate capabilities in the form of our Centers of Excellence (COE) and Innovation Labs, including the Government Health Services COE, helping CSC showcase and apply its capabilities and associated technologies to streamline health care systems and empower clients as we adapt proven best practices creating still-emerging "next practice" solutions. **As the original MITA prime contractor to CMS, CSC developed an Enterprise Architecture-based framework for transforming Medicaid within all states**. The transformation activity introduced new operational, business, services, data, and technology concepts along with a migration strategy. Team CSC's solution is based on open standards-based data exchange standards which can be applied to e-prescriptions and electronic health records. Further, the open solution integrates multiple technologies through open standards and supports future integration of health IT innovations. (**SOO 10.9-10, SOO 10.9-11)**

(10.9-10, 10.9-11)

As a current Medicaid Fiscal Agent for the state of New York, CSC understands and accepts the requirement to meet this objective. **Our performance in New York demonstrates that commitment. As New York State's Fiscal Agent for Medicaid, we annually process more than 450 million Medicaid claims for over 4 million**

"Pay claims correctly and in a timely fashion to the appropriate party."

recipients, valued at nearly $40 billion in provider payments. We have successfully operated the NYS Medicaid program since 1986, and **have never missed a payment cycle for claims paid via check or EFT.** Our Service Level Agreement (SLA) with New York does not allow for operational downtime of the online systems. In the last 3 calendar years, downtime has occurred once and the length of this occurrence was under seven minutes. Additionally, with our focus on provider outreach, CSC has assisted New York State in reducing its provider paper claim submission rate to an industry leading rate of less than 3%. Our success in provider outreach results in a better informed provider community making fewer mistakes and requiring less State and Fiscal Agent resources. The return of this investment for all stakeholders is an improved provider experience with claims paid accurately and on time, reducing expensive rework for the providers, the State and the Fiscal Agent.

"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."

Team CSC Replacement MMIS solution provides key new features supporting business intelligence capabilities. **The Replacement MMIS is built upon a relational database architecture providing enhanced access to the information contained within the Replacement MMIS enterprise.** Our solution offers a relational data store as a repository of data and information that can be utilized by the Replacement MMIS end user to query data, conduct various analyses and produce reports. The new Replacement MMIS will serve as a significant data feed to the new Reporting & Analytics (R&A) solution once operational. With the relational database architecture found in the Team CSC solution, data preparation and transfer to the R&A solution is significantly improved. Team CSC's solution will enable the R&A solution to receive data feeds directly from the source data store with little data transformation required. **(SOO 10.3.2-1)**

(10.3.2-1)

"Team CSC will improve operations of all internal and external stakeholders by increasing the level of automation."

Team CSC is committed to the effective automation of the State and Fiscal Agent operations through the utilization of Business Process Management (BPM) technology. Our Partner Pegasystems is the industry leader in rules-driven, flexible business process management (BPM) software to large organizations. **Experience demonstrates that these applications deliver a significant ROI providing flexibility and agility to respond to the changing business needs of State and Fiscal Agents.** Team CSC will integrate the full capabilities of the Pegasystems technology into the new Replacement MMIS seeking to automate expensive manual process workflows. With this technology, Team CSC delivers the power of the BPM technology coupled with the capabilities of the new Replacement MMIS business services to enable improved and more effective operations for our internal staff, and those external clients accessing the system through the Web portal. An example of the power of this technology would be the utilization of Web-based entry of a prior authorization request by a provider that creates a BPM work object with the Replacement MMIS. That work object is then routed to the appropriate work queues, where **policy business rules can be used to automate decision-making** via the rules

Pages D.1.1-6 through D.1.1-7 contains confidential information.

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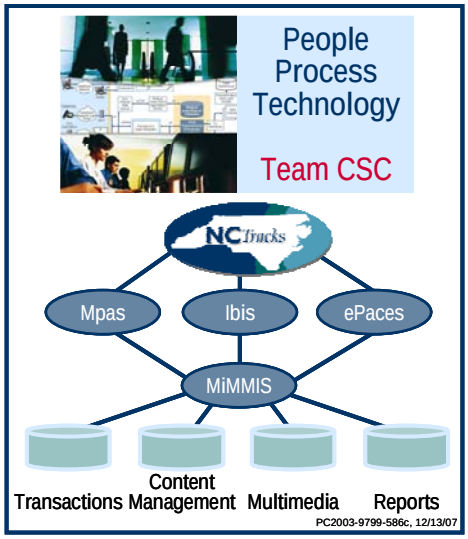
D.1.2 OVERVIEW OF SYSTEM SOLUTION AND SOLUTION FOR DDI

The Team CSC multi-payer Replacement MMIS will provide the State with a forward looking Solution enabling the State to manage its people, processes, and technology to generate an impressive ROI. The Team CSC DDI Solution provides the State a low risk, staged delivery of components enabling the State to evaluate progress and conduct interim testing that will lead to successful final User Acceptance Testing, start of FA Operations and CMS Certification.

The Replacement MMIS adapts the highly successful New York eMedNY system and DDI solution that enabled CMS to certify the MMIS within the CMS guidelines and timeframes.



Although every state is different, this baseline serves as a proven architectural starting point supported by a high volume, high performance infrastructure that can be easily scaled up should NC capacity demands increase above planned levels, and scaled out to cost-effectively accept new DHHS multi-payer or related missions.

The Replacement MMIS Solution. For North Carolina, Team CSC has carefully reviewed the State's Statement of Objectives in designing a forward-looking solution that best meets the State's short and long term goals. **Exhibit D.1.2-1** shows the Replacement System solution.

Our service oriented solution delivers the capability inherent in the baseline system and adds innovative components that support streamlining administration and improving the management of NC DHHS programs.

By developing a services oriented solution, we are providing added capability to automate business processes and improve operations for all stakeholders. The core Recipient, Provider, and Claims business services are operationally improved by workflow management and business rules. The **NC***Tracks* portal presents a personalized user interface in support of NC DHHS stakeholder needs to help each of them be more productive, while enabling us to reduce system TCO. **(SOO 10.9-10)**

(10.9-10)

Our Replacement MMIS extends the baseline system with a highly configurable table-driven multi-payer capability. Our solution will support DMA, DMH, DPH, and ORHCC payers with their multiple benefit plans. Additional fiscally responsible payers can be added without programmatic intervention by adding new benefit plan tables, coverage rules, and entries in pricing methodology tables, while the high performance characteristics of the baseline will ensure that the additional processing overhead can be easily supported. **(SOO 10.1-2, SOO 10.2-1, SOO 10.3.1-2, SOO 10.7-1)**

(10.1-2, 10.2-1, 10.3.1-2, 10.7-1)

Pages D.1.2-2 through D.1.2-10 contain confidential information.

Pages D.1.3-1 through D.1.3-19 contain confidential information.

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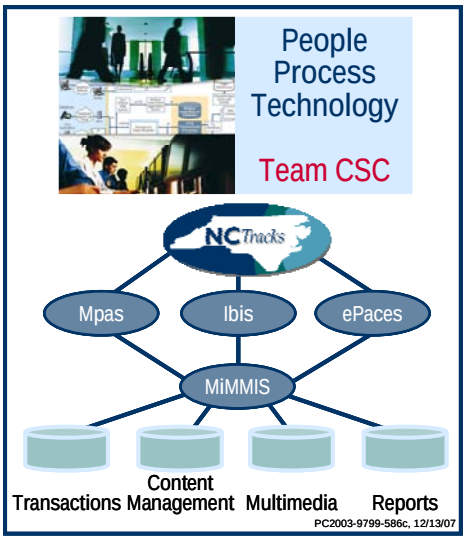
D.1.4.1 General System Requirements and Related General Operational Requirements

Our layered, service-oriented architecture (SOA) exceeds the General System and Operational Requirements, is aligned with the Statewide Technical Architecture (STA) and Medicaid Information Technology Architecture (MITA) — and provides a strong focus on improved citizen services through more flexible information technology.

The requirements requested under General System Requirements are for services and processes that are common to the majority of business areas required for the Replacement MMIS. The purpose of this section is to address each requirement once and eliminate the need for redundant explanations within each of the business areas. Team CSC will deliver a Replacement MMIS that exceeds the State's General Systems Requirements with a layered architecture that promotes reliability and adaptability and with a clear focus on business outcomes. Functionality is fully integrated and enhanced through the use of Commercial Off-the-Shelf (COTS) products and open standards.



Services Capability in a Layered Architecture

- The Replacement MMIS offers a set of common services that have been organized into layers
- These layered services allow the Replacement MMIS to evolve seamlessly over time
- These services provide unified access to the underlying business services and data
- The business services include traditional MMIS functions such as Provider, Recipient, and Claims from an enterprise perspective
- Added new capabilities that support improved productivity and empowering the State and Fiscal Agent to better manage their programs
- The Replacement MMIS fully integrates Workflow, Business Rules, and Document Management, accessed through customized Web Portals
- Added services that support collaboration and enterprise integration with other DHHS applications

DHHS will find that our solution supports an enterprise view of multi-payer, is aligned with the Statewide Technical Architecture (STA), provides a foundation for meeting other Health Care Reform challenges including the Medicaid IT Architecture (MITA) service-oriented capability, and implements the National Provider Identifier (NPI) initiative. **Exhibit D.1.4.1-1** summarizes the major features and benefits to HC DHHS of our proposed solution.

Pages D.1.4.1-2 through D.1.4.1-47 contain confidential information.

Page D.1.4.2-1 contains confidential information.

In the following sections, we describe Recipient Subsystem functionality in terms of:

- Recipient Subsystem Overview
- Online Inquiry and Search Capabilities
- General Database Design
- Recipient Database Maintenance
- DPH and ORHCC Program Updates
- Processing Medicare Part A/B Enrollment and Buy-in Updates
- Recipient Cost Sharing and Premium Processing
- Processing Medicare Modernization Act (MMA) Files
- Certificate of Creditable Coverage
- Letter and Report generation
- Interfaces
- Security and controls

D.1.4.2.1 Recipient Subsystem Overview

The Recipient Subsystem enables system-wide processing of Medicaid and other entitlement program workload by providing integrated access to accurate, consistent, and timely recipient information. The Replacement MMIS will provide the ability to effectively manage recipient information across multiple DMA, DMH, DPH, and ORHCC programs to support assignment of the correct financially responsible payer, multiple benefit plans, and specific pricing methodologies for each service billed on a recipient's claim. Both recipients and providers may enroll in multiple
(40.1.1.3) programs/plans. **(40.1.1.3)** The subsystem is fully integrated with all other components of the Replacement MMIS and is available to stakeholders and users through **NC***Tracks*. **Exhibit D.1.4.2.1-1** shows the operating environment and
(10.3.1-2) stakeholder, external systems, and other subsystems interaction. **(SOO 10.3.1-2)**

Pages D.1.4.2-3 through D.1.4.2-7 contain confidential information.

administered by DHHS. Team CSC will work with the State to implement a real-time interaction between the Recipient Subsystem and the CNDS to prevent potential duplicate recipient IDs and ensure compliance with DHHS' enterprise-wide policy on unique recipient IDs. We will also apply the CNDS governance rules for assigning recipient IDs, linking the IDs to the financial enrollment application, and implement priority rules for demographic data updates for recipients enrolled in multiple lines of business and benefit plans. **Additionally, to ensure data integrity, the Replacement MMIS Recipient Subsystem will track each request-response interaction with CNDS to perform daily reconciliations of all records received from CNDS and accounting for all successful and unsuccessful updates.** The manual processes supporting this function are addressed in Proposal Section D.2.1.3.7, Client Services. (**40.2.1.15, 40.2.1.83, 40.2.1.93, Comment CSC715)**

(40.2.1.15, 40.2.1.83, 40.2.1.93)

The Recipient Subsystem uses a system of unique internal IDs to perform the actual access to the Recipient database and maintains a cross-reference table to relate the internal IDs with the external IDs assigned by the state entities enrollment applications and the CNDS-assigned IDs. Each time an external ID is presented to the system for accessing recipient data, the Recipient Subsystem will use the cross-reference table to retrieve the internal ID for actual access to the database. The Replacement MMIS will retain the CNDS ID and store it on Claims History for reporting of recipient information required by MAR and other Federal agencies. This approach provides a unified access to all current and historical information, such as claims data, TPL, buy in, prior approvals, service limits and consents, related to a single recipient who may hold several IDs assigned by separate agencies. **(40.2.1.9, 40.2.1.20 – 40.2.1.22, Comment CSC301)**

(40.2.1.9, 40.2.1.20 – 22)

The cross-reference table plays a vital role in preventing duplicate IDs. When the Recipient Subsystem receives a recipient update transaction from Area Programs/Local Managing Entities (APs/LMEs), DPH, EIS, or ORHCC, it will use the recipient ID from the update transaction to query CNDS for the CNDS ID associated with the ID used in the query. If CNDS could not find a matching ID in its database, it will create a new CNDS ID to return to the Recipient Subsystem; otherwise, it will return an existing CNDS ID. The CNDS ID from CNDS is then checked for existence in the Recipient Subsystem's cross-reference table. If the returned CNDS ID does not exist in the cross-reference table, the Recipient Subsystem will generate a new internal ID and set up the associations among the new ID, CNDS ID, and the external ID in the cross-reference table. To support administrative oversight, a daily reconciliation process will be executed to account for, and verify that all records and segments received through the CNDS interface are processed or are listed on error reports. Additionally, the system can generate an on-demand report of CNDS cross-reference ID updates within and across lines of business. Team CSC realizes that in some cases the CNDS matching criteria may not determine a match on recipient ID when there is indeed a match. For these cases, the Replacement MMIS allows for the entry of online cross reference updates to the CNDS. (**40.2.1.23**, **40.2.1.25)**

(40.2.1.23, 40.2.1.25)

Prior to the operational startup of the Replacement MMIS, Team CSC will work with the State to convert and load both current and historical recipient data from Division

of Information Resource Management (DIRM) or Information Technology Solution (ITS) into the Replacement MMIS solution. In normal operations, a record deletion is not performed physically; instead a "void" indicator field is set to represent a "logical" deletion. This approach allows the recipient information to be kept online until they are moved offline through a periodic archive operation. Team CSC acknowledges the State's recipient data retention requirement and will provide for five years of historical recipient information online and five years near-line including changes to name, DOB, SSN, and recipient address. (**40.2.1.12, 40.2.1.19, 40.2.1.38**)

(40.2.1.12, 40.2.1.19, 40.2.1.38)

The recipient database is always available to the Replacement MMIS subsystems that need to access recipient data in the course of their processing. For example, the recipient's transfer-of-asset data is readily available to the Claims Subsystem. Any update made to the recipient database is also immediately available. For example, deductible information in an update transaction will be added to the Patient Liability table in the Recipient database and becomes immediately available to the Claims Subsystem. (**40.2.1.27, 40.2.1.64**)

(40.2.1.27, 40.2.1.64)

D.1.4.2.4 Recipient Database Maintenance

The Recipient database will be maintained by the following sources of recipient update information:

- Data feeds from the DIRM consisting of update transactions from the following systems: Eligibility Information System (EIS), North Carolina Health Choice for Children (NCHC), and Medicare enrollment updates, including Buy-in responses, originating from the Center of Medicaid Services (CMS) and the Social Security Administration (SSA) offices
- Real-time updates from the APs/LMEs, DPH and the Migrant Program in ORHCC
- Real-time adjustment transactions from authorized State users through online maintenance pages
- Merge notification from the State's Common Name Database System
- Other State authorized users. (**40.2.1.28**)

(40.2.1.28)

The EIS, maintained by DIRM, is the official source of recipient eligibility and demographic information for Medicare, Medicaid, and related waiver programs. Team CSC will provide online eligibility updates and establish batch-data exchange services with EIS to receive and process the daily and monthly EIS updates. The Recipient Subsystem will process the daily EIS transfer differently from the monthly transfer.

The daily EIS data, containing new or updated recipient information, will be subjected to rigorous validation, including State-specified edit criteria, to protect the integrity of the recipient information. Each EIS record is validated against the Recipient database to determine an appropriate data maintenance action such as the creation of a new recipient record, creation of a new eligibility segment, or the application of changes to existing recipient data elements. In the case where the update transaction has overlapping eligibility spans, the existing recipient eligibility record will be modified to reflect the combined eligibility span. The monthly EIS data will initiate a full file reload that will be used to replace only EIS-originated data in

the Recipient database. The full eligibility reload can be requested monthly, or on an ad-hoc basis, by the State. (**40.2.1.30**)

(40.2.1.30)

Several controls are implemented to ensure that updates to the Recipient database are complete, accurate, and consistent with originating sources. A daily batch total reconciliation is used to ensure that all daily EIS records have been completely received and processed. Additionally, a monthly reconciliation process compares the EIS-supplied recipient data with the Recipient database information to detect potential discrepancies between them. The reconciliation process will report on discrepancies such as: "Recipients on EIS but not on Recipient Subsystem," "Recipients on the Recipient Subsystem but not on EIS," or "Recipients are on both EIS and Recipient Subsystem, but with discrepancies." Reports are generated to indicate successfully-updated transactions, update transactions that failed edit validations, transactions that updated with soft edits, and those that failed or were suspended for online review and resolution (e.g., hard edits). **(40.2.1.7, 40.2.1.16**)

(40.2.1.7, 40.2.1.16)

Recipient eligibility for the State's Mental Health program is determined and maintained by AP/LME updates and will be transmitted to the Recipient Subsystem via the HIPAA 834 transaction. The Recipient Subsystem will validate the incoming transaction before applying changes to the Recipient database. In particular, before creating a new recipient record, the Recipient subsystem will query the CNDS system to determine whether the recipient ID submitted by the AP/LME already exists in the CNDS database. If so, CNDS will return a CNDS ID that will be used to query the cross-reference table within the Recipient database to determine whether the recipient is already registered with DMA, ORHCC, DPH or another AP/LME. If the recipient is already registered, the query will return an existing ID that will be cross-linked with the submitted ID and saved in the cross-reference table. Controls similar to those established for the EIS updates will be implemented to reconcile the 834 transaction counts accumulated by the Electronic Data Interchange (EDI) translator with the updates to DMH recipient data. (**40.2.1.6, 40.2.1.17**)

(40.2.1.6, 40.2.1.17)

Team CSC recognizes the need for State administrators to maintain recipient-related data elements that are not updated via the normal means and will provide an online facility for updating all recipient-related data including the ability to set specific overrides to the timely billing edit for claims processing. This online facility will also allow State users to add, update, and inquire into Medicare data for DMA, DMH, ORHCC, and DPH recipients. **To preserve data integrity, any direct online recipient data maintenance will be subjected to the same level of edits implemented in the batch update programs to ensure complete, accurate and consistent data values. We will work with the State to develop the Web pages for performing online updates to all recipient-related data elements as required by the RFP.** (**40.2.1.26, 40.2.1.49**)

(40.2.1.26, 40.2.1.49)

When a recipient update is being processed, the input transaction may carry indications that other associated activities must be performed. Based on these indications, the system will create request records that will be examined by other processes to complete the desired actions. The following potential request actions may be required in conjunction with a recipient update event:

- Each recipient update transaction that contains a managed care span with a begin date less than the current date will trigger the creation of a retroactive HMO enrollment to be processed by the Managed Care Subsystem.
- Each Medicare enrollment update transaction that contains a Medicare eligibility span begin date less than the current date will trigger the creation of a retroactive TPL adjustment request to be processed by the TPL Subsystem.
- Each recipient update transaction that contains a new Medicaid eligibility begin date less than the current date will trigger the creation of a retroactive claims adjustment request to be processed by the Claims Subsystem with a potential payment to a new health benefit program.
- Each recipient update transaction involving a new recipient under age 21 will trigger the creation of a Health Check request to be processed by the Health Check subsystem. (**40.2.1.41 – 40.2.1.42**)

(40.2.1.41 – 40.2.1.42)

During DDI, Team CSC will work with the State to determine the detailed parameters for generating notifications to specific business areas when a recipient is retroactively enrolled/disenrolled into/from a benefit plan. The workflow solution will generate the notifications and contain the detailed business rules to be followed in each business area. The Baseline System's existing Mass Adjustment process will be used to automatically re-adjudicate claims that meet the selection criteria defined by the State during DDI. (**40.2.1.40)**

(40.2.1.40)

The Recipient Subsystem has a detective measure to identify potential duplicate recipient records for corrective actions. Each week, a special process is executed to identify recipients that may potentially have multiple recipient IDs. A predetermined set of matching criteria is used to identify suspected duplicates and the identified suspects are saved to a Suspected Multiple IDs table and reports are produced for review. Case workers will have to review demographic, eligibility, TPL, and other data in order to determine if recipients have duplicate records. (**40.2.1.8**)

(40.2.1.8)

Mass Adjustments Processing for Recipient Updates

The Replacement MMIS allows users to view the impact of mass adjustments before the adjustment actually occurs.

The Recipient Subsystem provides an online link process to correct a situation where different recipient IDs are assigned to one person. For DMA, a link process involving a recipient must obtain prior approval from the EIS and CNDS systems. If the link request is approved, both EIS and CNDS will complete a merge of their database records and CNDS will send the approval notification back to the Recipient Subsystem. At this point, the Recipient Subsystem will update its own cross-references to synchronize the multiple recipient IDs to the internal system IDs of the target recipients, combine the prior approval, TPL, Buy-in, Enrollment Database (EDB), and service limit information of the multiple recipient records into that of the target recipient, and then delete the data belonging to the source recipient. Finally, a mass adjustment of claims that belonged to the source recipient is performed for the purpose of changing the internal system ID within the claim records from the source ID to the target ID. A similar process is conducted for merging DMH, DPH, or ORHCC recipients, except that the EIS is not

(40.1.1.26, 40.2.1.24)

involved in this case. A similar capability also exists for merged provider IDs (refer to Proposal Section D.1.4.5). (**40.1.1.26, 40.2.1.24**)

The Recipient Subsystem may also receive a merge notification from CNDS for recipients not enrolled with DMA, DMH, ORHCC or DPH. If the source and target IDs conveyed in the notification exist in the Recipient database, then a merge process will be conducted. If only one of the IDs exists in the Recipient database, no merge process will be undertaken; instead, the IDs will be set up in the cross-reference table.

A manual reversal is required to "delink" an erroneous merge or link operation. The corrective action will require a determination of the source and target IDs that are recorded in the merge process to a new recipient ID and recipient record for the source ID, reestablishment of demographic, eligibility data, TPL, buy in data, prior approvals, service limits, consents, and other data identified by the State and a mass adjustment to re-associate the claims which still have the old 'source' ID with the newly-established ID. (**40.2.1.10**)

(40.2.1.10)

D.1.4.2.5 DPH and ORHCC Program Updates

Team CSC acknowledges the State's requirement for a new Web-based enrollment component for DPH. We will work with the State to develop a Web-based application for recipients to obtain the application forms and design and implement the software and rules-based workflow elements to process both paper and electronic applications.

The potential recipient or eligibility specialist will access the Replacement MMIS Web Portal which will provide Web pages to assist in retrieving enrollment forms, instructions, and guidelines. The Web page that displays the application form can be downloaded for paper submission, or completed and submitted online. This Web page will also include an option for the potential recipient to attach and send soft copies of supporting documents. The potential recipient is also allowed to submit paper application including hard-copies of any necessary supporting documents. Paper applications and supporting documents (whether received simultaneously or at different times) are scanned by Fiscal Agent staff, stored in the Replacement MMIS central document repository and made available for online reviews. On receipt, both electronic and paper application data will be captured and stored in an Application file for downstream processing. The Application file allows abandoned or incomplete application data to be stored indefinitely. (**40.2.1.88 – 40.2.1.92, 40.2.1.106, 40.2.1.107, Comment CSC24**)

(40.2.1.88 – 40.2.1.92, 40.2.1.106, 40.2.1.107)

The following data elements are captured from the application submission:

- Multiple addresses for one recipient (including correspondence mailing, pharmacy mailing, residence, and alternate addresses); maintenance of address history
- Name, mailing address, and agency of the application interviewer
- Name, mailing address, and relationship of an individual other than the applicant/recipient to receive copies of notices and letters, if requested
- Time stamps at point of receiving an application and/or supporting documents.

Team CSC will work with the State to further define the specific application data requirements including the capability for producing reports on demand, based on

(40.2.1.100 – 102, 40.2.1.104, 40.2.1.110)

parameters for date-span and applicant/recipient characteristics. (**40.2.1.100 – 40.2.1.102, 40.2.1.104, 40.2.1.110**)

The receipt of a Web-based application will trigger a rules-based workflow process to orchestrate the chain of application evaluation and disposition activities. The workflow process will also be initiated by Fiscal Agent staff for paper applications. The application data is placed in a work queue for review, modification, and approval. The workflow process will support routing of work elements along a chain of process activities and provide notifications to designated staff of the progress of an application under review. The system will produce a weekly aging report that lists work queue status to assist administrative oversight over work progress status. (**40.2.1.95, 40.2.1.111, Comment CSC24**)

(40.2.1.95, 40.2.1.111)

Online pages will be provided to support administrative tasks involved in the review and final disposition of an application:

- Online pages are provided for changing data elements such as the income and deduction amounts, application status, completion status and reason codes, and comments for rejection or modifications made.
- Online pages will also allow State administrators to set the application status to indicate that an application is denied or complete and ready for disposition. This setting will trigger the system to generate letters/notices of approvals or denials.
- The system will calculate the potential recipient's income and compare it to program thresholds to determine financial eligibility.

CSC – Committed to Service

I have been working for FINEX Management Services, Inc. for 12 years and in that time I have worked through many insurance and administrative issues that challenge those in today's healthcare climate. Very rarely do I come across someone at an insurance company or third party payer that goes above and beyond the call of duty. Last week I called in a panic because one of my clients failed to take care of an administrative task that would lead to a major cash flow upset. [eMedNY staff] offered a solution so there wasn't any cash flow upset and called me back several times to assist me in getting the issue resolved.

– FINEX Vice President

- Online inquiry and search functions are provided for retrieving application records using various search criteria such as: application/case number, applicant name (partial or complete), applicant name phonetic (partial or complete), CNDS ID, SSN, and DOB. (**40.2.1.94, 40.2.1.96 – 98, 40.2.1.103, 40.2.1.105**)

(40.2.1.94, 40.2.1.96 – 98, 40.2.1.103, 40.2.1.105)

Once the workflow is completed and an application is set to 'complete' status, the system will create a transaction from the application data to update the Recipient database. The update process will involve collaboration with the CNDS to retrieve a CNDS ID for each new recipient in accordance with CNDS Governance Rules. Once the update to the Recipient database is completed, the new recipient's demographics, eligibility entitlements, and lock-in/lock-out information are available to the Claims Subsystem for use by the claims adjudication process. **Based on the State's direction, workflow processes and business rules can be created to streamline or automate aspects of the recipient enrollment process. (40.2.1.99)**

(40.2.1.99)

The system will produce identification cards for approved recipients which identify the recipient name and recipient's identification number, but do not contain any

eligibility information. State administrators will be provided with an online page to request an identification card for a recipient and will be able to print these cards locally. (**40.2.1.39, 40.2.1.112**)

(40.2.1.39, 40.2.1.112)

Team CSC acknowledges the State requires a capability for confidential enrollment with separate tracking needs and will work with the State to define and implement the exact requirements. We will also work with the State to define all necessary data elements to meet the reporting requirements specified in the RFP**. (40.2.1.122)**

(40.2.1.122)

For all recipients enrolled with DMH, DMA, DPH, ORHCC, Team CSC will leverage the Baseline System's Scope of Benefit Plan construct to manage the recipient benefits package, including the lock-in/lock-out features. Our Baseline System provides online pages for inquiring about and updating recipient lock-in to specific pharmacy, primary care provider, or prescriber. The system will allow for multiple active lock-in segments of any type to be assigned to a recipient concurrently. The database design allows for an unlimited number of lock-in segments to be assigned to each recipient. Each lock-in segment will have associated begin and end dates to indicate the period of constraint and a code to indicate the reason for applying the lock-in. Team CSC will further enhance the Baseline System Scope of Benefit functionality to support the lock-out feature. (**40.2.1.113 – 40.2.1.119**)

(40.2.1.113 – 40.2.1.119)

Online pages within the Replacement MMIS will also be provided to associate an individual recipient 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. **(40.2.1.123**)

(40.2.1.123)

D.1.4.2.6 Processing Medicare Part A/B Enrollment and Buy-in Updates

Team CSC understands that Medicare eligibility and enrollment information is critical for maximizing Medicare revenue to reduce the State's funding of benefit programs. This goal is supported by ensuring timely and accurate updates of Medicare eligibility and enrollment information coming through the DIRM interfaces from CMS and SSA.

Team CSC will establish batch-data exchange services with DIRM to accept and process EDB and Bendex update transactions for maintaining the Recipient database. These updates will be validated and reformatted for updating the recipient's Medicare Enrollment database tables. The updated Medicare enrollment information is immediately available to the Claims Subsystem process for determining Medicare and Medicaid entitlements during the adjudication process. (**40.2.1.11, 40.2.1.47 – 48**)

(40.2.1.11, 40.2.1.47 – 48)

The Recipient Subsystem includes a Buy-in process that transmits Buy-in request to CMS via the DIRM interface in accordance with CMS Redesign practices. A Buy-in Extraction process examines the Recipient database to identify and create a Medicare Part A and Part B Buy-in enrollment request file containing the requests to begin, change, or stop Buy-in benefits based on changes in recipient eligibility status due to income disqualification, end-dated eligibility period, or death of recipient. This

extraction process also produces a Buy-in activity report for DHHS and Team CSC staff to review and make the appropriate modifications.

The Recipient Subsystem also provides online pages for approved users to review or adjust Buy-in activities and create additional Buy-in requests. The online page will include the ability to display the full Buy-in history to support investigative work. On or before the 25th of each month, the final Buy-in cycle is initiated to generate the final Buy-in enrollment request file to be sent to CMS via the DIRM interface. At the same time, the system will create an electronic version of the final cycle reports that can be printed and delivered to DHHS within two days from the completion of the final cycle. Once the monthly Buy-in cycle is completed, the system will also generate the financial transactions for the Buy-in premium payments. State staff will be able to perform an online review or make adjustments to the financial transactions before the Claims Subsystem processes these transactions to effect payment. (**40.2.1.34 – 35, 40.2.1.43 – 46)**

(40.2.1.34 – 35, 40.2.1.43 – 46)

The Recipient Subsystem will receive and process the weekly and monthly response file from CMS coming through the DIRM interface and in accordance with CMS Redesign practices. The weekly response file contains acceptances, rejections, corrections, and interim responses. The monthly response file will contain additional Medicare Part A and Part B premium billings that have to be paid to CMS. Both types of files are edited for data validity and matched against the Recipient database prior to updating the recipient's Medicare Buy-in status. The validation will place special attention to the accuracy of any converted Railroad Retirement numbers. Each update process will generate control reports in accordance with the CMS Redesign practices, to indicate the total input transactions, successfully processed transactions, and failed transactions. The update process will also post the successful transactions to the Premium Billing table and the failed transactions to the Buy-in Reconciliation table for downstream processing. The Buy-in statuses recorded in the recipient enrollment table are immediately accessible to the Claims Subsystem for identifying Medicare and Medicaid HMO entitlements during the adjudication process. **(40.2.1.31, 40.2.1.33, 40.2.1.36, 40.2.1.37)**

(40.2.1.31, 40.2.1.33, 40.2.1.36, 40.2.1.37)

The monthly CMS response file, containing the Part A/B billings, will be used to generate warrant calculations. The Recipient Subsystem will produce four sets of warrant calculation files, in the CMS Redesign format, as follows:

- Part A and Part B warrant calculation files, each containing the current month premium information and county and program information
- Part A and Part B "previously unknown" warrant calculation files containing the previous month's premium information that could not be identified by county in the month processed.

These four files will be output to magnetic tapes to be sent to CMS via DIRM. **(40.2.1.32)**

(40.2.1.32)

The Recipient Subsystem provides online inquiry and maintenance pages for users to access, inquire, and update information related to Medicare, Buy-in, and HIC Number. **Exhibit D.1.4.2.6-1** shows the Medicare Part A/B Buy-in page. (**40.2.1.81**)

(40.2.1.81)

Pages D.1.4.2-16 through D.1.4.2-17 contain confidential information.

D.1.4.2.8 Processing Medicare Modernization Act (MMA) Files

The Recipient Subsystem will create a monthly Medicare Part D Enrollment file to be transmitted to CMS via the DIRM interface. This enrollment file will be created in a CMS-specified format to contain the recipient information extracted from the Recipient database in accordance with State-specified selection criteria for MMA. The enrollment file will also contain the required data for computing enrollees for the phased-down State contribution payment and include records of recipients eligible for Medicare Part D low income subsidy benefit. This process will also generate a report detailing the records transmitted to CMS. (**40.2.1.69 – 40.2.1.72, 40.2.1.74, Comment CSC12**)

(40.2.1.69 – 72, 40.2.1.74)

The Recipient Subsystem will also accept and process the CMS Medicare Enrollment Response file transmitted through a DIRM interface. The incoming transactions will be validated and matched against the Recipient database before updating the enrollment information. The update process will also generate a report of the failed transactions due to errors or non-matching recipient IDs. The Medicare Part D statuses recorded in the recipient enrollment table are immediately accessible to the Claims Subsystem for identifying Part D entitlements during the adjudication process.

Both successful and failed response transactions are stored for online administrative review and reconciliation. Authorized users can view summaries of successful and failed transactions and drill down to a specific MMA record of interest. The users will also be able to view the active Medicare Part A, Medicare Part B, and HIC coverage spans displayed in the Medicare Spans Section. **(40.2.1.73, 40.2.1.75 – 78)**

(40.2.1.73, 40.2.1.75 – 78)

D.1.4.2.9 Certificate of Creditable Coverage

The Recipient Subsystem includes a process to select recipients for Certificate of Creditable Coverage (COCC) report generation. The selection is based on recipients who were covered by certain specific Medicaid benefit plans for 18 months or more, but were recently terminated or deleted from these coverages. The selected records are then processed to produce the COCC at the team CSC mailroom. In addition, users are given online facilities to request a COCC to be printed for a recipient for a specific period. To support administrative oversight, the Recipient Subsystem will track the generation of COCC reports and, together with input from the mail room operations, can generate a monthly summary performance report showing the total COCCs mailed, total COCCs mailed within five days of the date of termination or request, and total COCCs mailed outside the five-day criterion. (**40.2.1.60 – 40.2.1.63**)

(40.2.1.60 – 63)

D.1.4.2.10 Letter and Report Generation

The Recipient Subsystem will provide for updateable letter templates for correspondence with recipients. These letter templates allow State users to add free-form text specific to a recipient data issue or of particular relevance to a specific recipient. (**40.2.1.14, 40.2.1.86**)

(40.2.1.14, 40.2.1.86)

The Recipient Subsystem will provide for various reports associated with transfer-of-asset activities including:

- Report of recipients with paid claims for targeted services for whom a transfer-of-assets indicator is not on file
- 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. This report will be produced in electronic form for DIRM.
- Report of individuals with a transfer-of-assets sanction
- Report of individuals with a transfer-of-assets sanction for publication for county DSS agencies. This report will be produced in electronic form for DIRM. (**40.2.1.65 – 40.2.1.68**)

(40.2.1.65 – 68)

D.1.4.2.11 Interfaces

Team CSC positions Web Services as a principal mechanism for real-time data-exchange between the Recipient Subsystem and other external systems to support the State's direction for an enterprise-wide recipient functionality. For business requirements and business partners that use other methods of exchanging information, Recipient Subsystem supports secure File Transfer Protocol, HIPAA standard 834 enrollment transactions, file extracts, and physical media as exchange mechanisms.

For the Replacement MMIS solution, Team CSC proposes the following interface implementations:

- Support online access to Medicare coverage data from EIS for Parts A, B, C, and D for Medicaid recipients, store this data in the Replacement MMIS, and make Medicaid/Medicare coverage data from EIS available for claims processing
- Provide an eligibility extract file for State-authorized contractors through File Transfer Protocol (FTP)
- Provide an extract of recipient data to the Client Services Data Warehouse (CSDW) using FTP
- Provide Web Services or FTP services to allow the Replacement MMIS solution to send, receive, and update Provider data with DHSR for placement of eligible recipients. (**40.2.1.79 - 80, 40.2.1.82, 40.2.1.85, 40.2.1.87, Comment CSC14, SOO 10.3.3-1**)

(40.2.1.79 - 80, 40.2.1.82, 40.2.1.85, 40.2.1.87, 10.3.3-1)

D.1.4.2.12 Security and Controls

Team CSC recognizes the importance of maintaining security and controls over all online updates to the Recipient databases. **Our proposed solution includes a centralized authentication mechanism coupled with role-based access control to ensure that access to Recipient data is granted only to authorized users. Further, our proposed solution makes use of the audit logging facility native to the database to provide a 100 percent complete logging of all updates to the Recipient data, including lock-in/lock-out segments. Any updates effected will be captured in an audit trail containing the before/after images of changed data, the ID of the person making the change, and a time-stamp of the event.** In addition we acknowledge and will implement audit logging for online inquiries on the DPH application or recipient information. The audit logs are kept online and accessible by State-authorized users. (**40.2.1.4, 40.2.1.108 - 109, 40.2.1.120 - 121**)

(40.2.1.1-40.2.1.109, 40.2.1.120-121)

D.1.4.2.13 Conclusion

The proposed Recipient Subsystem builds on the extensive capabilities of the proven eMedNY system, enhancing functionality through the application of Web-based services, automated workflow mechanisms, and user-defined and configurable business rules. Team CSC is committed to working with the State of North Carolina to implement the required interfaces, functionality, and capabilities to administer recipient information across multi-payer programs in an efficient and integrated manner that promotes program success.

Pages D.1.4.3-1 through D.1.4.3-3 contain confidential information.

Tool/Component	Function/Description
eCommerce Subsystem	Processes all incoming inquiries and outgoing responses, determining appropriate format and routing
Recipient Subsystem	Provides recipient eligibility information for response
Provider Subsystem	Maintains information regarding provider eligibility to furnish services
Third Party Liability Tables	Determines primacy of other insurers, including Medicare, for coverage of recipient's services.
Prior Approval Subsystem	Provides approval, referral, and override information
Pervasive COSMOS Translator	Converts incoming and outgoing transactions into appropriate format (i.e., X12, XML, or proprietary).
AVRS	Receive/return eligibility inquiries/responses from providers, recipients, other authorized users
CSC NC Medicaid Web-site	Receive/return eligibility inquiries/responses from providers, recipients, other authorized users

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Exhibit D.1.4.3.1-3. EVS Tools and Components. *The Eligibility Verification process seamlessly integrates with Replacement MMIS components to provide consistent responses through multiple access methods.*

D.1.4.3.2 Sources/Formats of Transactions

Team CSC will provide Eligibility Verification services through the EVS, employing read-only access to information in the Replacement MMIS relational database ensuring data integrity and security. This approach will ensure that EVS always returns the most current system information available. Databases that support EVS include Provider, Recipient, Third-Party Liability, and Prior Approval. These databases provide the information necessary to respond to inquiries, including recipient eligibility, other insurance coverage, Medicare coverage, prior approval, managed care enrollment, and service restrictions. **(SOO 10.12.3-6)**

(10.12.3-6)

Access to EVS will be available through CPU-to-CPU transmissions for switch vendors, magnetic media such as diskettes and tapes, the AVRS, and online, Web-based eligibility pages. **Team CSC will provide EVS Web Services 270/271 specifications for third-party vendors who seek to incorporate eligibility verification functionality into their own software. These specifications are based on work performed for the Primary Care Information Project, a Department of Mental Health and Mental Hygiene initiative to promote the adoption of electronic medical records in primary care practices**. This project, currently in progress with eClinical Works, includes eligibility verification as well as National Council for Prescription Drug Program (NCPDP) (SCRIPT) Meds History and Formulary at the point of care. Team CSC's advanced Web Services communications will accommodate all providers and other authorized users seeking to use the system, within the performance requirements stated in the RFP.

The Replacement MMIS eCommerce subsystem supports HIPAA-compliant ASC X12N 270/271 eligibility inquiry and response transactions. These transactions may be received in batch through direct connections and FTP. Team CSC will make modifications as needed to implement mechanisms necessary for the acceptance of electronic media such as tapes and diskettes. Transactions may also be received online from the Web, through Web Services, or the AVRS and processed in real-time. **(40.3.1.1)**

(40.3.1.1)

Our Baseline System currently supports X12N 270 eligibility verification by parameters that include recipient number and last name. Team CSC will make modifications as needed to implement recipient full name and date-of-birth (DOB), partial name and DOB, and SSN and DOB searching and verification. Necessary changes include:

- Recipient subsystem enhancements to return eligibility data according to search criteria
- User interface modification to accept these parameters on the 270 and return them on the outbound 271 transaction
- EVS enhancements to support additional searching and matching criteria
- HIPAA and eCommerce database modifications to capture inbound request and populate corresponding outbound information. **(40.3.1.2)**

(40.3.1.2)

Web pages will provide convenient access to the eligibility function for authorized users. The Verify Eligibility Page, available from the Recipient subsystem and shown in **Exhibit D.1.4.3.2-1** below, offers Team CSC and authorized State staff a convenient way to access eligibility information. The user enters appropriate Eligibility Criteria, clicks “Verify,” and the system returns appropriate “Day Specific Eligibility” responses.

Pages D.1.4.3-6 through D.1.4.3-7 contain confidential information.

D.1.4.3.4 Audit Trail, Tracking, and Reporting

The proposed Replacement MMIS has extensive audit trail, tracking and reporting capabilities to enable authorized users to monitor system activity, restrict information access, track transactions, and generate a broad array of reports for management needs.

Replacement MMIS Supports Full Audit Trail Functionality
An EVS Transaction Log maintains a record of all EVS inquiries and responses and assigns a unique Audit Number by which to track an individual transaction. The Audit Number will be returned to the provider for reference.

The eCommerce subsystem records all provider, recipient and state-authorized user inbound requests and outbound responses such as inquiries and verification responses made, records of information requesters, information conveyed, and rejected transaction results, as applicable, for audit trail and security purposes. The system will generate a reference number to be used in the identification of each transaction on the log. Our eCommerce application code and associated X12N 271 mapping will be modified to pass the reference number only to providers in response to their DMA/Medicaid eligibility queries. **(40.3.1.5, 40.3.1.7, 40.3.1.8, Comment CSC119)**

The Replacement MMIS eCommerce subsystem currently supports online inquiry to 24 months of all transactions submission summary information and produces a wide variety of reports based on transaction type and other criteria. Team CSC will enhance the existing Replacement MMIS pages to depict transaction statistics by provider and source of inquiry such as the Automated Voice Response (AVR) system, the web, or the EVS. Additionally, we will expand eCommerce application code to manage summary statistical information by provider and source and the eCommerce database will be modified to facilitate storing information by provider and source of inquiry. **(40.3.1.6)**

(40.3.1.5, 40.3.1.6, 40.3.1.7, 40.3.1.8)

D.1.4.3.5 Conclusion

Team CSC offers a demonstrated eligibility verification solution that fully meets the needs of the State of North Carolina. Our knowledge and expertise in implementing and supporting the country's largest eligibility verification system, CWF, and our understanding of the requirements of the North Carolina enterprise goals and requirements will enable us to furnish comprehensive, accurate, reliable, and quick eligibility verification processing to stakeholders.

Pages D.1.4.4-1 through D.1.4.4-2 contain confidential information.

- Web Capability.

Each subsection responds to the associated requirement from RFP Section 40.4.1. Requirements have been grouped by subject matter.

D.1.4.4.1 Automated Voice Response System Overview

The Avaya Voice Portal is a Web Services-based software platform that enables organizations to deliver efficient and satisfying voice self-service applications by combining the power of open standards and IP Telephony. It will connect stakeholders to the Medicaid program and deliver exceptional self-service. It quickly creates voice self-service applications for end users.

Voice Portal is a strong fit for the North Carolina Medicaid enterprise need for IT-managed speech solutions. The Avaya Voice Portal Management System (VPMS) can be loaded on a Media Processing Platform (MPP) server for a reduced hardware footprint. In this configuration, up to 48 ports of self-service applications can be supported on a single server.

The selected hardware/software platform will fulfill the AVRS requirements for the State of North Carolina. **Avaya's Self Service solution will provide North Carolina Medicaid stakeholders with convenient, cost effective, around-the-clock service via telephone/voice or Web. Users can get accurate answers to their requests regardless of time and location.** Team CSC's proposed service:

- Enables seamless customer relationship and experience
- Provides a standardized solution across the organization
- Enables customer segmentation (e.g., providers and recipients)
- Greatly increases first contact resolution rates.

Team CSC will use Accuvoice and ScriptBuilder to enable menu trees and

AVRS/IVR scripting. Multi-language support will be furnished through Accuvoice.

Exhibit D.1.4.4.1-1 illustrates the primary Replacement MMIS interactions.

Page D.1.4.4-4 contains confidential information.

The capabilities of the Replacement MMIS AVRS solution encompass several system components and tools which we reference in the following discussion. **Exhibit D.1.4.4.1-3** lists and briefly describes each element.

Component/Tool	Function/Description
Avaya Voice Portal	AVR/IVR hardware/software platform
Accuvoice, ScriptBuilder	Product for AVR scripting and call flows
eCommerce Subsystem	Processes all incoming inquiries and outgoing responses, determining appropriate format and routing
Client Subsystem	Provides recipient eligibility information for response
Electronic Eligibility Verification System	Enables eligibility checking through the AVRS/IVR service.
Provider Subsystem	Furnishes information regarding provider eligibility to furnish services
Third Party Liability (TPL) Tables	Determines primacy of other insurers, including Medicare for coverage of recipient's services.
Prior Approval Subsystem	Provides approval, referral, and override information
Automated Workflow	Workflow management
CSC North Carolina Medicaid Web-site	Provides Web access to North Carolina Medicaid information for multiple constituencies.

9799-999

Exhibit D.1.4.4.1-3. AVRS Tools and Components. *The suite of Avaya hardware and software components integrates seamlessly with Replacement MMIS systems to deliver robust AVR/IVR functionality.*

Team CSC will furnish access to the AVRS through a single toll-free telephone number that supports providers, recipients, and other stakeholders as specified by the State. We will ensure that the Replacement MMIS AVRS is available 24 hours per day, 7 days per week, 365 days per year, except for agree-upon scheduled downtime. Team CSC will collaborate with the State regarding the need for scheduled downtime for the proposed Replacement MMIS configuration. **(40.4.1.1)**

(40.4.1.1)

Team CSC will work with Avaya to build the necessary AVRS menu trees, call flows, and scripts and modify our eCommerce System code and database to capture pertinent information, including inbound inquiry requests and outbound response information for all transactions.

Team CSC will develop AVRS capability to include two distinct menu trees, one for DHHS providers and another for Medicaid recipients. At the beginning of the call, the caller will be asked to select the provider or recipient option. Cascading options will be developed to support the functions required for provider and recipient calls as specified in the RFP. Team CSC will develop and implement scripts to support these menu trees, modify application code to receive additional types of inquiries and return appropriate responses. **(40.4.1.9)**

(40.4.1.9)

Team CSC will support access via touch-tone telephone and provide the option of interactive voice response recognition using the sophisticated voice recognition/response capabilities of the Avaya hardware/software solution. The eCommerce Subsystem will capture, for audit logging and subsequent reporting, all erroneous transactions where speech recognition was unsuccessful. **(40.4.1.15)** For recipient inquiries, Team CSC and Avaya will create AVRS scripts using ScriptBuilder to speak-back the recipient's full name and spelling, as defined on the Recipient database, and to provide the associated spelling of the full name. **(40.4.1.10)**

(40.4.1.15)

(40.4.1.10)

The Replacement MMIS AVRS session will continuously capture the information furnished during the call, so that it may be transferred to the Call Center if the caller chooses to "branch out" to the Call Center. AVRS session information captured prior to the "branch out" option will be formatted as required for transfer to the Call Center application. Information transfer will occur via transmission of the AVRS session information to the Call Center application
(40.4.1.16) processing queue. **(40.4.1.16)**

The AVRS will provide a menu Help option that will be accessible at any time during the call which will allow the caller a choice of being transferred to the Call Center or being directed to a specific Web site where detailed written instruction are available.
(40.4.1.8) (**40.4.1.8**)

D.1.4.4.2 Eligibility Verification

The Eligibility Verification System (EVS) previously described in Proposal Section D.1.4.3 will be fully integrated with the AVRS capability. The eMedNY AVRS currently supports recipient eligibility verification requests by recipient identification number. Team CSC will enhance current capabilities to enable inquiry by SSN and date of birth, and date of service. AVRS scripts will be configured to accept such requests and the EVS will be modified to support additional matching criteria; these changes are included in modifications described in Proposal Section D.1.4.3.
(40.4.1.3) **(40.4.1.3)**

The Baseline System AVRS, through the EVS, allows eligibility verification across the full recipient database; access currently is not limited only to the previous 365 days. Team CSC will maintain recipient historical eligibility information in accordance with State requirements and allow access to all online recipient eligibility
(40.4.1.4) history. **(40.4.1.4)** The Baseline System fully meets the requirement to limit access to eligibility verification to dates of service not greater than the current date for Medicaid recipients. Eligibility inquiries for dates of service greater than the current
(40.4.1.5) date are not currently supported. **(40.4.1.5)**

Team CSC will modify the existing capability to identify DPH recipients and allow eligibility checking for dates of service not greater than the current date plus 365 days. The system will interrogate the Recipient database to determine whether the recipient is a DPH recipient. The eCommerce Subsystem will be modified to allow an EVS transaction with future dates and the EVS eligibility verification logic will be
(40.4.1.6) enhanced as well. **(40.4.1.6)**

D.1.4.4.3 Reporting, Audit Trail, and Tracking

The proposed Avaya AVRS solution has robust reporting and tracking capabilities. The capabilities of the eCommerce Subsystem complement AVRS functionality and support a combined robust reporting, tracking, and audit trail capability that fully meets the State's requirements in this area.

Both the AVRS and the Web-site will be integrated with the eCommerce Subsystem to record all inbound requests, outbound responses, and caller/inquirer identity information for tracking and reporting purposes, including the specific information conveyed to the caller. The eCommerce

Transaction History and associated Transaction Log database tables are utilized to support the recording of all transactional input and response information. Team CSC will develop the capability to access transaction history and log information online. (40.4.1.2) **(40.4.1.2)**

The proposed system has the capability to generate a significant number of reports that analyze provider and recipient inquiry activity for both the AVRS and the Web-site. The eCommerce pages will display submission summary information by both provider and recipient, including inquiry type and source. Team CSC will enhance these pages and modify eCommerce Subsystem code to summarize and pre-populate the provider and recipient summary statistical information. The eCommerce database will also be expanded to accommodate statistical reporting information. **(40.4.1.13, 40.4.1.34, 40.4.1.37)** (40.4.1.13, 40.4.1.34, 40.4.1.37)

The Avaya AVRS produces a number of system-generated monthly reports, including availability information from daily availability checks. **The system continually monitors availability and performance, collecting information for standard reporting, dashboard access to current performance statistics, and statistical analyses. (40.4.1.7)** (40.4.1.7)

For tracking and audit trail purposes, the Replacement MMIS eCommerce Subsystem assigns a unique Reference Number to all transaction submissions, including AVRS and Web-based submissions. This number will be used for identification, tracking, and reporting. (40.4.1.25) Both Replacement MMIS AVRS scripts and Web pages will be developed with the capability to provide the Reference Number information for DMA/Medicaid eligibility verification queries/response to providers only. Modifications to the eCommerce interface with the AVRS and Web-site will be necessary. **(40.4.1.26, Comment CSC119)** (40.4.1.25) (40.4.1.26)

D.1.4.4.4 Provider Services

Team CSC will develop responsive, complete, and easy-to-use AVRS and Web capabilities to support provider inquiry and processing as specified by the State. **Our proposed solution comprises powerful technologies and easily-configured capabilities to implement the flexibility and power that the State is seeking. Our solution will facilitate provider access and processing, making it easy and convenient for providers to obtain the information and services that they need in order to furnish recipients with optimal health care within the parameters of their program eligibility.** To facilitate provider access to the AVRS, Team CSC will accept the National Provider Identifier (NPI) or the Legacy Provider ID, which will be used by atypical providers. **(40.4.1.11)** (40.4.1.11)

Team CSC will develop new AVRS scripts using ScriptBuilder to accommodate the following types of inquiries:

- Claim status
- Checkwrite
- Drug coverage
- Procedure code pricing
- Modifier verification

- Procedure code and modifier combination
- Procedure code pricing for Medicaid Community Alternatives Program services
- Prior approval for procedure code
- Managed care overrides
- Medicaid dental benefit limitations
- Medicaid refraction and eyeglass benefits
- Medicaid prior approval for durable medical equipment (DME), orthotics, and prosthetics
- Prior Approval Submissions
- Pricing
- Prior Approval for DPH benefits
- Provider Checkwrite
- Recipient eligibility, enrollment, and Medicaid service limits
- Sterilization consent and hysterectomy statement inquiry
- Referrals
- Medicaid Carolina ACCESS Emergency Authorization Overrides.

These scripts will support gathering the information necessary to answer the specific inquiry and formatting request and response transactions that will be forwarded to, and received from the appropriate Replacement MMIS systems. These call flows will support general Replacement MMIS AVRS functionality including voice response, multiple languages, and "branch-out" options. **(40.4.1.22, SOO 10.12.3-8)**

(40.4.1.22, 10.12.3-8)

Team CSC will configure provider scripts to include an option to request printed copies of Remittance Advices (RA). A paper RA request transaction will be generated and passed by eCommerce to the Financial Subsystem's batch queuing request process. Such requests will be filled during a nightly batch process. The AVRS script will access the Provider file to obtain the mailing address which will be confirmed with the provider. **(40.4.1.21)**

(40.4.1.21)

Team CSC will also develop a script that allows the Carolina ACCESS referring provider and the Carolina ACCESS referred-to provider to inquire on the primary care provider referral status. We will enhance the eCommerce Subsystem to format and process a transaction to satisfy these requests. The request will be forwarded to the Referral component of the Prior Approval Subsystem to access the functionality being developed to meet the requirement defined in RFP 40.7.1.53 (refer to Proposal Section D.1.4.7). **(40.4.1.23)**

(40.4.1.23)

In addition to furnishing access for providers to Replacement MMIS program information and processing capabilities, Team CSC will enable AVRS capabilities to provide access to the Division of Health Service Regulation (DHSR) Health Care Personnel Registry (HCPR) and the DHSR Nurse Aide Training and Registry (NATRA) for inquiry on DHSR registry information. Team CSC will develop additional script trees and menu prompts/responses to support usage from provider callers, and non-Medicaid callers such as aides and potential employers. The

eCommerce sub-system will be enhanced to format and submit/receive transactions that interface with the DHSR processing system. Team CSC will work with the State and DHSR to determine the exact inquiries to be supported and the information that will be available via the AVRS to the various types of callers. **(40.4.1.14)**

(40.4.1.14)

Prior Approval. An area that is of special importance to providers and their ability to deliver appropriate health care to recipients is Prior Approval. **Team CSC will develop the scripts and transactions that accept and respond to provider-based Prior Approval requests via the AVRS in real-time.** These scripts will support the general capabilities of Replacement MMIS AVRS scripts with respect to speech recognition, multiple languages, and "branch-out" options. Prior Approval transactions submitted through the AVRS will be subject to the same eligibility and data validation edits as requests submitted via other channels. If the Prior Approval is automatically approved, the AVRS will return the Prior Approval Number to the caller. If the request is automatically denied, the provider will be informed of the denial and reason. If the transaction contains edit errors, the provider will be so notified and given the opportunity to correct the erroneous information via the AVRS. If the request requires submission of additional documentation for adjudication, the AVRS will so inform the provider. The AVRS will furnish a reference number to place on the documentation when sent in order to identify and link it to the "suspended" Prior Approval request in the Replacement MMIS. **(40.4.1.19)**

(40.4.1.19)

Team CSC will modify the Prior Approval and eCommerce Systems to enable fax verification (and/or e-mail verification, if no public health information is included) of entry, approval, or denial of a prior approval request. Using Accuvoice, Team CSC will include an option on the Prior Approval request script to indicate the caller's preference for fax or email and obtain the required fax number or email address. This information will be transferred to eCommerce as part of the PA request transaction input information. The automated workflow solution will enable seamless processing of fax and mail response requests by operating appropriate work queues, processed according to specific business rules. When fax or email is indicated, eCommerce will route the fax/email response information to the appropriate output distribution work queue where the response will be accessed in first-in/first-out (FIFO) order, formatted, and returned via the requested medium to the originator. **(40.4.1.20**)

(40.4.1.20)

Team CSC will work closely with the State and representatives from the provider community to implement best practices in the AVRS provider capability and develop the most convenient, responsive, and appropriate scripts and processes for AVRS-based provider business functions.

D.1.4.4.5 Recipient Services

Team CSC recognizes the special challenges that must be met in order to deliver a responsive, easy-to-use, and flexible AVRS capability for the recipient community. To make the AVRS experience rewarding and convenient, rather than confusing and frustrating, for the recipient population, options, menus, call flows, scripts, and responses must be easy to use and understand, flow logically, and support helping the caller at each interaction point. In addition to applying the capabilities of the Avaya solution in the most efficient manner to meet the requirements, Team CSC will take

extra care to ensure that we incorporate best practices and develop the optimal AVRS configuration for North Carolina Providers and recipients. We will employ various approaches to test our solution, including application of Avaya experience, lessons learned, and best practices, and pre-implementation testing by focus groups, recipient advocacy groups, and other resources identified by the State or stakeholders. Our goal is to build a recipient AVRS capability that can serve as the model for this service throughout the national Medicaid community.

Team CSC will develop new AVRS scripts using ScriptBuilder to accommodate the following types of Medicaid Provider and recipient inquiries:

- Medicaid eligibility
- Managed care enrollment information, including the primary care provider name, address, and daytime and after-hours phone numbers
- Third party liability
- Medicare coverage
- Well-child checkup dates
- Hospice eligibility.

These scripts will support gathering the information necessary to answer the specific inquiry and formatting request and response transactions that will be forwarded to, and received from the appropriate Replacement MMIS systems (e.g., EVS, Managed Care, Third Party Liability, or Health Check). These call flows will support general Replacement MMIS AVRS functionality including voice response, multiple languages, and "branch-out" options. **(40.4.1.24, SOO 10.12.3-7)**

(40.4.1.24, 10.12.3-7)

Team CSC will develop AVRS scripts using the same approach as for provider inquiries, to create the required call flows and information. **The AVRS user verification process will determine the recipient's identity based on Medicaid Number, date-of-birth, and Social Security Number (SSN). We will collaborate with the State to determine whether some or all of these parameters will be required for access.** We will expand the capabilities of the eCommerce Subsystem to handle recipient-based inquiries and to route these to the appropriate subsystem. The EVS will require modification to furnish information to satisfy AVRS requests from recipients. **(40.4.1.12)**

(40.4.1.12)

Team CSC recognizes the ethnic diversity of the North Carolina recipient base and the need to support the language needs of individuals so that they may understand their benefits and how to access care. We will enable AVRS functionality to include multi-lingual options. Team CSC will collaborate with the Sate to determine the languages to be supported. For these approved languages, AVRS prompts, responses, speech recognition, and speak-back and spelling functionality will be included. Multi-lingual speech recognition, speak-back and associated spelling functionality will be provided by the AVRS directly. For unique character set support, eCommerce will invoke a translation process to facilitate conversion from English to the target language, as required. **(40.4.1.17)**

(40.4.1.17)

The AVRS will also provide "branch-out" capabilities to enable recipient callers to transfer to the Call Center to access additional translator services which are available from Team CSC support staff. Refer to Proposal Section D.2.1.3.2, Call Center/AVRS. Team CSC will work with DHHS to define a default period of time by which a caller will be automatically transferred to the Call Center for additional translation services if a response to a given prompt has not been made. **(40.4.1.18)**

(40.4.1.18)

Team CSC will continually monitor our AVRS services to recipients, solicit input, and seek ways in which we can proactively expand, enhance, or improve our delivery of services and information.

D.1.4.4.6 Web Capability

Team CSC will develop Web-based access capabilities through **NC***Tracks* to support multiple user constituencies including providers and recipients. Our powerful and flexible SharePoint platform enables effective identification and management of multiple types of users and seamless transfers among subsidiary sites, as well as links to external sites.

The SharePoint technology allows us to control content and access according to the privileges associated with the specific type of caller. Thus, recipients will be directed to the Recipient area where information access will be limited to the specific areas authorized by the State and information transfer can be controlled based on recipient identification. Similarly, providers will access an area that presents information and access/processing options that reflect their defined roles. This approach allows Team CSC to maximize recipient and provider access capabilities, navigation, and convenience and furnish instructions and program information in an attractive, useful, and easy-to-understand format. The SharePoint portal capabilities also enable easy maintenance of links, content, and access options by Team CSC.

Our proposed Replacement MMIS Web-based applications currently use XML as the transaction format, rather than X12. We plan to house and maintain the Web and application servers in the Team CSC data center and, as such, do not require the reformatting of the transactions that utilize public networks. If the State determines that this is not acceptable and that these transactions must use HIPAA-compliant X12 inbound and outbound formats, enhancements will be made to the eCommerce Subsystem and the Web portal based on the a CSC electronic medical record (EMR)/electronic health record (EHR) regional health information organization (RHIO) pilot. Team CSC will negotiate with the State to determine the HIPAA compliance issues and need for changes to the current approach. **(40.4.1.28)**

(40.4.1.28)

(40.4.1.35)

The eCommerce Subsystem assigns a unique Reference Number to each transaction submitted, including Web-based inquiries, and recipient and nurse aide eligibility requests. This number provides the capability to uniquely identify and track each online inquiry and response. (40.4.1.35) Team CSC will enhance the existing Web-based eligibility verification process to return or display the Reference Number to the provider for DMA/Medicaid eligibility verification inquiries only, and other inquiries as needed. **(40.4.1.29, Comment CSC119)**

(40.4.1.29)

Team CSC will develop Replacement MMIS Web-site capabilities to provide access to various payer repositories and non-Medicaid information, including the Division of

Health Service Regulation (DHSR) Health Care Personnel Registry (HCPR) and the DHSR Nurse Aide Training and Registry (NATRA) for inquiry on DHSR registry information. Team CSC will develop additional access to support usage from providers, nurse aides, and potential employers. The eCommerce system will be enhanced to format and submit/receive transactions that interface with the DHSR processing system. Team CSC will work with the State and DHSR to determine the exact inquiries to be supported and the information that will be available via the Web-site to the various types of users. **(40.4.1.36)**

(40.4.1.36)

CSC has developed and maintains a User Manual that provides AVRS usage and training information. Using the existing manual format as a basis, Team CSC will customize this information to reflect the enhanced capabilities of the Replacement MMIS North Carolina Medicaid Web portal. This information will be downloadable from the Web and available in Adobe or HTML formats. Team CSC ensures that the information is kept current at all times. **(40.4.1.27)**

(40.4.1.27)

Recipient Web-site Capabilities. Team CSC will implement Replacement MMIS recipient Web-site and capabilities through NC*Tracks* to support access to the following eligibility and enrollment information:

- Medicaid eligibility
- Carolina ACCESS enrollment information to include the primary care provider name, address, and daytime and after-hours phone numbers
- Third party liability
- Medicare coverage
- Well child checkup dates
- Hospice eligibility.

The Recipient area of the Web-site will support gathering the information necessary to answer the specific inquiry and formatting XML request and response transactions that will be forwarded to, and received from the appropriate Replacement MMIS systems (e.g., EVS, Managed Care, TPL, Health Check). **(40.4.1.30)**

(40.4.1.30)

The Web-site will support secure recipient-based access to information associated with all recipient inquiry options. Team CSC will develop enhanced Replacement MMIS functionality to provide multi-lingual recipient access and services on the Recipient Web-site. Languages to be included will be negotiated with the State and include Spanish, Russian, and Hmong. Clearly labeled links will allow users to switch back and forth among the supported languages. Team CSC will utilize a document translator service with experience in health information content to develop and maintain static content and all downloadable written materials for recipients/consumers in the identified languages. Content will be in a format that is easy to download, such as Adobe. **(40.4.1.31, 40.4.1.32, 40.4.1.33)**

(40.4.1.31, 40.4.1.32, 40.4.1.33)

D.1.4.4.7 Conclusion

Team CSC's approach to implementing AVRS and Web-based access, inquiry, and processing capabilities for providers and recipients ensures that North Carolina Medicaid constituencies will benefit from the availability of the most technologically

advanced communications solutions available in the marketplace today. Team CSC will strive to maintain the currency and effectiveness of the North Carolina Medicaid AVRS and Web-site to serve as a model for other State programs.

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- Assignment of recipients to lock-in, a Primary Care Provider (PCP), or a Managed Care Organization (MCO)
- Claims adjudication
- Processing prior approval requests
- Handling financial transactions
- Management and Administrative Reporting System (MARS) and other required reporting.

Team CSC recognizes the critical nature of maintaining accurate and complete information to ensure that only appropriately licensed and qualified providers participate in the North Carolina medical assistance programs that serve covered North Carolina citizens. As such, we are proposing to implement a Provider Subsystem with unparalleled functionality including:

- Multi-payer efficiencies
- Complete record of all required data elements to enroll and credential providers as well as process their claims
- Normalized relational database to maintain provider relationships
- Workflow interdependencies
- Credentialing of all providers
- Interactive, real-time data exchanges
- User-friendly web pages with hot links for expediting users to other data components and
- Implementation of the NPI standard.

The technical characteristics of the new Provider Enterprise-wide functionality will be consistent with the State's emerging enterprise architecture principles and strategies as discussed in the North Carolina Statewide Technical Architecture (STA).

During the DDI Phase, Team CSC proposes to facilitate the establishment of a State-approved Provider Enterprise-Wide Review Committee composed of designated representatives with decision-making authority. We recommend that the committee include representation from:

- Each of the State agencies supported by the Replacement MMIS (DMA, DMH, DPH, and ORHCC)
- The Office of Medicaid Management Information System Services (OMMISS)
- The Office of State Controller
- The Office of State Budget and Management
- Information Technology Services
- State-selected providers
- State program recipient Ombudsman
- Team CSC

We propose that this committee help identify Provider Subsystem business requirements specific to the user environment. This committee will operate on a fast track to enable the approved functionality to be incorporated into Team CSC's requirements analysis, general system design, and detailed design documents. To assist with this process, Team CSC will rely on the State to provide its policies, principles, reference models, and standards for provider enrollment, credentialing, and data maintenance.

The cohesive partnership between the NC DHHS and Team CSC will result in the achievement of an enterprise Provider Subsystem that will support the current RFP requirements and present opportunities to incorporate additional State agencies or other financially responsible payers at a later time.

As discussed in Section D.1.8 Early Implementation Functionality, Team CSC proposes to assume responsibility for NC DHHS' provider enrollment, credentialing, and recredentialing tasks during the DDI phase. Working closely with DMA, DMH, DPH, and ORHCC, we will identify data elements necessary to support their respective business needs and implement an enrollment process that meets the needs of all divisions. We will create a new, secure provider database to maintain all required information. Using a DHHS-approved process, our team will perform enrollment and credentialing activities associated with new provider enrollments, as well as credentialing and recredentialing all active providers currently on the legacy MMIS provider file. We will use our new database to generate extracts to update the legacy MMIS with current provider data according to a schedule that is mutually agreed upon by Team CSC, DHHS, and the incumbent fiscal agent. At the time of implementation of the Replacement MMIS, this new provider database will be an input to the newly designed Provider Subsystem and provide a complete and clean data file of all providers. For additional information about the Early Implementation Functionality, please refer to Section D.1.8 of our proposal. **(SOO 10.7-1, SOO 10.7-2, SOO 10.7-3, SOO 10.12.4-1, SOO 10.12.4-7)**

(10.7-1, 10.7-2, 10.7-3, 10.12.4-1, 10.12.4-7)

The following sections provide detail of Team CSC's Provider Subsystem and our ability to process enrollment transactions and accurately maintain all provider data for multiple programs using this system. We have organized the sections as follows:

- Provider Subsystem Overview
- Provider Enrollment
- Provider Credentialing
- Provider Maintenance
- Provider Subsystem Related Tasks

D.1.4.5.1 Provider Subsystem Overview

Team CSC's base Provider Subsystem has a component-based design that has been created around natural clusters of business functionality and data. This design gives the State maximum flexibility to upgrade or replace components in the future or expose components for use by other NC DHHS-authorized State entities. Our base provider function has the ability to support interoperability and integration across State agencies' portfolio of systems, as well as the ability

to meet future Medicaid Information Technology Architecture (MITA) or other external architecture requirements.

Because the Replacement MMIS includes the Provider Subsystem from the *eMedNY* system that we implemented for the New York State Department of Health, we will be able to incorporate all modules required to support the business functionality of the NC DHHS and its divisions. The Provider Subsystem modules in the Base System and the major function of each module are as follows:

- **Provider Enrollment.** This module supports the acceptance of enrollment applications, as well as the review, credentialing, and approval of providers applying to participate in the North Carolina medical assistance programs. The Provider Enrollment module edits and loads provider enrollment and maintenance transactions to the Provider Enrollment Tracking database. It also provides online pages enabling users to review, update, and approve enrollment information. It will be enhanced to support requirements for participation in each of the North Carolina programs for DMA, DMH, DPH, and ORHCC and allow those pages to be accessed by authorized individuals from each of these divisions.
- **Provider Maintenance.** This module supports maintenance of providers enrolled in the Replacement MMIS. The Provider Maintenance module delivers online pages for the review and update of provider data. It will be enhanced to include the maintenance of all new data elements required by DMA, DMH, DPH, and ORHCC. It will also be updated to accept NPI taxonomy data from the individual providers.
- **Provider License Maintenance.** This module maintains valid license, specialty information for each provider and data regarding the ability of a provider to order services. The license information is used to verify the submitted license and specialty information during credentialing of providers. The module includes online pages for the review and update of license data. Minimal modifications will be required to support the State license and specialty information for North Carolina.
- **Provider Online Transaction.** This module supports provider validation requests from other North Carolina systems for various medical assistance programs. It validates the provider data required to process prior approvals, claims, Point of Sale (POS) transactions, financial transactions, MCO PCP assignment, and MARS reporting. Minimal modifications will be required to support provider validation requests from other subsystems for North Carolina.
- **Provider Extract.** This module produces extracts and files of provider information at State-required frequencies, including a daily extract of provider tables. Minimal modifications will be required to include all new data elements required by the North Carolina programs. **(40.5.1.83)**

(40.5.1.83)

- **Provider Reporting and Letter Generation.** This module produces system-generated reports and letters; and responds to ad hoc report queries and letter production requests. Team CSC expects changes to be minor. We will modify all reports to reflect North Carolina requirements.

These modules provide the foundation for all Provider Subsystem related tasks.

Page D.1.4.5-5 contains confidential information.

(40.5.1.1, 40.5.1.42, 40.2.1.87)

redundant administrative tasks that increase their costs. **(40.5.1.1, 40.5.1.42, 40.2.1.87)**

To improve operations of internal and external stakeholders, we propose to increase the level of automation to support the credentialing services. A matching process provides missing data, standardizes address and ZIP Code information, corrects demographic information, and performs a contrast analysis to compare database information. Potential duplicate provider records are flagged, and potential provider ineligibility criteria, such as bankruptcy, sanctions, criminal records, or death, are identified. Findings are provided to the State for review and action, as appropriate.

Team CSC's base Provider Subsystem is supported by a robust Image Management System, FileNET Document Retrieval, and Automated Workflow Management software products that have proven reliability, scalability, with quality performance in managing both content and processes. Our secure **NC***Tracks* Web portal will display customized dashboards to authorized users and provide access to a single source of provider information, serving multiple agencies. The dashboards will be used by a wide range of users including Team CSC staff, providers, NC DHHS staff, other authorized state users, and state business partners. We will incorporate the use of Microsoft's SharePoint software as our **NC***Tracks* Web portal to provide interactive management intelligence dashboards and role-based controls that prevent unallowable disclosure of data. A description of these products is provided in Section D.1.10, Proposed Technical Architecture. **(SOO 10.12.4-10)**

(10.12.4-10)

Exhibit D.1.4.5.1-2, Provider Inputs, Processes, and Outputs illustrates the inputs and processes that result in the outputs of the claims adjudication function.

Inputs	Processes	Outputs
Enrollment		
Online and paper applications and supporting documentation	• Receive paper documents • Image documentation • Store images • Input data into the online enrollment Tracking system • Verify credentials • Update data on files • Approve/disapprove applications • Notify the provider	• Images of documents • Letters for additional information • Electronic requests for data • Updated files • Letters notifying providers of approval or disapproval of application
Maintenance		
Online and paper requests for updates	• Log requests • Update files • Review error reports • Correct errors • Notify requester of update	• Updated files • Update reports • Notifications of updates
Correspondence		
Online and paper correspondence	• Receive email, faxes, and written correspondence • Image all paper documents • Route correspondence to appropriate staff • Read and research any questions • Respond to requests	• Images of paper documents • Letters or emails in response

Page D.1.4.5-7 contains confidential information.

- Approve applications for providers that meet requirements for participation in the North Carolina medical assistance programs operated by DMA, DMH, DPH, and ORHCC.

This module allows providers access to enrollment functionality via an online web-based application entry process; paper submissions using forms that are obtained directly from Team CSC or downloaded from the **NC***Tracks* Web portal; or facsimile transactions. For all data received electronically or on paper, the system maintains the name of the requestor, the submitter, the submission date, and the status of the application. **(40.5.1.3, 40.5.1.5, 40.5.1.24)**

(40.5.1. 3, 40.5.1.5, 40.5.1.24)

The Provider Enrollment module is able to generate and accept electronic and hard copy supporting documentation for enrollment, re-enrollment or verification functions. This module captures all information on the application as well as data from electronic or hard-copy supporting documentation. Upon approval or denial of the application, the system is able to generate a letter automatically that is sent to the provider with the final determination. **(40.5.1.2)**

(40.5.1.2)

Our enrollment process begins with a data entry transfer process that loads all captured data into the Enrollment Tracking System within the Provider Subsystem. Items received in this area are referred to as events. These events are available online on their arrival in the tracking system and are processed through a workflow engine using pre-established work queues. Events can be pre-defined to require Team CSC user intervention or they can be set to move to the next work queue automatically at the completion of the tasks established for that work queue. We are also able to recognize predefined events requiring State determination or intervention and route events to a State-specified work queue, as necessary. Replacement MMIS provider events include new enrollment applications, recredentialing applications, change of address requests, change of business ownership, and receipt of supporting documentation. **(40.5.1.35, SOO 10.12.4-10)**

(40.5.1.35, 10.12.4-10)

Public & Private Provider Access Through NC*Tracks*

- Carolina Access/Community Care Networks Clinics (CCNC)
- NC Local Management Entities
- NC Public Health Clinics
- Rural Health Centers (RHC)/ORHCC Providers
- Federally Qualified Health Centers (FQHC)
- Hospitals
- Long-Term Care Facilities
- Physicians (MD & DO)
- Physician Assistants
- Nurse Practitioners
- Certified Registered Nurse Anesthetist (CRNA)
- Certified Nurse Midwives
- Dentists
- Home Care Service Providers
- Behavior Health Providers
- Optometrists/Opticians
- Chiropractors
- Podiatrists
- Independent Practitioners (e.g. Occupational, Speech, Physical & Respiratory Therapists
- Hospice Services
- Ambulance Service
- Other Transportation Providers
- Durable Medical Equipment Providers
- Clinical Diagnostic Labs
- Pharmacies

D.1.4.5.2.1 Web-Submitted Enrollment Applications

Within the Replacement MMIS, our self-service **NC***Tracks* Web portal offers providers a secure and convenient method of enrollment or re-enrollment. All providers can access the **NC***Tracks* Web portal, select an enrollment application from a menu, and download the application. We will provide web portal functionality to permit online completion and submission of an enrollment application in lieu of a paper submission. All providers will be issued a secure log-on

identification and password that will allow access to the Replacement MMIS. With a log-on ID and password, a provider will be able to access a secure application within the **NC***Tracks* Web portal to submit a new application, recall a saved application, or check on the status of a submitted application. The **NC***Tracks* Web portal will allow the provider to select enrollment application instructions and guidelines to assist in the enrollment application development. The information will be reviewed online or downloaded to a paper document. **(40.5.1.4, 40.5.1.11, 40.5.1.19)**

(40.5.1.4, 40.5.1.11, 40.5.1.19)

When submitting a new application, the provider will be asked to complete general demographic information and additional application sections that are applicable to their provider type and specialty. We will include functionality to present customized enrollment application options based upon information that is provided in response to specific questions. For instance, if the provider indicates that they are applying to serve as an inpatient facility, then they will be asked to complete a section that includes information about the number of beds in their facility. A provider indicating that they are applying to serve as an individual medical doctor would not be asked for such information. **(40.5.1.17)**

(40.5.1.17)

For online application submission, the system performs presence and validity edits on all required data fields to ensure each required field contains appropriate data. When a provider submits the enrollment application, any incomplete fields are identified. The provider may enter the data for an incomplete field when the edit is posted or, may put the application in a hold status and return later to provide the missing data. The provider may also provide an electronic signature that is captured and maintained as a part of the provider database. At submission, the provider receives a system-generated notice of acceptance and an estimated processing time. **(40.5.1.39)**

(40.5.1.39)

As part of online provider enrollment feature, the **NC***Tracks* Provider Web portal enables providers to log-on and inquire on the status of a submitted enrollment application for applications submitted either by the **NC***Tracks* Web portal or on paper. Users inquire using an application tracking number or other criteria, such as name and SSN, NPI, FEIN, or a unique system-assigned identifier. Providers may update pending applications online via the web.

For re-enrollment applications and data maintenance updates, **NC***Tracks* Web portal pages are auto-populated for verification of existing data or submission of updated information. In addition, the Provider Subsystem can simplify data entry whenever auto-population of data is permitted, such as using a check box to indicate that a service and billing location are the same. **(40.5.1.104, SOO 10.12.4-5)**

(40.5.1.104, 10.12.4-5)

D.1.4.5.2.2 Paper-Submitted Enrollment Applications

All applications, provider correspondence, contracts, attachments, signatory documentations, and other supporting documentation that are submitted on paper are received in the Team CSC mailroom and processed. All hard copy documents are batched, scanned using the Image Management System, and efficiently processed through an automated workflow function. During the scanning process, all paper documents receive a document control number (DCN) that is used to retrieve images of the hard copy and to link associated documents with the application. An export server produces an index file that processes each batch. Each image is saved on

permanent storage and its corresponding index information written to the FileNET database. In order to import these documents into the workflow system, each document is written to the FileNET Distribution queue that serves as the point-of-entry into the workflow system. The automated workflow function allows authorized users to enter data directly from the image of the application and supporting documentation. **(40.5.1.7, 40.5.1.12, SOO 10.12.4-5, SOO 10.12.4-10)**

(40.5.1.7, 40.5.1.12, 10.12.4-5, 10.12.4-10)

Imaging and data capture activities occur when enrollment forms are received before processing begins in the Provider Enrollment module. The imaged data is entered and transactions created. These transactions are delivered to the Provider Enrollment module via the e-Commerce Subsystem. These transactions include both new enrollments and data maintenance items for previously-enrolled providers.

D.1.4.5.2.3 Data Management Interface

A data management interface within the Provider Enrollment module captures data from incoming enrollment applications, received either singly or in batches (i.e., multiple enrollment applications from a single provider) and batches the information to create an electronic file. The Data Management Interface file is then passed into the Provider Enrollment Tracking database. **(40.5.1.3, Comment CSC86)**

(40.5.1.3)

The interface file contains logically-related groups of records. Each group is enclosed within a header and a trailer record, and constitutes a batch. These batches can be classified into four main categories:

- The Enrollment batch contains transactions relating to a new provider enrollment. In addition, this process includes a duplicate check to see if the provider is currently enrolled and has an active provider record, or if the provider previously submitted an enrollment application. **(40.5.1.6)**

(40.5.1.6)

- The Maintenance batch contains transactions related to the maintenance or modification of an existing provider including, but not limited to, transactions for address changes, enrollment as a specialist, ownership, NPI taxonomy numbers, and group relationships.
- The Additional Information batch contains transactions related to a particular enrollment or maintenance batch previously submitted, but not completed due to a lack of information. Additional information can be requested from the provider with the assigned tracking number. The additional information record indicates the receipt of this requested information.
- The Incomplete Enrollment batch contains transactions to indicate enrollments that are returned to the provider as incomplete. These enrollment applications are determined to be incomplete during the initial screening. A Screening Checklist is completed, scanned, and data-entered. The transaction is then used to establish a record in enrollment tracking indicating that the forms are returned to the provider. This process loads data into the enrollment tracking tables as appropriate for the type of batch. After loading to the database, an appropriate stage and status is set in the Enrollment Status Detail Table for each batch.

The system edits and loads enrollment-related transactions to the Provider Enrollment Tracking database. **Edits are performed on the data before loading to the**

Provider Enrollment Tracking database. These edits relate primarily to validation of data and the ability to match submitted information to an existing provider enrollment, if required. Batches or transactions within batches that fail these edits are written to a 'Reject Report'. In case of a severe error, the process is aborted. Batch Transactions processed are identified on an 'Accept Report'. Totals for Batch Transactions read, accepted, and rejected appear at the bottom of both reports. The system edits also include checks for duplicate provider data for new enrollments, recredentialing, changes to provider database information, and so forth. The Provider Enrollment module assigns an Enrollment Tracking Number (ETN), which is used to link all related provider application data, correspondence, contracts, and signatory documentation throughout the application review process for retrieval by Team CSC or authorized State staff. Team CSC provider enrollment staff review the enrollment data and verify that providers have submitted completed applications and applicable credentialing documentation. In addition, the module enables Team CSC to produce system-generated attachments based on required criteria and affirmative responses. **(40.5.1.6, 40.5.1.7, 40.5.1.12, 40.5.1.18, 40.5.1.20)**

(40.5.1.6, 40.5.1.7, 40.5.1.12, 40.5.1.18, 40.5.1.20)

D.1.4.5.2.4 Enrollment Tracking

Once the data from a web or paper submission is loaded into the database, the Provider Subsystem provides online pages for tracking, reviewing, and updating data for enrollment applications that are in process. Our Enrollment Tracking System significantly enhances the productivity of our enrollment staff, expedites responses to the provider community, and reduces errors in processing or misplacement of applications and supporting documentation.

The Enrollment Tracking System enables us to track applications from the point of the receipt of the request to the final approval. This tracking system provides the capability to capture required application information from several sources, including **NC***Tracks* Web portal application submission, hard-copy entry, facsimile, email, and telephone call data entered by the customer service representatives.

During the DDI Phase, we will work closely with the NC DHHS to establish what information is required in the enrollment application for each provider type to support enrollment, credentialing and recredentialing, inquiry, and provider participation for each medical assistance program, including capturing information for special, atypical providers. We will capture all information required to identify provider eligibility, program eligibility, participation status with associated affiliations, effective dates, and end dates. The Provider database will be structured so we are able 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 dates. Each required data field will be captured and maintained on the Provider database. A status will be added to the Provider database for those providers who are State-funded or funded by assistance programs other than Medicaid. The Provider Subsystem electronically stores and links all historical provider identifiers, as well as a provider's Medicare number and other crossover information. In addition, we will ensure that we capture information on a provider's billing agents. **(40.5.1.10, 40.5.1.13 – 14, 40.5.1.16, 40.5.1.21 – 22, 40.5.1.30, 40.5.1.46, SOO 10.12.4-2, SOO 10.12.4-13)**

(40.5.1.10, 40.5.1.13 – 14, 40.5.1.16, 40.5.1.21 – 22, 40.5.1.30, 40.5.1.46, 10.12.4-2, 10.12.4-13)

Of key importance is for providers to be able to identify specific services that they will furnish for their provider entity and at each service location by denoting those services on the enrollment application. This information is captured and carried in the Provider Directory to assist program recipients in their provider choices. This information will also be captured in the NPI taxonomy and non-taxonomy data fields. **(40.5.1.8)**

(40.5.1.8)

Our Provider Subsystem limits update capabilities to authorized Team CSC and State users as well as providers who are able to access their application information via the **NC*Tracks*** Web portal. **The NC*Tracks* Provider Web portal maintains an audit trail of all access to secure information, including information submitted and retrieved by users. Additionally, the Provider Subsystem captures before- and after-images of transaction data received and returned, and the identity of the user account that performed the transaction.** The data recorded during the audit logging process can also be used to generate a historical report of web-based enrollment transactions.

The Enrollment Tracking Search Page, as shown in **Exhibit D.1.4.5.2.4-1,** allows our staff to search and find enrollment or maintenance items in process. The search page includes a provider information search and an enrollment tracking search. With the provider information search, users specify criteria such as, but not limited to, Provider Name, Social Security Number, and License Number to locate an enrollment or maintenance item in process. With the enrollment status search, users specify criteria such as Stage, Status, and User Assigned in order to locate all enrollments fitting the tracking criteria. After performing a search, the system returns a list of possible records that meet the search criteria. The user is able to select an enrollment or maintenance item and the details of that item are displayed.

Pages D.1.4.5-13 through D.1.4.5-14 contain confidential information.

addresses for a provider including city, state, and ZIP Code. When a user selects an address, the system displays the details for the specific address.

Additional tabs are available at the top of the page to access other information that is maintained in the Provider database. Each tab displays a page that captures required and optional information that is used to process the application appropriately and eventually to pay claims on behalf of eligible recipients. In **Exhibit D.1.4.5.2.4-3**, Enrollment Tracking System Tabs and Data, we present a table that identifies each of the available tabs and the data that may be captured on each associated page of the tracking system.

Enrollment Tracking System Tab	Data Maintained on the Database
Enrollment Tracking Details	• Header information including: – Provider identifier – Provider Type – Process Type – Indicator if a letter is sent – Number of days in process • Line information including: – Date of action – Stage of the review – Status of the action – Reason for the action – Team CSC user assigned to process the application
Provider Identification	• SSN • FEIN • Group Indicator • Application date, including date signed and date received • NPI • PIN • Previous provider identification numbers with effective dates • DEA number with effective dates
Category of Service/Specialty	• Category of service code assigned with enrollment status code and effective dates • Specialty code and effective dates • NPI Taxonomy numbers
License/Clinical Laboratory Improvement Amendment (CLIA)	• License Description • Profession code • License number • Facility identification number • Issue date of the license • Issuing agency
Affiliations	• Affiliation type • Member identification number and name • Group identification number and name • Effective dates • Associated enrollment tracking numbers and document control numbers (SOO 10.12.4-13)
Institutional	• Medicare data – Number of beds and associated effective dates • Medicaid data – Number of beds and associated effective dates – Facility code that indicates the type of ownership budget such as state teaching facility, private facility, private teaching facility, etc. – Review type that indicates the type of utilization review used for the facility
Medicare	• Medicare identification numbers

Enrollment Tracking System Tab	Data Maintained on the Database
	– Part A enrollment indicator – Part B enrollment indicator – Effective dates – Carrier name • Carrier Detail Information – Carrier code – Carrier name – Address — street, city, state, zip code – Telephone number
Notes	• Free form notes related to the enrollment application • Associated date and time stamp • User identification number for person entering the note
Ownership and Association	• Association type • Name • SSN • FEIN • Provider identification number • Effective dates • Provider Medicare identification number

9799-999

Exhibit D.1.4.5.2.4-3. Enrollment Tracking System Tabs and Data. *The Enrollment Tracking System maintains multiple tabs with associated pages to capture all required information about a provider.*

The Enrollment Tracking Category of Service (COS)/Specialty Page maintains the COS and Specialty information. This page will be expanded to include specialties and related NPI taxonomies with effective and end dates. In addition, the categories of services will be associated with each State program for which the provider has approved eligibility using participation status codes and the associated affiliations, and effective and end dates. **(40.5.1.32)**

(40.5.1.32)

Enrollment Tracking Ownership/Association Detail Page: This page maintains association and ownership information including the ability to cross-reference provider ownership information for each of the provider's business locations. The Association Type Code specifies the type of association (e.g., Employee, Board of Directors) between two providers. The information is captured and imaged and either key from imaging or may be manually entered from the State offices. All entries are registered as to the user ID, date, and time of action. The verification of new information is completed under the Provider Operations function as a manual effort. **(40.5.1.32, 40.5.1.34)**

(40.5.1.32, 40.5.1.34)

By clicking on a drop-down window, the system will display each provider's legal business filing status which includes, but is not limited to, non-profit, corporate, State-owned, Federally-owned, For Profit, and Tribal-owned. The system will capture and retain provider ownership information, cross-referencing it as appropriate. **(40.5.1.33, 40.5.1.34)**

(40.5.1.33, 40.5.1.34)

Local Managing Entity (LME) Information. Team CSC will work with DMH to identify appropriate LME demographic information to capture and maintain for providers that are seeking or have received appropriate endorsement from the LME,

including attending providers. We will create online pages to support DMH access to this data. Subsequently, DMH will be able to restrict or eliminate provider billable services if they are found to be disqualified by endorsement, certification, or licensure. Suspension of billable service periods will be carried on the LME record with effective and end dates. **(40.5.1.9, SOO 10.12.4-14)**

(40.5.1.9, 10.12.4-14)

Special Circumstance Enrollments. Team CSC's provider enrollment validation will be enhanced to support a category of enrollments classified as "special circumstance enrollments." These enrollments may be a border provider, one-time recipient medical need (emergent or non-emergent), Centers of Excellence, limited, and other State-approved situations. Providers assigned to this category will receive expedited enrollment processing and credentials will validate in accordance with State-approved policy and procedures. This procedure may include limiting data collected on the provider and retained on the provider database. Upon approval, indicators will be denoted on the Provider Database as to the provider limited service status. **(40.5.1.23)**

(40.5.1.23)

Other Provider Service Enrollments. The NC*Tracks* Web portal will provide additional page entries for billing agents, business trading partners, providers electing to use electronic fund transfers (EFT) and electronic or paper remittance advice. The information submitted is captured electronically and translated into a format that Provider Enrollment Specialists can readily use to process the requests. As with other web portal entries, a system-generated letter is issued to reflect the request and indication of the anticipated completion of the processing. All transactions are associated by the Transaction Number and enter the work queue processing based on the type of transaction. Before- and after-images of these transactions, received and returned, and the identity of the user account that performed the transaction is also captured electronically. As stated previously, data recorded during the audit logging process can also be used to generate a historical report of web-based transactions. **(40.5.1.16, 40.5.1.26, 40.5.1.31, 40.5.1.38)**

(40.5.1.16, 40.5.1.26, 40.5.1.31, 40.5.1.38)

National Provider Number and Taxonomy. The Replacement MMIS solution will include the implementation of the NPI and multiple associated taxonomies to drive claims payment, eliminating use of intelligence embedded in legacy provider IDs. (The Baseline System does not currently utilize any intelligence in the Provider ID.) The database currently maintains fields for the NPI and providers will be able to register their NPI number during enrollment, re-enrollment, or as a maintenance function. The submitted NPI will then be validated using a check-digit algorithm as part of the credentialing process. As mentioned above, the system will be enhanced to maintain multiple taxonomies by program with associated effective and end dates. All historical unique State-assigned legacy provider identification numbers will be linked to the NPI and maintained in effective/end dated segments where the information is available. The Replacement MMIS will use the linkage of the NPI with other provider identification numbers as a means to merge or decouple provider identification numbers. We will work with the NC DHHS during the DDI Phase to determine the best method for identifying providers who would require merging or decoupling of identification numbers and the associated data that is affected. For example, we will work with NC DHHS and the provider community to determine how best to

Pages D.1.4.5-18 through D.1.4.5-19 contain confidential information.

credentialing, and verification processes. During the DDI Phase, we will work closely with the NC DHHS and its divisions to ensure all required data elements are present in the specification, and ensure that new data elements are added to the target Replacement MMIS database. Prior to implementation of the Replacement MMIS, the new Provider Subsystem will capture, store, and allow updates to all critical credentialing data. **(40.5.1.50, SOO 10.12.4-7)**

(40.5.1.50, 10.12.4-7)

The Provider Subsystem will provide the capability to perform all required provider credentialing and source verification tasks. We present our understanding of the operational process flow in Section D.2.1.3 Client Services of our proposal. This process includes the use of workflow functionality of the Provider Subsystem to forward completed applications for credentialing or recredentialing and verification. **(40.5.1.40, 40.5.1.43)**

(40.5.1.40, 40.5.1.43)

If an application contains complete information, the application is electronically moved to a Team CSC work queue for review and source validation of the information submitted. When all documents required for validation have been received, Team CSC enters findings into the appropriate Provider Enrollment Tracking System page and moves the completed application to a work queue for a quality review as described in Section D.2.1.3 Client Services.

If the application is incomplete or is missing required supporting documentation, Team CSC is able to generate a State-approved letter template that allows entry of missing information. The letter is sent to the provider with a Return Information Routing Sheet Page that allows us to link the returned document to the original application in the Image Management System. This sheet is pre-populated by the Enrollment Tracking System and contains a barcode that automatically provides a link to the original document.

The application remains in the work queue and is monitored daily to determine if the missing information has been returned. A second State-approved system-generated letter is sent if the requested information has not been returned within 30 days. The letters are captured at the point of their release, imaged, and given a document control number that is associated to the provider name. This process enables linking to the enrollment application and allows Team CSC to continue the review process. When assured that appropriate documentation is attached to the completed enrollment application, it is forwarded to the appropriate work queue. Enrollments that cannot be completed due to non-response to additional information requests are stored in the Enrollment Tracking System for 90 days; the 90-day clock begins at the end of the second letter's request for information return date. These applications are subsequently denied and marked as inactive, but can be retrieved, if necessary. **(40.5.1.29)**

(40.5.1.29)

We will enhance existing workflow functionality to allow Team CSC staff to submit electronic verification requests to all required agencies/organizations. These requests are to obtain source verification for all data elements required for provider participation in Medicaid and other publicly funded medical assistance programs covered by DMH, DPH, and ORHCC. We will also be able to receive their responses electronically. In addition, for those agencies that

cannot receive electronic requests, the Team CSC enrollment staff will be able use other manual processes including the selection of a system-generated, State-approved letter template to request the required provider source information.

In each instance, the responses will be captured, imaged, linked to existing applications, and moved into the automated workflow work queues as appropriate. Electronic or paper verifications may be issued for, but not limited, to: **(40.5.1.47, SOO 10.12.4-10)**

(40.5.1.47, 10.12.4-10)

- State licensing boards
- Specialty/Certification boards
- Drug Enforcement Agency
- Clinical Laboratory Improvement Amendments (CLIA)
- National Provider Data Bank
- Office of Inspector General
- North Carolina State Provider Penalty Tracking
- Department of Motor Vehicles (for certain provider types)
- Center of Medicare and Medicaid Services (sanctions/reinstatement)
- Web-site for verification of excluded party listing
- National Plan and Provider Enumeration System (NPPES). **(SOO 10.12.4-6)**

(10.12.4-6)

Our credentialing process provides the capability to accept exclusion data from the Office of Inspector General (OIG) either manually or through a file interface. We will work closely with the OIG's office to establish an automated interface to include all participation exclusion data. In the same manner, we will work with the State to obtain current exclusion data in as automated a manner as possible from the North Carolina State Provider Penalty Tracking database. **(40.5.1.44 – 45)**

(40.5.1.44 – 45)

In addition, Team CSC ensures that work queues are established to manage the exchange of data between DHSR and the Replacement MMIS. We will assist DHSR in defining the best approach for this exchange that expedites data and reduces redundant efforts. Because of the architecture of the Replacement MMIS, Team CSC will be able to develop appropriate interfaces during the DDI Phase to support both batch and online, real-time access among other State entities using API and Service-Oriented Architecture (SOA) concepts. These interfaces will be established between EIS, Mental Health Eligibility Inquiry, the Client Services Data Warehouse (CSDW), Medicaid Quality Control, Online Verification, Automated Collection and Tracking System (ACTS), Health Information System (HIS) to the Replacement MMIS. Team CSC will provide a secure **NC***Tracks* Web portal and other interfaces that allow issuing agencies, authorized State entities and users access to the Replacement MMIS for sharing licensure, endorsement, and accreditation information. **(40.5.1.41, 40.5.1.51, 40.5.1.54, 40.5.1.82)**

(40.5.1.41, 40.5.1.51, 40.5.1.54, 40.5.1.82)

The Provider Enrollment module provides online pages for tracking enrollment and maintenance events. The system contains Stage, Status, and Reason values that provide a history of steps that enrollments have gone through. The system also indicates the work activity that is scheduled, the person/entity responsible for

performing the activity, and the status. It contains notes to explain exceptional situations that have occurred. The system provides reports to assist with the management of the inventory of enrollments in process. **(40.5.1.25)** (40.5.1.25)

Once the application has been approved, a unique, system-generated provider identifier is assigned and the provider information is transferred from the Provider Enrollment Tracking database to the Provider database. This unique provider identification number will be linked to the NPI for all except atypical providers. **(40.5.1.22)** (40.5.1.22)

Credentialing Tasks. Team CSC understands the importance of developing automated functionality that supports the ongoing efforts and protocols to maintain up-to-date provider files with qualified providers. We have built into our Credentialing/Recredentialing workflow system identification of providers who meet State-defined recredentialing time frame requirements, (i.e., every two or three years). Notification is sent to the provider 75 days prior to the anniversary of the initial credentialing period based on the expiration dates of key provider data, such as provider licensure, DEA number, CLIA certification, specialty board certifications, or other criteria as set forth by the State. **(40.5.1.49, 40.5.1.52, SOO 10.12.4-8, SOO 10.12.4-9)** (40.5.1.49, 40.5.1.52, 10.12.4-8, 10.12.4-9)

Providers receive a system-generated State-approved letter advising of the need for the recredentialing and instructions as to how to access the **NC***Tracks* Web portal for electronic submission or the downloading of a paper application. A time frame for submitting the information will be provided with sufficient time for Team CSC to obtain validation from all appropriate agencies.

Providers are given a second request letter at the 60-day status with a follow-up call at 45 days in an effort to ascertain why they have not responded and what assistance they may need. Non-responsive providers, or those requesting disenrollment, are disenrolled with an update transaction to the Provider database. A State-approved, system-generated notification letter is issued the same day as the Provider database update occurs, notifying the provider of the disenrollment. Providers will be advised of the procedures for obtaining reinstatement in the Program based on State-approved protocols. **(40.5.1.53)** (40.5.1.53)

Adverse reporting of provider data results may result in additional letters being generated from the system that explain the reason for participation denial and the appeals process. These letters are retained in the electronic provider file. All electronic and paper correspondence are imaged and maintained in electronic files. (**SOO 10.12.4-9)** (10.12.4-9)

A Monthly Provider Status Report is generated listing providers who have had no claims submission for one year. This report enables us to generate a letter from the Enrollment Tracking System to inquire of the provider's interest in continuing in North Carolina's medical assistance programs.

D.1.4.5.4 Provider Maintenance

The Provider Data Maintenance function comprises the receipt, input, maintenance, output, and related activities associated with provider data and information as it

pertains to the North Carolina Replacement MMIS. Accurate processing of provider data is demanded to ensure satisfaction and retention of certified medical service providers to care for and treat recipients covered by DMA, DMH, DPH, and ORHCC.

Exhibit D.1.4.5.4-1 Provider Enrollment Maintenance illustrates how the imaging and automated workflow enables online processing of routine provider maintenance requests. **(SOO 10.12.4-10)**

(10.12.4-10)

D.1.4.5.4.1 Manual and Automated Online Updates

Team CSC provides Replacement MMIS online pages to allow manual and automated updates to all provider data elements. Authorized personnel have the capability to add, change, or delete provider data fields or segments. All provider data elements reflect changes on an immediate online, real-time environment. This real-time update capability allows Team CSC to suspend or terminate providers immediately with proper notification and authorization from the State. It allows real-time updates of review or restriction indicators and dates on a provider's record to assist in monitoring a provider's services and updates the Provider database immediately, with State approval, to reflect changes brought to our attention by the State, providers, MCOs, or from our own staff. **(40.5.1.70, 40.5.1.81)**

(40.5.1.70, 40.5.1.81)

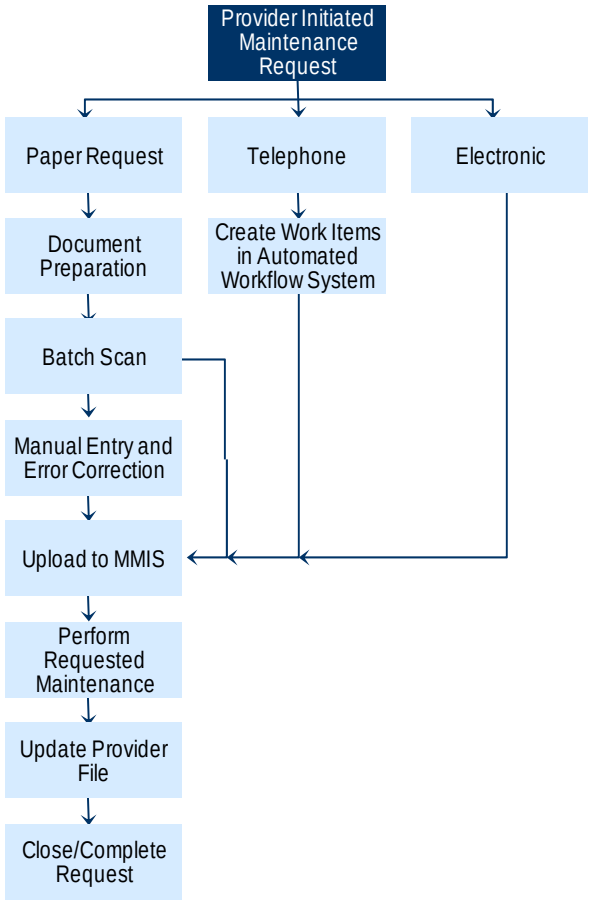

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Exhibit D.1.4.5.4-1. Provider Enrollment Maintenance. *The Replacement MMIS provides image management of all paper documents and automated workflow processing for routine maintenance requests.*

The Replacement MMIS maintains multiple provider identifiers including the provider's NPI, unique State assigned legacy provider identification numbers, system-generated identifiers, which are linked to the provider's tax identification/reporting number. These numbers will also be linked across agencies for tax and financial information. This linkage enables the capture of data related to agency-specific provider incentives, sanctions withholds and review processes with applicable begin and end dates, pre-payment, post-payment, payment review, compliance payment withholds and denials. Team CSC will collaborate with the State during the DDI phase to enhance existing functionality to provide the capability to place providers on review for withholds or to initiate incentives, at the line-of-business level, with an associated pre-payment/post-payment status, using the

provider tax ID or a single provider number within a tax ID. In addition, the linkage of provider numbers gives us the ability to accept budget codes for State funding of the provider's services. Associated payment summaries are also maintained using these numbers with agency-specific 1099s issued accordingly. **(40.5.1.64, 40.5.1.67, 40.5.1.68, 40.5.1.72, 40.5.1.78)**

(40.5.1.64, 40.5.1.67, 40.5.1.68, 40.5.1.72, 40.5.1.78)

The Provider database stores and maintains all data that is submitted on the enrollment application as described in the D.1.4.5.2.4, Enrollment Tracking above. This includes the ability to capture, update, and maintain CLIA information for providers on the License/CLIA tab of the Enrollment Tracking System. The Ownership and Association tab is able to identify and reference ownership across multiple occurrences and entities. The database will be enhanced during the DDI Phase to include capture of data to identify providers who participate in the Competitive Acquisition Program with begin and end dates by program. **(40.5.1.61, 40.5.1.69, 40.5.1.73)**

(40.5.1.61, 40.5.1.69, 40.5.1.73)

D.1.4.5.4.2 Online Edits

Online edits are used to ensure the integrity of the data and to verify accuracy of the provider database. The Provider Subsystem edits against other data in the current transaction as well as on the Provider database. Transactions are edited for presence, format, consistency of data, validity of data, and prevention of duplicate provider enrollment. When an authorized user enters an update transaction, the transaction is edited for State-specified criteria. If the transaction fails an edit, an error message appears at the bottom of the page detailing the error. The transaction is not allowed to update the Provider database until all errors have been resolved. If there are no failures, the user receives a message that the transaction has been successfully updated. Audit trail reports relay all changes made to the provider database and transaction logs provide a record of updates by individual users. Online editing ensures data integrity by prohibiting invalid data and segments containing errors from being released. These editing features allow our users to perform authorized provider data modifications with confidence. **(40.5.1.60)**

(40.5.1.60)

D.1.4.5.4.3 Monitoring Provider Data

The Provider Subsystem relies on State-approved business rules to identify data that, if not updated, may affect a provider's continued participation, such as valid license, DEA number, CLIA certification, endorsement, specialty certification, and so forth. The Baseline System currently applies rules for the Medicaid program in New York State, and we will enhance the system to support different business rules for the multiple programs and services provided in the North Carolina multi-payer environment. The Baseline System automatically generates reporting that identifies an issue is due for update or review. The system is also able to auto-generate letters that present the selected data for the provider to verify and update with appropriate supporting documentation, if needed. As the updates are returned, the information is imaged and subsequently entered into the workflow queues for processing. Team CSC will utilize the following methods to present data to providers for verification and update:

Page D.1.4.5-25 contains confidential information.

Provider Enrollment staff to issue provider enrollment packets and **NC***Tracks* Web portal enrollment information to enable the out-of-state provider to expedite his or her enrollment. Once the enrollment is approved, the claims can be recycled and pay appropriately. **(40.5.1.71)**

(40.5.1.71)

Returned provider mail is imaged and submitted into the Provider Workflow Management process where a special work queue is established to resolve mail-related issues. The Provider Subsystem allows authorized users to update the mail suppressant indicator that is maintained on the Enrollment Tracking Name and Address Page as shown in Exhibit D.1.4.5.2.4-2 above. If necessary, the provider can be placed in an inactive status to suppress claims processing. This process may require a phone call to the last known telephone number or other numbers that may be on the Provider database or even via other agency provider data to enable Team CSC to resend the mail to the provider. Team CSC will work with the State to establish all business rules for these efforts. All imaged data and final disposition are maintained in the provider's electronic file for future reference. **(40.5.1.77, SOO 10.12.4-10)**

(40.5.1.77, 10.12.4-10)

D.1.4.5.4.4 Electronic Receipt/Send Transactions

The Replacement MMIS supports online, real-time responses to Eligibility Information System (EIS), Division of Information Resource management (DIRM) and DHSR applications for all provider data processing transactions with DHHS-approved Provider database data elements. The information will be delivered in a format and medium required by the receiving entities. **(40.5.1.84, 40.5.1.85)**

(40.5.1.84, 40.5.1.85)

D.1.4.5.4.5 Provider Data Maintenance Support Via the **NC***Tracks* Web Portal

The Replacement MMIS offers providers an opportunity to submit provider data updates via our secure **NC***Tracks* Provider Web portal. Providers are able to:

- Download State-approved forms including, but not limited to: provider enrollment, provider contracts, and hysterectomy and sterilization forms **(40.5.1.57)** (40.5.1.57)
- Request the generation and distribution of a provider contract **(40.5.1.58)** (40.5.1.58)
- Access provider training information including the ability to download provider workshop registration, training materials, training evaluation forms, bulletins, broadcast emails, access to supporting documentation for training, and an audit history of provider training for the provider **(40.5.1.65, 40.5.1.86, SOO 10.10-9)** (40.5.1.65, 40.5.1.86, 10.10-9)
- Enter change of names, address, change of ownership, rate notification update and other pertinent data that is captured and passed to an appropriate work queue for Provider Enrollment staff to review prior to releasing into the system. This information is edited at the time of entry for appropriateness to the data field reducing administrative effort on the parts of both the provider and Team CSC in resolving incorrect data submitted. **(40.5.1.75)** (40.5.1.75)
- Enter registration to receive notifications or facilitate communications in a manner appropriate to each DHHS agency. **(40.5.1.79)** (40.5.1.79)

D.1.4.5.4.6 General Reporting

The Provider Subsystem maintains all provider data in a normalized relational database. Using this database, Team CSC is able to generate on-demand reports with

data span parameters for provider data using any data elements maintained on the Provider database. **(40.5.1.66)** (40.5.1.66)

D.1.4.5.4.7 On-line Security

Access to online inquiry and update capabilities is available to both Team CSC and State personnel and specified parties at the State's discretion and approval. Authorized personnel currently have update access to provider data through a security system that enables the State to maintain update capabilities for specified pages by use of a unique User ID.

Inquiry access can be limited for outside entities, State, and Team CSC personnel by a security system that is capable of granting specific permissions to specific individuals or groups of people. The security system enables Team CSC to maintain different levels of update and inquiry capabilities for specified pages and functions.

The Provider Subsystem's Maintenance Module supports online requests for maintenance of provider data by providers and other authorized users. Providers use the **NC***Tracks* Web portal provider pages to enter new or changed data. During the DDI effort, Team CSC will collaborate with the State to determine which data elements will be available for providers to update. Online programs edit the data to prevent invalid information from being added to the file. The subsystem maintains the information in the archive and retrieval system. If needed, it can be retrieved for hard copy printing. **(40.5.1.59, Comment CSC95)** (40.5.1.59)

D.1.4.5.5 Provider Subsystem Related Tasks

Imaging, workflow management, querying tools, and web functionality provide systems-related support to Provider Training and Publications operational tasks. The Replacement MMIS will be customized to meet the requirements specific to DMA, DMH, DPH, and ORHCC. Inquiry pages will be developed to provide listings that can be selected to enable the user to obtain additional detail.

D.1.4.5.5.1 Provider Training and Orientation

Team CSC deploys multiple training mechanisms to ensure provider's have quick and easy access to training information and materials. Providers will have web-access to download video training module(s) and supplemental training materials for the session specific to his/her claim type. For more information, please refer to Sections D.4, Training Approach and D.2.1.3, Client Services of our proposal. **(SOO 10.10-6, SOO 10.10-9, SOO 10.12.4-11)** (10.10-6, 10.10.-9, 10.12.4-11)

D.1.4.5.5.2 On-Site Training

Team CSC will be able to receive, capture, and maintain provider on-site visit requests via the **NC***Tracks* Web portal, email, facsimile, written correspondence, and provider calls to the Customer Call Center. All requests are maintained in the **NC***Tracks* application and routed to appropriate Team CSC staff via automated workflow functionality that is part of the application. They may also be initiated by State or Provider Relations staff if deemed appropriate due to urgent provider participation status, or excessive claim denial rate reports that are produced from the MAR Subsystem. These reports can be generated to identify providers who have denial rates of 20 percent or higher. **(40.5.1.87, 40.5.1.88, 40.5.1.96, SOO 10.10-5)** (40.5.1.87, 40.5.1.88, 40.5.1.96 10.10-5)

Electronic requests are captured and moved to a designated work queue for the Provider Relations representatives to process in accordance with performance standards. Paper requests are routed to imaging and then routed to the designated work queue following the same steps as the electronic request. All requests are processed in accordance to earliest date received or if identified as urgent.

Provider Relations representatives performing an on-site visit to a provider's office will have a laptop to access the Replacement MMIS. In addition, each representative will carry a cell phone to access Team CSC functional support, if needed.

At the completion of the visit, Provider Service Representatives complete an online form that is attached to the provider file along with the imaged training materials, training evaluations, and other correspondence associated to the visit. Providers will be provided the opportunity to complete the training evaluation online or while the representative is on-site. The tracking system provides the capability to identify provider requested visits and develop reports on the number of visits performed and the information provided. Data is collected and reported monthly. Both detailed and summary On-Site Visit Reports will be prepared and made available to authorized users. **Exhibit D.1.4.5.5.2-1**, Detailed On-Site Visit Report and **Exhibit D.1.4.5.5.2-2**, Monthly On-Site Summary Report are provided as examples of these reports. We will work with the State during DDI to finalize report development. **(40.5.1.91 – 93, SOO 10.10-8, SOO 10.10-10, SOO 10.12.4-12)**

(40.5.1.91–93, 10.10-8, 10.10-10, 10.12.4-12)

Provider ID_____
Provider Name_____
Provider Location:

Provider Staff Names in Attendance (identify responsible parties for billing issues):
(List) _____
_____
_____

Visit Initiated By:
_____State
_____CSC
_____Provider

Purpose of Visit:

_____ Provider Initial Program Orientation
_____ Excessive Claims Billing Support
_____ Other (indicate)_____
_____Approved Training Materials

Provider On-Site Visit Evaluation Submitted Date_____

Follow-up Required:_____
_____
_____

Provider Relations Representative Performing Visit:_____

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Exhibit D.1.4.5.5.2-1. Detailed On-Site Visit Report. *The On-Site Report provides a detailed record of the purpose of the visit and who attended.*

Provider On-Site Monthly Summary Report

Provider Number	Provider Name	Date of Visit	Reason for Visit	Follow-Up Required	PR Rep Name

9799-999

Exhibit D.1.4.5.5.2-2. Provider On-Site Monthly Summary Report. *Every month a summary report is produced to document provider on-site visit for the past month.*

D.1.4.5.5.3 **NC***Tracks* Provider Web Portal

NC*Tracks* Provider Web portal functions include:

- Form ordering (hysterectomy, sterilization, change of address, and so forth or the use of downloading for instant availability)
- Provider directory that supports specialty and second opinion referral, suspended provider information
- Medical assistance program information
- Provider manual

- Provider bulletins
- Provider workshop training schedules
- Provider workshop training materials
- Provider training tutorial that can be tailored to facilitate training in a variety of subjects **(40.5.1.89)** (40.5.1.89)
- State-approved Provider Basic Training Tutorials (both initial and updated versions) **(40.5.1.98)** (40.5.1.98)
- Provider Database Information Inquiries
- Claim Status
- Function for submitting Request for On Site Visit
- Online submission of service evaluation forms
- How to obtain Electronic Media Claim (EMC) Support
- EMC Manual
- Most frequently asked questions **(SOO 10.10-9)** (10.10-9)

D.1.4.5.5.4 Training-Related Documentation Archiving and Retrieval

Team CSC maintains imaged training-related documentation that is retained throughout the life of the contract. The documentation is categorized in folders and dated. Such documentation is available for online access for two years. Subsequently, it is archived and available upon request. Training data subject to this service includes:

- Annual Training Plan
- Quarterly training analysis and supporting documentation
- Draft training materials through State-approved final copy such as:
  - Training schedules
  - Training registration forms (includes captured input from the **NC***Tracks* Web portal)
  - Training coordinator scripted training dialogue as approved by the State
  - Training materials
  - Training Workshop Sign-In Sheets
  - Training evaluations and summaries for each workshop **(40.5.1.90 – 91, 40.5.1.94 – 97)** (40.5.1.90 – 91, 40.5.1.94 – 97)

D.1.4.5.5.5 Provider Communication

The Team CSC Customer Relationship Management (CRM) System Solution provides a secure web enabled single repository for the capture of all telephone inquires and correspondence from providers and recipients. Team CSC's CRM provides automated call logging, tracking, monitoring, and reporting of all inquiries. Other channels of inquiries including: email, fax, and mail correspondence are gathered and documented by the communication center agents. Each call record is assigned a service tracking number. Calls are categorized based on the nature of the call to assist in determining trends to improve the quality of services and customer

satisfaction. The CRM maintains a repository of all provider demographics to be searched on and retrieved via the **NC***Tracks* Web portal. The capability to review call records is based on the name of the provider, the unique State assigned legacy provider identifier, the National Provider Identification (NPI), the name of the recipient, recipient identifier, type of request, urgency and priority of request, prior approval number, and service tracking number. **(40.5.1.99, 40.5.1.100, 40.5.1.101, 40.5.1.102, 40.5.1.103)**

(40.5.1.99, 40.5.1.100, 40.5.1.101, 40.5.1.102, 40.5.1.103)

All Replacement MMIS functional areas will have access to review all communications, as approved by the State. Inquiries are managed via the automated workflow solution, where a request can be assigned to a specialized user if additional research or skill is required to resolve the inquiry. This provides capability for communication tracking business area to interface with other functional areas. The automated workflow process includes letter generation and correspondence to providers and recipients. **(SOO 10.12.4-10)**

(10.12.4-10)

State staff has the capabilities to review call records via the **NC***Tracks* Web portal that can be searched based on the callers demographic information, the unique State assigned legacy provider identifier, NPI, and service tracking number. The CRM solution provides a menu driven predefined group of reports as agreed upon with the state, for standardized reports as well as reporting capabilities for more specialized reporting and analytics, such as trends and issues that may impact the program. (**SOO 10.12.4-11**)

(10.12.4-11)

D.1.4.5.12 Conclusion

Team CSC is committed to working with the NC DHHS and its divisions during the DDI Phase to design, develop, and implement a new Provider Subsystem that meets or exceeds the RFP requirements for a multi-payer enterprise-wide system. We bring our experience of operating a Provider Subsystem for the State of New York that processes provider enrollment applications and maintains provider data similar to the requirements for the business needs of each of the divisions, DMA, DMH, DPH, and ORHCC. We are dedicated to developing a database that captures and maintains all required provider information to support enrollment, credentialing, recredentialing, and verification of information in support of all NC DHHS divisions supported by the Replacement MMIS. We provide a Provider Subsystem and toolsets that allow us to support all provider business functions seamlessly across the enterprise.

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Page D.1.4.6-1 contains confidential information.

The following subsections describe the proposed Reference functionality in terms of:

- Reference Subsystem Overview
- Edit and Audit Controls
- Diagnosis Code Tables
- Procedure Code and Pricing Tables
- Diagnosis Related Groups (DRG) Code Maintenance
- Drug Code Maintenance
- Reporting
- Interfaces
- Data Change Control Process.

Each subsection responds to the associated requirements from RFP Section 40.6.1 and requirements 40.1.1.4 – 5. Requirements have been grouped by subject matter.

D.1.4.6.1 Reference Subsystem Overview

A Reference Subsystem, by its designated role of being the central repository of support data for claims processing, will continuously be faced with legislative and business changes affecting healthcare benefit coverage and service reimbursement policy. It has to be carefully designed with the capability to embrace future data changes easily with minimal impact on the program codes but at the same time provide rapid data access performance to support real-time claims adjudication. **Our experience and skill in designing large, complex databases from previous Medicare and Medicaid implementations will help the State to meet this challenge.**

eMedNY Medicaid Database

The eMedNY database is one of the largest in the Medicaid World with 726 database tables and an overall size of 16 terabytes.

The Baseline System contains the appropriate data structures to support a multi-payer environment with flexible table-driven design to simplify data administration and maintenance. **Our proposed solution includes the relevant design factors, inherited from the Baseline System, which will provide a smooth transition to the State's requirements for date-specific fees, rates and modifier pricing data, maximum reimbursement rate settings, and multi-payer pricing methodologies resulting in reduced total cost of ownership.**

Exhibit D.1.4.6.1-1 shows the operating environment for our proposed Reference Subsystem with clear identification of the stakeholders, external systems, and other Replacement MMIS subsystems with which the Reference Subsystem must interact.

Pages D.1.4.6-3 through D.1.4.6-4 contain confidential information.

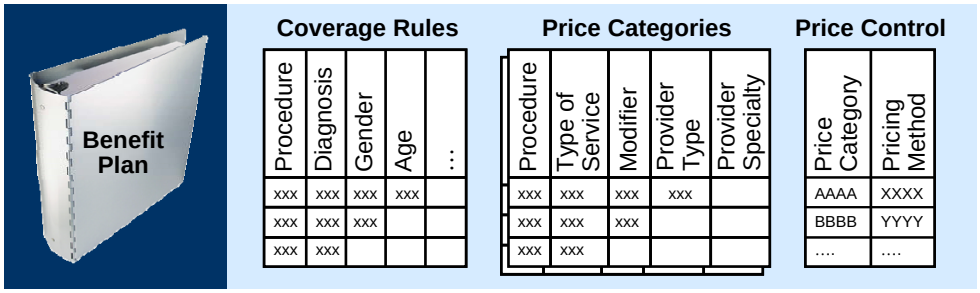

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Exhibit D.1.4.6.1-4. Benefit Plan Definition. *A benefit plan is a collection of tables that includes criteria for services covered and the applicable pricing categories and price controls.*

Typically, a benefit plan is implemented as an information structure called a benefit package which contains a set of Coverage Rules (such as procedure codes, diagnosis codes, age, and gender) that is used to determine whether a tendered service is covered by a benefit plan. The business rules governing the scope of benefits, the eligibility criteria, and the pricing methods applicable to each benefit plan are specified in the Price Category and Price Control tables. Multiple concurrent benefit plans can be maintained through the use of an unlimited number of start- and end-dated database segments. This table-driven approach will provide the desired flexibility to support the addition of new benefit programs or modifications to existing benefit programs through data configuration changes, without incurring additional software development.

In conjunction with Benefit Plan definition, the Replacement MMIS will also implement a table-based hierarchy of payer criteria to determine the most appropriate financial payer and benefit plan for a claim service that is covered by more than one benefit plan**.** The Recipient and Provider Subsystem database structures will also be populated with benefit plan codes to link providers and recipients to benefit plans and support the coordination of benefits process. Refer to Proposal Section D.1.4.1, General System Requirements, for additional information about multi-payer design. **(SOO 10.2-3, SOO 10.2-6)**

(10.2-3, 10.2-6)

Pricing. The design of the Reference database provides a table-driven approach for pricing both pharmacy and medical claims. The pricing methodologies are determined by several pricing criteria elements electronically stored and maintained in the Reference database tables. For example, we are store and maintain all State-approved pharmacy pricing methodologies using a Drug Price-Type code, associated with each drug code. The Drug Price-Type code is used to identify the pricing method and rate for computing the base amount for pharmacy service. A Revenue-Type code, similar to the State's accommodation code, is associated with each revenue code and used to identify the pricing method and accommodation rate for computing the base amount for institutional and non-inpatient claims such as inpatient, nursing home, clinic, dental clinic, managed care, and home health claims. Finally, a set of pricing indicators, similar to the State's PAC code, is associated with each procedure code and used to identify the pricing method and fee schedule rate for computing the base amount for procedure-based claims such as practitioner, DME, laboratory, and dental. These pricing criteria are also tied to Major Program codes (similar to Population

Groups) to support the specific reimbursement requirements of each benefit program.

The structure and contents of the Reference database tables reflect a proven flexible design that has supported the State of New York's complex reimbursement methodologies. Team CSC will bring this proven flexibility to implement the pricing mechanism to support the NC DHHS program requirements for pharmacy and other pricing methodologies. (**40.6.1.53, 40.6.1.74, 40.6.1.75**)

(40.6.1.53, 40.6.1.74, 40.6.1.75)

Access. Our proposed solution provides for both batch and direct online updates to the Reference database. Mass updates, such as data files from First DataBank and the Centers for Medicare & Medicaid Services (CMS) are processed in a batch mode. Online screens are provided for inquiry and maintenance of almost all data elements in the Reference database. The only exceptions are fields such as internal processing indicators and time stamps. During DDI, Team CSC will review all online pages with the State and customize appropriate pages to display any additional Reference data requested. All data must pass validation and edit routines before being stored in the Reference Subsystem tables. **For batch updates, all incoming data is validated and edited during the update process and reports are produced to record the update activities together with control totals of data input, processed, and rejected. Online transactions are validated and edited at the time of entry.** (**40.6.1.2 – 3, Comment CSC74, SOO 10.12.1-21)**

(40.6.1.2 – 3, 10.12.1-21)

Normalized Database. The flexible table-driven design in our proposed solution is a reflection of the work expended in developing a normalized database design in our Baseline System. A normalized database design, besides eliminating data redundancies, allows repeating groups of information to be represented by multiple database rows. This approach supports the State's requirement for unlimited pricing and other information spans with date ranges by increasing the number of rows to represent the growing information needs. This adaptable design strategy will also be apparent in our discussions of the other Reference tables in subsequent sections. (**40.6.1.41**)

(40.6.1.41)

Code Tables. The Reference Subsystem accommodates procedure codes (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), drug codes, edits, rate methodologies and calculations, and professional fees that reflect specific State policy. Team CSC recognizes there will always be variations in code values from state to state and will work with each division with the NC DHHS to define, customize, and configure the Reference Subsystem to store the pricing rates, code values, administrative rules, and other supporting information as required by the RFP. During the DDI phase, we will analyze the data files from the legacy MMIS to expedite the creation of the pricing rate and other applicable code tables with automation tools. In support of the State's requirement, all reference data will be retained for a minimum of five years to meet claim history requirements; data related to services that have life-time limitations will be marked by the claims adjudication process for indefinite retention. (**40.6.1.8, 40.6.1.25, 40.6.1.43, 40.6.1.38, Comment CSC266, SOO 10.2-4, SOO 10.12.7-2**)

(40.6.1.8, 40.6.1.25, 40.6.1.43, 40.6.1.38, 10.2-4, 10.12.7-2)

Pages D.1.4.6-7 through D.1.4.6-8 contain confidential information.

adjudication. This design can accommodate an unlimited number of edit numbers. The data in the Claim Edit tables support the following activities:

- Selection of edits by claim types to be applied during claim adjudication
- Disposition of claims according to policy requirements applicable to each benefit program
- Provision of edit error message text
- Inclusion of EOB text in remittance advices
- Routing of failed claims to appropriate review destinations applicable to each benefit program
- Exception processing during claims adjudication

(40.6.1.35, 10.9-12, 10.12.7-2)

- Provision of the informational content for an online edit resolution manual. (**40.6.1.35, SOO 10.9-12, SOO 10.12.7-2**)

Exhibit D.1.4.6.2-2 illustrates the contents of the Claim Edit tables, which can support program-specific validation and control rules.

Claim Edit Table Name	Content
Claim Edit Dependencies	• A pair of inter-dependent edit codes that allows claims adjudication to identify edit dependencies.
Claim Edit Disposition	• Program-Specific dispositions for edit codes including Force Pay/Deny and Pend Severity values
Claim Edit Explanation Of Benefits (EOB)	• EOB text for Remittance Advice (RA)
Claim Edit Suspended Claim Routing Location	• Program- specific routing location associated with a given edit code
Claim Edit Resolution Text	• Instructions for resolving edit errors.
Claim Edit Code	• General information and edit override codes such as management override, eligibility override and drug override indicators
Claim Edit Text	• Program-specific edit description text.

Exhibit D.1.4.6.2-2 Primary Claim Edit Tables. *These tables provide the capability to set a broad range of edits.*

Online screens are provided to inquire on, and update information contained on the Claim Edit tables. **Exhibit D.1.4.6.2-3** shows the Status Disposition page used to specify the Claim Edit code status.

Page D.1.4.6-10 contains confidential information.

D.1.4.6.3 Diagnosis Code Tables

Diagnostic Code Table

Design provides a user-configurable, table-driven approach for rules regarding diagnostic codes and claim data attribute relationships and provides a flexible approach for configuring control indicators and other policy rules used by Claims.

The Reference database maintains a Diagnosis Code table accessible to all Replacement MMIS subsystems including the pharmacy and medical claims adjudication processes. The Diagnosis Code table provides information related to the diagnosis code and the associated policies, restrictions, and other rules that are used by the Claims Processing Subsystem. Our proposed solution uses the same set of diagnosis code information for both medical and pharmacy claims adjudication processes, including both National Council of Prescription Drug Programs (NCPDP) and physician drug program claims. (**40.6.1.6, 40.6.1.44**)

(40.6.1.6, 40.6.1.44)

The Diagnosis Code table is refreshed with updates from CMS. The update process involves a comparison of the CMS Diagnosis Update Tape against data in the Diagnosis Code table to identify all covered and non-covered International Classification of Diseases (ICD)-9/ICD-10 diagnosis codes and any field changes or deletions to existing diagnosis codes. Team CSC will also perform a comparison of the CMS Diagnosis Update Tape against the legacy MMIS diagnosis codes and produce a report on all covered and non-covered ICD-9/ICD-10 diagnosis codes and any field changes or deletions to existing diagnosis codes for the State's use. (**40.6.1.4 – 5**)

(40.6.1.4 – 5)

The Diagnosis Code table design provides a user-configurable, table-driven approach for implementing administrative rules regarding relationships between diagnosis codes and claim data attributes. Some examples of the data elements from the Diagnosis Code table that are used to direct policy enforcement during claims adjudication are:

- Min/Max age restriction values
- Gender restriction code
- Diagnosis Accident indicator
- Prior Approval (PA) Required indicator
- Diagnosis Pregnancy Indicator
- Attachment requirement indicators
- Sterilization code
- Family Planning code
- Manual Review code
- Covered code indicator
- Control Code
- Diagnosis Classification Code.

The Diagnosis Code table will provide a flexible, non-programmatic approach for configuring control indicators and other policy rules to be used by the Claims and other Replacement MMIS subsystems. Team CSC will work with the State during the DDI phase to enhance the Diagnosis Code table with additional data elements, customize the codes values, and make provision for future transition to the ICD-10 code format. (**40.6.1.13, SOO 10.9-12, SOO 10.12.7-2**)

(40.6.1.13, 10.9-12, 10.12.7-2)

D.1.4.6.4 Procedure Code and Pricing Tables

The Reference database maintains a set of Procedure Code tables accessible to all Replacement MMIS subsystems. The Procedure Code tables provide information related to Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS) and ICD-9-CM codes and their policies, restrictions, and

other processing rules that are used by the Claims Processing and other Replacement MMIS subsystems.

The Procedure Code and pricing tables are refreshed with updates from CMS. The update process applies the CMS HCPCS updates to the Procedure Code table and the CMS Resource-based Relative Value Scale (RBRVS) updates to the Procedure Pricing and Revenue Code tables. The RBRVS system assigns geographically-adjusted relative values to procedures performed by physicians and other providers. These relative values are then multiplied by fixed conversion factors to calculate the payment amounts (i.e., fee schedules).

For the RBRVS update, Team CSC will retrieve the annual RBRVS update information from the CMS website and process it to produce a report of all proposed updates and an error report detailing exceptions occurring during processing. We will submit the reports to DHHS so that the State can modify the update information to reflect State policy. Once proposed updates have been approved, we issue a file maintenance request through the Change Control System and update the Reference tables and apply the data to pricing. New pricing amounts are set as the current amounts, and prior amounts are retained in end-dated segments to preserve historical pricing information. Although these updates occur annually, Team CSC will also perform large-volume interim updates using this process. Small-volume interim updates will be applied through the online pages. **(40.6.1.22, 40.6.1.93, Comment CSC239)**

(40.6.1.22, 40.6.1.93)

The Procedure Code tables provide a user-configurable, table-driven approach for implementing administrative rules for edits, pricing and audits during claims adjudication. The data elements in these tables are used to identify the conditions for applying edit or rules, identify appropriate third-party liability (TPL) actions, identify requirement for the presence of other claim fields, validate appropriate claim data values, identify pricing methods to be applied, provide various types of procedure descriptions, and compliance with retention requirements. **Exhibit D.1.4.6.4-1** illustrates some examples of these data elements used for directing policy enforcements during the claims adjudication process. The Procedure Code tables also maintain the indicators to identify which of the procedure or revenue codes should be subject to the audit/edit actions. (**40.6.1.23, 40.6.1.46, 40.6.1.48, SOO 10.9-12, SOO 10.12.7-2**)

(40.6.1.23, 40.6.1.46, 40.6.1.48, 10.9-12, 10.12.7-2)

Data Elements	Usage in Claims Adjudication Process
Age and Gender Restriction Codes	• Identify eligibility based on age range and gender values
Abortion, Hysterectomy and Sterilization Indicators	• Identify attachment requirements for certain diagnostic codes
Claim Type Include/Exclude Code	• Identify claim type requirements for a particular procedure code
Cost Avoidance Code	• Identify a cost-avoidance (TPL) for a particular procedure code
Diagnosis Required Indicator	• Identify requirement for presence of diagnostic code for a particular procedure code
Duplicate Edit Check Code	• Identify requirement for history audits for a particular procedure code
Family Planning Indicator	• Identify family planning diagnostic code
Modifier Required Indicator	• Identify requirement for presence of modifier code for a particular procedure code
Pa Required Indicator	• Identify PA requirement for a particular procedure code
Point Of Sale (POS) Code	• Identify valid POS values for a particular procedure code
Provider Type Exclusion Code	• Identify excluded provider type for a particular procedure code
Provider Restriction Code	• Identify provider restrictions for certain category of service

Data Elements	Usage in Claims Adjudication Process
Pricing Indicators	• Identify pricing methods to be exercised for a particular procedure
Provider Specialty Code	• Identify provider specialty for a particular procedure code
Procedure Code Required Indicator	• Identify requirement for presence of a procedure code for a particular revenue code
Procedure Laboratory Code	• Identify requirement for CLIA validation for a particular a procedure code

9799-999

Exhibit D.1.4.6.4-1. Data Element Usage in Claims Adjudication. *This table shows some important Reference data elements that are used to support the edit, pricing and audit functions.*

The Baseline System maintains a variety of Reference modifier information to support accurate claims payment. As with other Reference information, we maintain historical modifier data through the use of begin- and end-dated segments within the Reference tables. Online pages currently enable access to modifier information for maintenance and inquiry purposes. Team CSC will leverage this existing functionality to design and develop comprehensive online access to modifier information, as specified in the RFP, for authorized State/Fiscal Agent staff. During DDI, we will work closely with the State to determine additional modifier-related information that must be maintained, design the format of online pages, verify search parameters and capabilities, and define user access permissions. Additionally, as part of multi-payer implementation, we will develop the capability to manage modifier information by benefit plan. **(40.6.1.45)**

(40.6.1.45)

The base Reference Subsystem provides 16 pricing tables to store date-specific fees, revenue rates, as well as provider-based and modifier-based rates to support a variety of pricing methods. We can accommodate rate variations due to factors such as procedure code modifier, Major Program, provider identification number, provider type, provider specialty, category of service, place of service, county codes. Team CSC will leverage the Baseline System tables to support the pricing requirements for DMA, DMH, DPH, and ORHCC. The Baseline System's pricing criteria makes use of three important data elements, similar to the legacy system's PAC code, accommodation code, and population group, for identifying appropriate price methods and rates for pricing claims. The Pricing tables will provide pricing rates to support RFP requirements including the ability to set maximum rates based on provider, population group, specific recipient attributes, DME and laboratory codes. We will modify the Baseline System to store, maintain, and process panel laboratory procedures and adjudicate claims submitted against panel procedures. The Procedure Code tables will provide a flexible, non-programmatic approach for configuring control indicators and other policy rules to be used by the Claims Processing and other Replacement MMIS subsystems. Team CSC will work with the NC DHHS during the DDI phase to enhance the Procedure Code tables with additional data elements, customize the codes value and make provision for future transition to the six-character HCPCS code. (**40.6.1.7, 40.6.1.32, 40.6.1.37, 40.6.1.39, 40.6.1.58, 40.6.1.59, Comment CSC106, SOO 10.12.7-2**)

(40.6.1.7, 40.6.1.32, 40.6.1.37, 40.6.1.39, 40.6.1.58 – 59, 10.12.7-2)

During the DDI phase, Team CSC will perform data mining on the legacy MMIS pricing, procedure and claims data and work with the DHHS divisions to define and implement the following functions:

- Ability to audit HCPCS codes and associated National Drug Codes (NDC) against pharmacy NDCs to prevent duplicate services. The Baseline System utilizes a

single claims processing engine as well as a single claims history database, allowing pharmacy and medical claims to be audited against without inherent changes to the baseline. The specific editing necessitated by this requirement may, however, require changes to support State-defined business rules. The State Requirements Matrix has been updated to reflect this situation. **(Comment CSC84)**

- Ability to create a crosswalk of claim type, provider type and provider taxonomy combinations to State, family planning, and federal categories of service for all types of service.
- Ability to indicate whether pricing is performed on the revenue code or the CPT code when a combination of the two is billed
- Ability to create a crosswalk of HCPCS Level I and Level II codes in the Physician Drug Program to NDC/Generic Classification Code (GC3) codes
- Ability to create a crosswalk of HCPCS Level I and Level II codes to rebateable NDCs
- Ability to add, delete or modify any provider maximum reimbursement rates on an basis or mass provider basis
- Ability to maintain budget criteria information for use by the Claims Processing Subsystem
- Ability to replicate rates from one type of provider and service to another like-type of provider when the service and rate are equal

(40.6.1.15, 40.6.1.42, 40.6.1.47, 40.6.1.54 – 55, 40.6.1.57, 40.6.1.67 – 68, 40.6.1.72)

- Ability to access or link State online policies while researching changes in CPT and ICD-9/ICD-10 codes. (**40.6.1.15, 40.6.1.42, 40.6.1.47, 40.6.1.54 – 55, 40.6.1.57, 40.6.1.67 – 68, 40.6.1.72**)

D.1.4.6.5 Diagnosis Related Groups (DRG) Code Maintenance

The Reference database maintains a set of DRG tables used by the Claims Processing Subsystem for pricing inpatient claims. The DRG tables contain various DRG factors, including the DRG weight, that are used to compute DRG-based inpatient claims including disproportionate share values for qualified facilities. The DRG tables are refreshed with updates from CMS. Team CSC will schedule the updates to be completed no later than October 1st each year. We will also review the DRG update control report to identify and resolve any update errors. The Baseline System Reference Subsystem includes a custom-version of the Medicare Code Editor (MCE) software that has provided great operational flexibility for the State of New York's MMIS operation. During the DDI phase, Team CSC will review the use of the MCE software versus the Baseline System's custom version and implement the appropriate version of MCE software for use by the NC DHHS. (**40.6.1.26, 40.6.1.31**)

(40.6.1.26, 40.6.1.31)

D.1.4.6.6 Drug Code Maintenance

The Reference database maintains a set of Drug tables used for pricing pharmacy claims and to perform Prospective Drug Utilization Review (ProDUR) evaluations and recover drug rebates. The Drug tables provide a user-configurable, table-driven approach for implementing administrative rules for edits and pricing during claims adjudication. **(SOO 10.12.7-2)**

(10.12.7-2)

Team CSC will work with the State to establish the process for refreshing the Drug tables with updates from our contracted vendor, First DataBank, or the State-owned drug update service on a frequency determined by the State; this process will include incorporation of software modifications to support new drug modules. The update process will allow for State-customized updates and new modules, non-overriding of designated State values, and generation of control reports to identify the updates received, updates that were bypassed, and the existing data on the Drug tables. It will also provide for drug rate updates on a schedule determined by the State that allows drug price indicator to be turned on or off for coverage. (**40.6.1.27 – 40.6.1.30, 40.6.1.80, Comment CSC225**)

(40.6.1.27 – 40.6.1.30, 40.6.1.80)

The Drug tables maintain information on drug identification, therapeutic classifications, rebates, pricing, various usage-related factors, as well as control parameters used to effect State administrative rules such as: service restrictions, PA-required thresholds for drug acute level and duration, lock-in/lock-out, identification of Medicare Part D drugs, Prescription Advantage List (PAL) tiers, step-therapy data, and proper maintenance of associations among Generic Code Number (GCN) data for drugs with similar indications or therapeutic features. (**40.6.1.83 – 84**)

(40.6.1.83 – 84)

Online screens are provided to inquire and update information contained on the Drug Code tables. The Drug Code Selection page is the entry page for drug code maintenance in the Reference Subsystem. The user may enter an NDC, a Drug Name, a Generic Sequence Number, a GCN, a therapeutic class, or a drug therapeutic class code to retrieve the drug details. A partial search can be performed on any of the searchable fields. From here, a user can select a particular drug code to retrieve the Drug Code Main page which displays general drug information including generic, packaging, NDC, therapeutic, strength, code, dosage, and Drug Efficacy Study Implementation (DESI) information. This page also allows for online updates to the following fields: Drug Name, Termination Date, Min/Max ages, Sex and Therapeutic Class Code. During the DDI effort, Team CSC will work with the State to determine which fields require phonetic search capability and develop the appropriate indexing and modify the search interfaces to implement this functionality. **(Comment CSC107)**

The Drug Code Main page includes a menu bar to allow navigation to other search screens such as:

- A Drug Code Price page displays pricing data for the NDC selected, including Average Wholesale Prices, federal Maximum Allowable Cost (MAC) Prices, Wholesale Acquisition Cost, Direct Prices, and State Maximum Allowable Charge (SMAC).
- A Drug Code DUR page displays Drug Utilization Review (DUR) data including precautionary information, and drug interactions. This page is inquiry only and can be searched using various search criteria.
- A Drug Code Rebate page displays rebate data for the NDC selected and is inquiry only.
- A Drug Code Conversion page displays conversion data for the NDC selected. Values for selected conversion segments can be updated.

- A Drug Code CMS Exclude page displays rebate exclusion data for the NDC selected.
- A Drug Code Miscellaneous page displays date specific coverage information along with coverage and bypass indicators. All data on this page is updateable by authorized users.
- A set of Group Inquiry/Update Display pages displays and allows updates to the Drug Group tables. First, the Group Selection page allows a user to add, change or inquire on Group information regarding pharmacy reimbursement calculations and group identification information. Another, the Group Main page displays the names of contact people for a group, the pharmacy network code assigned to the set of pharmacies allowed to serve this group of clients, claim filing limit, and the plan numbers for this group. Finally, the Group Pricing page is used for pharmacy reimbursement calculations. (**40.6.1.24, 40.6.1.49 – 52, 40.6.1.56, 40.6.1.76 – 79)**

(40.6.1.24, 40.6.1.49 – 40.6.1.52, 40.6.1.56, 40.6.1.76 – 40.6.1.79)

A Drug Benefit Package is used to capture the rules that pertain to the recipient's drug coverage and entitlements. Generally, all drugs are covered unless the Drug Benefit Package is set up otherwise. Detailed drug limit and coverage information for each drug benefit program is entered in the Drug Benefit Package using the first nine characters of the NDC, route code, generic code number, generic sequence number, drug category, drug class, Drug Enforcement Agency (DEA) schedule code, specific therapeutic class. These parameters can be entered as a single identifier or as a range of identifiers. The Drug Benefit Package also holds the parameters used to determine drug co-payment information. The Drug Benefit Package may limit the coverage for a drug based on a set of criteria defined on the Drug Benefit Package Custom dataset. Online screens are provided to inquire and update information contained on the Drug Benefit Packages. To facilitate Drug Benefit Package administration, a user may copy Drug Benefit Package and associated custom data from an existing Drug Benefit Package ID to a new Drug Benefit Package ID.

Exhibit D.1.4.6.6-1 shows the Drug Code Main page which includes a menu bar to allow navigation to other search screens.

Pages D.1.4.6-17 through D.1.4.6-20 contain confidential information.

The Parameter Reporting facility can be used to request the following reports:

- Procedure Code Report
- Revenue Code Report
- Selective Procedure Code Report
- Current Fee Schedule
- Procedure Abbreviated Listing Report
- Claim Edit Status File Listing
- Claim Edit Code List
- PA Edit Status File Listing
- PA Edit Status Summary Listing
- DRG Code Report
- DRG Current Pricing Segment Report
- Selective Drug Code Report
- Drug Code by DEA Code Report
  Drug Code by Generic Name Report
- Drug Code Report Drug Code by Brand Name Report
- DESI and IRS Drugs Report
- All Prices for All Drug Codes Report
- Drugs With Pricing Source of State In Drug Name Sequence
- Covered Drugs Not Rebateable Report
- Text File Report
- Price Report
- Diagnosis Code Report
- Prepay Utilization Review (UR) Criteria File Report
- Selective Provider Rate Code Report
- Date Specific Provider Rate Code Report.

(40.6.1.89 – 40.6.1.91)

During the DDI phase, Team CSC will work with the State to further define the detailed implementations for fee schedule and other related rate report requirements specified in the RFP. (**40.6.1.89 – 40.6.1.91**)

D.1.4.6.8 Interfaces

Team CSC's proposed solution provides data-exchange capability between the Reference Subsystem and other external systems to support the State's direction for enterprise-wide functionality. For business requirements and business partners that use various methods of exchanging information, the Reference Subsystem supports secure File Transport Protocol, file extracts, Web Services, and physical media as exchange mechanisms

(40.6.1.40, 40.6.1.69, 40.6.1.92)

For the Replacement MMIS solution, Team CSC proposes the following interface implementations: electronic extracts of Reference Files for State use; FTP transmission of claims pricing information to the Divisions of Vocational Rehabilitation and Services for the Blind; **NC***Tracks* Web Portal and Web Services to collect and maintain county DSS mailing addresses. (**40.6.1.40, 40.6.1.69, 40.6.1.92**)

(40.6.1.88)

Our proposed Reference Subsystem maintains prior approval requirement links among various Reference code sets. Team CSC will work with the State during the DDI phase to enhance the Reference Subsystem, possibly with a simple inclusion of prior approval initiation and end-date elements, to provide an online separate file of services that require prior approval to the Prior Approval business area. (**40.6.1.88**)

D.1.4.6.9 Data Change Control Process

The integrity of the Reference database is vital for accurate claims adjudication. In this regard, bulk data updates must be controlled and managed by Team CSC's change management process.

Team CSC only performs bulk data updates to the Reference on authorization from the State. This authorization is formalized with a State-issued Memo or Maintenance Request with clear instructions for file changes to procedure codes, diagnosis codes, revenue codes, dental codes, etc. On completion of the data updates, Team CSC provides notification of the change status back to the State.

During the Operations Phase, Team CSC operates an automated change management system to track change requests and update status. State users are granted access to the change management system to make Reference data maintenance request. The system logs the change request creation time, as well as the change completion events including the data maintenance completion time, operator completing request, and supervisor validation date. The Reference data maintenance facility includes a provision for the fiscal agent's operator to include edit/audit and other reference information from the State's change request. (**40.6.1.9)**

(40.6.1.9)

The reference information, as well as the before and after images of the reference data that was changed, is captured in both the appropriate Reference database tables as well as in the audit logs to provide a more complete and convenient tracking of file updates with the State's change request including the ability to link the updates with applicable edits/audits and other Memo reference data. This process maintains ProDUR data updates with before and after images, dates of the update, as well as change request information such as source of the change, Customer Service Representative (CSR) number, and memo number to satisfy State and federal auditing requirements. During the DDI Phase, Team CSC works with the State to implement a parameter-driven, ad hoc reporting of update activities from the system log. (**40.6.1.10 – 12, 40.6.1.60, 40.6.1.66**)

(40.6.1.10 – 12, 40.6.1.60, 40.6.1.66)

Team CSC provides sufficient storage capacity to allow the change management system to store unlimited electronic copies of all change communications including the State's policy change requests for Reference data changes, date of receipt, change approval, change assessments notes, audit trails of changes made, change completion records and our change status responses to the State. **(40.6.1.36)**

(40.6.1.36)

Both State and fiscal agent users are granted online access to the change management system to make change requests, add notes, update status, monitor change progress and completion status, and request online status reports of State memos. Finally, our change management process retains 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. **(40.6.1.61 – 65, 40.6.1.70)**

(40.6.1.61 – 65, 40.6.1.70)

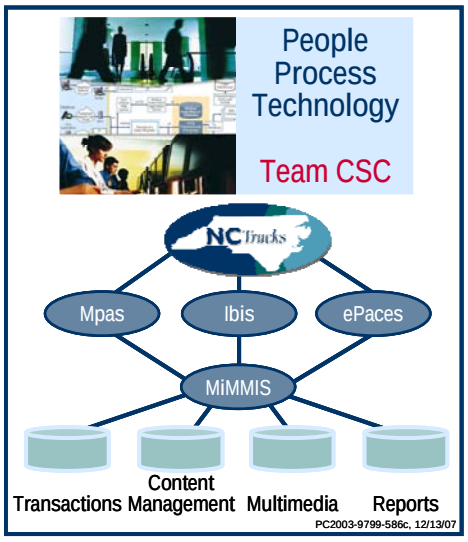
D.1.4.6.10 Conclusion

The proposed Reference Subsystem offers the State a flexible, rules-driven capability to maintain accurate reference data for all Replacement MMIS functions. The subsystem design supports implementation of the State's multi-payer capability and ensures that Team CSC can accommodate future expansion of the State's healthcare entitlement programs with a minimum of programming changes. (SOO 10.9-12)

(10.9-12)

D.1.4.7 Prior Approval Subsystem

The extensive capabilities of the Prior Approval Subsystem to manage approvals, referrals, and overrides will enhance providers' ability to deliver covered services to recipients, improve recipients' access to these services, enable provider payment for services rendered, and protect the State from inappropriate expenditures of DHHS medical assistance program funds.



Team CSC understands that prior approvals, referrals, and overrides are key factors in administering multiple benefit plans, managing expenditures from limited funding sources, and verifying the medical necessity and appropriateness of program services. Accurate and reliable processing of these transactions promotes both optimal delivery of services to recipients and responsible fiscal administration of public funds. Similarly, appropriate administration of referrals and overrides supports effective service delivery, as well as provider and recipient convenience. Team CSC's comprehensive approach to meeting the State of North Carolina's requirements is predicated on our understanding of the Prior Approval (PA) program and applies our industry-leading technical solutions to offer a fully-integrated, automated capability that promotes efficiency, cost-effectiveness, ease-of-use, and accuracy in the disposition of this workload.

The Replacement MMIS Prior Approval Subsystem enables complete prior approval receipt, adjudication of prior approval transactions, management of services and funds, updating of services utilization, encumbrance of funds, and reporting. The system effectively maintains the status of prior approved services, interfacing with the claims processing function to verify approval and accurately increment/decrement the services used/remaining information. In conjunction with the Reference and other subsystems, our solution enables easy definition of a broad range of prior approval parameters, including services requiring approval, edits/dispositions, and limits and exclusions, to name only a few. The proposed system is able to manage approvals for multiple overlapping entitlement programs and benefit plans to support the State's multi-payer processing environment. The Replacement MMIS prior approval capability fully automates workflow, reduces or eliminates paper, streamlines processing for more effective and cost-efficient operations, and provides a vehicle for accurately specifying and applying State clinical and practitioner coverage policy to services rendered. **(SOO 10.12.5-9)**

(10.12.5-9)

The Prior Approval component is fully integrated with all other aspects of the proposed Replacement MMIS. **Exhibit D.1.4.7-1** shows the primary features and benefits of the prior approval solution to the State of North Carolina.

Page D.1.4.7-2 contains confidential information.

The following subsections describe the proposed prior approval, referral, and override functionality in the areas of:

- Prior Approval Subsystem Overview
- Receipt and Management
- Entry and Editing
- Inquiry and Update
- Tracking/Audit Trail and Reporting
- Claims Processing
- Letter Generation
- Pharmacy Benefits Management.

Each subsection responds to the associated requirements from RFP Section 40.7.1. Requirements have been grouped by subject matter.

D.1.4.7.1 Prior Approval Subsystem Overview

The Baseline System Prior Approval Subsystem supports prior approval processing for multiple types of prior approvals and has the flexibility to support other prior approval types as specified in the RFP with minimal modification. Prior approval requests are accepted by the system from authorized users from a variety of media, edited, adjudicated, and stored in the integrated relational database for use in claims processing. Team CSC will develop additional functionality to accept prior approval adjustments. **Exhibit D.1.4.7.1-1** illustrates the primary Replacement MMIS interactions.

Pages D.1.4.7-4 through D.1.4.7-6 contain confidential information.

- Magnetic media (tape, diskette)
- Electronically-transmitted batch transactions
- Electronically-transmitted transactions from a point-of-sale devices (for pharmacy requests)
- Web transactions submitted through the **NC***Tracks* Web portal
- Paper transactions received via mail, secure email attachment, or fax (subsequently key entered into online pages)
- Telephone/voice transactions received through the AVRS.

Secure Electronic Processing:
• Covered transactions conducted in HIPAA-compliant format • eCommerce Subsystem maintains comprehensive submitter and user access information • NC*Tracks* Web portal and AVRS have effective authentication capabilities.

All electronic transactions, regardless of source (i.e., batch transmission, magnetic media, point-of-sale (POS) device, AVRS, the NC*Tracks* Web portal, and online pages), are conducted through the eCommerce Subsystem of the Replacement MMIS. eCommerce maintains a secure environment for processing and routing all transactions to and from the appropriate senders/receivers and Replacement MMIS subsystems. Through the eCommerce Subsystem, Team CSC maintains stringent control over authorized submitter information to assure full security and appropriate processing and routing of electronic files and records. Access/submission is permitted for authorized providers, billing agents, State agencies, and designated State contractors.

CSC conducts all covered electronic prior approval request and response transactions in HIPAA-compliant ASC X12N 278 or NCPDP format in a secure electronic environment. Additionally, State-contracted prior approval vendors and certain Local Managing Entities (LME) may submit adjudicated prior approval data using either the 278 format, or a proprietary format. If requested by the State, Team CSC will work with these vendors to accept these transactions in a proprietary format, since they do not constitute HIPAA-covered requests or adjustments. Team CSC will accept authorizations for Specialized Therapies, Psychiatric Services and Pre-Admission Screening and Annual Resident Review (PASARR) from approved vendors. PASARR approvals will be assigned a "PASARR" approval type code and the PASARR number and start/end dates will be retained in the Prior Approval tables, in the same manner as other prior approval transactions. Team CSC sends responses to all vendor-submitted prior approval transaction files, including PASARR, to verify receipt and account for each transaction. **(40.7.1.3, 40.7.1.15, 40.7.1.16, SOO 10.12.5-12)**

(40.7.1.3, 40.7.1.15, 40.7.1.16, 10.12.5-12)

Team CSC will implement additional functionality to accept referrals, overrides, and adjustments in a secure electronic environment. We will accept referrals via AVRS, Web portal, mail, and fax. Overrides and prior approvals will be accepted through the Web, mail, fax, or telephone requests received in the Provider Call Center. We will accept adjustments via 278 or Web-based transaction. **(40.7.1.4, 40.7.1.5)**

(40.7.1.4 – 5)

D.1.4.7.2.1 Web and AVRS Receipt

The *eMedNY* Medicaid Web portal and the AVRS are available 24 hours per day, 7 days, per week, 365 days per year with no scheduled downtime. Based on this demonstrated performance, Team CSC is confident that we can support the State of North Carolina's availability requirements (i.e., 6:00 a.m. to 11:00 p.m., Eastern Time, Monday through Friday and 7:00 a.m. to 7:00 p.m. on Saturdays and Sundays) for online inquiry, data entry, and update access for prior approval, referral, and override processing. CSC's excellent uptime record is a function of various factors including the zero failure rate of selected equipment, diligent monitoring of performance statistics, and training and availability of qualified staff to oversee operations. Team CSC will apply these approaches to achieve similar results for the State of North Carolina. We will confer with the State to determine any needs for scheduled downtime and the times at which that downtime will occur. Our objective is to exceed the State's requirements and maximize online availability of processing functions on the **NC*Tracks*** Web portal and the AVRS. **(40.7.1.20)**

(40.7.1.20)

The NC*Tracks* Web Portal enables secure, real-time, online entry and adjudication of prior approval requests and generation of responses using existing prior approval Web pages which will be enhanced to include additional State of North Carolina functionality. The AVRS also supports real-time prior approval entry, adjudication, and response notification. Team CSC will augment these existing capabilities to include processing of referral requests, both through the Web portal and the AVRS, and overrides through the Web portal. We will implement additional Web pages, similar in look, feel, and functionality, to the prior approval pages, to enable referral and override input, editing, response, and update. **(40.7.1.8, 40.7.1.18, SOO 10.12.5-10)**

(40.7.1.8, 40.7.1.18, 10.12.5-10)

When processing referrals, Team CSC will provide functionality in the Web-based referral processing to return a confirmation page in readable Adobe (i.e., PDF) format once a referral transaction has been successfully submitted. **(40.7.1.52)**

(40.7.1.52)

D.1.4.7.2.2 Image/Workflow Management

Team CSC will use its existing, effective processes for acquiring and managing paper input related to the prior approval, referral, and override functions. Documents will be received in the Mailroom and sorted, batched, and imaged by the FileNET Imaging system. **As documents are imaged, the system assigns a document control number (DCN) that is permanently tied to that item and passed to the Replacement MMIS. Multi-page transactions or transactions with attachments are imaged together and assigned the same DCN plus a sequence number. The DCN remains with the transaction throughout its life and is maintained in the relational Prior Approval database.**

Imaging and Workflow Management:

- Document Control Number (DCN) identifies all imaged documents
- Attachment relationships with original documents are maintained through DCN
- Subsequently-submitted material is tracked through Attachment Cover Sheet or Attachment Tracking Number.

When Team CSC requests paper documentation to support a previously-received prior approval, we issue a letter/cover sheet to be used when submitting the

attachment. This cover sheet shows the Prior Approval ID Number of the prior approval so that the incoming attachment may be associated with the correct transaction and indexed accordingly. Electronic (278) prior approval transactions for which the provider is also submitting paper documentation use the Attachment Tracking Number field in the ASC 12N 278 format to identify the attachment. The incoming document is marked with the Attachment Tracking Number which Team CSC uses to index it to the correct electronic prior approval transaction. Team CSC generates a unique number for the attachment, using a combination of the Attachment Tracking Number, the Provider ID, and the Recipient ID; this process prevents duplication of numbers due to similarity in provider schemes for numbering attachments.

Team CSC will handle medical photographs in the same manner as any other attachment and retain them in the image repository.

Team CSC will modify our existing process for prior approval receipt and imaging to accommodate referrals and overrides, developing appropriate indexing and user interface capabilities. We will continue to use the DCN to electronically link transactions and documentation and make them available to users online. **(40.7.1.6, 40.7.1.7)**

(40.7.1.6 – 7)

Effective Referral and Override Processing

Team CSC will apply our proven imaging, indexing, workflow management, and business rules approaches to the efficient disposition of referrals and overrides.

The Prior Approval Subsystem supports automated workflow management through configurable native business rules that place transactions into appropriate work queues for processing in first-in/first-out order. Once imaging is complete, prior approval transactions are placed in work queues for data entry through Viking. The system then automatically uploads keyed transactions to the Enterprise Blade Server and routes and queues prior approval edit/adjudication and resolution workload according to Replacement MMIS business rules defined in user-configurable tables. Team CSC will implement a similar capability for referrals and overrides. **(40.7.1.56)**

(40.7.1.56)

D.1.4.7.3 Entry and Editing

The Replacement MMIS identifies each prior approval with a unique number to prevent duplication. Prior approval number assignment controls are in place to ensure prior approval numbers are unique regardless of the type or input source. Prior approval numbers are assigned upon entry into the system, either manually or electronically, thus ensuring that approved, denied, and pended transactions will always be uniquely identified. Team CS C will implement similar unique numbering capabilities to identify and track referrals and overrides. **(40.7.1.28)**

(40.7.1.28)

Electronic transactions submitted via the Web, POS, and AVRS proceed through the eCommerce gateway which routes them directly to the Prior Approval Subsystem where they are numbered and adjudicated online, in real-time; the Replacement MMIS sends a Web, POS, or voice response back to the submitter. Access to these functions is available to all users authorized by the State, including State personnel and State prior approval contractors. Authorized users receive unique identifiers that grant role-based access to portal, POS, and AVRS functionality. **(40.7.1.14)**

(40.7.1.14)

Batched electronic transactions are processed in batch mode, entering the Prior Approval Subsystem and proceeding through the editing process. The Replacement MMIS generates response files for return to the submitter; these responses include the disposition of each transaction and its unique identification number.

D.1.4.7.3.1 Replacement MMIS Entry

The Replacement MMIS provides online pages through which Team CSC staff and other authorized users enter and process prior approval workload according to native business rules. The pages and capabilities available to the user are a function of each user's role and access permissions as defined in the system. The Replacement MMIS automatically determines which pages the user may see and what functions may be performed (e.g., whether the page is read-only, or update is allowed).

The PA Review group of pages is used to enter, search, update, adjudicate, and generate letters for prior approvals. Each page has a series of tabs that allows the user to move back and forth among these pages. These pages include the:

- **PA Header Page** — contains header information pertinent to all lines of the prior approval, including Prior Approval ID Number, Dates, Recipient, Prescribing Provider, Billing Provider, Status, and attachment information.
- **PA Detail Page** — contains the detail line item information and includes edits and approval information.
- **PA Edit/Routing Page** — gives edit override capability for a Reviewer to change the current edit disposition for a given edit on the current prior approval, or to assign a different Business Location or Reviewer Unit to the current prior approval.
- **Comments/Letter Page** — allows letter selection and generation and entry of separate comments text for inclusion on provider and recipient letters.

The Header and Detail pages are the main pages used for prior approval data entry. Since content varies somewhat according to the type of prior approval, the Replacement MMIS provides different pages for the different prior approval types. The system automatically presents the correct type of Header and Detail page, based on the prior approval type selected by the user.

The Baseline System currently supports the following prior approval types:

- Dental
- Eye care
- Hearing aids
- Out-of-state nursing facilities
- Prosthetic shoes
- Medical supplies
- Durable medical equipment (DME)
- Transportation
- Pharmacy
- Day treatment
- Medical practitioner surgical admissions to inpatient care and ambulatory surgery
- Elective admissions
- Personal care services
- Private duty nursing services
- Identified physician services
- Bed reservation.

The PA Header Page appears in **Exhibit D.1.4.7.3.1-1** below. In this case, the user has selected a Physician type of prior approval. The user enters the recipient, provider, and date information. The Replacement MMIS generates the unique Prior Approval ID Number and auto-populates non-entry fields from information in the Recipient and Provider files. The user then proceeds to the PA Detail page using the Detail tab.

Page D.1.4.7-12 contains confidential information.

The PA Detail Page, shown in **Exhibit D.1.4.7.3.1-2**, is used to enter the specific approval request information associated with each line of the transaction. In this case, the user enters the procedure information and the requested quantity/amount fields. When the user clicks the Add button, the line item moves to the table below and the line input area clears for entry of the next line item. If the user wishes to change a previously-entered line, that line can be selected from the table by clicking on the caret to the left of the desired entry and information from that line will be filled into the entry areas where it can be modified. A comments box is available to capture comments on a prior approval request. (The system will also capture and provide access to comments sent by providers in electronic format. These comments can be used to justify the prior approval request.) Team CSC will develop similar functionality for referrals and overrides. **(40.7.1.19)**

(40.7.1.19)

Page D.1.4.7-14 contains confidential information.

The proposed system has extensive editing capabilities and the ability to define and apply business rules to govern prior approval processing. The Prior Approval database consists of tables that maintain all information necessary to accept, process, and manage the requests, dispositions (approvals/denials), service, and pricing parameters, unique identification, utilization tracking, and tracking and audit trail information. The subsystem accesses data in the Recipient, Provider, and Third Party Liability (TPL) Subsystems to obtain eligibility criteria for limiting services and referral requirements. The Replacement MMIS also accesses Reference files which maintain edits such as defining which services require prior approval. Building on the current functionality, Team CSC will implement similar capabilities for referrals and overrides. **(40.7.1.25)**

(40.7.1.25)

The Reference Subsystem also defines and maintains all edit disposition and edit routing parameters and enables users to create and modify prior approval edits online. Tables and online pages provide users with access to data elements to maintain edit and audit dispositions and control routing of a prior approval when an edit is posted. **The online features give the user flexibility and the means to quickly react to changes in policies and services. In addition, the user receives immediate confirmation for correct entries and notification when attempting to enter incorrect or inconsistent data.** The PA Edit Status pages enable access by PA Edit Code and Description.

The PA Edit Code Search Page, shown in **Exhibit D.1.4.7.3.2-1**, allows the user to locate a specific PA edit code, modify it, or add a new code.

Pages D.1.4.7-16 through D.1.4.7-18 contain confidential information.

D.1.4.7.3.3 Prior Approval Transaction Editing

The Replacement MMIS data validation process will include:

- Recipient eligibility checking
- Provider eligibility checking
- Third party coverage verification
- Data checking (using multiple native business rules, edits, and code verification against information in the Reference Subsystem)
- Extensive duplicate checking against prior approval history, using parameters such as same provider, same recipient, same dates of service and procedure/drug, as appropriate to the type of approval being processed.

Management of Multiple Prior Approval Line Items

A prior approval may contain multiple line items with differing dispositions. This feature enables a single transaction to contain a combination of approved, pended, and denied line items.

When edit errors are found, the Prior Approval Subsystem posts an exception to the line item, or to the overall request, as appropriate. The system maintains a status for each of the multiple line item services (Line Determination), along with an overall status (Control Status) for the request. Each line item status is set based on the status of the exceptions posted to the line and maintained independently of the other line items. This feature allows a single prior approval request to contain a combination of approved, pending determination, and denied line items. The overall status for the request is based on a logical combination of the line item status. For example, a prior approval request will not be approved unless at least one of the line items is approved. The system will allow up to 25 exceptions to be posted for each prior approval request. It will not be possible to approve a prior approval until all of the significant exceptions are addressed.

For each prior approval line request, one or more edit(s) can be posted when an error is detected. These errors appear on the PA Detail Page (see the "PA Edits" in Exhibit D.1.4.7.3.1-2). The PA Edit Disposition Table in the Reference Subsystem defines the following possible dispositions assigned for each Edit Number, Prior Approval Type, and PA Medium Source Code combination:

- **Reject** — Edit causes prior approval to reject.
- **Pay/Report** — Edit is posted but not used in determining or validating prior approval line determination code.
- **Ignore** — Edit logic is bypassed.
- **Suspend** — Edit causes prior approval to Suspend for manual review.

(40.7.1.34)

Edit rules establish whether or not a prior approval requires manual review. Prior approvals that do not require manual review are not suspended, but finalized as "Approve" or "Reject." Prior approvals may be auto-denied when the provider is suspended or on review. The system edit rules can be set to access the Provider database and check the Enrollment Status and Enrollment Status Date fields for codes indicating suspension or review during the authorization date range requested. Team CSC will develop this capability for referral requests. **(40.7.1.34)**

Edits may be resolved at prior approval entry, or authorized users may retrieve the suspended prior approval and review and adjudicate it. The Replacement MMIS automatically assigns suspended prior approvals to a prior approval **Business Location** and/or **Reviewer Unit** (i.e., work queues) using business rules established for the State. In New York, prior approvals are assigned by County and Prior Approval Type. Team CSC will work with the State to determine criteria for routing workload and configure these business rules as needed.

D.1.4.7.3.4 Enhancements

Dynamic Routing of Workload
Workflow queues and locations for handling suspended prior approvals may be defined by the State and implemented through easy-to-change business rules that govern prior approval flow.

In addition to the capabilities available today, Team CSC will expand the appropriate databases, and modify existing pages and programs to accommodate the requirements of the North Carolina multi-payer environment, as needed. Additionally, Team CSC will implement similar, stringent editing and validation for referrals and overrides. (40.7.1.49) **(40.7.1.49)**

Team CSC will enhance the Replacement MMIS to contain the following edit functionality:

- To handle instances in which a prior approval is received for a recipient who is not yet on file, Team CSC will work with the State to determine how we would identify a pending eligibility situation and how long the prior approval request should be maintained. We will then develop and implement a capability to adjudicate and suspend such prior approval requests for a specified period of time (e.g., 60 days) until the recipient is enrolled and appears on the Recipient database. (40.7.1.12) **(40.7.1.12)**
- Team CSC will implement the capability to process prior approval requests by line of business (LOB) as part of implementing multi-payer functionality. We will capture LOB and benefit plan data on the transaction, using available fields in the ANS X12 278 transaction and modifying existing pages to include these fields. (40.7.1.13) Benefit Plan and LOB will be added to the Recipient database. **(40.7.1.13)**
- To retain the relationship of recipient-based hospice information, Team CSC will define a Hospice prior approval type and support capture and maintenance of this information. We will expand existing prior approval pages, Web pages, and the database to accommodate this information. We will collaborate with the State to determine the rules for relating the span of coverage to the recipient's eligibility. (40.7.1.17) **(40.7.1.17)**
- For DME approvals, we will enforce duplicate checking to include checking for the same service over the same timeframe by different providers. We will also capture the place of residence and include it in the editing process, making the appropriate page, database, and business rules modifications to edit DME prior approvals in accordance with State policy. The DME approval process will also include verifying that the recipient's age is appropriate for the equipment being approved. (40.7.1.47) **(40.7.1.47)**

- The Prior Approval Subsystem currently has the capability to apply prior approval logic by Prior Approval Type or Medium Source Code. In the multi-payer environment, Team CSC will capture line of business on the prior approval transaction and add it to the Prior Approval Edit Disposition tables. Additionally, we will expand prior approval edit logic to include benefit plan and recipient eligibility category checking. **(40.7.1.36)**

(40.7.1.36)

- To control how a claim will process when the limitation associated with a PA has been exceeded, Team CSC will add a Claim Edit Status Override column to the PA detail information; this status can indicate deny, track, re-enter, or other actions specified by the State. The claims adjudication process will access this information when processing a claim for services that exceed the PA. We will collaborate with the State to determine the detailed business rules for processing the State-specified statuses. **(40.7.1.67)**

(40.7.1.67)

D.1.4.7.4 Inquiry and Update

The prior approval inquiry and update process allows authorized Replacement MMIS users to access Replacement MMIS prior approval information, adjudicate a suspended prior approval, or update a prior approval which was already finalized.

Search pages allow users to search existing prior approvals using either a single Prior Approval Number or one or more of the following fields:

- Current Recipient ID
- SSN
- Ordering/Prescribing Provider Medicaid ID or Ordering/Prescribing Provider License number and Profession Code
- Billing/Requesting Provider ID
- Fiscal County.
- The following search fields are optionally used along with the above fields:
- Prior Approval Type (service type)
- Submit Date From and Submit Date To
- Formulary Code and, optionally, Formulary Code Modifier
- Procedure (HCPCS)/Item Code and optionally Procedure/Item Code modifier
- Rate Code
- Control Status or Line Determination.

(40.7.1.41)

Team CSC will enhance prior approval search functionality, and develop override search functionality, to enable searching by service type, issuing and authorizing provider name, recipient name, clerk identification, effective dates, approval type, diagnosis code, revenue code, and any combinations thereof. **(40.7.1.41)**

Using a radio button, users have an option of selecting the prior approval search results format either by PA Control Status, where Prior Approval Header level information is returned, or by Prior Approval Line Determination, where line level information is presented. Information returned is determined by the identity and authorization level of the user. Selection pages enable reviewers to select transactions from the search list. **Authorized users can work from the Suspended Queue by**

selecting a Business Location and Reviewer Unit and by clicking the "Review Next" button. Suspended prior approvals will be presented in the order of first-in/first-out (FIFO) to the reviewer on the respective prior approval type page.

Flexible Retrieval and Workload Processing
Prior approval search results can be displayed at the header or detail line level. Workload can be retrieved sequentially in first-in-first-out order using the convenient "Review Next" button.

Reviewers use the PA Header and Detail pages for the specific prior approval type to update prior approvals. The Physician PA Detail Page, shown in **Exhibit D.1.4.7.4-1**, is the same page used to enter the approval request originally, but it now presents in Update mode to enable processing and modification of an existing prior approval.

The Physician PA Detail Page shows the line items on the selected prior approval and the edit(s) associated with each. To process a line item, the user selects the line from the list presented by clicking on the caret to the left of the line. The Replacement MMIS places the line information in the input boxes at the top of the page. The reviewer can approve, deny, or modify and approve the line item. To approve a line without changes, the user may use the Autofill button which automatically approves the line for the requested services. The Replacement MMIS fills in the Approved Quantity, Amount, and Date information as appropriate. CSC implemented this capability for the State of New York to reduce the number of adjudication keystrokes to the minimum necessary. The Line Determination of "Approved" is automatically selected, as well as the "Approved" PA Determination Reason Code.

To modify the prior approval, the reviewer enters alternate information in the Approved fields and selects the approved/modified Line Determination from the pulldown menu. The reviewer selects one or more Determination Reasons from the Determination Reason menu, indicating which is primary by clicking the radio button associated with that reason. The user can also enter free-form comments in the Comments box.

Page D.1.4.7-23 contains confidential information.

Auth. ID, security tables are accessed to see if the Auth. ID has update authority for the prior approval that is being routed to him/her; if not, the system displays an error message.

System Navigation Capabilities:
• Access other subsystems by using convenient tabs at top of every page • Access pages, search capabilities, data maintained outside of the Prior Approval Subsystem • Access all claims associated with a prior approval online

Users can easily navigate to other parts of the Replacement MMIS by accessing the major function tabs at the top of the page. For example, to review stored recipient health information, provider data, or online claims, the user clicks the Recipients, Providers, or Claims tabs. The system transfers to the selected subsystem and the user accesses information via the pages provided in that part of the system. To view the claims associated with a prior approval, the user accesses a claims search page to retrieve the claims using the Prior Approval ID Number, and Provider and Recipient IDs. **(40.7.1.9)**

(40.7.1.9)

In instances where a prior approval request requires the submission of additional information (e.g., a service which can only be authorized after review of related lab results), the Replacement MMIS pends the request and places it in a queue for manual review. The reviewer uses the Comments/Letter page to issue a Missing Information letter and Missing Information cover sheet to the provider. This communication specifies the additional documentation that the provider must submit in order for the request to be adjudicated (refer to Proposal Section D.1.4.7.7, Letter Generation) and also contains the unique Prior Approval ID Number. The provider must attach the Missing Information cover sheet to the documentation being submitted, enabling Team CSC to associate it with the pended prior approval and index it accordingly in the imaging system. Receipt of the missing information automatically re-suspends the prior approval. A Reviewer accessing the suspended work queue may then retrieve the attachment image, view the lab results or other information, and adjudicate the prior approval. **(40.7.1.10)**

(40.7.1.10)

Users can also update existing, approved prior approvals, for example to increase or reduce the amount of services remaining, or extend or decrease the authorization timeframe. The user simply retrieves the prior approval and enters the revised values in the appropriate fields. The Replacement MMIS retains original information which can be viewed by right-clicking on the field. Refer to Proposal Section D.1.4.8, Claims Processing Subsystem, for a discussion of automated screening of drug claims.**(40.7.1.40)**

(40.7.1.40)

D.1.4.7.4.1 Enhancements

Prior approval inquiry access is also available via the **NC***Tracks* Web portal and the ARVS. Authorized users including physicians, pharmacists, and other health care professionals receive a secure user ID and password and have access to appropriate transactions (i.e., those with which they are associated on the Prior Approval database). Team CSC will enhance the Replacement MMIS and other system components to provide expanded inquiry access to prior approvals, inquiry access for referrals and overrides, and access for recipient inquiries. We will enhance existing prior approval pages and programs to accommodate search criteria to meet the State's

business needs. Similar capabilities will be developed to enable referral and override inquiry through the online Web pages and NC AVRS. **(40.7.1.38)** (40.7.1.38)

Enhanced referral and override capability will include functionality to:

- Search referrals by recipient ID, referring provider ID, referred provider ID, and referral number. Search access will be furnished through new online pages that are similar in appearance, functionality, and navigation to the Replacement MMIS Prior Approval Search pages. **(40.7.1.42)** (40.7.1.42)
- Search for a provider for the purposes of authorizing a referral. Functionality currently exists to use the Provider Name Search capability within the Provider Inquiry pages to locate a specific provider. Team CSC will enable tabbed access to the Provider and other Replacement MMIS subsystems from the referral pages. **(40.7.1.50)** (40.7.1.50)
- Use new Web pages that enable an authorized provider to retrieve his/her last 25 unique provider IDs to whom referrals were made. The display page will contain the list of provider IDs, names, and possible other data elements as needed or negotiated with the State. **(40.7.1.51)** (40.7.1.51)
- Allow the referring provider and the referred-to provider to inquire on referrals. When providers enter prior approval requests through the **NC***Tracks* Web portal, they receive Prior Approval Rosters reflecting their submitted transactions. Team CSC will consult with the State to determine the feasibility of using Referral Rosters for both the referred-to and referring providers to meet this requirement. **(40.7.1.53)** (40.7.1.53)

D.1.4.7.5 Tracking/Audit Trail and Reporting

The prior approval capabilities of the Replacement MMIS include tracking and audit trail functionality and robust reporting to satisfy the needs of the State.

D.1.4.7.5.1 Tracking/Audit Trail

All prior approval records contain the date of receipt, date of decision, denial/reduction in service reason, and decision notification date, as well as a myriad of other informational items pertaining to the prior approval and its adjudication and utilization**. The Prior Approval Subsystem protects fields such as the date of receipt and date of decision from being modified. An audit logging mechanism enables tracking of changes at the field level. The system tags any field that has been changed and records that change in history; the Replacement MMIS retains the old value, date and time, and operator ID for any changes to the database.** To view the change history, the user right-clicks on the field and the history displays. **(40.7.1.21)** (40.7.1.21)

Team CSC's Complete Audit Trail Capability:
• Records changes at the field level • Retains original values • Records operator ID, date, time of any changes • Protects specific fields against change • Change history available online by right-clicking on field.

Hardcopy transactions (e.g., mail, fax) are date/time-stamped upon receipt, imaged, and indexed to enable retrieval of the original document. Transactions are then key-entered into Viking. The system records the ID of the user keying the transaction. The database stores the image cross-reference number for each transaction so that the

original may be retrieved at the user workstation if needed. Once keyed and entered into the Replacement MMIS, transactions include a complete audit trail of any changes as described above.

Team CSC will implement similar tracking capability for handling overrides, including capture of date and time received. Automated transactions carry a date and time stamp for the time they enter the system; hard copy transactions are stamped in the Mailroom upon receipt. **(40.7.1.22)**

(40.7.1.22)

For transactions that will be keyed by State personnel, or State-approved vendors, Team CSC will issue User IDs and make access to online pages available through the **NC***Tracks* Web portal. User ID information will be captured in either method and associated with the transaction throughout its life. Team CSC will develop similar capabilities for handling of referrals and overrides. **(40.7.1.24)**

(40.7.1.24)

The capability to search and track therapeutic leave by patient identification is available using the Bed Reservation PA Type and the Recipient ID Number. The Provider ID indicates the specific provider types (i.e., child care facilities, nursing facilities, and intermediate care facilities for the mentally retarded (ICF-MR)). The Rendered Days field in the prior approval record is updated by claims processing and shows the number of days used. This information can be accessed on an individual basis using the PA Search Pages and the Recipient ID, date range (i.e., calendar year dates), and PA Type to view the Days Rendered. For yearly reporting to the State on an entire program population, Team CSC will determine the State's preference for format, content, timing, and distribution and develop a report. **(40.7.1.57)**

(40.7.1.57)

D.1.4.7.5.2 Record Retention

The Prior Authorization Subsystem includes a parameter-driven file purge process to control the length of time that prior approvals are retained on-line. System parameters, which specify the number of months of historical information which is to be retained on file, will be used (in conjunction with other purge criteria specific to the type of request) to identify records to be purged from the Prior Approval database.

This feature will provide authorized staff with control of the file purge process and the flexibility to easily change purge criteria.

Flexible Records Retention
Team CSC can retain prior approval data for any amount of time specified by the State. Record retention ensures that all information necessary to adjudicate service requests is available (e.g., limited services, once-in-a-lifetime services, etc.)

For our New York account, CSC maintains five years of transactions online and an additional five years in near-line archives that enable convenient retrieval. The system can retain historical data, limited only by the amount of available storage media. For the Replacement MMIS, Team CSC will retain prior approvals for each North Carolina program's recipients for five years from last occurrence online and an additional five years near-line. We will also maintain all usage by recipients for those benefits that are considered to be periodic or lifetime; this information will be maintained online indefinitely. Additionally, the retention process will take into account retention of associated claims history; prior approval history will not be purged while claims history is still online. **(40.7.1.26)**

(40.7.1.26)

(40.7.1.27) We will implement equivalent functionality and processes to retain referral and override information in the same manner. **(40.7.1.27)**

D.1.4.7.5.3 Reporting

The system produces a variety of reports designed to provide all levels of Medicaid staff with information that reflects the recipient utilization level being supported. These reports include, but are not limited to:

- Daily activity reports
- Weekly, monthly, quarterly, and annual reports that show processing counts
- Reports of approvals requested and approved by type of service
- Editing statistics
- Utilization by type of service, county, provider, and provider type
- Ranking reports
- Approvals not used within 120 days of approval
- Cost savings reports, comparing amounts requested to amounts approved
- Ad hoc reports to support other reporting requirements, as well as operations management and workload processing.

Reports will be maintained online by the Team CSC enterprise output solution, Mobius, and available to authorized users for viewing or printing.

The system can also easily produce electronic files as needed by State staff to support data analysis requirements.

Team CSC will develop custom additional reports as described below:

Convenient and Robust Reporting

The Prior Approval Subsystem offers comprehensive reporting capabilities. In addition, using the convenient data access afforded by the integrated relational database, Team CSC will develop custom reports to satisfy the State's business requirements.

- Team CSC will develop a prior approval statistical processing report, based on batch feeds, detailing contracted prior approval vendors' submissions. This report will indicate 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. The eCommerce Subsystem within the Replacement MMIS maintains comprehensive information regarding batch file receipt, response, and balancing. The EDI process includes the verification of submitter credentials, logging of date and time transmissions are received, and recording of detailed statistics regarding the disposition of files and transactions. Team CSC will modify the eCommerce Subsystem to pass batch identifier information to the Prior Approval Subsystem, to enable capturing the batch identifier on the individual prior approval record. Team CSC will reassociate processed prior approval records through the batch number, to the eCommerce input and output transaction statistics to generate the desired report. We will confirm with the State that our design and approach meets State requirements and intent. **(40.7.1.23)** (40.7.1.23)
- Initially, Team CSC will provide recipient profiles through ad hoc reporting requests to Team CSC Business Analyst staff who will generate these profiles using name, number, specific date or date-ranges, or lifetime procedures. The

Business Analysts will produce these reports in the format specified by the State, or submit a proposed format for State approval. Team CSC will collaborate with the State to determine the frequency of such reporting requests. If needed, we will automate the report request process by modifying the existing Replacement MMIS ad hoc report request pages. These pages enable user entry of parameters for report generation; reports will be produced and routed to Mobius for disposition. (40.7.1.35) **(40.7.1.35)**

- As part of developing the referral management capability, Team CSC will design and develop a new report that lists all open referrals (i.e., those for which a corresponding claim has not been received) within a user-specified period of time. We will develop a proposed format and report content for State approval. This report will be available on request, or scheduled to be produced regularly, and maintained by Mobius. (40.7.1.54) **(40.7.1.54)**
- Team CSC will design and develop a new report that lists the total number of referrals processed within a given month, broken out by referral media type and referral type. We will develop a proposed format and report content for State approval. This report will be available on request, or scheduled to be produced regularly, and maintained by Mobius. (40.7.1.55) **(40.7.1.55)**

D.1.4.7.6 Claims Processing

Prior Approval and Claims Processing Integration

The Claims Subsystem accurately adjudicates all claims using up-to-date prior approval information from the relational database. Prior approval amounts/units are drawn down, or restored, as indicated by claims and adjustments.

The claims processing function accesses processing rules to identify claims that require prior approval or referral. The system accesses the Prior Approval database to locate the approval and process the claim accordingly. The Claims Subsystem will update the record in the Prior Approval database upon payment for a prior approved service and the rendered units/dollar amounts of the prior approval record will be adjusted appropriately. The Claims adjudication function processes adjustments, voids, and refunds to increment approved units, frequency counts, pricing amounts (funds remaining) for all claims with associated prior approval transactions. (40.7.1.31) **(40.7.1.31)** The Claims adjudication function processes paid claims, adjustments, and refunded claims to decrement approved units, frequency counts, pricing amounts (funds remaining) for all claims with associated prior approval transactions. When services are exhausted or zero units remain within the approved timeframe, the prior approval is closed out and future claims denied or suspended. (40.7.1.32) **(40.7.1.32)**

Team CSC will develop the capability for specific State programs to encumber funds for prior approvals. An indicator will be placed in the Reference database to identify programs and services for which funds must be encumbered. We will develop encumbrance data tables and an Encumbrance Page to display and update information. This page will provide access to the forecast amount for each DPH benefit plan and prior approval type combination. This forecast amount will be used to determine the DPH encumbrance amount on an encumbrance report for each benefit plan. The Encumbrance Page will be able to search for records for a specific benefit plan or fiscal year benefit plan combination. We will enable un-encumbering

funds when associated prior approvals are modified or claims are paid against the prior approval. Team CSC will work with the State to determine the detailed approach for implementing this functionality. **(40.7.1.29)** (40.7.1.29)

Team CSC will enhance the Replacement MMIS to integrate referral transactions into the adjudication process. If the claim includes a referral number, the system will search the database for the appropriate authorization and process the claim accordingly, ensuring that the referred-to provider rendered the billed service, and applying override parameters to extend services. If the service requires a referral, and a referral number is not present, the system will suspend or deny the claim. This processing will mirror the capabilities currently implemented for prior approval processing.

Team CSC will develop the capability to establish variable recipient co-pay percentages on prior approvals. We will add a copay percentage table to the Prior Approval database and modify the Claims adjudication function to access and apply this percentage when pricing the claim. **(40.7.1.30)** (40.7.1.30)

D.1.4.7.7 Letter Generation

The Replacement MMIS produces a variety of letters for delivery to providers and recipients regarding the decisions made about prior approval requests after they are finalized (approved, approved as modified, or denied). Notifications are also produced when a prior approval is pended and missing information is needed. The letter format will allow for the mailing address to be printed on the letter and to be viewable in a window envelope. Letters can be produced in English and Spanish. Postal bar codes are printed on all letters and are viewable through a window envelope.

Prior approvals that are approved as submitted are reported on a PA Roster for each provider. The Roster can contain one page per prior approval or multiple prior approvals per page and shows the pertinent information for each recipient for services approved. Rosters are sent to providers daily (physicians and dentists) or weekly, depending on provider type. For prior approvals that are modified and approved, denied, or pended due to missing information, the reviewer generates the desired letter using the PA Comments/Letter page, shown in **Exhibit D.1.4.7.7-1**. This page has a drop-down menu that presents the complete list of letters available, depending on prior approval type and primary receiver. **(40.7.1.33)** (40.7.1.33)

Page D.1.4.7-30 contains confidential information.

Team CSC will implement updatable templates. Templates can be developed for new letters, such as adjudicated appeal letters, by defining the letter text, areas to be populated with variable data, and template identifier. **(40.7.1.59)** The PA Comments/Letter page allows entry of transaction-specific free-form text for internal comments, provider comments and recipient comments. The provider and recipient comments appear on provider and recipient letters respectively. **A comments area can be defined for any new letter template and tied to a comments area on an online page. (40.7.1.37)**

(40.7.1.59)

(40.7.1.37)

D.1.4.7.8 Pharmacy Benefits Management

Pharmacy service prior approvals may be submitted via POS device or electronic batch transmission using HIPAA-compliant NCPDP transactions, AVRS, or Web-based pages or secure emails on the NC*Tracks* Pharmacy portal. Pharmacy transactions are handled in the same manner as other prior approval transactions. Processing of all pharmacy prior approval transactions is guided by automated workflow/imaging processes that facilitate accurate and efficient first-in/first-out processing and return of responses to requesters. **(40.7.1.58)**

(40.7.1.58)

The POS prior approval request/response and adjudication process accepts, processes, and allows pharmacists to obtain prior approval for prescriptions (and subsequently submit a claim) while the recipient is at the counter. Transactions occur in real-time, returning appropriate disposition information to the pharmacy.

The following subsections describe the Pharmacy Web-site and Web-based entry and processing. **(SOO 10.12.5-10)**

(10.12.5-10)

D.1.4.7.8.1 Pharmacy Web-site

Team CSC's Pharmacy Prior Approval Web-site features:

- Secure provider access and transaction processing
- Recipient information accessibility
- Email prior approval capability
- Automated workflow with first-in/first out processing.

Team CSC proposes to implement **NC*Tracks***, an integrated North Carolina Web-site, based on enhancement of our existing *eMedNY*.org site, that will serve the needs of providers, recipients, stakeholders, and the State; refer to Proposal Section D.1.4.1, General System Requirements, for a complete description. This Web-site will provide a link for accessing all required pharmacy functionality, including 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), Monthly Pharmacists Report, and a link to the DHHS web-site for providers to access the Prescription Advantage List (PAL) and other pharmacy-related information. The CSC Pharmacy Web-site will also be able to include information about upgrades to the drug list, updates to criteria, evidence-based medicine (EBM) prescriber updates to clinical pearls and updates to other information for providers and recipients. The Pharmacy Portal will also enable provider submission of prior approval requests and receipt of responses through Web-based pages, in the same manner as other Web-based prior approval requests. Prior approval editing for pharmacy requests will include recipient eligibility verification, provider program participation, and third party coverage editing during adjudication,

in a manner similar to prior approval processing described for non-pharmacy services. (40.7.1.61 – 62) **(40.7.1.61, 40.7.1.62)**

The extremely flexible and powerful SharePoint technology will enable Team CSC to distinguish what type of user is accessing the Web-site (e.g., provider or recipient) and to show materials and options appropriate to that type of user. We will furnish informational materials in an easily-readable and downloadable format such as Adobe. We will provide links to other information sources and sites as appropriate.

The Web-site will support email submission of prior approval requests and receipt of responses; providers will attach requests to their emails. **Since approval requests and responses necessarily contain protected health information (PHI), these attachments must be encrypted in accordance with HIPAA privacy and security requirements. Thus, Team CSC and the sender must conduct an exchange of encryption key information before these transactions can be submitted and processed.** Once received, approval request emails will be handled by the automated workflow system which will place them in a queue to route them for input and processing in first-in/first-out order. Responses to email-submitted requests will be placed in an automated work queue for return to the sender via secure email. (40.7.1.63) **(40.7.1.63)**

D.1.4.7.8.2 Web-based Processing

The Replacement MMIS will also provide Web-based input pages to enable online entry/response for pharmacy prior approval requests by authorized providers through the Pharmacy Web-site. Existing functionality enables providers to inquire regarding the status of their prior authorizations. **Exhibit D.1.4.7.8.2-1** shows the format in which providers receive status information. The provider enters the search criteria and all prior approvals found are listed by recipient ID.

Pages D.1.4.7-33 through D.1.4.7-34 contain confidential information.

includes the NDC, Team CSC will determine the most efficient method of enhancing the Reference, Claims, and Prior Approval Subsystems to perform a crosswalk between the NDC and other data element. The Reference Subsystem can validate the need for a prior approval based on any of these codes; tables will be established to include a flag on those codes that require prior approval. If the NDC will continue to be present on the prior approval, a batch process can be used to update the PA Code NDC based on the data element specified. **(40.7.1.39, 40.7.1.43)**

(40.7.1.39, 40.7.1.43)

The MMIS online Drug Code Search page enables users to search for covered drugs using the following parameters:

- NDC
- Drug Name
- Generic Name
- GCN
- GCN Sequence
- State-specific Therapeutic Class
- Therapeutic Class Code (TxCL).

During the Implementation phase, Team CSC will enhance the existing search capability to include the functionality to search by additional parameters including: Effective and termination dates and date ranges, HICL, Ingredient List ID (HICL) Code, HICL-sequence, label name manufacturer, Universal Product Code (UPC), GC3, and American Hospital Formulary (AHF) code. We will collaborate with the State to confirm that our enhancements satisfy the State's business needs. **(40.7.1.64)**

(40.7.1.64)

To implement the capability to dispense a 72-hour supply of drugs without prior approval in emergency situations, Team CSC will modify the Claims Subsystem logic to approve such claims. We collaborate with the State to determine which drugs may be dispensed in this manner, the maximum amount of each such drug that may be paid, and the parameters by which we define an "emergency" situation. **(40.7.1.44)**

(40.7.1.44)

Pharmacy claims history maintains complete information regarding the recipient and the pharmacy (drug) services that were adjudicated. When aberrant utilization patterns are identified, the online pages available in the Recipient and Claims Subsystems enable retrieval and capture of information for specific recipients. Claims history can be accessed by Recipient ID and Claim Type (e.g., Pharmacy) to retrieve information regarding specific drugs. During implementation, Team CSC will collaborate with the State to confirm that existing functionality fully supports the State's search, retrieval, and capture requirements. **(40.7.1.60)**

(40.7.1.60)

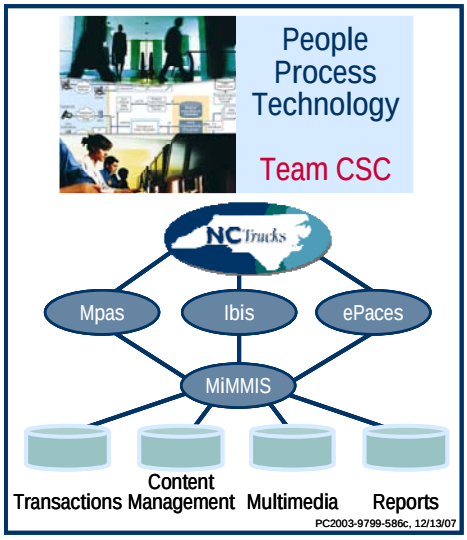
D.1.4.7.9 Conclusion

The Replacement MMIS' automated processing capabilities will enable the State to configure extensive prior approval, referral, and override business rules and edits, optimize workload processing through proven workflow management tools, and perform robust program monitoring and reporting. Providers' administrative workflow will benefit from access to a convenient and flexible prior approval request/response process and their ability to furnish covered

services to eligible recipients will be enhanced. Recipients will benefit from access to their prior approval information and facilitated access to the care to which they are entitled. And finally, the State will have enhanced means to ensure Medicaid and other program funds are not expended inappropriately. Team CSC's solution will improve provider delivery and recipient utilization of services while saving administrative and benefit dollars for the State.

D.1.4.8 Claims Processing Subsystem

CSC is a leader in delivery of innovative healthcare IT solutions and will implement an online, real-time Claims Processing Subsystem that is capable of processing current and future claims volumes and supporting multi-payer functionality according to North Carolina policies and procedures.



Team CSC understands that accurate and timely claims adjudication and appropriate payment are crucial to the success of North Carolina's multiple healthcare programs as managed by DMA, DMH, DPH, and ORHCC. Upon conversion from the legacy MMIS, NC DHHS will obtain the benefits of a new, robust Claims Processing Subsystem capable of adjudicating all claim types in a multi-payer environment in accordance with North Carolina policy and easily modifiable as those polices change to meet the needs of North Carolina citizens. **(SOO 10.3.1-1)**

(10.3.1-1)

Team CSC proposes, in close collaboration with the State, to modify and implement the Claims Processing Subsystem from the Baseline System, *eMedNY*. The baseline Claims Processing Subsystem provides most of the functionality required by the RFP and currently processes very high volumes of claims for the State of New York. The Baseline System is capable of processing all claim types required for North Carolina and provides the ability to receive claims in paper formats as well as HIPAA-compliant electronic formats.

Claim Processing Volumes

The Claims Processing Subsystem in the Replacement MMIS is capable of handling North Carolina claims volumes since it has accurately adjudicated more than 450 million claims per year for the State of New York.

From July 2006 through June 2007, the baseline Claims Processing Subsystem adjudicated more than 450 million claims, including almost 97 million pharmacy claims, according to the policies and procedures of the New York Department of Health. Based upon claim statistics provided in the Procurement Library, the proposed Replacement MMIS has more than sufficient capacity to accurately process the projectable workloads for the entire life of the contract. **Our experience and technology well positioned Team CSC for a low risk implementation of a Claims Processing Subsystem to meet current and future needs of NC DHHS.**

In **Exhibit D.1.4.8-1**, Claims Processing Subsystem Features and Benefits, we illustrate some of the major features of the baseline Claims Processing Subsystem and the benefits for the State of North Carolina provided by our solution.

Page D.1.4.8-2 contains confidential information.

efficiently. From our initial analysis of the medical assistance programs administered by NC DHHS, Team CSC has determined that our Claims Processing Subsystem, with some modification, is capable of adjudicating payment requests from these various programs. Currently, our MMIS pays typical fee-for-service claims for Medicaid programs; processes encounter claims for managed care programs; generates capitation payments; and processes and pays pharmacy claims. We will modify the Baseline System to permit the incorporation of efficient claims processing for DMA, DMH, DPH, and the Migrant Health Program administered by ORHCC. Our approach to developing a multi-payer solution will allow us to incorporate additional North Carolina medical/benefit programs in the future without significant development or modification. For additional information about assignment of the financially responsible payer, benefit plan, and pricing methodology for each service tendered on a claim, please refer to Section D.1.4.8.5.1, Determination of Financially Responsible Payer and Eligibility/Population Group, below. **(40.1.1.1, SOO 10.1-2, SOO 10.2-1)**

(40.1.1.1., 10.1-2, 10.2-1)

In support of our efficient claims processing objective, the Team CSC Claims Processing Subsystem meets the business needs of each division within NC DHHS by maintaining applicable rules, NC DHHS-approved policies, and pricing methodologies. We **control all claims, adjustments, and financial transactions** in the Claims Processing Subsystem **using a unique control number assigned to each individual payment request and maintain an audit trail** throughout the processing cycles. Transactions follow system logic through a series of edits, audits, and detailed pricing logic resulting in either adjudication for payment or denial, or suspending for additional manual review. The outputs from our advanced Claims Processing Subsystem are fully adjudicated claim records, accurate calculation of payments, timely reports on claims inventory, processing statistics for management review, and claims history files. The claims history files provide a timely, accurate, automated, and date-sensitive data repository of all claims processing data.

The proposed claims processing solution provides automated means for handling all paper documents in our mailroom and innovative approaches to submission of electronic claims by providers. **Team CSC realizes that providers are typically more willing to participate in Medicaid and other state-funded medical/benefit programs if their interface with these programs closely resembles their interfaces with other payers, simplifying their billing procedures and lowering their costs.** For providers able to take advantage of these benefits, we **emphasize the desirability of electronic claims submissions** through HIPAA-compliant EDI transactions, and web-based claims entry and claims submission applications. We propose **to optically scan and image all hard copy claims,** including CMS-1500, CMS-1450 (UB-04), ADA dental, and pharmacy universal claim forms. In addition, we propose to use Optical Character Recognition (OCR) technology to capture the data from all clean CMS-1500 and CMS-1450 claim forms.

The Claims Processing Subsystem is an integrated part of the Replacement MMIS and functions seamlessly with all other subsystems to process all claims accurately. The proposed solution allows all enrolled providers to submit claims on behalf of eligible North Carolina recipients and processes all claims according to appropriate

Page D.1.4.8-4 contains confidential information.

Inputs	Processes	Outputs
Mailroom and Data Entry		
Paper Claim Forms from US Mail and Courier deliveries, returned checks	Sort, batch, image, date stamping, OCR, data correction, data entry, batch control, data validation, data translation	Images of paper documents, electronic claim records formatted in the Replacement MMIS required format, return to provider letters, system reports
ASC X12N 837 I, P, D; NCPDP Claim Transactions and Web Claim Submissions	Data entry, batch control, data validation, data translation	Electronic claim records formatted in the Replacement MMIS required format; HIPAA-compliant acknowledgement of receipt, system reports
Claims Adjudication		
Claim records formatted in the internal record layout	Split medical claims with multiple lines into claims with one line, determine financial payer and benefit plan, perform edits, audits, and pricing according to financial payer, determine allowed amount, suspend or deny claims that fail edits and audits, allow for manual pricing of claims	Claim records with a status of paid, denied or suspended, system reports
Pharmacy claim transactions	Determine financial payer and benefit plan, perform edits, audits, and pricing according to financial payer, determine allowed amount, suspend or deny claims that fail edits and audits, allow for manual pricing of claims, perform ProDUR editing, return DUR alerts to pharmacy	Claims records with a status of paid, denied or suspended, system reports
Capitation and management fee transactions	Process through the adjudication cycle	Capitation and management fee records with a status of paid or denied, system reports
Suspense Correction		
Suspended claim records	Correct keying errors, resolve edit errors, route claims to appropriate queues, manually price claims, perform prepayment review, release resolved claims	Claim records with correct fields and force/deny codes, system reports
Adjustment Processing		
Individual claim, or other transaction adjustments	Determine financial payer and benefit plan, perform edits, audits, and pricing according to financial payer, determine allowed amount, suspend or deny claims that fail edits and audits, allow for manual pricing of claims	Claim records with a status of paid, denied or suspended, system reports
Mass adjustment requests	Identify claims matching request, reprocess and re-price claims, post special edit number, produce adjustment report, review report, release claims	Mass adjustment report, re-priced claims, suspense release report

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Exhibit D.1.4.8.1-2, Claims Processing Inputs, Processes, and Outputs. *The powerful Claims Processing Subsystem accurately adjudicates all claim types and produces the desired payments.*

The processes listed in the table above are described in detail in the sections that follow. The Claims Processing Subsystem must access other subsystems in order to adjudicate claims correctly and employs other tools to support claims submission. The Replacement MMIS claims processing solution comprises several components and tools that are referenced throughout the remaining discussions. **Exhibit D.1.4.8.1-3**, Claims Processing Tools and Components, lists each component and provides a brief description of the function.

Tool/Component	Function/Description
Baseline Claims Processing Subsystem	Subsystem performs claims adjudication according to North Carolina business rules for each line of business
NC*Tracks* Web Portal	Accepts and processes claim submission transactions
Image Management System	Imaging of hardcopy claims and storage in FileNet; OCR functionality for data capture and correction
Automated Workflow	Workflow and business rules capability
Recipient Subsystem	Subsystem maintains recipient eligibility data and business rules
Provider Subsystem	Subsystem maintains provider eligibility data and business rules
Reference Subsystem	Subsystem maintains edit and business rule information
Prior Approval Subsystem	Subsystem maintains prior approval data
Health Check Subsystem	Maintains data related to EPSDT services
Third Party Liability Subsystem	Maintains data related to other insurance carriers
Managed Care Subsystem	Maintains data related to health plans and primary case management activities
Mobius	Online report retrieval and storage capability

9799-999

Exhibit D.1.4.8.1-3, Claims Processing Tools and Components. *The Replacement MMIS provides an integrated claims processing solution with imaging, OCR, web-based claims submission, workflow, rules based edits, and other state-of-the-art tools.*

The Claims Processing Subsystem is available via the **NC***Tracks* Web Portal through the Claims tab of the main Replacement MMIS page. Providers are able to access claims submission software through special links from **NC***Tracks* available for their use. They are able to submit claims and check recipient eligibility via **NC***Tracks* as well as check on the status of submitted claims. The Replacement MMIS provides authorized users with an integrated solution for viewing claims, resolving suspended claims, and viewing other subsystems.

D.1.4.8.2 Document Intake

From our experience, Team CSC recognizes that a successful fiscal agent operation requires an excellent technical solution for the receipt, tracking, and processing of all documents that are submitted as part of routine business functions. We understand that proper control and innovative approaches to handling the volumes of paper and electronic documents are critical. In this section, we describe our technical solution for receiving, controlling, and processing both electronic and paper documents required for the support of multiple fiscal agent business functions.

The Claims Processing Subsystem provides a variety of ways for providers to submit claims and encounters for adjudication and payment of services. In addition to the submission of paper documents, we provide a comprehensive **NC***Tracks* Web Portal for authorized providers to use for the submission of individual claims or to upload batches of claims generated by their practice management software. Team CSC also establishes interfaces to large providers and widely used Value Added Networks (VAN), such as Emdeon, for the receipt of electronic transactions that are transmitted in HIPAA-compliant and NCPDP formats over a virtual private network (VPN). These methods for receiving claims into the Replacement MMIS **improve recipient and provider satisfaction and increase overall program efficiency, and integrity**.

(10.12.5-2)

Exhibit D.1.4.8.2-1, Claims Receipt and Entry Functionality, shows the breadth of the functionality provided for the receipt of electronic and paper claims. **(SOO 10.12.5-2)**

Claims Receipt and Entry Functionality						
	Paper Imaging and OCR	Paper Imaging and Direct Entry	Web Portal Individual Claim	Web Portal Batch Claims	Dial-up Submission	Virtual Private Network
Submission Type						
Interactive Entry		✓	✓		✓	✓
Interactive Correction	✓	✓	✓		✓	✓
Batch File				✓	✓	✓
Claims and Adjustments						
Original Claim	✓	✓	✓	✓	✓	✓
Void	✓	✓	✓	✓	✓	✓
Adjustment	✓	✓	✓	✓	✓	✓
Encounter			✓	✓	✓	✓
Claim Types						
Professional (CMS-1500)	✓	✓	✓	✓	✓	✓
Institutional (CMS-1450)	✓	✓	✓	✓	✓	✓
Dental	✓	✓	✓	✓	✓	✓
Pharmacy	✓	✓	✓	✓	✓	✓

9799-999

Exhibit D.1.4.8.2-1. Claims Receipt and Entry Functionality. *Team CSC provides a robust solution that allows providers to submit claims using various submission types, claim types, and submission methods.*

Our Claims Processing Subsystem accurately and quickly processes claims and encounters according to State-approved guidelines. Submission methods include HIPAA-compliant electronic formats such as the X12N 837 transactions, NCPDP version 5.1, and paper claim forms.

We accept and process crossover claims for Medicare Part A and Part B and claims for Medicare HMO cost sharing on paper and through direct electronic submissions. For paper submissions, the billing provider uses the CMS-1500 claim form for the reimbursement of Part B services originally billed to Medicare on the CMS-1500 form, and the CMS-1450 claim form for the reimbursement of Part A and Part B services originally billed to Medicare on the CMS-1450 form. For direct electronic submissions, the approved carriers and intermediaries submit claim information using the appropriate electronic record layouts for Part A and Part B services. **(40.8.1.101)**

(40.8.1.101)

As shown in **Exhibit D.1.4.8.2-2**, Document Intake Process, we provide a comprehensive solution for handling the input of paper documents received via US Mail or other courier services, and electronic documents received through our **NC***Tracks* Web Portal or other electronic data interchange methods. We employ **the best processes to control and track all documents** and produce the necessary output formats to continue appropriate processing for each document type. **(SOO 10.12.5-1)**

(10.12.5-1)

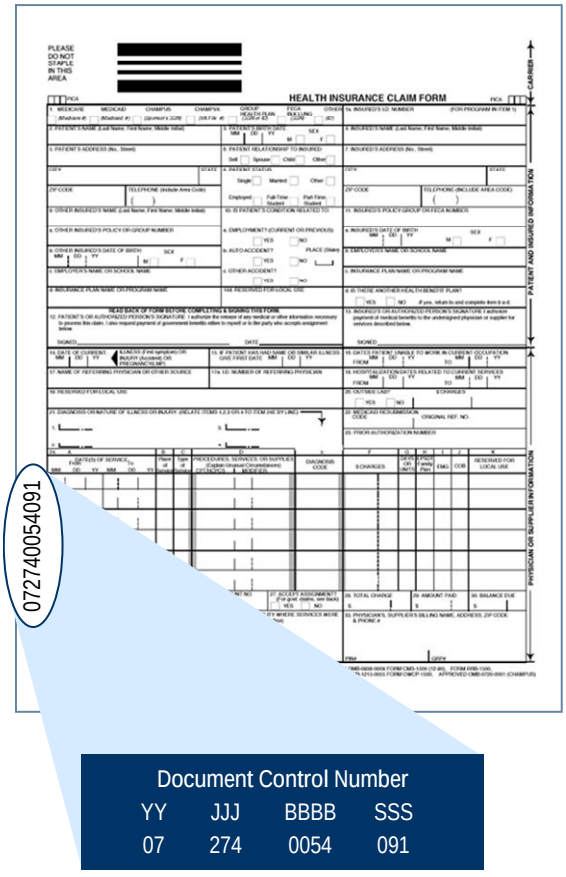
Page D.1.4.8-8 contains confidential information.

All paper documents are grouped or batched by common document types and processed through high-powered scanners that imprint each hardcopy document with a **unique Document Control Number**. This control number contains the date of receipt, a batch number, and a sequence number within the batch. This process ensures that all mail, including claims, claim attachments, adjustment requests, and other claims-related documents, receives a mechanized date stamp at the earliest time possible and records the day Team CSC receives the paper. The scanner places an imprint of the number on the physical document and the number is part of the digital image. All authorized users are able to identify and track documents from day of receipt through final disposition using this control number. **(40.8.1.1, 40.8.1.7)**

(40.8.1.1, 40.8.1.7)

As depicted in **Exhibit D.1.4.8.2.1-1**, Document Control Number, the control number placed on each document during the imaging process is a 12-digit number. The number is formatted to include five digits for the Julian date of receipt (two for the year and three for the day), four digits for the batch identification number, and three digits for the sequence number within the batch. We typically place no more than 100 documents in a batch and at this rate, the current numbering scheme allows us to generate control numbers for up to 999,900 documents every day. **(40.8.1.7)**

(40.8.1.7)



PC2003-9799-318a, 10/19/07

Exhibit D.1.4.8.2.1-1. Document Control Number. *This number provides a unique tracking and control mechanism that remains with the document through final disposition.*

The document control number becomes a key for locating images of the paper documents. During processing and formatting prior to entry into the claims adjudication process, the document control number is linked to a longer transaction control number that is used for processing and controlling claims, adjustments, attachments, and financial transactions throughout the system. We routinely reserve certain batch number ranges for particular document types. For example, batch numbers 9950 through 9999 are reserved for provider enrollment applications and associated documents. **(40.8.1.8, 40.8.1.9)**

(40.8.1.8, 40.8.1.9)

Team CSC images all paper claims, including those missing key data elements. Our data capture software easily identifies claims with missing required data elements and rejects the claims. These claims do not flow into the work queues for correcting data, and our Automated Workflow Management system routes the claims to individuals who are able to generate a return-to-provider (RTP) letter automatically, based upon the type of data that is missing. Team CSC staff is able to insert specific instructions in the RTP letter for the provider on how to complete the claim form with the correct information and to resubmit the document for processing. For instance, we image a claim submitted without a recipient identification number, but reject the claim immediately and route it for return to the submitting provider with the appropriate letter attached. **(40.8.1.5)**

(40.8.1.5)

D.1.4.8.2.2 Web Portal Document Receipts

The **NC***Tracks* Web Portal provides the entry point for electronic submission of claims when the provider is not able to take advantage of submission through a value added network. The portal allows providers and other authorized users to enter professional, institutional, and dental claims, as well as other form types, both individually and in batch formats. We understand that providers often prefer to submit electronic documents rather than paper because **electronic submission reduces the cost of managing the provider's practice and improves the turnaround time for payment to the provider**. Therefore, **NC***Tracks* provides online tools that permit data entry of individual claims via ePACES or batch submission of large groups of claims generated from a practice management system via eXchange.

Providers log onto ePACES over the Internet and ePACES automatically submits transactions for processing, eliminating the need to mail files on diskettes and tapes. The HIPAA-compliant transactions are transmitted electronically to the Replacement MMIS using a secure data transfer protocol. The ePACES application integrates with the Claims Processing Subsystem via a translator, which reformats the data being transferred to a structure expected by the adjudication engine.

Because ePACES is a web-based application, it is not necessary to distribute application software for provider installation. The most current version of the ePACES application is available to the client PC each time a provider accesses the system over the Internet. **Providers only need a PC, browser, and connection to the Internet to access ePACES**. Providers are not required to install any custom software or incur additional expenses.

Pages D.1.4.8-11 through D.1.4.8-16 contain confidential information.

claim that was in the batch. After editing a claim, the user must re-batch the claims.

- **Sent:** When a user submits a claim, the status is changed to "sent."
- **Replaced:** When a Replacement claim is submitted, the "sent" claim being replaced has the Status changed to "replaced."
- **Voided:** When a Void claim is submitted, the "sent" claim being voided has the Status changed to "void."

A feature of ePACES that helps providers who submit claims for the same recipients on a routine basis is the ability to **select a claim with a status of "sent" and choose to edit the claim**. If a "sent" claim is edited, the Submission Reason is automatically changed to Original and all the fields on the claim are available to be edited except the Submission Reason, Recipient Identification Number, date of birth, and gender. There is no association between the previously sent claim and the new claim. The provider is able to change diagnosis codes, dates of service, procedure codes, and any other pertinent data on the claim prior to resubmission. This feature allows the provider **to save some time keying information repeatedly for the same recipient**. It is the provider's responsibility to ensure that other insurance information and any referral or prior approval information is correct prior to submission.

The solution allows providers to generate batches of X12N 837 transactions from their practice management systems for submission without having to rekey the data into ePACES. For providers who are able to create the HIPAA-compliant 837P, 837I, or 837D transactions, we provide the capability to upload the transactions via eXchange. Providers must have an assigned user identification and password for authentication purposes before logging into eXchange. Once they are logged into the system, they use a browse function to search for a claim batch file on their PC. The function automatically uploads the file and allows the provider to submit the claims for processing.

All claims submitted for processing are routed through the eCommerce Subsystem for: data validation, and format editing; translation from the HIPAA-compliant format into a claim record format that is usable within the Claims Processing Subsystem; and batch control processing to ensure duplicate claims are not entered into the system. The provider receives a HIPAA-compliant acknowledgement and claim status within 24 hours after submission. All responses are available for viewing through either ePACES or eXchange. **(40.8.1.27)**

(40.8.1.27)

D.1.4.8.2.3 Electronic Data Interchange Receipts

We have incorporated electronic data interchange (EDI) functionality into the Replacement MMIS to **support the maximization of electronic claims submission, thus improving overall program efficiency, cost-effectiveness, and provider satisfaction**, as well as **minimizing operational costs for the provider and the State**. Our EDI services currently provide for acceptance and translation of all HIPAA X12N transactions as well as NCPDP 5.1 submissions and will be updated to include new transactions when required. The system accepts the HIPAA-compliant X12N 837 professional, institutional, and dental transactions for translation and entry into the Claims Processing Subsystem for further editing and adjudication of claims.

Typically, pharmacy claims are submitted using the NCPDP 5.1 format and are processed in real time to a final adjudication status. All EDI submissions are processed through the eCommerce Subsystem to validate the appropriate electronic format and verify the record count. The eCommerce Subsystem returns a HIPAA-compliant acknowledgement of the claim receipt within 24 hours of the original receipt. The eCommerce module logs the record count, pre-screens claims to identify any global error conditions, monitors submissions to ensure duplicate submissions are rejected, and determines whether the records can be submitted to the Claims Processing Subsystem for editing, pricing, and final adjudication. The eCommerce Subsystem rejects claims with errors or duplicate submissions and returns all individually rejected or entire batches of claims to the submitter with reason codes identifying the errors. **(40.8.1.12, 40.8.1.27 – 29)**

(40.8.1.12, 40.8.1.27 – 29)

Prior to submission of valid records to the Claims Processing Subsystem, eCommerce assigns a transaction control number that contains the Julian date of submission and a unique batch number and sequence number. **The system balances the number of records received to the number of records submitted to the Claims Processing Subsystem for processing.** Since the Claims Processing Subsystem is capable of processing claims 24 hours per day, 7 days a week, the Replacement MMIS is capable of returning a claim status to the submitter of EDI transactions within 24 hours of the receipt date.

D.1.4.8.2.4 Access to Data via Mailroom System Logs

Pitney Bowes hardware and associated software packages provide an automated method for receiving, tracking, controlling, and accounting for all mailroom receipts and outgoing envelops and packages. This software simplifies delivery logging, and reporting. It allows us to use barcode readers to identify and record the name of the carrier that delivered particular items. This process enables us to maintain data such as who sent the package, who signed for the receipt of the package, and the date and time we received the package. Our mailroom staff tracks the contents of the package using the Image Management System as described above. Pitney Bowes hardware and software also provide the capability to handle all outgoing shipping responsibilities. We are able to make informed choices for the best and most cost effective method for shipping packages. In addition, the mail system automatically generates logs to track shipping and mailing costs across the enterprise. **(40.8.1.2, 40.8.1.4, 40.8.1.6)**

(40.8.1.2, 40.8.1.4, 40.8.1.6)

In the event we receive a check, our staff follows a **documented procedure** to ensure that we process all returned payments and other checks in a secure and controlled manner. Our **secure process** includes having a supervisor photocopy all checks, and imaging the photocopy with any supporting documentation sent with the check. We **catalog each check electronically** in a relational database with the capability to capture the name of the person/organization sending the check, the type of check, the check number, the check amount, and a notation if we received paperwork with the check. **(40.8.1.3)**

(40.8.1.3)

All reports generated from the database used to monitor mailroom receipts are available for viewing by the State and authorized users via the NC*Tracks* Web Portal.

D.1.4.8.3 Claims Entry

Team CSC uses Emdeon Trans*form*™ to process claim forms with dropout and non-dropout ink and generate an electronic image of all claim documents, including original claim forms, claim attachments, and adjustments. The Trans*form* application streamlines claim form processing by automating the conversion of paper claims data to electronic data. Once the claims are imaged using Emdeon Trans*form*, the claims data is captured and converted to an electronic record that can be processed by the eCommerce Subsystem for translation into the claim record format used in the Claims Processing Subsystem. Verify is a **high-performance data capture software** that is able to **optimize and maximize the recognition of claims data from paper forms**. The Verify application is capable of recognizing various claim types including CMS-1500, CMS-1450, dental, and pharmacy forms. Team CSC configures the application to capture all required data fields on each claim form to ensure the data required to process every claim type is available for submission to the Claims Processing Subsystem. This includes capture of indicators for third party insurance, accidents, tooth number, and tooth surface numbers. **(40.8.1.37, 40.8.1.306)**

(40.8.1.37, 40.8.1.306)

The system is capable of editing the captured data for presence and format. For example, the application can verify that a required field actually contains data, and if a field that should contain numeric data, in fact, has all numeric characters. We use extract tables that contain key elements to verify the validity of captured claim information, including information such as recipient names and identification numbers, as well as provider name and identification numbers. **(40.8.1.18-19)**

(40.8.1.18-19)

The Verify application only presents claim data with missing or inaccurate characters, data the application interprets as questionable, or data that fails an edit or data validation. The operator is able to review and correct any highlighted data using information that is available on the image of the original document. Claims that cannot be corrected are rejected with the assignment of a valid reason code. The claim is separated from the batch and a Reject Report is generated. Team CSC is able to configure the application to reject only claims that cannot be processed by the Claims Processing Subsystem due to errors or omissions. We use an automated workflow process to route rejected claims to individuals who determine if the claim can be processed through a key-from-image process, or if the claim must be returned to the provider with an auto-generated letter identifying the error conditions, and the requirements for correcting data and resubmitting the claim. **(40.8.1.23)**

(40.8.1.23)

D.1.4.8.3.1 Key from Image

The forms processing software may not be able to process some paper claims, which may include claims on black and white forms or print that is too light. These claims are scanned and keyed from the image directly into the Verify application screens as shown in **Exhibit D.1.4.8.3.1-1**, Verify Claims Entry Page. Team CSC also keys special batches requiring immediate attention directly into the Verify software so that they may be adjudicated. **(40.8.1.196)**

(40.8.1.196)

Page D.1.4.8-20 contains confidential information.

Subsystem maintains a Batch Tracking Module, which assigns batch numbers and provides batch-tracking capabilities to verify effectiveness of batch controls. (40.8.1.96)

(40.8.1.96)

The batch number consists of a five-position Julian date followed by a four-position sequential number. This structure allows a maximum of 9,999 unique batch numbers to be reserved for a particular date.

As previously described, staff in our mailroom prepares paper documents for processing in the Claims Processing Subsystem. This process includes imaging of documents and the use of Optical Character Recognition (OCR) or direct data entry by keying data from images of documents. The captured data is formatted into input records for later processing through the Claims Processing Subsystem. The tracking of each claim starts with the bundling of like documents into batches, and ends with the successful processing of the resulting input records in the Replacement MMIS.

Batch Reservations

The eCommerce Batch Tracking Module allows authorized users to reserve up to 9,999 unique batch numbers every day. Since we typically include up to 100 paper documents in a batch, we are able to assign unique numbers to almost one million paper documents each day.

For paper documents, the batch control process begins with the reservation of batch numbers in the e-Commerce tracking system and the generation of batch header pages. Before forwarding a stack or a batch of documents to a scanner station for the imaging process, a Claims Preparation Clerk reserves batch numbers and prints batch header cover pages by logging onto the e-Commerce Batch Reservation application. When the logon is successful, the Batch Tracking Paper Reserve Tracking Number screen is displayed. Using this screen, a Claims Preparation Clerk enters the number of batches to be reserved for each type of form listed on the screen. The clerk may request batch numbers for more than one type of form, including CMS-1500, CMS-1450, pharmacy, and dental claim forms; prior approval requests for various program types; and provider enrollment forms. The Batch Reservation application reserves the requested number of batch numbers automatically and then prints out batch header cover pages for each batch number reserved. The Batch Reservation application assigns the batch numbers for all incoming claims and prior approval requests, regardless of the submission method. The application assigns the numbers for the paper documents processed through the mailroom and for all electronic transactions submitted via the **NC***Tracks* Web Portal, or as an EDI transaction using the same pool of numbers for each Julian date. The reservation application makes sure that unique batch numbers are assigned and creates batch audit trails. At the end of the imaging process, the Claims Preparation Clerk is able to update the reservations using a maintenance screen and delete any batch reservations that were not used. **(40.8.1.10)**

(40.8.1.10)

The eCommerce Subsystem is responsible for **monitoring and tracking all transactions that enter the Claims Processing Subsystem**. **A prescreening batch input process matches batch numbers that are part of the transaction record to the batch numbers maintained on the Batch Reservation Table.** If no matches are found, the batch is rejected and the Batch Control Table is updated with the reject reason. If the numbers match, the Batch Control Table is updated to record that a

reserved batch has been activated and transmitted to the Claims Processing Subsystem. Each day, a batch control report is generated for management review. This report allows us to verify that all paper batches are transmitted in a timely manner and to resolve and potential problems with batches that are rejected or fail to balance to control counts. **(40.8.1.11)**

(40.8.1.11)

D.1.4.8.5 Claims Adjudication

The adjudication process is the foundation of the Claims Processing Subsystem. Within this process, all claims are subjected to a full set of edits, audits and pricing algorithms to adjudicate every claim to the fullest extent possible. When new claims enter the system, an authorized user corrects errors and releases suspended claims, or an authorized user submits a mass adjustment request, the Claims Processing Subsystem initiates the adjudication process, as depicted in **Exhibit D.1.4.8.5-1**, Claims Adjudication Process **(40.8.1.15)**

(40.8.1.15)

Claim Processing Volumes
The Claims Processing Subsystem in the Replacement MMIS is capable of handling North Carolina claims volumes since it has accurately adjudicated more than 450 million claims annually for the State of New York.

All claims and adjustments entering the Replacement MMIS are processed through the claims adjudication engine where claims data is validated and edited against data maintained in other subsystems including Provider, Recipient, Reference, Prior Approval, and Third Party Liability, as well as applying edits, audits, benefit structures, and pricing methodologies in accordance with DMA, DMH, DPH, and ORHCC policy and procedure. This process ensures that payment amounts are calculated for the correct payer, according to the payer's policies and procedures, to enrolled providers on behalf of eligible recipients. Claim types subject to the adjudication process comprise professional, institutional, dental, pharmacy, and Medicare crossover claims, including claims for Medicare Part D dual-eligible recipients. **(40.8.1.16, 40.8.1.20, 40.8.1.213, 40.8.1.295, SOO 10.12.5-5, SOO 10.12.5-8)**

(40.8.1.16, 40.8.1.20, 40.8.1.213, 40.8.1.295, 10.12.5-5, 10.12.5-8)

As depicted below, the adjudication process evaluates all claims against automated benefit plans, payer determination criteria, and edit/audit criteria, and determines the status based on a State-approved error disposition hierarchy. The assigned claim status determines the course of action taken through the adjudication process. One step in the process ensures that the correct payer is determined and a payer status is assigned so that the appropriate benefits are considered and edits, audits, and pricing follow the rules for the payer. As the claim continues to process through the adjudication cycle, various error codes may be assigned if the claim does not meet the edit or audit criteria established by the payer. When errors codes are posted, the claim is assigned a disposition code that directs the claim through the adjudication process.

Claims with a disposition of suspend must under go a review and error correction process. When the Claims Processing Subsystem assigns a suspense status to a claim, the claim record identifies the timing and suspense status; error codes posted; the occurrences of errors at the header level and the detail level; and maintains this information as an audit trail. The audit trail is available for review and tracking of all edits and audits posted to the claim from the moment of suspense to final adjudication. Ultimately, the Claims Processing Subsystem assigns the claim a status of "to be paid" or "denied" and allows the claim to move to the Financial Management and Accounting Subsystem to complete the appropriate financial processing tasks. **(40.8.1.47, 40.8.1.137, 40.8.1.139, 40.8.1.214, 40.8.1.219, Comment CSC61, SOO 10.12.5-3)**

(40.8.1.47, 40.8.1.137, 40.8.1.139, 40.8.1.214, 40.8.1.219, 10.12.5-3)

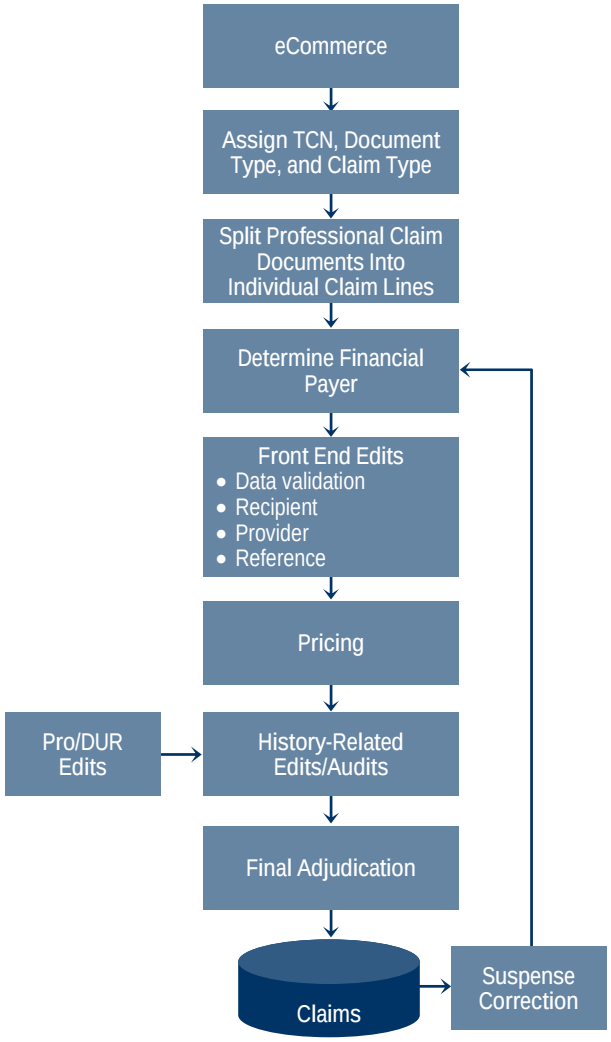


Exhibit D.1.4.8.5-1. Claims Adjudication Process. *The claims process provides thorough adjudication to report all errors and determine final claims status as quickly as possible.*

D.1.4.8.5.1 Determination of Financially Responsible Payer and Eligibility/Population Group **(Comment CSC206)**

Team CSC understands that a principal objective for the Replacement MMIS is the implementation of a multi-payer system that is able to coordinate payment for benefits among the various healthcare benefit programs managed by the divisions within NC DHHS — DMA, DMH, DPH, and ORHCC. It is important that claims submitted by enrolled providers on behalf of eligible recipients are reimbursed and charged to the most relevant payer and the most appropriate funding source for the payer. Based upon our review of the Detailed System Design (DSD) for multi-payer functionality as documented in the Procurement Library, Team CSC proposes to develop and implement a North Carolina-specific multi-payer solution that can analyze data submitted for each service line on a claim to identify:

- The most appropriate benefit program to cover the service
- The financially responsible payer for the service, and the most appropriate and available funding source for the payer

- The edits, audits, and pricing methodology to apply during claims adjudication for the billed service according to the rules and policies for the benefit plan and financially responsible payer
- The payment methodology and budget functions appropriate for the benefit plan and payer combination.

(40.1.1.9, 10.1-2)

We will enhance functionality that exists in our Baseline System and implement a solution that meets the goals of NC DHHS. **(40.1.1.9, SOO 10.1-2)**

For the Claims Processing Subsystem to edit, price, and adjudicate a claim in a multi-payer environment, Team CSC will modify several subsystems to accommodate the new functionality. The Replacement MMIS currently maintains a Major Program code, which the system will use in the identification of the benefit plan covered by one of the financially responsible payers, including DMA, DMH, DPH, and ORHCC. Each financial payer will be able to define its benefit plans using online pages in the Reference Subsystem. In addition, the financial payer will be linked to the benefits plans, the eligibility/population groups the payer is responsible to cover, and the funding sources for the services within the benefit plans. During the Design Phase, **we will work with the LOB financial payers to define benefit plans** in a manner similar to the approach defined in the DSD as provided by the NC DHHS in the Procurement Library. For example, one step will be the development of a matrix similar to the one in **Exhibit D.1.4.8.5.1-1**, Benefit Plan Matrix, which shows some of the financial payers and some of the various benefit plans as defined in the DSD for each payer.

DMA Benefit Plan Code	DMA Benefit Plan Name
ACII	Medicaid Enhanced Case Management
CA	Medicaid Primary Care Case Management
MAFD	Medicaid Family Planning Waiver
NCHC	North Carolina Health Choice for Children
NCXIX	Medicaid
DMH Benefit Plan Code	**DMH Benefit Plan Name**
ADAO	Adult Developmental Disability Assessment and Outreach
ADCEP	Adult Developmental Disability Community Enhancement Program
ASAO	Adult Substance Abuse Assertive Outreach and Screening
ASCDR	Adult Substance Abuse IV Drug User/Communicable Disease
CDAO	Child Developmental Disability Assessment and Outreach
DPH Benefit Plan Code	**DPH Benefit Plan Name**
DPH01	Children's Special Health Services
DPH02	Cancer Diagnostic & Treatment
DPH04	Kidney
DPH05	Sickle Cell
DPH14	HIV

9799-999

Exhibit D.1.4.8.5.1-1, Benefit Plan Matrix. *The Team CSC multi-payer approach allows for definition of multiple benefit plans for each major program/payer.*

By using a matrix similar to the one displayed above, we will be able to ensure that all benefit plans for each payer are identified, and that each benefit plan is linked to one and only one payer. In addition, the matrix can be expanded to link the benefit plans to all appropriate funding sources. These mappings will assist with the

definition of the State-established hierarchy of benefit plans and funding sources to be applied during claims and financial processing. After all benefit plans are identified, authorized users will use the Reference Subsystem to define the scope of benefits, eligibility criteria, pricing methods, and funding sources applicable within a specific health benefit program for a population group as defined by the payer associated with the benefit plan. For additional information about benefit plans, please refer to proposal Sections D.1.4.1.2.1 Multi-Payer Information Architecture, and D.1.4.6.1 Reference Subsystem Overview for more detail about benefit plans. The Replacement MMIS will be able to edit claims billed under one of the benefit plans and ensure that the policies, procedures, and business rules of the financially responsible payer are applied and that procedures or rates are paid according to the business rules established by the payer. For DMH benefit plans, the system will be capable of selecting a plan with the highest rate first and then applying a hierarchy of plans determined by the department thereafter. This capability will allow us to edit claims for adults in an ICF-MR program and allow payment for services for these recipients that would otherwise be limited to individuals under 21 years of age. Using specially-designed benefit plans, we will be able to adjudicate and pay for services as well as track services for Health Check recipients that are typically non-covered services under other programs. **(40.1.1.2, 40.8.1.160, 40.8.1.198)**

(40.1.1.2, 40.8.1.160, 40.8.1.198)

Benefit Plan Definition

Using the Major Program Code in the Baseline System, Team CSC will be able to develop benefit plans that are associated with eligibility/population groups that are covered by financial payers such as DMA, DMH, DPH, and ORHCC.

In the Replacement MMIS, the financial payers will provide eligibility data for all recipients, allowing us to identify the enrollment of recipients in one or more benefit plans. Our Recipient Subsystem is capable of maintaining multiple date-sensitive eligibility segments for each recipient and these segments will be associated with a benefit plan. The user-maintained benefit plan will define the covered services, pricing methodologies, associated funding sources, and other rules that control the adjudication and payment processing of claims. We will maintain the link between the recipient and the benefit plan within the Recipient Subsystem and can accommodate this link in the current table structure of the Replacement MMIS with some modifications.

As providers are enrolled, their records within the Replacement MMIS are updated with provider taxonomy codes for which they are credentialed. We will modify the provider database to include multiple date-sensitive segments that identify which specific benefit plans the provider is allowed to bill under for each financially responsible payer. The benefit segments for the providers will be based upon enrollment information including the provider's taxonomy codes. **(40.8.1.85)**

(40.8.1.85)

As illustrated in **Exhibit D.1.4.8.5.1-2**, Benefit Plan Determination Process, we will implement an approach for the identification and assignment of the financially responsible payer, benefit plan, and associated funding source applicable to each service on the claim that considers information applicable to both

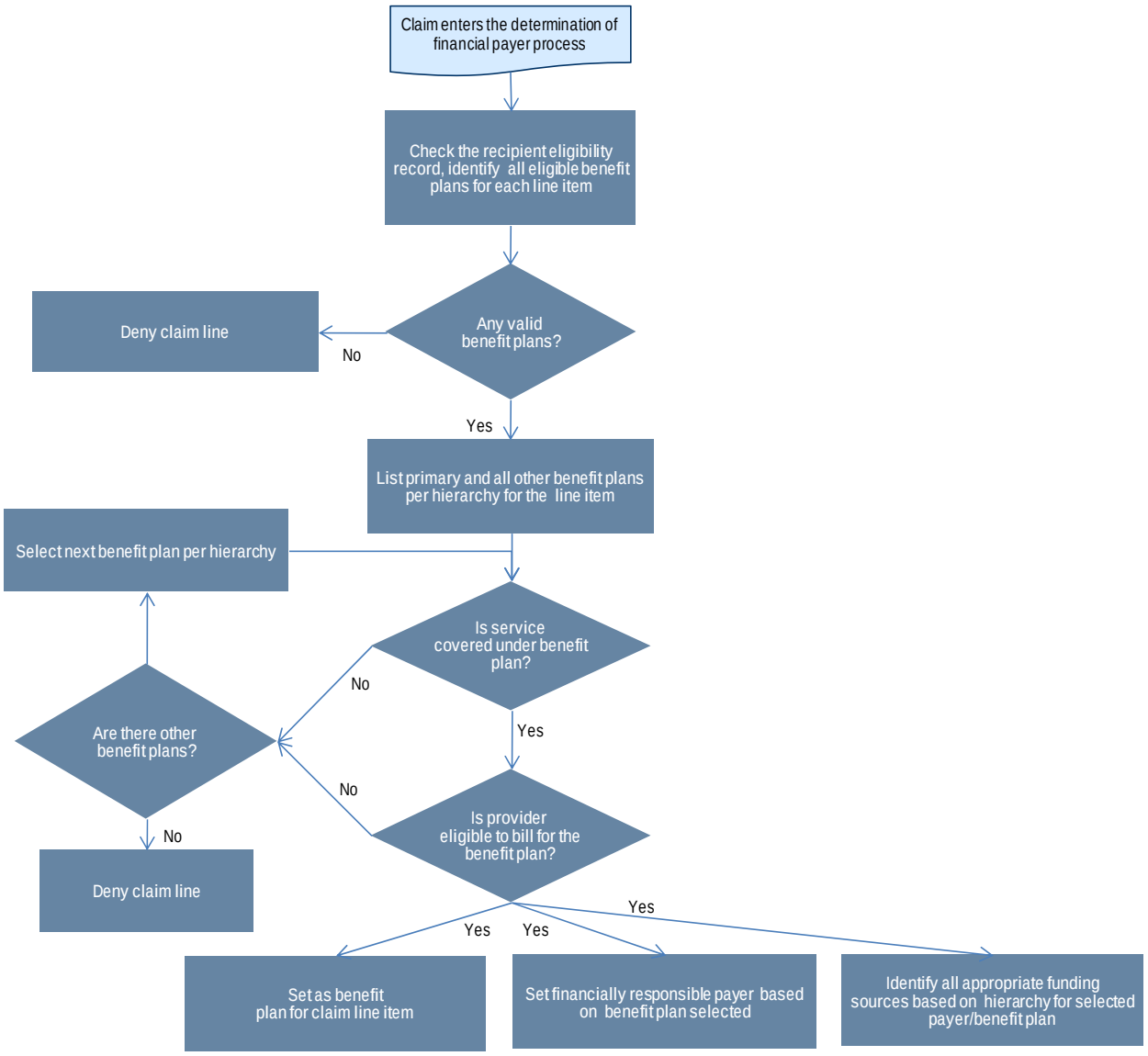


Exhibit D.1.4.8.5.1-2, Benefit Plan Determination Process. *The Team CSC approach allows the capability to establish a benefit plan, associated funding source, and a financially responsible payer early in the claims adjudication process.*

the recipient and provider of a submitted claim and their associated benefit plans. The Claims Processing Subsystem will perform the payer determination process early in the daily claims adjudication process to ensure the system adjudicates claims according to the business rules and policies associated with the financially responsible payer. The Replacement MMIS will consider any retro-eligibility determinations and funding availability and reprocess claims through the appropriate claims adjudication or financial processes, if there are changes to a recipient's eligibility or if sufficient funds are not available in any of the associated funding sources/budgets for the primary financially responsible payer. **(40.1.1.6, 40.8.1.87)**

(40.1.1.6, 40.8.1.87)

The Team CSC multi-payer solution will allow all claims to process through the system according to specific business rules, policies, and procedures defined in the individual benefit plan for the financially responsible payer for each line item or claim, as appropriate. Currently, pharmacy claims are processed individually at the line item level and in the future will be subject to payer and benefit plan determination at the line level. Institutional claims are processed at the document level. Since all line items on the claim are part of the complete services provided to one recipient for one episode of care, these claims are paid by one payer. Therefore, institutional claims will have the benefit plan and payer determined at the claim document level. In the new North Carolina multi-payer solution, the Replacement MMIS will split professional and dental claims early in the claims processing cycle to process each line item on a claim document as a separate claim. Since the current system processes professional and dental claims as documents, we will add a field to the claim record to track the claim line number for each document's transaction control number. Therefore, all line items for a claim document will track back to the original document and yet process separately through the system according to the rules for the appropriate line of business. **(40.8.1.86, 40.8.1.92, 40.8.1.93, 40.8.1.94, SOO 10.2-5)**

(40.8.1.86, 40.8.1.92 – 94, 10.2-5)

As claims/claim lines enter the adjudication process, the transactions will be subject to logic to determine the financially responsible payer and all potential benefit plans for which the recipient is eligible. All claims flowing through the adjudication process are subject to data validity edits, and we will ensure that only claims with valid data are allowed to flow through the logic to determine the responsible payer for the service. As shown in **Exhibit D.1.4.8.5.1-2,** Benefit Plan Determination Process, the first step in determining the payer is that the system will identify all benefit plans for which the recipient is eligible based upon enrollment codes maintained in the Recipient Subsystem and the dates of service for the claim line being processed. If there are no valid benefit plans for the recipient, we will deny the claim line, otherwise we will determine if the benefit plans associated with the recipient cover the service billed. If none of the valid recipient benefit plans covers the billed service, we will deny the claim line. **(SOO 10.2-3, SOO 10.12.5-4)**

Claim/Claim Line Adjudication
Each claim or claim line that enters the adjudication cycle is subject to edits, audits, and pricing methodologies that are associated with the financially responsible payer for the service tendered.

(10.2-3, 10.12.5-4)

If there are benefit plans associated with the recipient that cover the service, we then determine if the provider is eligible to bill for any of the benefit plans, based upon the provider's enrollment data maintained in the Provider Subsystem and dates of service on the claim line. If the provider is not eligible to bill for services under any of the benefit plans associated with the recipient, we will deny the claim line.

If there are multiple plans for the recipient and multiple plans under which the provider is able to submit claims, the system will compare the recipient's benefit plans to the provider's benefit plans for the services billed on the claim to see if there is one benefit plan or multiple plans in common. If there is only one benefit plan in common, the system will set the benefit plan for the claim, set the financial payer for the benefit plan, and identify any potential funding sources associated with the benefit

plan. If more than one benefit plan covers the service, a pre-determined financial payer and benefit plan hierarchy will be used to assign a primary benefit plan, payer, and funding source. All other eligible benefit plans and funding sources will be carried on the claim record for the line item to assist with later processing decisions, if necessary. If no matching benefit plan exists, the claim line will be denied. **(SOO 10.2-7)**

(10.2-7)

Once the benefit plan, financially responsible payer, and funding source have been assigned, the system will be able to use the benefit plan business rules for the billed service for claims adjudication processes. As shown in **Exhibit D.1.4.8.5.1-2a,** Multi-Payer Claims Adjudication Process, the claim line will then flow through the remainder of the adjudication process, and will be subject to edits, audits, and pricing logic that are specific to the financially responsible payer for the primary benefit plan as defined in the Reference Subsystem. If the claim line is adjudicated and denies, the system will review the claim line record to see if other benefit plans could be used to process the claim line. If so, the claim line would be reprocessed under the next benefit plan, per the NC DHHS reprocessing criteria and benefit plan hierarchy, on the claim line record according to the financial payer and appropriate funding sources associated with the new benefit plan. If no other benefit plans are available, the system denies the claim line for the most appropriate error codes associated with the benefit plan. Once a claim line is finalized in the adjudication process, it is either set to "to be paid" or "denied." During the DDI Phase, we will work with the State to determine if the claim line is sent to the Financial Management and Accounting Subsystem for all financial processing or if each claim line will be held until the entire claim with all associated claim lines is ready for processing through the Financial Management and Accounting Subsystem.

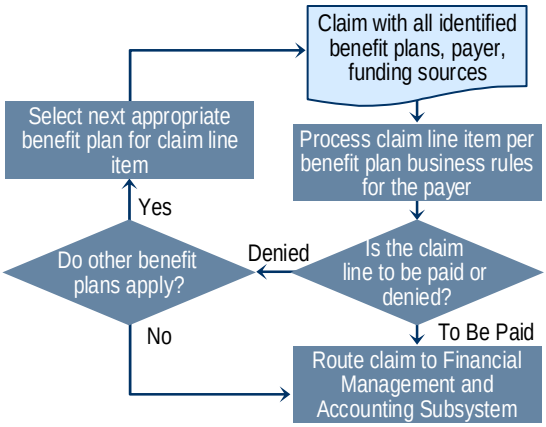


Exhibit D.1.4.8.5.1-2a, Multi-Payer Claims Adjudication Process. *Once the claim record is updated with all potential benefit plans, the financially responsible payer, and potential funding sources, the claims is ready for claims adjudication according to all applicable business rules.*

We will add new fields to the claim record to store and display a primary benefit plan and funding source, as well as all benefit plans that could potentially cover the billed service and all other potential funding sources. Authorized users will be able to view all eligible benefit plans associated with the claim and determine which benefit plan was used to determine payment and which benefit plans were considered during processing. This approach allows us to reprocess the claim automatically, if the Claims Processing Subsystem determines the service is to be denied under the primary benefit plan, or the Financial Management and Accounting Subsystem

(40.1.1.1, 40.1.1.7, 40.8.1.88 – 90, 40.8.1.106, 40.8.1.383)

determines that none of the funding sources/budgets has sufficient funds to pay for the service. The financial payer determination logic will be performed as appropriate when claims are reprocessed. This ensures that any data corrections made subsequent to the initial payer determination are incorporated and that the services for which payment is requested are covered by the appropriate State benefit program. **(40.1.1.1, 40.1.1.7, 40.8.1.88, 40.8.1.89, 40.8.1.90, 40.8.1.106, 40.8.1.383 – Comment CSC140)**

The Claims Processing Subsystem does not verify if funds are available in the appropriate budget. As shown in **Exhibit D.1.4.8.5.1-2b**, Multi-Payer Financial Process, once claims reach the Financial Management and Accounting Subsystem, those claims or claim lines assigned a status of "to be paid" are subject to logic that ensures there is sufficient funding in the appropriate budget to pay the claim. Claim lines that do not have sufficient funding available for the primary General Ledger Budget Code assigned are either updated to a status of "pend," or "denied," or allocated funds from an associated General Ledger Budget Code based upon a NC DHHS established business rules. A customizable table that can be updated online by authorized users will be used to determine which action to take when sufficient funding is not available for a specified General Ledger Budget Code. For additional information about how the Financial Management and Accounting Subsystem will determine which of the potential funding sources to use to pay the claim, and the process for pending or denying claims for lack of funds, please refer to D.1.4.14, Financial Management and Accounting Subsystem.

D.1.4.8.5.2 Adjudication Process Initialization.

As claim transactions enter the adjudication process, the Claims Processing Subsystem first determines if the claim is a pharmacy, medical, or institutional claim. Pharmacy claims follow one set of programs through the adjudication process while medical and institutional claims follow another set. In either case, a unique identifier is assigned to the transaction and two key data elements are set for each claim processed — the Claim Document Type and the Claim Type.

Unique Tracking Control Number
The Claims Processing Subsystem assigns a unique 17-digit tracking number called the Transaction Control Number. This number remains with the claim during the entire adjudication process and is used to monitor and track the claim until it is paid or denied.

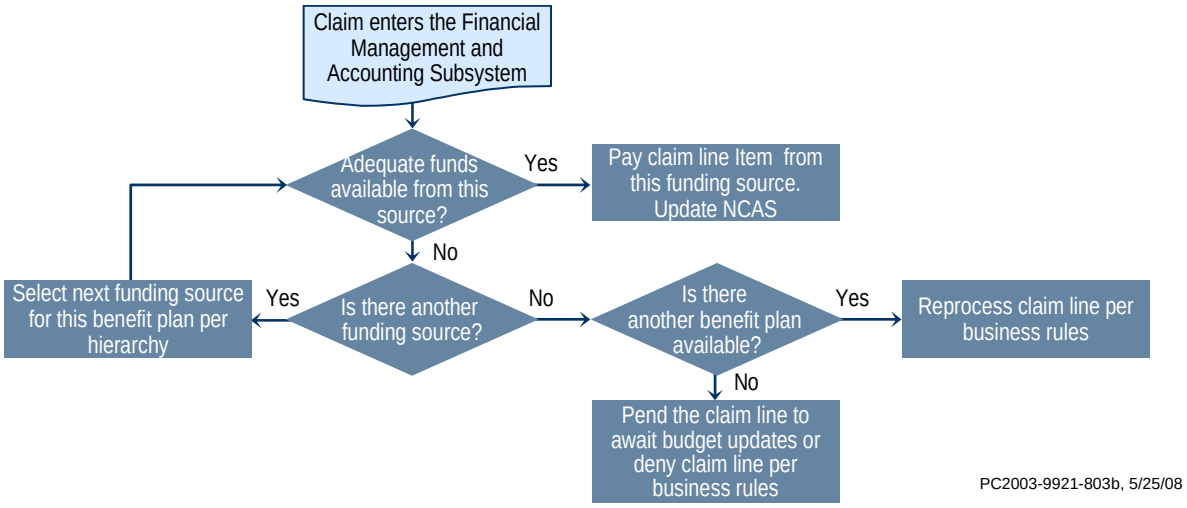


Exhibit D.1.4.8.5.1-2b. Multi-Payer Financial Process. *After entering the Financial Management and Accounting Subsystem, the claim is checked to see if funds are available from the appropriate budget, if not other sources are checked or business rules applied for final processing.*

The unique identifier assigned to the claim transaction is the Transaction Control Number (TCN), a 17-digit number that allows the transaction to be tracked and monitored throughout the claims adjudication process. The TCN maintains a format similar to the DCN that was assigned during the imaging process in the mailroom. The TCN comprises a five-digit Julian date, 10 digits for the sequence number, one digit for the media type, and one digit for the adjustment indicator.

The two key data elements assist in the determination of what edits the system uses during processing and the pricing methodology used for each claim line. The Claim Document Type distinguishes between fee-for-service claims, encounter records, and Medicare crossover claims. The Claim Type designates the type of service provided, such as physician, dental, vision, hospital, nursing home, transportation, and so forth. During the Claim Type assignment, the system evaluates the rendering provider, provider type, type of bill, and other key fields on the claim to determine a claim type, category of service, and specialty code, and stores this information on the claim record.

Establish Active Edits. To improve the editing process, the Claims Processing Subsystem extracts active edits with a status other than “ignore” from the Claim Edit Disposition table. These active edits are then stored in memory as the claim processes through the adjudication module and are used to determine if the logic for an edit needs to be executed or not. If an edit is not listed as active, the edit logic is bypassed. **The establishment of active edits allows the claim to process much more efficiently**.

In addition to focusing processing on only active edits, the Claims Processing Subsystem uses the Claim Edit Dependencies Table. During the adjudication process, this table helps determine what edits to bypass when other edits fail. For example, if the recipient identification number from the claim is not on the recipient database or is not a valid number, then the Claim Edit Dependencies Table allows the claim to

Pages D.1.4.8-31 through D.1.4.8-35 contain confidential information.

As displayed in **Exhibit D.1.4.8.5.3.2-1** above, there are multiple tabs for the Claim Edit Status pages. The HIPAA Codes tab is used to specify HIPAA-compliant codes and indicators that are applied to pharmacy claims, including the prescription denial code and all associated NCPDP reject codes for the edit.

The Claim Edit Status Disposition page allows authorized users to specify how an edit is applied to a claim during the adjudication process through combinations of settings, including:

- Major Program — Allows edits to be set by unique benefit plans for DMA, DMH, DPH, and ORHCC programs
- Document Type — Allows edits to vary according to the document type such as fee-for-service, encounter, or Medicare crossover
- Media Type — Indicates the medium used to input a claim such as paper, electronic, or POS
- Claim Type — Indicates whether the edit applies to a specific claim type such as dental, vision, physician, DME, or pharmacy
- Disposition — Indicates what should happen to a claim when the edit posts such as pay and report, deny, ignore, or suspend; the "ignore" disposition is used to turn edits off as directed by the State.
- Begin Date/ End Date — Establishes the dates the edit is effective
- Force Pay/Force Deny — Specifies whether the edit may be forced to pay or forced to deny
- Pend Severity — Identifies the level of severity of an edit.

Since the system has the ability to apply date spans for each edit status, edits can be turned on and off by the effective dates associated with each edit. All combinations from the disposition table appear on this page, with the ability for the user to view and update the associated disposition settings. The Replacement MMIS does not allow rows to be removed from the table once added, but any row can have an end-date added. **(40.8.1.143, 40.8.1.146)**

(40.8.1.143, 40.8.1.146)

Effective Dates for Edits
Every edit is established with effective dates, which allows authorized users to "turn on" and edit at a specific time, or "turn off" and edit at a specific time.

Exhibit D.1.4.8.5.3.2-2 shown below is a sample of the Claim Edit Status Disposition page. This page allows authorized users to define the disposition of edits so that an edit can be processed differently for paper or electronic submissions as necessary. The authorized user is able to define which edits can be overridden by designating that they are Force Pay or Force Deny. This provides the capability to override edits such a presumptive eligibility, Medicare A, B, and C, HMO coverage, TPL, and timely filing limits based on whether the claim was submitted electronically or on paper. It also allows for the override of service limitations for Health Check recipients. **(40.8.1.24 – 25, 40.8.1.142)**

(40.8.1.24 – 25, 40.8.1.142)

Page D.1.4.8-37 contains confidential information.

- tooth number. Another example is a parameter to deny a claim for an electrocardiogram that is billed before, during, or after a cardiac stress test for a recipient on the same date of service. Contraindicated parameters can also be used to develop edits for Medicare Correct Coding Initiative (CCI). Since many of the CCI edits are based on standards of medical/surgical practice, we can develop edits that compare services provided to recipients and ensure that providers correctly code services based upon those generally accepted standards.
- **Medical limit parameters** — These parameters are used to ensure that maximum unit or dollar amount restrictions are placed on services during a specified period. Limit parameters may apply to either a revenue code or a procedure code. For example, we are able to define a limit parameter for physical therapy services to allow payment for 10 physical therapy sessions in a 30-day period after a provider has billed for a surgical procedure that indicates physical therapy is appropriate.

According to Forrester

CSC's strongest attributes are its IT outsourcing and BPO services that can help plans get the most out of their claims platform investment. Buyers should look to CSC if they want to focus on process improvements or if they are looking to outsource their claims operations.

- Medical contraindicated parameters allow authorized users to establish audits by setting various criteria used to identify claims that the system must compare to enforce North Carolina medical policy during claims adjudication. The criteria that are available to establish an audit include:
- Number of days in the period being monitored
- A bypass indicator if the service is prior authorized
- History indicator to establish whether to compare historical claims before or after the dates of service on the claim being audited
- Effective dates for the audit
- The procedure code or rate code to identify on the claims in process
- The procedure codes or rate codes to find in historical claim files
- The provider number or a list of provider numbers to include in the comparison
- Procedure modifiers to include or exclude from the comparison
- Indicators to establish whether to include or exclude claims for anesthesia or an assistant surgeon
- Designation of various claim data elements on the historical claim to be the same or different than the claim in process, to include:
  - Date of service
  - Provider number
  - Provider type
  - Provider specialty
  - Category of service
  - Modifier code
  - Diagnosis code
  - Tooth number
  - Tooth surface
  - Oral cavity
  - Anesthesiologist
  - Assistant surgeon
- Minimum or maximum ages for recipients

Page D.1.4.8-39 contains confidential information.

Exhibit D.1.4.8.5.3.3-2, Medical Limit Parameter Page, depicts a view of the page used to add or update rules related to limit parameters. The Reference Subsystem allows us to establish Medical Limit audits by setting criteria for:

- Claim type
- A bypass indicator if the service is prior authorized
- Effective dates for the audit
- The procedure code or rate code to identify on the claims in process
- The procedure codes or rate codes to find in historical claim files
- The period that defines when the limits are to be applied, such as for the same calendar year, for a specific number of days, during the same state fiscal year, once in a lifetime, during the same month, or during the same week
- The quantity of claim services to allow in the defined period
- History indicator to establish whether to compare historical claims before or after the dates of service on the claim being audited
- The provider specialty or list of provider specialty codes to include in the audit comparison **(40.8.1.146)**

(40.8.1.146)

- The provider number or a list of provider numbers to include in the comparison **(40.8.1.146)**

(40.8.1.146)

- An indicator to set the limit amount for the number of units or dollar amounts, whether the limit is cumulative, and the total quantity allowed **(40.8.1.147)**

(40.8.1.147)

- Pricing codes that specify a pricing technique that is used to calculate a claim payment amount such as reducing the payment by specified price amount, reducing the payment by a percentage, reducing the payment to account for an all inclusive amount for a procedure **(40.8.1.147)**

(40.8.1.147)

- Pricing value indicator to specify either a dollar amount or a percentage to alter the claim payment amount based on the pricing code **(40.8.1.147)**

(40.8.1.147)

- Designation of various claim data elements on the historical claim to be the same or different than the claim in process, to include:
  - Provider
  - Provider type
  - Modifier code
  - Procedure
  - Rate
  - Provider specialty
  - Primary diagnosis
  - Tooth number
  - Tooth surface
  - Tooth quadrant
  - Anesthesiologist
  - Assistant surgeon
  - Oral cavity
  - Category of service
- Minimum or maximum ages for recipients

Pages D.1.4.8-41 through D.1.4.8-42 contain confidential information.

D.1.4.8.5.4 Front End Edits

After entering the Claims Processing Subsystem, all claims are subject to a complete set of edits, audits, and pricing logic. The Replacement MMIS is capable of processing all claim types including pharmacy claims and uses the same editing modules for all claim types. This use of modules **reduces the amount of maintenance for the system and increases processing efficiency**.

(40.8.1.110, 40.8.1.161)

The process begins with basic "front-end" edits that check the claims data to ensure that claim record contains valid, consistent, and well-formatted data. We also verify that claims are processed according to timely filing limits. **(40.8.1.110, 40.8.1.161)**

D.1.4.8.5.4.1 Data Validity Edits.

The Claims Processing Subsystem performs data validity editing for every field captured on all claim types, including pharmacy claims. Data validation processing checks data elements for required presence, syntax, format consistency, reasonableness, and allowed values based on the assigned claim type and according to NC DHHS-approved design specifications. For example, the system ensures that fields such as quantity dispensed or units of service contain numeric data.

The system also processes other fields, such as the provider or recipient number, through a polynomial evaluator (check digit routine) to determine if the last character of the provider-supplied field matches a calculated "check digit" value. For some fields, the system confirms the presence of valid entries (commonly called "valid values"). For example, the drug refill code submitted on a pharmacy claim must be a value from zero through five, or the emergency indicator must be a Y or N. The system also sets pharmacy claim default values to specific required claim fields and assigns the claim's appropriate Claim Header Type Code. The adjudication process uses this field to identify the edits that apply to a particular claim.

The Claims Processing Subsystem also performs verification of total claim charges as well as relationship edits between line and header dates. The system also enforces timely filing policies using the dates submitted on the claim. If an error is detected, an edit is posted to the claim header or line item.

The system also performs data validity edits on credit/adjustment requests. If edit errors are found, edit codes are posted to the claim record for each of the fields in error.

D.1.4.8.5.4.2 Recipient Edits

The Claims Processing Subsystem begins editing recipient information by ensuring the recipient identification number on the claim form is a valid number and is valid for the name of the recipient on the claim. The system is able to compare the recipient identification number, name, and date of birth on the claim to the Recipient database and verify that the first and last name and the date of birth from the claim match the record on the database. **(40.8.1.113)**

(40.8.1.113)

Once it is determined that the claim is for a valid recipient number, the recipient's eligibility is determined by comparing the claim dates of service with the recipient's enrollment, eligibility coverage date spans, and eligibility category maintained by the Recipient Subsystem. The Recipient Subsystem maintains an unlimited number of

eligibility segments with begin and end dates for each different eligibility segment. The system is able to determine if the recipient is eligible for a special program that may apply program-specific service limitations or restrictions. This determination is part of the financial payer determination process described above. If the recipient is ineligible on the claim's dates of service, or if the recipient's aid category limits the service performed, the Claims Processing Subsystem posts an edit to the claim. **(40.8.1.97, 40.8.1.112, 40.8.1.114)**

(40.8.1.97, 40.8.1.112, 40.8.1.114)

In addition, the Replacement MMIS will require recipients to have current benefit plan coverage for the dates of service on the claim. The solution will maintain an unlimited number of date-specific benefit plan coverage iterations including coverage under multiple benefit plans if the recipient participates in multiple programs. This includes the ability to use Medicaid and Medicare coverage data from EIS to define the specific benefits and coverage for each recipient. The Claims Processing Subsystem is able to determine whether the recipient has TPL coverage, or has Medicare/Part D coverage. The system also accesses the Recipient database to obtain the following data needed for proper pharmacy claim adjudication: **(40.8.1.34, 40.8.1.83)**

(40.8.1.34, 40.8.1.83)

- Restricted recipients
- Managed care scope of benefits
- Medicare coverage/Qualified Medicare Beneficiary (QMB) qualification
- Nursing home residence status.

For recipients that are enrolled in a managed care program or covered under a capitated program, we are able to determine what services are considered to be out-of-plan and pay those services as a regular fee-for-service claim. Our proposed solution allows the administrative rules for each managed care or capitated program to be implemented as a Benefit Plan that is used for enforcing program-specific rules during the claims adjudication process. The claims adjudication process can use the Benefit Plan data to identify and apply the edits/audits for referral, in-plan service, and out-of-plan service validations. In-plan services are processed as an encounter claim and zero paid, where as out-of-plan services are paid at fee-for-service rates. **(40.8.1.360)**

(40.8.1.360)

For nursing home claims and other non-hospital institutional claims, the Claims Processing Subsystem ensures that the correct level of care and living arrangement support the claim information. The system verifies:

- The approval dates match the dates of service
- Patient liability amounts
- Patient deductibles
- Medicare denials
- Reserve bed and leave days
- Admission and discharge dates for hospital stays **(40.8.1.115, 40.8.1.118)**

(40.8.1.115, 40.8.1.118)

In addition, an edit will be established to verify the recipient living arrangement is valid within the dates of service for the services billed on any claim type. **(Comment CSC214)**

Based on NC DHHS policy, the Claims Processing Subsystem is able to post an edit to claims with a recipient on review or a recipient that has a status that requires action.

Currently, the Replacement MMIS can "lock in" a recipient with a particular provider. Team CSC will add functionality to allow a recipient to be "locked-out" from services from a specific provider. We will develop and implement appropriate editing logic in the Recipient and Claims Systems, enhance online recipient and claims pages to display and manage lock-in/lock-out information, modify the Recipient and Claims databases, and enhance claims history to store the related information. By using a "lock-in/lock-out" provider, NC DHHS **may prevent or reduce the recipient's ability to abuse program benefits and limitations**. The reduction in abuse is achieved by requiring the recipient to receive services from or restricting the recipient from receiving services from a particular pharmacy, primary care provider, or prescriber. **(40.8.1.75)**

(40.8.1.75)

When a claim is received for an eligible recipient who is locked-in, the provider number for the billing physician or the pharmacy on the claim must match the provider number on the lock-in record for the recipient in the Recipient Subsystem. If not, an edit posts to the claim and the claim either suspends or denies according to NC DHHS policy. If a provider is part of an affiliation or doctors' group, the lock-in may be specific to the individual provider number or to the group number. By adding the lock-out functionality, we will be able to process claims so that a claim will suspend or deny when the billing provider matches the lock-out provider number associated with a particular recipient for a particular period of time.

The system currently supports pharmacy lock-in, and allows for recipient-level exceptions to the lock-in restriction. Authorized users can maintain exception information through the Recipient Detail: Exception/Restriction page, shown in **Exhibit D.1.4.8.5.4.2-1**. **(40.8.1.150)**

(40.8.1.150)

For recipients enrolled with a Primary Care Physician (PCP), the Claims Processing Subsystem ensures that the rendering provider on the claim is the PCP or a designee, as indicated in the Recipient Subsystem, or that an appropriate referral was received from the PCP for another provider to perform the service.

Page D.1.4.8-46 contains confidential information.

(40.8.1.13, 40.8.1.153)

certification for providers who bill for laboratory procedures. The Provider Subsystem maintains license certification and other qualification requirements in the provider database, which is available for update and inquiry by authorized users via user-friendly pages. **(40.8.1.13, 40.8.1.153)**

The Claims Processing Subsystem also determines if the provider is under review or has a status that requires action, and posts edits accordingly.

The provider edit process validates other provider numbers submitted on the claim to ensure that they are valid for the program billed on the claim. The Claims Processing Subsystem performs edit reviews on the billing provider, referring provider, attending provider, and other provider fields on institutional claims, including verification checks for primary care physicians and lock-in/lock-out providers.

D.1.4.8.5.4.4 Reference Edits

The claims adjudication process performs **reference edits to validate procedure codes, diagnosis codes, National Drug Codes (NDCs), Diagnosis-Related Groups (DRGs), rates, and revenue codes**. For all claim types, including Medicare crossover claims, the reference edits ensure that all codes are valid and covered by the Major Program as previously determined for the claim or claim line. Reference edits are capable of reviewing and validating each diagnosis billed, whether at the header level or for each line item on the claim. In addition, the Claims Processing Subsystem is capable of editing claims to ensure the units of service billed do not exceed the maximum allowable number of units. The Reference Subsystem maintains the maximum number of units allowable for each procedure code and allows multiple units of service to be billed for a span of dates of service. **(40.8.1.14, 40.8.1.133)**

(40.8.1.14, 40.8.1.133)

The Claims Processing Subsystem also uses Reference edits to ensure that the service billed is valid for the client's age and gender. Reference edits also scrutinize the provider type, category of service, provider specialty, place of service, and procedure code modifiers to ensure they are valid for the claim's service. The Claims Processing Subsystem performs relationship edits to ensure that the bill type is valid for the billed service, and the claim's provider is valid for the billed service. For instance, we are able to establish reference edits to allow ambulance services to be billed using multiple claim types. The Baseline System will be modified to allow ambulance services to be billed on multiple claim types, including institutional claim types. The system also performs editing for pharmacy claims on the Quantity Dispensed, Refill Number, and Days Supplied fields to verify information on the claim. **(40.8.1.50, Comment CSC182)**

(40.8.1.50)

Reference edits are also used to validate the Clinical Laboratory Improvement Amendment (CLIA) number for the laboratory service billed. The Reference Subsystem maintains the valid CLIA Laboratory Class Codes with begin and end dates, and the CLIA Certification Type Codes with begin and end dates. **(40.8.1.13, 40.8.1.153)**

(40.8.1.13, 40.8.1.153)

The Claims Processing Subsystem is able to determine if the procedure code for the billed service requires prior approval, or if the service requires an attachment. In addition, we will make certain that the system references authorization information

supplied by DMH for services supplied by LMEs. The procedure code, DRG, or revenue code segments on the reference tables indicate prior approval requirements. Since the Reference Subsystem will be modified to include definition of benefit plans for population groups for the addition of multi-payer functionality, **we will be able to set prior approval indicators for procedure codes for services provided to recipients in the Medicaid for Pregnant Women (MPW) program that are different than services provided in other programs**. This will ensure recipients in the MPW program only receive postpartum care services after the date of delivery unless the services are prior authorized. In addition, the Prior Approval Subsystem will be modified to process referrals and overrides and the Claims Processing Subsystem will be modified to edit for referrals and overrides as it does for prior approvals. The claims adjudication process examines the prior approval required code on the reference tables and, when prior approval is required, determines if an active prior approval record is on file, and performs prior approval processing during the final adjudication process. Team CSC will also ensure that referrals and overrides will be identified by information on the claim form and identify the record on the prior approval file for appropriate processing. **(40.7.1.45, 40.8.1.95, 40.8.1.119)**

(40.7.1.45, 40.8.1.95, 40.8.1.119)

Specific edits cause claims that require attachments to suspend for review. If the attachment was not submitted with the claim, adjustment, or crossover claim, the claim or adjustment can be denied and returned to the provider for correction. **(40.8.1.22)**

(40.8.1.22)

(10.12.5-6)

D.1.4.8.5.5 Pricing (SOO 10.12.5-6)

The Claims Processing Subsystem applies clinical and pricing business rules during the claims adjudication process. Clinical business rules are applied during the routine edit and audit processes while pricing business rules are applied during the pricing process that applies pricing actions and reimbursement methodologies according to NC DHHS standards. The Claims Processing Subsystem currently supports a wide variety of pricing methodologies, including all of the methodologies required in the RFP, and we will modify the system to allow appropriate pricing by rules specific to the financially responsible payer and population group. These methodologies rely on pricing method criteria tables in the Reference Subsystem to support:

- Fee-for-service and managed care encounter claims pricing
- Fee schedules based on procedures codes including combinations with:
  - Procedure modifiers
  - Type of service
  - Provider identification number
  - Provider specialty
  - Provider type
  - Category of service
  - Major program **(40.8.1.338)**

(40.8.1.338)

- Per diems and other institutional rates
- DRGs, for all recipients including undocumented aliens

- Fee schedules for anesthesia base units, global surgery days, relative-values
- Pharmaceutical pricing using NDC and J-codes with appropriate dispensing fees **(40.8.1.340)**
- Manual pricing.

(40.8.1.340)

The Claims Processing Subsystem maintains the logic for assigning the appropriate pricing methodology to each service on a claim and uses the pricing tables maintained in the Reference Subsystem to support accurate pricing for each methodology. Once system determines the claim allowed charge, it performs a series of checks to verify the provider's charges. Each service's charges are compared to the claim's allowed charge. If the provider's charge is over or under the allowed charge by more than a NC DHHS-specified percentage, the Claims Processing Subsystem posts an exception to the claim. **(40.1.1.8, 40.8.1.130, 40.8.1.151, 40.8.1.168, 40.8.1.335 – 336, 40.8.1.365, 40.8.1.369)**

(40.1.1.8, 40.8.1.130, 40.8.1.151, 40.8.1.168, 40.8.1.335 – 336, 40.8.1.365, 40.8.1.369)

The Baseline Claims Processing Subsystem currently supports key functions for pricing claims accurately through the application of clinical and pricing rules, by indentifying and calculating pricing amounts according to the fee schedules, per diems, rates, and business rules. To price claims according to NC DHHS pricing standards, the Baseline System supports the capability to:

- Maintain multiple date specific pricing segments for Procedure and Rate Codes
- Maintain multiple date specific pricing segments by National Drug Code for Wholesale, State, and Federal prices
- Maintain and apply up to four (4) modifier codes to a base price at the line level
- Perform customized pricing for anesthesia claims using a system parameter table that contains the anesthesia base conversion factor
- Apply customized pricing fees based on various combinations of Place of Service, Specialty Code, and Category of Service for fee-for-service claims
- Store all base rate changes in the claims history database using a base adjustment reason code and corresponding dollar amount
- Perform DRG pricing for Inpatient claims using a third party call module to return the applicable 'grouper'; all pricing calculations for the add-on amount occur internally using baseline tables; separate fees are used, when applicable, to calculate payments for Inlier and Outlier days.
- Support Ratio of Cost Charge Pricing (RCC) where payment amounts are calculated by applying a percentage to the submitted Claim Charge Amount; the resulting amount is then subjected to applicable high dollar amount edits
- Store co-payments, deductibles, dispensing fees and other key pricing fields on updateable system parameter tables
- Maintain Pharmacy Group Pricing data in an updateable online table
- Perform line level 'Grouper' pricing for Ambulatory Patient Group (APG) Institutional claims.
- Provide the ability to attain the fee to use to price a claim directly from the Prior Approval (PA) for that claim.

While the Baseline System satisfies the key North Carolina pricing methodologies detailed in the North Carolina NCLeads DSD, the system will still require some modification to meet all of the detailed NC DHHS pricing standards. Many specific details of the pricing standards can be addressed during the DDI Phase, but some areas that have been identified where modifications will be required include:

- The use of Revenue Codes to perform Ratio of Cost Charge Pricing (RCC) instead of Rate Code as currently in the Baseline System
- Pricing of some NC institutional claim types at the line level while in the Baseline System these same claim types are assigned units at the line level using the line level Service Dates but the actual fee applied is attained from the Rate Code and applied at the document level
- Satisfying unique pricing exceptions for the State of North Carolina; for example, the pricing requirements related to 'Panel' procedure codes. **(Comment CSC20)**

Currently, The Claims Processing Subsystem is able to price procedure codes automatically with up to four pricing-related modifiers and edits for the appropriateness of the modifiers. The Claims Processing Subsystem is able to process DME claims for appropriate payment according to pricing methodologies established for DME procedure codes. We are able to process DME claims that span calendar months and allow appropriate Medicaid payment that is consistent with Medicare payment processing. **(40.8.1.49, 40.8.1.164, Comment CSC167)**

(40.8.1.49, 40.8.1.164)

The system begins the pricing process by assigning a base rate to the service or item billed on the claim form. This base rate is determined by the pricing methodology associated with the type of claim submitted and the service being billed. For instance, a CMS-1500 claim form submitted by a physician with a procedure code as the identifier for the service rendered is priced according to the set price on an appropriate fee schedule for the procedure. The solution allows the fee schedule to vary and can be different based upon provider type, provider specialty, major program, or even a price established for a specific provider. The Reference Subsystem maintains pricing information in a relational database and maintains all pricing information according to multiple date ranges for each applicable provider, procedure code, revenue code and DRG. Reducing or increasing the claim allowed amount by a percentage during pricing is a standard feature of the Claims Processing Subsystem. The Baseline System will be modified to allow claims pricing to apply a percentage of an existing fee schedule rate for different provider specialties. **(40.8.1.355, 40.8.1.366, Comment CSC122)**

(40.8.1.355, 40.8.1.366)

The Replacement MMIS maintains system lists and parameters that contain processing rules and allow flexibility and quick response to policy changes. **System lists and parameters allow NC DHHS to change processing rules without the need for programming changes**. In addition, the Baseline System currently processes Ambulatory Surgical Center claims automatically based upon prices set in the Reference database. Institutional claims are typically priced according to a set per diem or other rate established in the reference database. The system is capable of calculating payments by multiplying the number of days billed times the rate. We will modify pricing logic as needed to prorate the monthly rate for days billed according

to State business rules, including the application of direct and indirect Graduate Medical Education costs to the reimbursement for inpatient claims. **(40.8.1.361 – 362, 40.8.1.368)**

(40.8.1.361 – 362, 40.8.1.368)

(10.12.5-6)

D.1.4.8.5.5.1 Pharmacy Pricing **(SOO 10.12.5-6)**

The Claims Processing Subsystem fully supports Pharmacy claim pricing by NDC. The system utilizes information from the claim, the drug data, the financially responsible payer, and the benefit plan data. Calculation of the maximum allowable unit cost includes comparing package size/quantity information from the claim with standard packaging and pricing information for that drug on the Drug Code database within the Reference Subsystem, and adjusting the charge if appropriate. **(40.8.1.82)** Claim pricing also takes into account the maximum pricing level allowed by current NCPDP and FDB parameters; this information is stored in the Reference System pricing tables. **(48.8.1.370)** The Replacement MMIS uses the number of decimal units on claims up to the maximum allowed by NCPDP standards and performs pricing using the actual decimal units, rather than rounding to a whole unit. Pharmacy pricing is able to use the lesser of logic, taking into consideration all State pricing policies as maintained in the Reference database, to price the claim at the lowest amount appropriate. **(40.8.1.57, 40.8.1.59, 40.8.1.343)**

(40.8.1.82)

(48.8.1.370)

(40.8.1.57, 40.8.1.59, 40.8.1.343)

The Replacement MMIS maintains information on drugs mandated by Federal regulations, the Federal upper limit (FUL) drugs, and the State Maximum Allowable Cost (SMAC) drugs in user-updateable, online tables in the Reference Subsystem. The system manages drug information by NDC, including pricing and CMS exclusion data. **(40.8.1.363)** The Replacement MMIS accesses this information during adjudication to obtain processing logic, pricing, and other business rules. The system does not pay for DESI-indicated drugs, which are also identified in the Drug Code tables. **(40.8.1.78)**

(40.8.1.363)

(40.8.1.78)

Exhibit D.1.4.8.5.5.1-1 shows the Drug Code Price Tab page, which contains pricing data for the selected NDC.

The Replacement MMIS pricing algorithms include the capability to apply State policy, and maintain and apply flexible State-determined dispensing fees, to price for pharmacists' professional services according to the cognitive service provided, and to reimburse pharmacy-enhanced professional service fees. Dispensing fee information resides in the Drug Group Pricing Span Table in the Reference database, and can be stored as a dollar amount or a percentage. The Replacement MMIS automatically adds the appropriate dispensing fee when pricing the claim. **(40.8.1.68, 40.8.1.76, 40.8.1.342)**

(40.8.1.68, 40.8.1.76, 40.8.1.342)

Page D.1.4.8-52 contains confidential information.

compound drugs, and apply ProDUR edits/alerts within the same claim line. (40.8.1.81) **(40.8.1.81)**

To utilize algorithms that support State pricing, editing, and reporting requirements, Team CSC will develop an interface with Comprehensive Neuroscience (CNS) program's Behavioral Pharmacy Management System (BPMS) to access quality indicator algorithms developed by CNS. Team CSC will work cooperatively with CNS and the State to ensure that we develop an appropriate interface. (40.8.1.60) **(40.8.1.60)**

Team CSC will also enhance the Replacement MMIS to implement Prescription Advantage List (PAL) tier calculations. We will modify the Reference System to include a tier indicator on each NDC and produce paper and electronic lists to all providers. PAL tier pricing capability will also be confirmed in the pharmacy claims pricing process. (40.8.1.341) **(40.8.1.341)**

D.1.4.8.5.5.2 Encounter Pricing

One of the impressive features of our proposed the Claims Processing Subsystem is that it processes encounters through the same adjudication logic as fee-for-service claims. Edits that apply to encounters are controlled via online pages that allow the user to enter edit criteria for encounters. (40.8.1.167) **(40.8.1.167)**

The Claims Processing Subsystem is able to process encounter transactions and automatically:

- Recognize these transactions as encounters
- Perform the NC DHHS required adjudication edits specific to encounters
- Price the encounter and determine the Medicaid allowable rate as if it were a fee-for-service claim and set the status to paid or denied
- Apply deductions such as TPL or copayments
- Retain the encounter in claims history without a payment to the provider.

The edits that apply to encounters are controlled by user-defined edit status and edit disposition tables in the Reference database. (40.8.1.291, 40.8.1.354) **(40.8.1.291, 40.8.1.354)**

The Claims Processing Subsystem will be modified to allow the capability to process and track claims, as mandated by the Legislature, for services provided by specific LMEs when the claims are zero paid because the LME is paid for the services outside the system. These claims would be processed and edited in a manner similar to encounters. The zero paid claims would be stored on the Claims History Database and used during edit and audit processes against future claims. (40.8.1.382) **(40.8.1.382)**

D.1.4.8.5.5.3 Multi-Payer Pricing

Additional pricing functionality will be added as the Claims Processing Subsystem and the Reference Subsystem are modified to incorporate North Carolina-specific requirements for multi-payer processing. Since benefit plans will be defined within the Reference Subsystem in the multi-payer environment according to major programs, we will be able to price claims using any combination of procedure code, population group, billing provider, attending provider, and recipient. All rate data maintained in the Reference Subsystem for each procedure code, population group, billing provider, attending provider, or recipient specific combination will be date-

sensitive. Pricing capabilities will include use of multiple modifiers to calculate program-specific reimbursement at varying percentages of the allowable amount; this information will be maintained in the Reference tables and accessible via user-friendly pages. **Since the system will allow a benefit plan to be developed specifically for Health Check recipients, the multi-payer functionality will also enable the Claims Processing Subsystem to identify and price Health Check procedures at a higher rate when it applies**. **(40.8.1.337, 40.8.1.346, 40.8.1.352, 40.8.1.356)**

(40.8.1.337, 40.8.1.346, 40.8.1.352, 40.8.1.356)

D.1.4.8.5.5.4 Medicare Claims Pricing

The Claims Processing Subsystem is capable of pricing Medicare crossover claims according to current NC DHHS regulations, including the application of percentages for dual eligible recipients. We are able to price or deny claims with Medicare participation, including Medicare HMOs according to NC DHHS program rules. The Claims Processing Subsystem can process crossover claims and allow for Medicare cost sharing charges based upon claim input. For line item services that are denied by Medicare, the system has the capability to automatically pay the service at the Medicaid rate, if appropriate. **(40.8.1.163, 40.8.1.171, 40.8.1.339, 40.8.1.364)**

(40.8.1.163, 40.8.1.171, 40.8.1.339, 40.8.1.364)

D.1.4.8.5.5.5 Manual Pricing

All claims have the potential to be manually priced or invoice priced, depending upon the codes used to bill the services and the pricing methodology associated with the code. This determination is made from indicators set on the Reference database. For claims that are manually or invoice priced, there are additional reasonableness edits performed by the system to reduce the possibility of error. All claims billed using State-specific services can be processed by the Claims Processing Subsystem. Claims with State-specific services can be priced in at least two different methods. First, we are able to carry pricing segments in the Reference database for each local code that will allow services to process automatically and price according to the fee schedule or other appropriate pricing methodology. Second, if the State-specific service requires Prior Approval (PA), we can establish prices through allowed amounts on the PA record. Payment for services priced on the PA can be paid automatically by allowing payment for billed services up to the approved amount on the PA record, or claims can be suspended for manual review and pricing based upon State business rules. Claims submitted for services using unlisted procedure codes suspend for manual review and pricing. Comparable codes are maintained on the Reference database and can be accessed by medical claims reviewers to determine comparable pricing. **(40.8.1.159, 40.8.1.172, 40.8.1.344, 40.8.1.359, 40.8.1.371, Comment CSC153)**

(40.8.1.159, 40.8.1.172, 40.8.1.344, 40.8.1.359, 40.8.1.371)

D.1.4.8.5.5.6 Third Party Liability Edits

Another key function during the pricing process is third party liability (TPL) editing. TPL edits reduce NC DHHS' liability to pay for recipient claims and ensure that State programs are the payers of last resort. Claim costs are reduced through cost avoidance, which is a process that takes place during claims adjudication. The claims adjudication engine attempts to match verified and non-verified TPL resources and Medicare coverage to claims during adjudication, depending on the business rules and using State-approved procedures for processing "Medicare Suspects." When claims

(40.8.1.102, 40.8.1.104, 40.8.1.111, 40.8.1.350, 40.8.1.357)

are matched, TPL edits are posted to the claim and the edit status table specifies whether the claim is denied, suspended, or paid. The Replacement MMIS is capable of ensuring appropriate diagnosis, procedure, revenue, or denial codes are present on claims or attachments for Medicare crossover claims or other claim types with suspected TPL coverage. **The adjudication process allows claims that suspend for potential TPL or Medicare coverage to be reviewed and a determination made whether an appropriate TPL payment was made or that documentation of a TPL denial is present as an attachment. (40.8.1.102, 40.8.1.104, 40.8.1.111, 40.8.1.350, 40.8.1.357)**

It is critical to NC DHHS to identify potential third-party payers and ensure that accurate, alternative insurer information is gathered, managed, and evaluated during the claims adjudication function to avoid paying claims that should be paid by another responsible party.

The Replacement MMIS uses information maintained in its Reference, Recipient, and TPL databases, in conjunction with submitted claim data, to identify payment resources for a recipient and is capable of distinguishing between Medicare and other private insurance. The system retrieves information for all of the recipient's TPL resources and determines the types of coverage the recipient has available for the claim's dates of service. This includes the use of Enrollment Database (EDB) and Beneficiary Data Exchange (BENDEX) information to detect Medicare and Medicare HMO entitlement. Other payers include:

- Medicare Parts A, B, C, and D
- Court ordered medical support
- Private insurance
- Workforce Safety and Insurance
- Accident or liability insurance.

(40.8.1.38, 40.8.1.103)

The TPL edits are performed in accordance with NC DHHS' policies and Federal requirements to deny payments based on the need for Medicare or other private insurance to pay first, thereby ensuring that the Medicaid program is the payer of last resort. **(40.8.1.38, 40.8.1.103)**

(40.8.1.351, 40.8.1.358)

If the Claims Processing Subsystem detects a TPL error (e.g., a claim should have initially been billed to a third party), the system posts an exception to the claim. Providers may resubmit claims rejected for TPL edits by submitting information in the "Other Insurance Indicator" field, along with the payment date and amount paid by the primary payer. The Claims Processing Subsystem subtracts the amount paid by the primary payer from the allowed amount. **(40.8.1.351, 40.8.1.358)**

If the recipient has no other insurance listed, but the claim indicates insurance or Medicare, the Claims Processing Subsystem posts an exception. This allows users to access the claim easily for evaluation and possible update of the shared TPL data.

D.1.4.8.5.5.7 Cost Sharing

We recognize that most States have developed various programs that involve the recipient sharing the cost of service, such as "medically needy eligibility" and patient

liability for nursing home stays. Referred to as both recipient liability and recipient spend-down, these cost share methods function in a similar manner, depending on business rules defined by the State. **The Replacement MMIS has the ability to mange the entire liability process and to deduct liability/spend-down amounts for recipients who must reach a level of medical expenditure or share of cost**. The Claims Processing Subsystem is able to either deduct a provider-reported deductible amount or use an amount maintained on the Recipient database. **(40.8.1.108, 40.8.1.347)**

(40.8.1.108, 40.8.1.347)

The Replacement MMIS retrieves the eligibility information for a recipient with liability, along with the required share of cost for the specified time period from the Recipient database. This includes liability associated with Patient Monthly Liability (PML) as well as varying copayment and deductible amounts. We will modify the Recipient database, as necessary, to include the maintenance of transfer of assets data that will be used during claims processing. The Claims Processing Subsystem then processes incoming claims against this share of cost data until it is met. The Claims Processing Subsystem considers all members of the recipient's household with liability obligations to determine if the threshold has been met. Once the household liability paid meets the liability threshold, subsequent claims are not subject to share-of-cost processing. **(40.8.1.32, 40.8.1.259 – 260, 40.8.1.345, 40.8.1.379 – 380)**

(40.8.1.32, 40.8.1.259 – 260, 40.8.1.345, 40.8.1.379 – 380)

As claims are received, they are processed through an adjudication cycle to derive the claim amount that is paid if the recipient is eligible and the claim is valid for payment. Claims processing subtracts any applicable liability amounts from the claim allowed charge as part of the final reimbursement calculation and applies it to the recipient's outstanding share of cost. For recipients classified as medically needy, the system is capable of using non-Medicaid charges first, and applying the remainder to the allowed charges based upon the first bill received. **(40.8.1.348)**

(40.8.1.348)

Partial or complete claims processed after the share of cost has been met are adjudicated and paid like other fee-for-service claims, as long as the client remains eligible. Cost share is usually defined with a time parameter, often a month, so that this process of meeting a cost share amount starts over with incoming claims for the new time frame. The Replacement MMIS maintains the liability expense on a page within the Recipient Subsystem so that authorized users can view the original share of cost, and the amount applied to the share of cost.

The system also allows the recipient liability amount to be assigned to specific providers. The Recipient Subsystem maintains a page with the recurring medical expenses amount for which the recipient is responsible, and the relationship between the recipient and the provider. This page is currently used to provide the functionality to reduce the amount paid to a nursing home by the amount the recipient is responsible to pay each month. **(40.8.1.349)**

(40.8.1.349)

When a provider reports a recipient liability amount on a claim, the system determines if there are recipient liability amounts for the same time frame in the Recipient Subsystem. If the amounts are in conflict, the Claims Processing Subsystem follows a State-defined hierarchy to determine the correct amount to use. The Claims

Processing Subsystem applies the liability amount on the recipient database to all applicable claim types as defined by NC DHHS policy.

Team CSC will modify the Baseline System to allow all claims to apply variable recipient copay percentages based upon data maintained on the Prior Approval database. Currently, the system does not link the prior approval record with the copayment amounts. **We will work closely with the State to define the percentages and variances by recipient income levels**. We will add fields to the prior approval record to allow payments to be made based upon approved services and pricing methodologies with copayments for the recipients being deducted according to pre-determined percentages. **(40.8.1.367, Comment CSC213)**

(40.8.1.367)

D.1.4.8.5.5.8 Final Allowed Amount

Adjustments to the base rate, such as additional payments (i.e., dispensing fee) and cut-backs (i.e., co-payments, third party liability payments), are carried separately in the claim record. The base rate and all adjustments to the rate are calculated to determine a preliminary allowed charge. Generally, this preliminary allowed amount is compared to the billed amount, and the lesser of the two becomes the claim's allowed charge. For claims that are to be paid, the TPL amount and recipient obligations, such as co-payments, transfer of assets data, or deductibles, are applied to the allowed charge (as well as other posted allowed-charge add-on and cut-backs, such as recoupment or negative balance amounts) to arrive at the final reimbursement amount. **(40.8.1.371)**

(40.8.1.371)

D.1.4.8.5.6 History-Related Editing

Once the system has calculated the allowed charge, but before the final payment amount is determined, the claim goes through history-related editing or the audit phase. **This phase of the adjudication process involves a comprehensive cross-check and analysis of the relationship between the claim being adjudicated and the recipient's existing claim history, including editing across claim type**. During the audit phase, the system accesses and analyzes online claims history, including claims with once-in-a-lifetime services, and in-process claims. In addition, suspended claims will be accessed, as appropriate. We ensure that a minimum of five years of previously paid and denied claims history is available to support duplicate checking and utilization review audits. In addition, we maintain claims with once-in-a-lifetime services on the claims database for services that require more than five years of data for audit purposes. The Reference Subsystem enables us to identify procedures that should be maintained for longer periods of time. **(40.8.1.46, 40.8.1.125 – 126, 40.8.1.144, 40.8.1.164)**

(40.8.1.46, 40.8.1.125 – 126, 40.8.1.144, 40.8.1.164)

The audit process includes a duplicate checking process that will be modified to meet North Carolina specifications. For all claim types, including pharmacy, the system determines if a billed service is an exact duplicate, potential duplicate, or possible conflict with another paid claim or claim-in-process. The duplicate check audits compare specified data elements on the claims including provider information, billed service codes, and dates of services. Potential duplicate or possible conflict claims include claims with similar services or modifiers, or the same service provided by members of the same group, service billed from multiple provider locations, and

services billed across provider and claim types. The Claims Processing Subsystem reviews all history, suspended, and same cycle claims to determine whether a duplicate error code should post to a claim or line item. The base system is able to compare services billed across various claim types to identify duplicate billings, such as comparing drug claims billed by physicians on a CMS -1500 to drug claims billed by a pharmacy. **(40.8.1.31, 40.8.1.134 – 136)**

(40.8.1.31, 40.8.1.134 – 136)

Team CSC will work with the State to enhance our current duplicate-checking processes to meet all program requirements and aggressively prevent duplicate billing. We will:

- Edit across lines-of-business
- Perform cross-claim history edits to include J-codes and NDCs to prevent duplicate billing for nursing home and inpatient stays, and to prevent drugs from being billed under both the Physician Drug Program and Pharmacy POS
- Edit pharmacy claims against DME, physician, or Competitive Acquisition Program (CAP) claims. **(40.8.1.64, 40.8.1.84)**

(40.8.1.64, 40.8.1.84)

The audit process also includes a complete prepayment Utilization Review (UR) process. This process cross-checks the current claim against the recipient's entire claim history. The prepayment UR process is defined and controlled through a series parameter maintained in the Reference Subsystem as described above. Using online pages, users can enter limits to be used by the prepayment UR process, depending on the type of claim being processed.

Medical criteria are used to define four types of exception conditions:

- General medical criteria are used to restrict diagnosis codes for a given type of service and procedure code combinations or procedure and modifier combinations with up to four modifiers. **(40.8.1.164)**
- Limit parameters are used to enforce maximum unit or dollar amount restrictions placed on services during a specified time period.
- Contraindication parameters are used to detect inconsistencies between two different services rendered to a recipient over a specified period of time.
- Institutional criteria are used to control the unit or dollar amount allowed for ancillary services for a specific diagnosis.

(40.8.1.164)

The system provides Team CSC the ability to develop many edits and audits required to support the Medicare Correct Coding Initiative (CCI). The purpose of the CCI edits is to prevent:

- Fragmenting of one service into component parts and coding each component part as if it were a separate service
- Billing separate codes for related services when one combined code includes all related services
- Breaking out bilateral procedures when one code is appropriate
- Down-coding a service in order to use additional codes when a higher level code is appropriate

- Separating and billing for surgical access from a major surgical service.

CMS implemented these edits for Medicare claims processing to ensure that only appropriate codes are grouped and priced. The unit-of-service edits determine the maximum allowed number of services for each HCPCS code.

We propose to use the existing functionality of the Utilization Review Criteria Rules, as described in Proposal Section D.1.4.8.5.3.3 Utilization Review Criteria Rules above, to develop edits to support the CCI. Currently, the Baseline System has many CCI edits incorporated and we will receive file updates from CMS to maintain tables in the Reference Subsystem to support UR edits. CMS supplies two CCI edit tables on a quarterly basis. We will use the CMS "Column One/Column Two Correct Coding Edit Table" and the "Mutually Exclusive Edit Table" to maintain current edits, add new edits, or modify functionality required to support the coding initiative.

We will work with NC DHHS during the DDI Phase to determine which CCI edits are required by North Carolina for the Replacement MMIS. We will ensure all appropriate edits are created using the Baseline System and NC DHHS is able to specify which CCI edits are active and which are inactive at any time. In addition, the UR process and UR parameters in the Reference Subsystem allow authorized users to establish edits for disproportionate share hospitals by including specific provider numbers and lists of providers. **(40.8.1.21, 40.8.1.165, Comment CSC278)**

(40.8.1.21, 40.8.1.165)

Each audit is assigned a specific exception code. This assignment differentiates the errors posted during the audit process and assists in error resolution. Within the Replacement MMIS, we establish audits that support the Medical Procedure Audit Policy (MPAP) and ensure that resolution of all audits is accomplished at the claim detail level, according to the MPAP. The entire audit process is tailored to meet ongoing NC DHHS requirements through the prepayment UR component of the Reference Subsystem. The audit process supports claim denials, automatic recoupments, cutbacks, suspended claims for review, and support of specific pricing algorithms. **(40.8.1.127 – 128)**

(40.8.1.127 – 128)

Similarly, the Pharmacy claims processing modules perform a number of history-related audit functions for pharmacy claims. These audits include duplicate check audits, as discussed above, and utilization-review type audits. The Pharmacy claims processing modules use specific criteria to perform historical audit processing for program coverage. Through the benefit plan file and the drug file, benefit limit parameters are established. The Pharmacy claims processing modules control the audit process using the following criteria: formulary drug coverage, drug exclusions (i.e., DESI drugs, and OTC), dispensing limits, co-payment limitations, days supply limitations, and refill-too-soon limitations.

D.1.4.8.5.7 Final Adjudication

Following the audit process, final adjudication processing determines the final disposition/status and final payment amount for all claims, including pharmacy claims. During this process, the system performs:

- Prior approval edits

- Provider on review edits
- Automated Void processing
- Final reimbursement amount calculation.

In addition, the system reviews all exceptions posted to the claim and determines the appropriate final disposition. The system retains all information in the claim record that is necessary to reconstruct how the final reimbursement amount was determined. This information is displayed online and is available for reporting and processing purposes. Those claims that are to be paid or denied are written to the Claims database with a paid or denied status, while those claims that are to be suspended are written to the Claims database with a suspended status for subsequent correction.

D.1.4.8.5.7.1 Prior Approval Edits

The Claims Processing Subsystem performs prior approval processing when a billed service on a claim requires prior approval and will be modified to check for authorization of services for DMH LMEs. The system compares data on the claim form to data maintained in the prior approval database. **The prior approval number on the claim is used to ensure a valid prior approval record exists in the database**. If the billed service requires a prior approval and no prior approval record exists or the record is inactive, an error code is posted to the claim line and the service is denied. The Claims Processing Subsystem applies edits to ensure that the claim's dates of service are covered by the prior approval. For hospital claims, the system ensures that the admit dates and discharge dates are consistent with the approval and verifies authorization of any required surgical procedure. The system denies hospital claims that are billed for services when appropriate prior approval records are not on file. A lock-in primary care provider or prescriber can request a prior approval for particular services on behalf of a recipient. These services can be rendered by a provider other than the lock-in primary care provider or prescriber. When the rendering provider submits a claim for the service, the Claim Processing Subsystem automatically processes the claim and verifies that the service was prior approved and that a record exists on the Prior Approval database for the service, for the dates of service and for the rendering provider. **(40.8.1.123, 40.8.1.129, 40.8.1.217)**

(40.8.1.123, 40.8.1.129, 40.8.1.217)

Edits are available to monitor that the prior approval limit is not exceeded. The claim line information is compared to the prior approval line information. When prior approval limits are present on the matching prior approval, the system compares the claim-allowed charge with the prior approval remaining amount or the claim units of service with the prior approval remaining units. If the billed units of service and the claim allowed amount do not exceed the remaining amounts on the prior approval record, the units of service and the allowed amount are accepted and both the units used, units remaining, and dollar amount paid are updated on the prior approval record based on the approved usage for the claim. If only a partial prior approval amount or unit remains, the system performs cutbacks on the units of service or allowed amount, according to NC DHHS policy. The Claims Processing Subsystem maintains a comprehensive audit trail of cutbacks so that the user has a complete understanding of how the system derived the allowed units and amount. **(40.8.1.120, 40.8.1.124, 40.8.1.162, 40.8.1.353)**

(40.8.1.120, 40.8.1.124, 40.8.1.162, 40.8.1.353)

For pharmacy claims, the system first performs a primary match on a combination of prior approval number and formulary code (NDC) from the claim to determine if a prior approval exists for the service. The match of the NDC portion of the primary search key is done by comparing against a starting and ending range of NDCs associated with the prior approval number to ensure that all possible matching prior approval records are checked. If this primary search results in a not-found condition, an edit is posted to the claim. When the pharmacist receives the response, the Replacement MMIS allows the provider to request an immediate prior approval online, receive approval if appropriate, and complete the claim and adjudication process. This feature enables the recipient to receive the prescription without delay. **(40.8.1.56)**

(40.8.1.56)

If the primary match condition is satisfied, the status of the approval is checked to determine if the prior approval request was approved or denied. If the matching prior approval has a Denied status, then an edit is posted to the claim. Team CSC will implement functionality in the Replacement MMIS to override prior approval edits when an emergency 72-hour supply of a drug is required. We will also modify processing to bypass limit accumulation in these instances. **Team CSC will work with the State to define the specific parameters for identifying and limiting such situations**. **(40.8.1.148)**

(40.8.1.148)

Secondary matches on the prior approval are performed if the primary match condition is satisfied. The secondary matches include a comparison of the claim type and prior approval type so that a pharmacy claim is not allowed to process against a prior approval issued under DME or another non-pharmacy setting. In addition to a Recipient ID match, the service date from the claim is compared to the effective/expiration date range established for the prior approval.

Prior approval affects the claim's total reimbursement amount when excess pay is indicated on the prior approval. In order to price a claim based on prior approval excess pay, the system determines a per unit price from the prior approval by dividing the total dollar amount approved by the total units approved. This per unit price is multiplied by the units billed on the claim that results in the maximum reimbursable amount for the claim. However, if the total number of authorized units, dollars, or refills being requested on the claim is not available on the prior approval record, an edit is posted to the claim and no change is applied to the prior approval. The prior approval record is only updated during final adjudication to reflect the correct number of units and amounts used.

D.1.4.8.5.7.2 Provider Prepayment Review

Within the Claims Processing Subsystem, providers are subject to prepayment review of claims according to criteria established by authorized users. Staff from NC DHHS or Team CSC may set criteria in the Provider Subsystem to place a provider on review. The system allows authorized users to establish a criteria set for the prepayment review process. As shown in **Exhibit D.1.4.8.5.7.2-1**, Provider Prepayment Review Page, users are able to select multiple criteria for suspending claims for review prior to payment. These criteria are arranged in criteria sets. The criteria set is linked to the begin and end date of the review period by either date of

Page D.1.4.8-62 contains confidential information.

D.1.4.8.5.7.4 Document Status and Final Reimbursement Amount Determination

During final adjudication, the system determines the final claim status. This determination is based on the status of the individual claim lines. The records are analyzed via the reject codes to select the highest priority of status codes on the Reject Control File. If any claim line has a reject code of “suspend,” the status on the Claims Header table is set to suspend. If there are no suspended claim lines and there is at least one line with a reject code of “pay and report,” the claim status is set to “paid.” If there are only denied claim lines, the claim status is set to “denied.” The document’s location code is also set during the final adjudication process. For suspended documents, the document’s location code is set based on the edit with the highest severity. If any of the override indicators on the claim are set to override the reject code and the Reject Control File indicates that overrides are allowed, the claim is forced. State policy regarding edits that cannot be overridden based on severity or significance levels is also maintained in the Reject Control File within the Reference Subsystem. The Replacement MMIS does not suspend pharmacy claims submitted as a POS transaction. **(40.8.1.69, 40.8.1.74)**

(40.8.1.69, 40.8.1.74)

Once a claim is approved for payment, if a copayment is identified as being applicable for a POS transaction, the Recipient Co-payment Period Accumulated Amount on the Recipient database is updated with the calculated copayment amount and the final reimbursement amount is validated. If reductions in the reimbursement amount result in a negative amount for a claim, the system sets the reimbursement amount to zero and the claim's status to "to be paid." For claims with a status of "denied," the system always sets the claim’s reimbursement amount to zero.

If the claim being processed is a void or adjustment request, the system locates the original history claim on the Claims History database using specific claims data, such as the Provider ID, Fill Date, and Prescription Number for pharmacy claims. The system performs data validity edits on the credit/adjustment request. If the final disposition is “paid,” the void claim or credit side of the adjustment is built, based on the history record of the claim being adjusted or voided. The void claim or credit side of the adjustment looks exactly like the claim being adjusted or voided, except that the payment amount on the credit is negated. If a prior approval is associated with the claim, the system automatically adjusts the quantities. Adjustment capability includes allowing for online pharmacy reversal or adjustment within one year of the date of service. Additionally, unit dose credits are processed using the appropriate data fields on the NCPDP 5.1 transaction. **(40.8.1.63, 40.8.1.209)**

(40.8.1.63, 40.8.1.209)

Once all adjudication is complete, the claim is reformatted and the response returned to the submitter via a Value Added Network (VAN), or as appropriate. **(40.8.1.174)**

(40.8.1.174)

During this process, the Claims Processing Subsystem maintains all edit codes that require reporting to the provider on the Remittance Advice. The edit codes from the header and the line level cause specific Explanation of Benefit (EOB) codes to be accrued during processing during the payment cycle in the financial system. The EOB codes are used to print messages on the Remittance Advice (RA) notifying the provider of errors that have caused a claim or a claim line to deny or suspend. The document status is ultimately updated by the Financial Subsystem for documents with

Pages D.1.4.8-64 through D.1.4.8-65 contain confidential information.

The Replacement MMIS also tracks all inquiry transactions, maintaining the identity of the inquirer, date, time, and information viewed. This process maintains compliance with HIPAA privacy requirements. (40.8.1.65, 40.8.1.71)

(40.8.1.65, 40.8.1.71)

D.1.4.8.6 Capitation Payments and Management Fees ***(SOO 10.12.5-7)***

(10.12.5-7)

Team CSC will work with the NC DHHS during the DDI Phase to develop appropriate modifications to the Replacement MMIS so the Claims Processing Subsystem will fully support all North Carolina-specific requirements for processing capitation payments and various management fees for recipients who participate in managed care or case management programs. We recognize that we need to be able to support multiple managed care programs, including Primary Care Case Management (PCCM), and the Pre-Paid Inpatient Mental Health Plan (PIHP) that are in existence today. In addition, we understand that various other case management programs are in existence to assist recipients enrolled for Medicaid and Mental Health services, and covered under programs such as Health Check, or have care managed by Area Programs (APs) or Local Management Entities (LMEs).

During the DDI Phase, we will ensure that the new functionality that is incorporated to support the multi-payer enhancements includes functionality that supports the complex needs of the managed care programs. We will include modifications to existing Case Management pages to ensure that we can make assignment to a case manager by the benefit plan associated with the case management program. In the Reference Subsystem, we will ensure that the Provider Rate Code page is modified to include maintenance of capitation and management fees associated with the benefit plans for which the providers are enrolled to supply services.

Once we have established the link between the recipient and the provider who is responsible for providing the managed care or case management service, and we have set the rates for the capitation payments or management fees, the Replacement MMIS will be able to generate capitation payments automatically. We will work with the divisions within NC DHHS to define the appropriate schedule for making managed care capitation payments and applying management fees for PCCM, Health Check, and AP/LME providers who are performing case management functions for specific recipients.

Using the schedule and other rules associated with payment generation, the Replacement MMIS will routinely accumulate a list of all recipients who are in a managed care program or who have an assignment to a provider for case management services. Since all recipients will have a specific provider number associated with these services on their record in the Recipient database, we will be able to sort the recipients by provider number to obtain a list of all recipients for a provider. Then the Replacement MMIS will generate payment records for each recipient according to the rate established for the provider. Once the Replacement MMIS generates the capitation payments, these transactions are processed through the claims adjudication process like any other claim for payment. They are subject to edits and audits as other claims and checked for duplicates. During the generation of the capitation payments or management fees, the Replacement MMIS will be capable of processing changes to fees based upon retroactive eligibility changes or retroactive changes in enrollment

in managed care or case management programs. In addition, authorized users will be able to submit adjustments to previously paid capitation payments or management fees since they will be maintained on the claims history file in the same manner as an original claim. **(40.8.1.285, 40.8.1.287–290)**

(40.8.1.285, 40.8.1.287 – 290)

Finally, the capitation payment and management fee transactions are processed through the claims payment cycle at the appropriate time. During the payment cycle, capitation payments are subject to processing for the calculation of the final paid amount just as a fee-for-service claim and the system is capable of withholding a percentage of the capitation payment prior to finalizing the payment amount. The payment cycle results in the generation of the payment to the provider and all capitation and management fee payments are noted on the Remittance Advice. The Replacement MMIS will support weekly or monthly capitation payments based on a NC DHHS-specified payment schedule. **(40.8.1.286)**

(40.8.1.286)

D.1.4.8.7 Suspense Correction

The Claims Processing Subsystem suspends claims and adjustments for review and provides a suspense correction functionality to support online, real-time correction and resolution of suspended claims, as required by the State. This means that authorized users correcting suspended claims and adjustments for all claim types immediately know the status of the claim without waiting for a batch cycle. Because of the Replacement MMIS' flexible architecture, claim correction can occur virtually 24 hours a day, 7 days a week. **(40.8.1.169, 40.8.1.175)**

(40.8.1.169, 40.8.1.175)

Our suspense correction feature provides the capability to perform an inquiry search to locate suspended claims and adjustments by searching on:

- Location/queue
- A combination of location and user identification number or edit or claim type
- A specific claim transaction control number
- Provider identification number and begin date and end date
- Recipient identification number and begin date and end date.

The inquiry search page will be modified to include the capability to search by adjustment initiator identification, date of service, ranges of dates, and prior approval number. The result of the search is a list of claims or an individual claim that meets the search criteria. Authorized users are able to select a claim and view the details of the header and line level, including all errors posted to the claim. **(40.8.1.177)**

(40.8.1.177)

The Replacement MMIS provides the capability of establishing queues that allow specific types of edits to be routed for review by individuals who specialize in resolving particular types of claims. For instance, some claims fail edits and can suspend to special locations when they require manual review because they are billings for specific types of medical conditions such as hysterectomies, abortions, sterilizations, external insulin pumps, equipment repairs, miscellaneous pediatric items, miscellaneous drugs, off-labeled drugs, and all PAC 1 codes. The edit error codes and associated messages, maintained through the Reference tables, clearly indicate the reasons for claim suspensions. **(40.8.1.170, 40.8.1.178, 40.8.1.182)**

(40.8.1.170, 40.8.1.178, 40.8.1.182)

The Claims Processing Subsystem provides users with the online ability to identify and correct any errors posted to suspended claims including errors resulting from data entry, if they occur, or claims suspended for provider or recipient prepayment review. All suspense correction processing allows users to approve or deny specific line items or entire claims. The Baseline System will be modified to allow our resolutions staff to add notes from all reviews of claims. This will be maintained as free-form text in the database and made available for view when an authorized user performs an inquiry request on an adjudicated claim. **(40.8.1.26, 40.8.1.100, 40.8.1.109, 40.8.1.181)**

(40.8.1.26, 40.8.1.100, 40.8.1.109, 40.8.1.181)

During online claim correction processing, the suspended claim is displayed on the Pend Resolution page. The page displays all of the claim's data as received, entered, or subsequently corrected. The system provides a view of the suspended claim that identifies all error codes and associated messages that identify the reason for the suspension. An authorized user reviews the original claim form and attachments in an attempt to resolve edits posted to the claim. The online page also provides users a link to the image of the claim and any attachments to verify data on the original claim form and to see that required attachments have been submitted. **Exhibit D.1.4.8.7-1**, Pend Resolution Page, shows the fields that are available for review and correction as well as the link to the image of the claim in suspense. The user makes the required corrections to the claim, and the system re-adjudicates the claim online. The Claims Processing Subsystem processes a corrected claim through all editing logic, even if it has failed one or more edits. **(40.8.1.36, 40.8.1.107)**

(40.8.1.36, 40.8.1.107)

Page D.1.4.8-69 contains confidential information.

instance, an edit may post to a claim that requires a resolution specialist to verify related limitations for which a recipient has received services. **Based upon the edit, the specialist has the ability to use hyperlinks from the Pend Resolution page and automatically link to the Recipient Subsystem, Provider Subsystem, Reference Subsystem, or Prior Approval Subsystem to review information about limitations. This allows users to work efficiently and effectively by having all necessary information available for review as quickly as possible. (40.8.1.191)**

(40.8.1.191)

(40.8.1.191)

An authorized user may correct data on the claim and release the claim for re-adjudication, or may elect to force payment or deny selected edits. The Claims Processing Subsystem currently assigns a status of “Force Pay” and “Force Deny” to claims that have been resolved. If necessary, we will modify this process to allow the system to assign a unique status for claims that have only had corrections. If the user forces an edit, the system processes the claim as though the edit had never posted to the claim. If the user denies the edit, the Claims Processing Subsystem provides the capability to assign multiple error codes that trigger messages to print on the remittance advice, and set the edit status to deny, causing the claim or line item to deny. **The Claims Processing Subsystem provides detail reports to monitor the use of override codes during claim correction to identify potential abuse as directed by NC DHHS-defined guidelines**. **(40.8.1.141, 40.8.1.192 – 194)**

(40.8.1.141, 40.8.1.192 – 194)

After the claim is corrected, the Claims Processing Subsystem re-adjudicates and re-edits the claim. **This complete reprocessing of suspended claims ensures that corrected claims process as thoroughly as newly entered claims**. In some cases, an edit may post due to erroneous or missing data that is so severe that subsequent claim editing is not meaningful. However, once the user corrects the original data, the interactive editing process allows the system to reevaluate the claim without user intervention. In addition, user activity is logged for future quality control and reporting. **(40.8.1.176)**

(40.8.1.176)

The identification numbers of the resolution specialists initiating and approving the changes and date of last update are stored on the claim record for audit trail purposes. The Replacement MMIS also maintains the image of the original claim as submitted prior to claim updates for audit trail purposes.

D.1.4.8.7.1 Edit Disposition.

The edit status table in the Reference Subsystem plays an integral role in the claim correction process. Each of the suspended claim’s edit codes has an associated disposition status. The status is maintained, using the edit status table pages. The edit status table also indicates which edits can be forced or denied. This ensures that only authorized edit codes are forced or denied through online suspense correction processing. The Claims Processing Subsystem maintains user login identification for any edit that is forced or denied through the online claim correction facility. Please refer to Section D.1.4.8.5.3.2, Edit Status Rules of our proposal for more information about the edit status tables and the edit status disposition.

D.1.4.8.7.2 Locations

Each edit is assigned a location code or a work queue, which is maintained using the exception control pages. The adjudication process assigns the routing location to the suspended claim based on its edits and each claim can be forwarded to multiple locations depending upon the edits posted to the claim. Similar edits are grouped together assigned to specific locations. Each of these locations is assigned a number. The numbers, which are in descending order, range from high numbers for major edits down to the single digits. The goal is to work the minor edits first. For example, if a separate group performs medical review of claims, these claims may be difficult to work so they are assigned to a higher location to ensure that most edits are worked prior to medical review and manual pricing. **(40.8.1.179)**

(40.8.1.179)

D.1.4.8.7.3 Routing Claims.

Suspended claims are routed to work queues either manually or automatically using the location codes assigned to the edits.

Manual routing occurs based on the override location field that is presented on the detail online screen for a claim; this feature allows the user to re-assign claims to different location queues as needed. To manually route a claim, a user enters the location code to route the claim in the override location field. This causes the specified location to be assigned as the claim's current location.

Automatic location routing occurs based on the edits posted to a claim and is controlled by the edit status table. When determining the proper location for a suspended claim, the Claims Processing Subsystem first inspects the override location field. If an override location is specified, this becomes the claim's current location. If an override location is not specified, the Claims Processing Subsystem inspects the edits posted to the claim to determine the proper location. The workflow engine routes claims by queue and location and displays the oldest claims in a location first for correction.

D.1.4.8.7.4 Edit Reports.

The edit status table also allows the user to control edit report formats. Edit reports are used in conjunction with the queuing feature during the claim correction processing. These reports and queues are routed to the appropriate location based on information on the edit status table.

D.1.4.8.7.5 Suspense Release

The Claims Processing Subsystem provides an additional feature to assist authorized users in correcting suspended claims. Since all claims are maintained on the suspense file until they are corrected, **the suspense release transaction page provides authorized users the capability to release a group of related claims. If the release option is selected, all claims meeting the specified criteria are automatically reprocessed through the adjudication cycle**. This allows Team CSC to reprocess and re-edit claims that may result in different outcomes based upon changes that have been made to policy or other data in the database. **(40.8.1.195, 40.8.1.197)**

(40.8.1.195, 40.8.1.197)

The system provides the option of releasing all suspended claims or specific groups of claims. A user may select claims to be released based on edit code, provider number, recipient number, location code, or all claims.

The suspense release transaction page enables a user to add, change, or delete a suspense release transaction online. All release request transactions are processed during the next adjudication cycle. Claims processing reports provide an audit trail of the transactions processed by the Claims Processing Subsystem and claims that were released during adjudication processing.

D.1.4.8.8 Adjustment Processing

The Claims Processing Subsystem provides the capability to process individual, and mass claim adjustments, as well as financial transactions. Claim adjustments and financial transactions can be changes that alter the payment made to the provider, or changes that trigger an internal mechanism to reallocate money from one funding source to another and do not affect the provider's payment. The latter changes are usually history only changes and may reflect money that changed hands outside the system, such as TPL payments. Some TPL recoveries can be tied to specific claims and to line level details. Authorized users are able to submit adjustments for TPL recovery claims that are processed through the Claims Processing Subsystem and subject to all edits and audits defined for adjustments, including duplicate checking. **(40.8.1.48, 40.8.1.184)**

(40.8.1.48, 40.8.1.184)

The system accepts all types of adjustments, voids, and financial transactions on paper. It also accepts individual adjustment and void request via HIPAA-compliant ANSI X12 837 transactions. Through an online mass adjustment request, users can select previously adjudicated groups of claims to be adjusted or voided based on NC DHHS-specified factors and claim data. The Claims Processing Subsystem currently maintains one adjustment reason code to identify the reason for initiating the adjustment, such as incorrect pricing, incorrect provider paid, or third party liability collection. In addition, the system maintains a claim adjustment/void code that identifies a transaction as an original claim or one of the several types of voids or adjustments. We will modify the claim record, as necessary, to add a secondary reason code. **(40.8.1.30, 40.8.1.187)**

(40.8.1.30, 40.8.1.187)

The Replacement MMIS allows for the special input of claims data directly into the claims adjudication process to correct payments for claims that were overpaid or paid in error. We are able to retrieve a claim, make a modification, if necessary, and resubmit it directly into the Claims Processing Subsystem with a new TCN assigned. This transaction either voids the original payment or creates an adjustment to the original claim payment. **(40.8.1.254)**

(40.8.1.254)

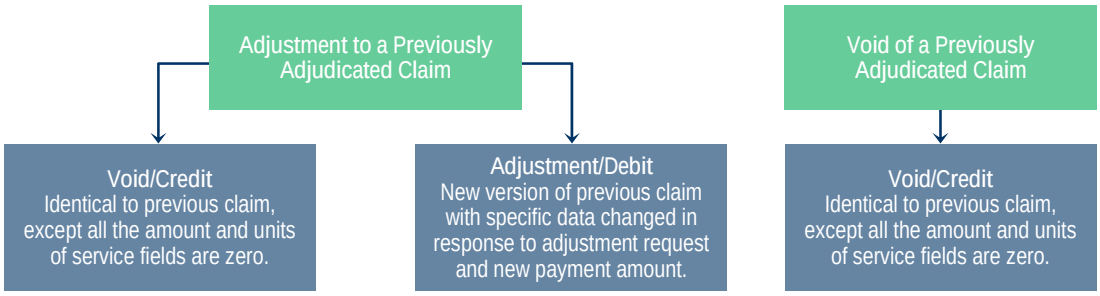
The Claims Processing Subsystem accepts changes online to claims data submitted on the adjustment and re-edits, re-prices and re-audits each adjustment transaction, including checking for duplication against other regular and adjustment claim records, in history and in process. It also reapplies benefits and service limitations such as prior approvals to the adjusted claim. Dental claims can be adjusted with a change to data such as the tooth surface and processed as an adjustment. The system is capable of bypassing certain edits and audits for individual and mass adjustments

according to NC DHHS policy, and bypasses most edits and audits for void transactions. Adjustments that fail an edit or audit are suspended for online review and error correction in the same manner as original claims. **(40.8.1.185 – 186, 40.8.1.188, 40.8.1.208)**

(40.8.1.185 – 186, 40.8.1.188, 40.8.1.208)

D.1.4.8.8.1 Claim Adjustments and Voids

When a previously adjudicated claim is adjusted, whether initiated from an individual adjustment or mass adjustment request, the Claims Processing Subsystem creates two new records for the previously adjudicated claim — a credit or void record and a debit or adjustment record. When the system performs a void of a previously adjudicated claim, whether initiated from a mass void request or individual void request, it creates a new void record for the voided claim. These records are illustrated in **Exhibit D.1.4.8.8.1-1**, Claim Adjustment and Void Records. The void or credit record reverses the payment of the previously adjudicated claim and sets the original paid amount to zero. The adjustment claim is a new version of the claim with the updates applied. It contains two additional data fields, the previously adjudicated claim's TCN and the reason for the adjustment.



PC2003-9799-314a, 10/18/07

Exhibit D.1.4.8.8.1-1. Claim Adjustment and Void Records. *The Replacement MMIS automatically creates the required credit or debit claims when performing an adjustment or void.*

Both records process through the same adjudication process and payment cycle, are retained in claims history, reported on the provider's remittance advice, and reflected in the provider's check or accounts receivable balance, as appropriate. Adjustments result in a net change in the reimbursement of a claim to a provider rather than a complete reversal or void. A claim void is a complete reversal or offsetting of a previously adjudicated claim. The void is reported on the provider's remittance advice and reflected in the provider's check or accounts receivable balance, as appropriate. **(40.8.1.183)**

(40.8.1.183)

The Claims Processing Subsystem assigns a new TCN to adjustments and voids. The adjustment/void TCN uniquely identifies the adjustment or void. The TCN is a 17-digit identifier that includes five-digits for the Julian date, 10 digits for a sequence number, one digit for the media type and one digit for the adjustment type. The adjustment type is one digit at the end of the TCN that displays a zero for the original claim, a one for the credit, and a two for the debit.

D.1.4.8.8.1.1 Claim Adjustment and Void Audit Trail

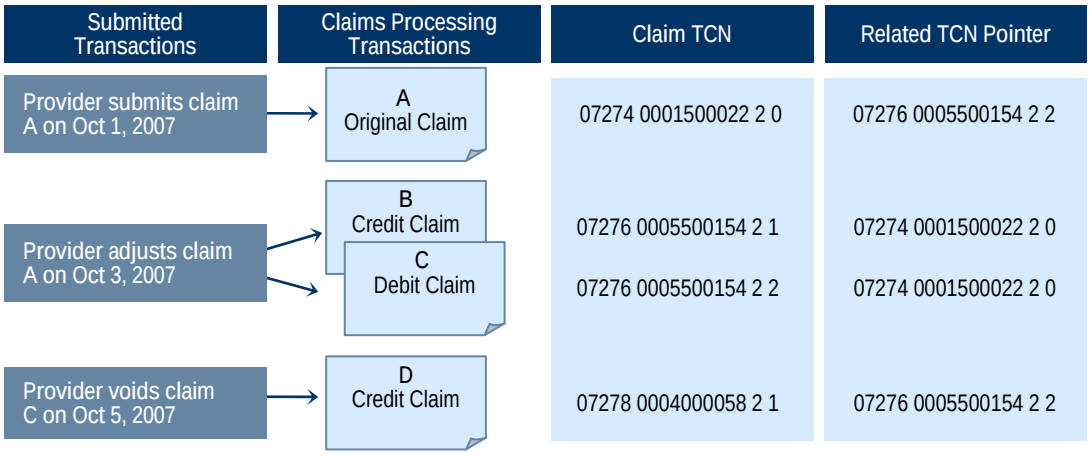
The Claims Processing Subsystem has no limit to the number of times a claim can be adjusted, and keeps a complete and accurate audit trail of each

adjustment or void. The system allows the user to view the complete history of a voided or adjusted claim in chronological order including all associated transactions. (40.8.1.218) **(40.8.1.218)**

Anytime a claim is adjusted or voided, the Claims Processing Subsystem maintains the reason for the adjustment or void and the disposition of the claim (for example, additional payment, overpayment recovery, third party payment, and third party recovery) and the user that initiated the adjustment or void. These fields are available for viewing via the **NC***Tracks* Web Portal as well as for reporting purposes.

Whenever a previously adjudicated claim is adjusted or voided, it is linked to the adjustment or void using TCN pointers. The pointers ensure that once a previously adjudicated claim is adjusted or voided, it cannot be adjusted or voided again. However, the adjustment becomes available for adjustment or void. During the adjustment process, the Claims Processing Subsystem populates a field on the original claim record with the TCN for the adjustment claim. This allows the previously adjudicated claim to point forward to the adjustment or void. Likewise, the system populates a field on the adjustment or void record with the previously paid claim's TCN. This allows the adjustment or void to point backward to the previously adjudicated claim. Through this process, adjustment chains are created that consist of the various versions of a claim all linked together by TCN pointers. (40.8.1.206) **(40.8.1.206)**

For example, **Exhibit D.1.4.8.8.1.1-1**, Claim Adjustment History, shows a series of adjustments and voids to a claim and the generated claims and TCNs created by the Claims Processing Subsystem.



PC2003-9799-315a, 10/18/07

Exhibit D.1.4.8.8.1.1-1. Claim Adjustment History. *The Team CSC solution uses TCN pointers to track all original claims and subsequent adjustments.*

D.1.4.8.8.1.2 Individual Adjustments and Voids Submission Methods

Individual adjustment/void transactions received via **NC***Tracks* or batch transactions do not require manual intervention unless they suspend. Web Portal and paper submission methods identify the claim to be adjusted, present it on an online page, and allow the provider or an authorized Team CSC user to change the fields that need to be adjusted with minimal entry of new data.

NC*Tracks* Web Portal. The Replacement MMIS' Web portal claim void and adjustment feature provides an interactive process for providers to adjust and void claims, and eliminates mailing costs, manual processing errors, and delays associated with paper processing of adjustments and voids.

Adjusting and voiding claims are two of the many Web-based functions available to North Carolina providers. Data is transmitted via secure encryption and cannot be pirated through unauthorized access, which secures the confidential handling of Protected Health Information at all times. For additional information about security features of the Replacement MMIS, please refer to Section H.1.1 of our proposal.

Team CSC believes strongly in providing North Carolina providers, health plans, and other user groups the benefits of the self-service features inherent in our **NC*Tracks*** solution. These features provide a convenient means for providers to interact with the Replacement MMIS around-the-clock without having to make a phone call or wait for assistance.

With our portal, providers and other authorized users can adjust and void previously processed claims via HIPAA data content-compliant pages, and see the online claim adjudication results immediately. For instance, when the submitted adjustment's adjudication status is to-be-paid, **NC*Tracks*** displays the anticipated reimbursement amount to the user immediately after adjudication is completed. If the adjustment is in a to-be-denied or suspended status, the provider sees the reasons that prevented the adjustment from reaching a to-be-paid status.

Batch. The Claims Processing Subsystem accepts provider adjustments and voids through batch electronic submission. The system uses the HIPAA-compliant X12N 837 professional, institutional, and dental transactions when editing and processing adjustments and voids. Preprocessor jobs are periodically scheduled throughout the day to process all batch adjustments and voids received.

Paper. The Claims Processing Subsystem supports real-time adjudication of paper adjustments and voids. The Team CSC analyst processing the request immediately knows the status of the adjustment or void without a batch cycle.

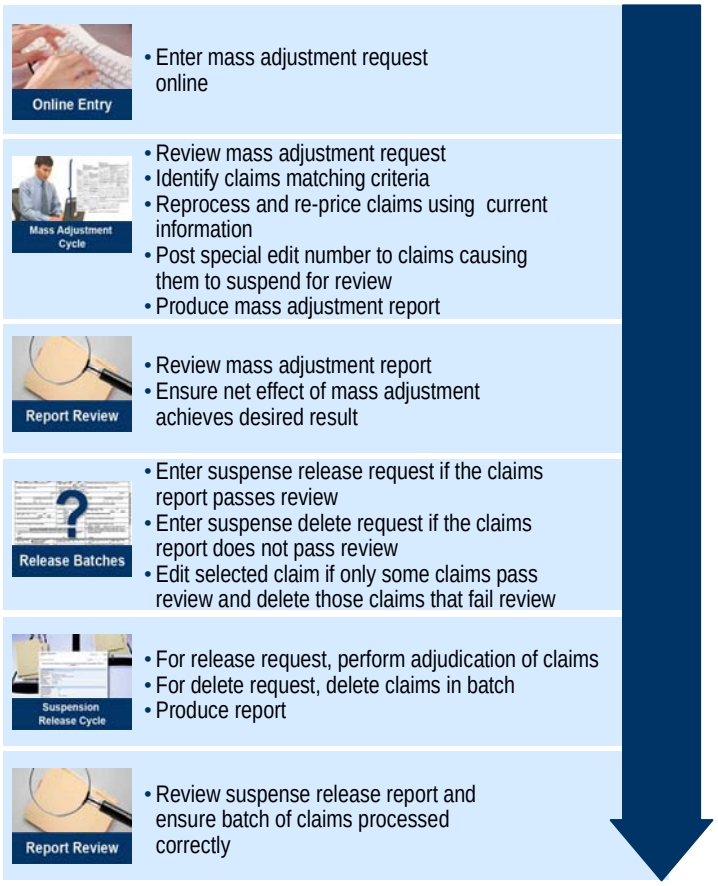
Team CSC includes functionality to scan and image all paper adjustment and void requests. Adjustment and void requests are imaged and processed through the Replacement MMIS workflow component, which routes the requests for further processing. The Replacement MMIS allows the correction of any data element on the adjustment that NC DHHS policy allows. Most adjustment requests involve a change to a single field on a claim, such as the procedure code or billed amount. A void request seeks to credit the entire claim.

D.1.4.8.8.2 Mass Adjustments

Instead of adjusting one TCN at a time, a mass adjustment allows many claims to be pulled and reprocessed together as a batch.

The Claims Processing Subsystem is able to identify and re-price the selected claims in the same adjudication cycle. Reasons for mass adjustments include:

- Retroactive changes to rates or pricing **(40.8.1.207)** (40.8.1.207)
- Changes to a recipient's payment amount
- Changes to recipient or provider eligibility such as recipient's death, or provider termination
- Other changes requiring reprocessing of multiple claim records.



PC2003-9799-316a, 10/18/07

Exhibit D.1.4.8.8.2-1. Mass Adjustment Request Processing. *The Team CSC approach for Mass Adjustments allows authorized users to review the results of the potential adjustments prior to final processing.*

IMPROVED OPERATIONS

Mass adjustments are completed quickly because the selection criteria are entered online and can be processed at any time. The mass adjustment request processing is depicted in **Exhibit D.1.4.8.8.2-1**, Mass Adjustment Request Processing.

IMPROVED OPERATIONS

The Claims Processing Subsystem allows users to select claims based on user-specified selection criteria and systematically generate claim adjustments or voids for each of the previously adjudicated claims meeting the selection criteria, including claims with billed amounts less than allowed amounts.

Authorized users enter mass adjustment requests through the online system. To enter a request, the user specifies the desired claim selection criteria identified in **Exhibit D.1.4.8.8.2-2**, Mass Adjustment Selection Criteria.

When the Replacement MMIS processes the mass adjustment requests, it selects the appropriate previously adjudicated claims based on the selection criteria. These claims are then completely reprocessed through the Claims Processing Subsystem including the application of all relevant edits and audits. In addition, the claims are re-

priced according to the current reference database information. A special edit is posted to each claim so that the claims are held in claims history until the results of the mass adjustment are analyzed to ensure that the desired results are achieved.

The mass adjustment/void analysis report lists all of the claims included in each mass adjustment batch and compares the anticipated payment amount of the claims with the previous payment amount. **Exhibit D.1.4.8.8.2-3**, Mass Adjustment Analysis Report, includes the following adjustment/void details and totals:

If the results of the mass adjustment are as intended, the system allows the authorized user to release the appropriate batch from claims history to allow final adjudication of the claims. If the results are not as intended, the user may update selected claims through the claims correction feature, delete selected claims and release others, or delete the entire batch. In addition, to reduce the number of adjustment claims processed as a result of a mass adjustment request, the user may delete all adjustment claims in a mass adjustment batch that resulted in a net payment difference of zero if that still meets the requirement of the adjustment.

Mass Adjustment Selection Criteria	
Request Type	• Mass Adjustment • Mass Void
Payment Type	• Pay Provider • History Only
Claim Status	• Paid Only • Denied Only • Both
Adjustment Reason Code	• Reason for the adjustment or void
Time Period	• First Date of Service • Last Date of Service • Adjudication Date
Codes	• Claim Type • Procedure • Revenue • DRG • Edit • Rate • Provider Type • Category of Service
Other Criteria	• Transaction Control Number • Recipient Identification Number • Billing Provider Number • Rendering Provider Number • Major Program • Remittance Advice Number

9799-999

Exhibit D.1.4.8.8.2-2. Mass Adjustment Selection Criteria.
Authorized users are able to request a Mass Adjustment online based upon multiple criteria.

D.1.4.8.8.2.1 Systematic Mass Adjustment

These adjustment/void requests are triggered by events such as the addition of other insurance coverage resource identification. **System-generated mass adjustment requests allow the system to reprocess large subsets of claims automatically without any manual intervention**.

The Claims Processing Subsystem generates systematic mass adjustment requests when it receives updates to data maintained within the system, such as updates to the client's date of death so that any claims paid after the client's date of death are voided.

D.1.4.8.8.2.2 Gross Adjustments

Gross adjustments are payments made between a provider and NC DHHS or one of the divisional payers. For example, if a court ruling orders a provider to reimburse DMA for consistent over charging, or if DMA makes a lump sum payment to a provider, a gross adjustment is used to process the payment. Gross adjustments do not apply to specific claims. The Claims Processing Subsystem uses financial transaction to support processing and reporting, thereby tracking gross adjustment receivables and payables from entry to payment.

Mass Adjustment/Void Analysis Report	
Adjustment/Void Details	• Void or Adjustment TCN • TCN to be Voided or Adjusted • User ID • Provider Number • Recipient Number • Claim Type • From Date of Service • Through Date of Service • Original Claim Reimbursement Amount • Adjusted Claim Reimbursement Amount • Difference in Amounts
Totals	• Pay Provider • History Only

9799-999

Exhibit D.1.4.8.8.2-3. Mass Adjustment Analysis Report. *This report allows the Mass Adjustment requester to view the potential results of the adjustment process and determine whether to proceed with the adjustment.*

The system controls and monitors all gross adjustments by assigning a unique control number to each transaction. The control number is displayed on all financial pages and is maintained in claim history for those claims affected by financial transactions.

During the claims payment cycle, gross adjustment receivables are paid down based on the total reimbursement amount of a provider's claims in the payment cycle; it also updates the gross adjustment receivable balance if it uses claims to pay down the receivable. The payment cycle also pays the provider for gross adjustment payables that require a system check. The payment cycle reports payments, receipts and any other outstanding accounts receivables on the provider's Remittance Advice.

D.1.4.8.9 Pharmacy Point-of-Sale, ProDUR, and RetroDUR

The Replacement MMIS offers the State of North Carolina a **comprehensive, flexible, and powerful pharmacy point-of-sale (POS) and Prospective Drug Utilization Review (ProDUR) solution based on the system that we operate for the State of New York**, as well as the ability to maintain drug data for Retrospective DUR (RetroDUR) analysis by the State's vendor. Our solution adjudicates point-of-sale drug claims in real time and in accordance with State drug benefit provisions. Complete adjudication of all pharmacy claims includes consistent editing and auditing for recipient eligibility, drug coverage and benefit limitations, pharmacy network enrollment, third party liability, automated ProDUR and other clinical edits, and pricing. Once this processing completes, the Replacement MMIS immediately sends a message back to the pharmacy stating that the claim has been paid or denied. Any edits on the claim are also relayed back to the pharmacy. **(40.8.1.61, 40.8.1.173)**

(40.8.1.61, 40.8.1.173)

Real-time Claim Adjudication

POS entry supports real-time adjudication of pharmacy claims. Providers immediately know the final status of the claim without a batch cycle.

The Replacement MMIS fully supports receipt and return of NCPDP 5.1 or newer format responses to the pharmacy providers, including enhanced messaging capabilities for DUR and other edits to detail reasons for claim denial. Such messaging allows pharmacies to override edits when permitted by program policy and resubmit claims for successful adjudication, thus avoiding excess calls to the pharmacy help desk and improving the efficiency of the claim submission process for providers. **(40.8.1.52, 40.8.1.58)**

(40.8.1.52, 40.8.1.58)

The Replacement MMIS uses the First DataBank (FDB) drug utilization review protocols. Our ProDUR solution provides online, real-time screening of prescription drug regimens against the industry-standard National Drug Data File clinical database. Users can configure this module to reflect policy and parameter settings furnished by the State. Team CSC proposes to use FDB for North Carolina, contracting for drug update services and making available all clinical and editorial highlights, newsletters, product information, and modules to the Medicaid program and the State. ProDUR processing ensures automated screening of each POS claim against accepted, evidence-based criteria. **(40.8.1.77, 40.7.1.10)**

(40.8.1.77, 40.7.1.10)

The Replacement MMIS offers extensive flexibility and a full range of ProDUR features including:

- Easy-to-use menu-driven functionality
- Online, real-time adjudication of prescription drug claims, 24 hours a day and 7 days a week
- Extensive computer edits including data validity, eligibility verification, duplicate checking, prescription verification, and pricing, that occur online, in real time, at the point-of-sale
- Unlimited drug benefit plans and flexible, online definition of covered/non-covered benefit provisions
- Extensive ProDUR edits, in full compliance with OBRA-90, that advise pharmacies at the point-of-sale of possible drug-therapy conflicts before the prescription is filled
- Extensive online capability to “filter” ProDUR edits and specific DUR conflict codes set to pay, ignore, or deny in specific situations
- Online, real-time drug formulary reference file administration
- Complete package of management and utilization reports
- Medical profiles to allow for unique benefit design at the member level, which are important for online administration of prior approvals and medical necessity programs.

The Replacement MMIS currently is capable of accepting pharmacy claims via point-of-sale device, on paper, or via batch files. As part of developing the CSC North Carolina Medicaid Pharmacy **NC***Tracks* Web portal (refer to Proposal Section D.1.4.7.8), Team CSC will implement the capability for providers to submit and receive Web-based requests/responses for POS/ProDUR transactions. **(40.8.1.66)**

(40.8.1.66)

Additionally, Team CSC will develop the capability to support script transactions from e-prescribing services and access to formulary and benefit information by enrolled providers using the NCPDP 1.0 (or more recent) formulary and benefit standard. Team CSC will develop the appropriate transaction processing, inquiry pages, and database. **We will collaborate with the State and State-designated e-prescribers, as well as selected providers wishing to use this service, to determine the optimal implementation of these capabilities. (40.8.1.80)**

(40.8.1.80)

Regardless of submission method, all transactions enter the system through the eCommerce Subsystem where preliminary edits validate the transaction version number, bin number, processing control number, and transaction code. If any of these fields is in error, reject codes are posted to the claim and the claim is rejected.

The Replacement MMIS then formats pharmacy claims into an internal format and routes them for processing. The system passes batch claims individually so that they are processed through the same programs and edits as interactively submitted transactions. (SOO 10.12.5-8) This approach ensures consistency in processing and reduces system maintenance costs by consolidating edits and programming logic. As with any other claim processed by the Replacement MMIS, pharmacy claims proceed through the following steps:

(10.12.5-8)

- Data validity editing
- Provider editing
- Recipient editing
- Reference editing
- Pricing
- History editing (including duplicate checking, service limitation editing, and utilization review editing)
- Final adjudication (including response formatting and reply).

The description of these steps for pharmacy claims is provided in Proposal Sections D.1.4.8.5.4 – D.1.4.8.5.7 above. In addition, all pharmacy claims are subject to comprehensive ProDUR processing, inclusive of edits/audits/overrides as maintained in the Reference database and consistent with State policy. We describe ProDUR processing in the following section. **(40.8.1.62)**

(40.8.1.62)

D.1.4.8.9.1 ProDUR Processing

The ProDUR program establishes and maintains an efficient and cost-effective review of the appropriate use of pharmaceuticals within North Carolina Medicaid, encourages appropriate drug therapy, and fosters optimal prescribing habits. The purpose of ProDUR processing is to help prevent the dispensing of inappropriate drugs through direct intervention by the pharmacist. The Replacement MMIS maintains sophisticated and flexible review criteria and uses an extensive and robust set of easily tailored DUR parameters that control all aspects of ProDUR analysis. This flexibility allows changes to utilization review criteria to be made quickly and efficiently.

The Replacement MMIS assesses the appropriateness of each prescription, based on the available recipient history and specific criteria used to identify exceptions. By monitoring drug utilization in a prospective manner, ineffective, inappropriate, contraindicated, and potentially fatal drug delivery can be identified before the prescription is dispensed. Automated POS ProDUR processing also provides consistency in adjudication of claims for pharmacy benefits. **(48.8.1.173)**

(48.8.1.173)

ProDUR occurs as part of the POS claim adjudication process. ProDUR auditing involves the analysis of related claims history to determine if the current prescription conflicts with any other prescriptions for the recipient. In seconds, ProDUR searches for drug therapy problems that may result from possible conflicts. POS drug data is screened against pre-established criteria and the recipient's adjudicated pharmacy claims, and a DUR rejection or warning ("alert") to the pharmacist is instantly issued. This process provides safety for the recipient and allows the State to decrease costs by reducing or eliminating drug utilization problems. ProDUR processing includes editing against all State-determined DUR alerts. DUR alert information is maintained in the Drug Code tables in the Reference System and defines the business rules for claims editing. Authorized users can access and update this information to reflect State policy using online pages.

The ProDUR process also includes editing for Food and Drug Administration (FDA) Drug Efficacy Study Implementation (DESI) identified drugs. DESI information is maintained on the Drug Code Tables in the Reference System. The Replacement MMIS provides the capability to edit and deny claims for DESI drugs. The ability for any edit to be overridden is a feature built into the Reference Subsystem that is controlled by authorized users. This provides Team CSC the capability, when reprocessing a denied claim, to override DESI drug edits based on business rules. **(40.8.1.73, Comment CSC108)**

(40.8.1.73)

Exhibit D.1.4.8.9.1-1 shows the Drug Code Main page. For the selected NDC, the information on this page includes generic, packaging, NDC, therapeutic, strength, code, dosage, and DESI information. This page also contains tables that enable the user to navigate to other Drug Code pages, including Price, DUR, Rebate, Conversion, CMS Exclusions, and Miscellaneous information.

Page D.1.4.8-82 contains confidential information.

Adverse drug reactions occur when drugs have a different, usually undesirable, effect than anticipated. The ProDUR system detects potential adverse reactions through edits for drugs that influence the effects of the originally prescribed drug. For example, if a patient is taking Theophylline and Tagamet simultaneously, then the effects of the Theophylline may be increased. Examples of editing to detect potential adverse drug reactions include:

- **Drug/disease contraindication** — A drug/disease conflict occurs when the prescribed drug is contraindicated for use in a patient's documented disease state (e.g., prescribing a cough syrup containing sugar for a diabetic). The Replacement MMIS is able to edit the prescribed drug against historical diagnostic data (ICD-9 codes), or the pharmacist can submit the ICD-9 code on the drug claim.
- **Drug-to-drug interaction** — Drug-to-drug interaction edits check for potentially dangerous or contraindicated drug combinations. Team CSC recognizes that the pharmacist's judgment on the relevance of ProDUR drug-to-drug interaction alerts is essential. Team CSC also relies on severity and incidence coding, supplied by First DataBank, to determine whether drug-to-drug interaction alerts should be issued. The Replacement MMIS permits drug-to-drug alerts to have their relevance coding changed or alert messages suppressed according to State policy.
- **Excessive duration** — Excessive duration occurs when the prescribed quantity and days supply exceed the recommended safe duration of use or maximum days needed to achieve the desired clinical response. The Replacement MMIS checks for excessive duration and sets ProDUR conflicts accordingly.
- **Excessive utilization** — To detect overutilization, the Replacement MMIS checks for the early refill of a drug or excessive prescription-filling behavior. For example, if a prescription is refilled too often, it could be an indication that the disease is worsening, and perhaps an additional medication is indicated. The Replacement MMIS tracks the quantity of a recipient's prescription based on days supply and calendar days between dispensing. The pharmacist is advised if a recipient attempts to refill a prescription that exceeds the allowed quantity. **In addition, the Replacement MMIS automatically sends a message back to the pharmacy indicating the appropriate date for a refill to occur, thereby eliminating unnecessary phone calls and improving provider and recipient relations**.

The Replacement MMIS also has the functionality to exempt certain drugs or recipients from prescription limits. Recipient exemption information is stored in the recipient database; drug exemption information is stored in the reference tables. **This information can be easily maintained by authorized users through the online Replacement MMIS pages, available in these systems**. **(40.8.1.70)** The State also has the ability to place variable limitations on prescription benefits for individual recipients. The Recipient Utilization Limits Table in the Recipient System maintains service limitation information for categories of service, such as pharmacy. Authorized users can update recipient drug benefit limits through the Replacement MMIS Recipient Detail Utilization Threshold/Copay page, shown in **Exhibit D.1.4.8.9.1-2**. Prescription drug limits can be set for frequency, duration, quantity, and maximums. **(40.8.1.149)**

(40.8.1.70)

(40.8.1.149)

Page D.1.4.8-84 contains confidential information.

Duplicate prescriptions often occur when multiple prescribers have difficulty obtaining accurate medical histories from patients. Abusive utilization by recipients may also be a cause of ingredient and therapeutic duplication. This abuse may take the form of excessive drug use (especially in cases of addictive narcotics and drugs with an expensive street value) or benefit sharing among family members and friends. ProDUR alerts effectively limit this type of abuse before it occurs.

- **High-dose/Low-dose Alerts** — Dosing alerts occur if the daily dosage of a drug (calculated by dividing the number of units dispensed by the days supply) is outside of the recommended minimum or maximum daily dose for that drug. The edit is designed to catch doses that may be too low to produce the desired result, or may exceed the recommended safe daily dose for a product. The edit is posted only on adult patients. Claims that exceed the maximum daily dose by more than 200 percent are denied, but can be overridden at the pharmacy by using the standard NCPDP intervention and outcome codes. The ProDUR system uses First DataBank reference information compiled from package inserts and accepted compendia to determine the daily dose range.
- **Drug/Age precautions** — Age precautions are posted when the prescribed drug is deemed inappropriate based on the patient's age. The Replacement MMIS calculates the patient age and reads the drug/age precaution file for a match. The Replacement MMIS sends messages only on precaution codes with a severity level of one (absolute contraindication) as determined by the First DataBank clinical staff. As with all edits, filters can be used to change the status of edits to deny or eliminate messages that are deemed unnecessary or inappropriate.

ProDUR also edits for Brand Certification Failure. Before pharmacists can be paid for brand-name drugs with generic equivalents, the Replacement MMIS can edit for the presence of Dispense As Written (DAW) code 1. If the code is not present, the Replacement MMIS has the capability to deny the claim or avoid claim generation.

Team CSC will obtain and implement the Step Therapy module from First DataBank to enable application of step therapy criteria and protocols for selected drugs. NDCs requiring step therapy editing are identified in the Reference System Drug Code database. Step therapy enables payment of prescriptions for nonpreferred drugs after established criteria have been met, controlling drug expenses. Step therapy ensures that preferred drugs in a therapeutic class are dispensed before drugs in the next tier are permitted. **Exhibit D.1.4.8.9.1-3** provides a sample illustration of the step therapy process. In this example, the patient must use three drugs from Level A for 90 days or one drug from Level A for 120 or more days before getting authorization to move to Level B. A person with arthritis would be required to use drugs at levels A, B, or C before being authorized for Celebrex. **(40.8.1.121)**

(40.8.1.121)

Pages D.1.4.8-86 through D.1.4.8-87 contain confidential information.

- Drug-Drug Interaction Warnings
- Drug-Disease Contraindications
- Drug-Pregnancy Alerts
- Pediatric Precautions
- Lactation Precautions
- Geriatric Precautions
- High Dose/Low Dose warnings.

For the State of North Carolina, we will ensure that a State-determined hierarchy is used for DUR Conflict Codes during the POS claims adjudication process and the hierarchy will be reflected in the response format sent to the provider. This will allow the provider to respond to alerts by overriding alerts or reversing the claim submitted based on the State-determined hierarchy. **(Comment CSC166)**

D.1.4.8.9.2 Pharmacy and ProDUR Reporting.

The Replacement MMIS will produce all of the required ProDUR outputs, as well as a comprehensive set of integrated management and utilization reports. These reports provide critical information essential to program monitoring and management and include such information as:

- Rankings for drugs, physicians, and pharmacies
- Recipient and physician profiles
- Drug class utilization.

The State can request any or all of these reports on a monthly or otherwise scheduled basis. The following information applies to the Replacement MMIS standard reporting package:

- Reports can be produced by group. A recipient total (all groups) can be printed at the end of each report.
- Report selection criteria can be maintained by the system via an online interactive process.
- Prescription drug information can be reported for any range of dates. The online report selection criteria support the input of date ranges for each report.

All standard reports are stored in Mobius, Team CSC's enterprise report viewing and distribution system. Mobius is an advanced report viewing and distribution system specifically designed to support high-volume, high-performance, simultaneous-access requirements in distributed environments, and direct online access. This product provides a user-friendly, easy-to-use navigational tool for locating documents, the ability to display documents of diverse formats simultaneously, and the ability to annotate, move, freeze, zoom, and scale document elements as needed. With Mobius, users can export documents, in whole or in part, to other desktop applications such as spreadsheets, word processors, and analytical tools. Mobius also provides access to documents over the LAN, WAN, and Intranet. Mobius greatly improves the utility of the many reports produced by the Replacement MMIS.

Team CSC offers the State a proven, flexible, and high-performance solution to meet ProDUR processing requirements. The Replacement MMIS provides ProDUR processing features and capabilities far exceeding those of any other MMIS. **By selecting the Replacement MMIS to meet its ProDUR requirements, the State will acquire a powerful tool to support the ongoing initiative to reduce pharmacy costs and protect the health and well-being of North Carolina recipients**.

D.1.4.8.9.3 Retrospective Drug Utilization Review

Team CSC understands that the State of North Carolina contracts with another vendor for RetroDUR services. We further understand our responsibility for furnishing timely, accurate, and complete pharmacy claims data to this vendor so that State-mandated processing can be performed. **Team CSC will work cooperatively with the RetroDUR vendor to supply the required extracts. We will meet with the vendor and the State to determine timing, delivery media/location, contents, and format of the required extracts. We will schedule and prepare extracts in accordance with the mutually agreed-upon specifications and apply our oversight and quality assurance processes to deliver complete and compliant extracts.**

To prepare specific extracts, Team CSC Business Analysts will develop routines to produce the:

(40.8.1.200)
(40.8.1.201)
(40.8.1.202)

- File of paid drug claims **(40.8.1.200)**
- File of physician, clinic, hospital, and pharmacy provider data **(40.8.1.201)**
- File of recipient data. **(40.8.1.202)**

Additionally, Team CSC will maintain and make available the data to produce, or support the State in producing, the CMS Annual Drug Utilization Review Report in the CMS-specified format and in accordance with report submission requirements. **(40.8.1.203)**

(40.8.1.203)

D.1.4.8.10 Claims History Updates

Claims and encounters are retained on the history tables for a minimum of five years. The history tables are the primary source of current and historical claim/encounter information in the Replacement MMIS and include all claims processed to final disposition (paid and denied), as well as premium payments, adjustments, and financial transactions. All claims/encounters on the history tables are available for online inquiry, audit processing, adjustment processing and are used to generate printed responses to claims inquiries. History data includes all data originally submitted with the claim/encounter (including tooth number and tooth surface) as well as derived data that the Replacement MMIS used to adjudicate the claim/encounter, including all associated actions that changed the original makeup of the claim details and funding sources associated with payments generated. **(40.1.1.10, 40.8.1.35, 40.8.1.43 – 44, 40.8.1.46, 40.8.1.91, 40.8.1.131, 40.8.1.306)**

(40.1.1.10, 40.8.1.35, 40.8.1.43 – 44, 40.8.1.46, 40.8.1.91, 40.8.1.131, 40.8.1.306)

As one of its primary functions, the monthly history archive cycle removes all eligible claims/encounters from history and moves the data to the archived file. Claims/encounters remain in the archived file indefinitely and contain key elements of the history claim/encounter.

Claims/encounters are primarily selected for archive processing once the payment date indicates the claim/encounter is older than five years. In some cases, claims/encounters are maintained in history and available beyond the five-year standard retention period as directed by NC DHHS. For instance, claims/encounters with a current record on the TPL billing table are always retained on the history tables as well as claims/encounters with a credit or adjustment in progress, lifetime claims/encounters are also retained on history indefinitely.

D.1.4.8.11 Medicaid Eligibility Quality Control and Payment Error Rate Measurement Reporting

Team CSC recognizes that the Centers for Medicare and Medicaid Services (CMS) requires that all states perform a Medicaid Eligibility Quality Control function to assure State and Federal management that medical services are provided to eligible recipients, that the services are appropriate and authorized, and that the payment for the services is correct. We understand that DMH and DMA are required to gather samples of recipient cases to determine whether medical services were provided to eligible recipients under their programs. We will support this effort through the creation of new pages that will be available through our NC*Tracks* Web Portal for the submission of negative and positive parameters. The negative parameters will be used to generate a random sample of denied and terminated recipient cases. The positive parameters will be used to generate a random sample of active recipient cases. The NC DHHS will be able to determine from these samples whether appropriate action was taken to deny or terminate the cases from the negative sample and to determine that no claims have been paid for these individuals during a period after the denial or termination date. The active sample will be used to select paid claim information for review by NC DHHS to ensure that correct payments have been made on behalf of the eligible recipients. We will accept negative and positive parameters from DMH and a positive sample file from DMA via DIRM each month. The negative and positive parameters will define the universe of recipient cases to sample, the period of time for the sample, and the definitions of the offset and interval used to generate the random sample for each universe being sampled. We will also provide support to produce reports required to support the case sampling and to produce the claim history reports used to determine if claims have paid correctly. **(40.8.1.39 – 42, SOO 10.12.8-1, SOO 10.12.8-2)**

(40.8.1.39 – 42, 10.12.8-1, 10.12.8-2)

Team CSC also understands that we are required to support claim sampling functionality for the Payment Error Rate Measurement (PERM) program mandated by CMS. The purpose of the PERM program is to estimate state-level payment error rates and, from these, national-level payment error rates for Medicaid and the State Children's Health Insurance Program (SCHIP). The error rates will be based on reviews of Medicaid and SCHIP fee-for-service (FFS) and managed care payments made in the fiscal year under review. States will conduct eligibility reviews and report eligibility-related payment error rates also used in the national error rate calculation.

We realize that CMS announced in the October 5, 2006 interim final regulation that in response to public comment it has adopted a national contracting strategy to measure improper payments in the Medicaid and SCHIP program to comply with the

Improper Payments Information Act of 2002. The national contracting strategy involves three contractors: a statistical contractor, a data documentation contractor, and a review contractor. CMS has selected The Lewin Group as the statistical contractor, Livanta LLC as the data documentation contractor, and Health Data Insights as the review contractor for the Federal Fiscal Year (FFY) 2007 PERM program. It is also our understanding that CMS has created three groups of states to participate in the PERM sampling process over the next three years with each state participating once every three years. We also understand that North Carolina is part of the first group to perform PERM sampling, which occurs during FFY 2007.

We are prepared to support NC DHHS in performing the reporting requirements required by the PERM program. We will support the State in generating required quarterly universe files of Medicaid claims in the format specified by the statistical contractor. We will help identify the payments that are required for submission, stratify the claims database to categorize all claims into one of the four required program areas established by CMS, and create the universe files. The NC DHHS will submit the files containing all claims in each universe to the statistical contractor. The statistical contractor will draw a random sample from the quarterly universe files submitted by NC DHHS. The statistical contractor will send a file containing the randomly selected claims to the data documentation contractor and to NC DHHS. The data documentation contractor will request that NC DHHS return a file of additional claim and line details for the selected samples, recipient and provider information associated with the sampled claims, and copies of Medicaid and SCHIP program policies (e.g., payment policies, benefit coverage policies) to assist the review contractor in its payment processing and medical reviews. Team CSC will assist NC DHHS in gathering the required claim header and line detail data, and the required recipient and provider information to submit to the data documentation contractor.

(40.8.1.372) **(40.8.1.372)**

Upon receipt of the detail information, the data documentation contractor will compile the data into a standardized format for the review contractor. The review contractor will be responsible for medical review and claims processing review for fee-for-service payments and a processing review for managed care payments. The review contractor will receive the standardized claim and line item detail associated with the sampled claims and the medical records received from fee-for-service providers. For the medical review, the review contractor will refer to the claims data in combination with the medical record and the coverage and benefit policies provided by NC DHHS to produce an error report that identifies any claims paid for services that were not covered or appropriate under NC DHHS policy. The error report is supplied to the statistical contractor for the determination of the error rate for each universe of claims.

Team CSC is prepared to use our relational database that contains the required claims, recipient, and provider information to support the PERM program submission requirements. We will assist the NC DHHS in defining the claims universe, generating the universe files, and subsequently gathering and formatting files with the detailed information required to support the random sample of claims selected. We will use the PERM Data Submission Instructions generated for the FFY being

sampled and work closely with State representatives in producing the data required for submission.

D.1.4.8.12 Conclusion

Team CSC is committed to partner with the NC DHHS and its divisions during the DDI Phase to design, develop, and implement a new Claims Processing Subsystem that meets or exceeds the RFP requirements for a multi-payer adjudication system. **We bring our experience of operating a high function, high volume Claims Processing Subsystem for the State of New York** and our

dedication to superior service to the State of North Carolina. The Baseline System that we will use to develop the Replacement MMIS brings powerful features that support the business needs for each of the divisions, DMA, DMH, DPH, and ORHCC. Our system incorporates table-driven and rules-based editing and auditing that supports NC DHHS' goal for a system that is easy to maintain and can be easily

modified when business rules change. **We are providing a system that processes both medical and pharmacy claims through the same logic, which reduces or eliminates database synchronization issues and data integrity problems.** We provide an excellent method for resolving suspended claims and can ensure that all claims are paid as quickly as possible to enrolled providers on behalf of eligible recipients.

How Your Current MMIS Operates	How CSC Will Operate Your Replacement MMIS
The legacy MMIS architecture is outdated and requires significant maintenance to implement most mandated business rules. System limitations inhibit the division's ability to set up efficient reimbursement practices and detect spending or treatment patterns. Furthermore, important changes to the system are difficult due to the complexity of patched legacy systems which are becoming so old that vendors have begun discontinuing technical support. This creates situations where many of the desired modifications are obsolete by the time they are implemented, if implemented at all - NC DHHS Business Plan prepared by the Office of Policy and Planning, December 1, 2006	*CSC was very accommodating with regard to change requests, special projects, and fixes to the system on an emergency basis…. CMS greatly appreciates the effort and dedication that the CSC staff has provided, as well as the professionalism it has exhibited during the recently ended award fee period.* - CMS Director of Business Applications Management Group, October, 2006 contract award fee letter *The CSC management team provided a solid partnership with CMS that allowed CMS to implement in just 9 months a development project [MARx] that would have taken 3 years under normal circumstances.* - CMS Contractor Performance Evaluation

Pages D.1.4.9-1 through D.1.4.9-3 contain confidential information.

Managed Care Table	Content
Managed Care PCP Enrollment table	This table contains date sensitive information pertaining to recipient enrollments and disenrollments in managed care plans. Each row on the table represents one enrollment span for a recipient that includes the associated Recipient ID, PCP provider ID, benefit package code, PCP Capitation code, County code and Case Worker code.
Benefit Plan Header table	This table contains date sensitive data used to verify service eligibility. One or more rows are used to represent the eligibility criteria, such as Inpatient Hospital, Physician In Office, Emergency Room, Clinic, Psychiatric Inpatient, Psychiatric Outpatient, Physician In Hospital, Pharmacy, Lab X-ray, Dental, Nursing Home, Home Health, Transportation, Substance Abuse Inpatient, Substance Abuse Outpatient, DME, Optical, for a specific Benefit Plan. Other information included are Provider ID, Associate Provider ID, PCP Type Code (HMO, Provider Case Management or Fee For Service), and Enrollment Capacity, relevant to a specific Benefit Plan.
Benefit Plan Claim Type table	This table contains date sensitive service constraint information defined for the Benefit Plans. One or more rows are used to represent the service constraints, such as Provider Specialty, Procedure Code, Drug Item Type and Category of Service, Referring/Specialty Provider validation, relevant to a specific Benefit Plan.
Benefit Plan Enhanced Fee table	This table contains date sensitive enhanced fee criteria defined for the Benefit Plans. One or more rows are used to identify the Enhanced Fee procedure code and fee amount relevant to a specific Benefit Plan
Benefit Plan Referring/Specialty Provider table	This table contains date sensitive provider criteria defined for the Benefit Plans. One or more rows are used to represent the Provider ID, Referring/Specialty Provider validation, relevant to a specific Benefit Plan.

9799-08-999

Exhibit D.1.4.9.1-4. Managed Care Key Data Elements. *These data elements enable system-wide administration of Managed Care programs.*

The Managed Care Benefit Plan tables support the implementation of multiple Managed Care programs such as the State's existing Primary Care Case Management (PCCM), Community Care Networks, and PIHP, as well as future programs that might be administrated by the State through the Replacement MMIS solution. Our proposed solution allows the administrative rules for each program to be implemented as a Benefit Plan that is used for enforcing program-specific rules during the claims adjudication process. The claims adjudication process can use the Benefit Plan data to identify and apply the edits/audits for referral, in-plan service, and out-of-plan service validations. **Further our flexible, normalized database design allows for the creation and support of an unlimited number of Benefit Plans to meet the State's future needs, thereby reducing development costs. (40.9.1.3, 40.9.1.5 – 6)**

(40.9.1.3, 40.9.1.5 – 6)

The Managed Care Subsystem relies on the support from the Recipient and Provider Subsystems for controlling service utilization and imposing provider sanctions, respectively. The Recipient Subsystem maintains a Recipient Utilization table that contains date-specific, recipient utilization information which includes actual service usage, warning, and overuse data for all types of recipients including those enrolled in the Managed Care programs. The Recipient Utilization table is used during the claims adjudication process to accumulate service usage and prevent payment for services beyond a preset threshold**. The information collected can be used to analyze utilization rates and cost across different recipient categories for cost stewardship purposes. (40.9.1.7)**

(40.9.1.7)

The Managed Care PCP Enrollment table provides the necessary information for computing the time-periods of member enrollments in each Benefit Plan. The enrollment time-periods are computed by age-groups for each aid category and can account for partial month of eligibility. This information together with the rates from the Reference Subsystem and claim information are used to compute and generate the monthly management and capitation fees, including prorated partial month of eligibility, for providers enrolled in the Managed Care programs. The system also

(40.9.1.10, 40.9.1.21 – 40.9.1.23, 10.12.3-1)

allows for the generation of retroactive capitation fees going back a year in time. **(40.9.1.10, 40.9.1.21 – 40.9.1.23, SOO 10.12.3-1)**

The Managed Care Enrollment and Benefit Plan tables, together with the encounter fee information from the Reference Subsystem, are used to establish the encounter costing elements for the State History File, Finalized Claim Activity File, and other cost-performance analysis. Team CSC will work with the State to define and configure the encounter fees for supporting the costing of encounter processing data. (40.9.1.15) **(40.9.1.15)**

Large Scale Managed Care Expertise

CSC designed and developed CMS' replacement Medicare Managed Care System (MMCS) - a large-scale, web-centric, transaction-intensive system that provided a high degree of availability, scalability, redundancy, and extensibility in order to support over 5,000 web users; process over 200 million transactions per year; and maintain a sustained peak processing rate of over 200 transactions and 3,000 database calls per second. This system was the cornerstone enrollment and payment system used for the subsequent development of the current Medicare Advantage Prescription Drug (MARx) project.

Almost all Managed Care Subsystem data fields are updateable online and available for online access and inquiry. Online transactions are validated and edited at the time of entry. Detail level reports are produced during each batch update process including summary reports with control totals of data input, processed, and rejected.**)**

Team CSC will work with the State during the DDI phase to define and configure the online screens, data structures, and code values to implement the requirements expressed in the RFP including the online facilities to maintain the capitation and management rates in the Reference Subsystem. (40.9.1.4) **(40.9.1.4)**

D.1.4.9.2 Online Inquiry, Search, and Update Capabilities

Team CSC's proposed solution uses the familiar Web browser, together with native database search capability, to provide quick and powerful inquiry and search functions across the Recipient, Provider, Claims, Managed Care, and Reference databases. Authorized users may submit inquiries for both current and up to five years of historical Managed Care data. Based on the Baseline System's ergonomic user interface design, all Managed Care information inquiries are initiated from a common home page that is immediately presented after a user has logged on to the system. From the home page, a user may activate the "Recipient," "Case Management," and "Provider" options on a top menu task-bar to display additional inquiry options. (40.9.1.2) **(40.9.1.2)**

The "Recipient" option on the top menu task-bar provides the following inquiry and search capabilities:

- Perform a direct search for recipients using either a recipient ID or a partial search using various search criteria such as: Social Security Number (SSN), Names, Date of Birth, Age, County, Case Number, and Gender Code.
- Retrieve recipient eligibility-related information such as "attending" and "referring" provider, delivered service units, ordered laboratory units, ordered pharmacy units, co-pay types and unit, etc.

- Retrieve a recipient's case information using a known Case Number associated with the recipient and optionally enter a County code to restrict the search for only recipients within a known county.

The "Recipient" option on the top menu task-bar also provides a "MC Benefit Plan Search" option that furnishes the online pages to view, update, or create new plans or elements of existing plans:

- The "MC Benefit Plan Search" page is used to enter search criteria for existing Managed Care Benefit Plans for inquiry purposes, or to select an existing Managed Care Benefit Plan for updates, or data replication (Claim type and Provider Data).
- The "MC Benefit Plan Headers" page is used for inquiry and update of detailed Managed Care Benefit Plan Header information.
- The "MC Coverage Code Segments" page is used for inquiry and update of Coverage Codes associated with a specific Benefit Plan. Coverage codes are specified and stored for a MC Benefit Plan based on date ranges.
- The "MC Benefit Plan Specialist/Referring Providers" page is used for inquiry and update of detailed Referring and Specialty Provider information associated with a specific Benefit Plan.
- The Enhanced Fee Search Window is used for entering criteria used to search for and display Enhanced Fee data.

During Implementation, Team CSC will work with the State to define the detailed approach for providing additional managed care data access, by individual fields specified in the RFP or combinations thereof, and enable the required capabilities for the Replacement MMIS. This functionality will include retrieval by Recipient ID or Name, Provider ID or Name, Procedure Code or Description, Prior Authorization Number, and Clerk ID. **(40.9.1.24)**

(40.9.1.24)

The Provider Subsystem furnishes an online facility for imposing sanctions on all types of providers including the PCPs enrolled in the Managed Care programs. The provider sanction information is used by the claims adjudication process to deny or withhold payments for claims billed by a sanctioned provider. The "Provider" option on the top menu task-bar furnishes access to the online screens that allow users to search, access, and update sanction information for a provider. The user can retrieve an existing sanction by using the "Provider Sanction Search" page and providing the necessary search criteria. The retrieved sanction can then be updated using the "Provider Sanction Detail" page. The "Provider Sanction Detail" page is used to maintain records of sanctions applied to providers and non-enrolled business entities. It allows authorized users to add, update, or delete sanction information. Team CSC will work with the State to further enhance the provider sanction information to include dollar amount or percentage data that can be applied to withhold or affect the provider's monthly management/coordination fees. The enhancement will include tracking and reporting of sanction withholding status. **(40.9.1.13)**

(40.9.1.13)

Exhibit D.1.4.9.2-1 shows the "MC Benefit Plan Search" page which is used to search for existing Managed Care Benefit Plan data, perform updates, or replicate data to a new plan. After completing the search criteria, the system will display one or

Pages D.1.4.9-7 through D.1.4.9-11 contain confidential information.

Team CSC proposes the following processing logic for the automatic PCP assignment requirement:

- On a monthly basis, the Managed Care Subsystem will identify all eligible recipients who have not been assigned PCPs to generate notifications for PCP selection.
- Letters will be dispatched to each recipient to request his/her PCP finalization, within a 30-day period, from a list of five potential PCPs identified through a State-defined algorithm.
- The system will track the notifications to verify the PCP status of all notified recipients after 30 days from the date of notification.
- For those recipients who have not selected their PCPs, the Managed Care Subsystem will generate and transmit PCP assignment request interface files to the State's Eligibility Information System (EIS). The returned assignment results from EIS will be used to update the recipient's assigned PCP and generate assignment and non-assignment notification letters depending on the EIS assignment results.
- The Managed Care Subsystem will also track the auto-assignment process and will generate and transmit a weekly file to EIS to report on the auto-assignment results.

During the Replacement MMIS phase, Team CSC will work with the State to implement online facilities for Team CSC and authorized State staff to define the recipient selection criteria such as specific counties, exempt codes, and aid program categories that will be used to control the auto-assignment process for enrolling all mandated recipients while protecting freedom of choice. **(40.9.1.8, 40.9.1.17)**

(40.9.1.8, 40.9.1.17)

D.1.4.9.4 Data Exchanges and Interfaces

The Replacement MMIS solution's inherent normalized database design allows for easy extraction and composition of data elements from the individual database tables. Team CSC will bring this advantage to the Replacement MMIS phase for customizing the exact extract file format and content required in this RFP.

We will work with the State to define and implement the following file extracts:

- Extract information from the Managed Care Enrollment table and Provider database to create a Managed Care Provider Directory for nightly transmission to DIRM
- Extract information from the Managed Care, Recipient, and Provider databases to create a file of North Carolina Health Choice recipients linked with provider/administrative entity for transmission to the North Carolina State Health Plan by the third business day of each month.

Team CSC recognizes the importance of ensuring successful transmission in any data exchange operation. Our quality assurance practice in this area includes logging of all data transaction activities and automatic monitoring transmission status to alert our operations staff for corrective actions. **(40.9.1.18, 40.9.1.20)**

(40.9.1.18, 40.9.1.20)

D.1.4.9.5 Workflow, Letter Generation, and Reporting

Team CSC will work with the State to implement a rule-based workflow component with letter-generation capability and telephony integration. The solution will provide

for updateable letter templates, including the ability to insert free-form text, for correspondence with recipients regarding their enrollment status, availability of chosen plan, PCP assignments, and any changes to the Managed Care program. The letter templates will also be used to inform providers and administrators of any adjustments to the management fee rates and the reason for the change. **More importantly, the rules-based workflow engine can be equipped with business rules to customize the letter generation process to handle any specific needs based on age, gender, or claim information. The workflow engine will also track the letter generation and dispatch events to provide a report of mailed letters. (40.9.1.9, 40.9.1.12, 40.9.1.28, 40.9.1.33 – 34)**

(40.9.1.9, 40.9.1.12, 40.9.1.28, 40.9.1.33 – 34)

As described in the Provider Subsystem, the workflow engine will have pop-up screens initiated by a call from a provider. **The pop-up screen displays the provider profile information and allows the entry of notes regarding a provider compliant. The notes entered by a user are saved and tracked by the workflow engine. (40.9.1.1)**

(40.9.1.1)

The Replacement MMIS solution's third-normalized database design allows for flexible extraction and composition of data elements from the individual database tables. Team CSC will bring this advantage to the Replacement MMIS phase for customizing the reporting requirements required in this RFP.

We will work with the State to define and implement the following reporting requirements:

- Generate and transmit a Provider Availability Report to DIRM on a nightly basis
- Generate a monthly Federal report of all auto-assigned Medicaid recipients
- Generate monthly Managed Care Enrollment reports
- Generate a PAL scorecard report for Managed Care providers
- Generate a monthly report of all adjusted management fees. **(40.9.1.16, 40.9.1.19, 40.9.1.25 – 26, 40.9.1.29, Comment CSC25)**

(40.9.1.16, 40.9.1.19, 40.9.1.25 – 26, 40.9.1.29)

We will work with the State to define and implement quarterly utilization reports based on paid claims for all CCNC providers. The utilization reports will provide comparative information on provider service rates and PMPM costs for each provider against other provider types within each peer group, and including enrollment figures for each CCNC provider. The quarterly utilization report will also include the computation of utilization outliers. An online screen will be provided for user-configurable options to generate utilization reports based on user-defined date spans, provider-related information, service categories, diagnosis, Current Procedural Terminology (CPT) codes, and Diagnosis Related Group (DRG) codes. Team CSC will work with the State to further enhance the reporting facility to include inclusion of disease management and system care groupings, drug utilization and other group comparisons. **(40.9.1.30 – 40.9.1.32)**

(40.9.1.30 – 40.9.1.32)

D.1.4.9.6 Security and Controls

Team CSC recognizes the importance of maintaining security and controls over all online updates to the Managed Care databases. Our proposed solution includes a centralized authentication mechanism coupled with role-based access

control to ensure that access to Managed Care data is granted only to State-authorized users.

Our proposed solution makes use of the audit logging facility native to the database to provide a 100 percent complete logging of all updates to the Managed Care data including changes to capitation fees, administrative entity provider ID, file maintenance activity time-stamps, operator making changes, and supervisor name. The audit logs are kept online and accessible by State-authorized users. **(40. 9.1.11, 40.9.1.14)**

(40. 9.1.11, 40.9.1.14)

D.1.4.9.7 Conclusion

Team CSC understands the importance of Managed Care programs and the relationship of effective Managed Care administration to both optimum recipient health and benefit payout savings. We offer our Managed Care capability, enhanced with application of state-of-the-art technology, to implement the processing model required by the State. We are committed to working with the State to tailor our technologies and powerful systems components to meet evolving Managed Care needs within the North Carolina health care entitlement programs. **Our solution has the capability to significantly improve Managed Care operations and help the State manage these benefits cost-effectively through streamlined workflow, enhanced information availability and efficiencies gained through automation.**

Page D.1.4.10-1 contains confidential information.

The following subsections describe the Health Check Subsystem functionality in terms of:

- Health Check Subsystem Overview
- Online Inquiry, Search, and Update Capabilities
- Health Check Database Maintenance
- Health Check Letters
- Web Portal for Health Check Coordinators
- Health Check Reports
- Security and Controls.

Each subsection responds to the associated requirements from RFP Section 40.10.1. Requirements have been grouped by subject matter.

D.1.4.10.1 Health Check Subsystem Overview

The Health Check Subsystem enables the State to conduct all required EPSDT activities and meets Federal and State EPSDT processing requirements. The Health Check program provides a vital service to North Carolina recipients by promoting available services, pursuing care provision for individuals due for screening or needing treatment, and working to achieve optimal health outcomes for the vulnerable EPSDT population. The Health Check Subsystem is fully integrated with all other components of the Replacement MMIS and is available to stakeholders and users through the **NC***Tracks* Portal. **Exhibit D.1.4.10.1-1** shows the primary interactions and operating environment of the Health Check Subsystem. **(SOO 10.12.3-3)**

(10.12.3.-3)

Page D.1.4.10-3 contains confidential information.

(for example, to view Recipient information). The **Health Check Subsystem data is stored and maintained in an integrated relational database that makes available current, accurate program information to and from all other subsystems.** The capabilities described for the Replacement MMIS Health Check solution encompass several subsystem components and tools which we reference throughout the following discussion. **Exhibit D.1.4.10.1-3** lists and briefly describes each major element.

Tool/Component	Function/Description
Recipient Subsystem	Maintains recipient demographic information and enables selection of recipients eligible for Health Check services
Claims Subsystem	Using service data from paid claims, enables tracking of services received, adherence to treatment plans, and determination of follow-up needs
Provider Subsystem	Enables selection of appropriate providers to furnish Health Check services.
TPL Subsystem	Enables confirmation that recipient is not eligible for services under another program
Workflow	Automated processing and optimization of workload
Periodicity Schedule	Defines age-appropriate screening and treatment services for recipients and drives notification process
Web Portal	Enables enhanced access to Health Check data by stakeholders including Health Check Coordinators
Mobius Document Management Capability	Online report retrieval and storage capability

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Exhibit D.1.4.10.1-3. Health Check Tools and Components. *Powerful software components interact seamlessly with Replacement MMIS subsystems.*

D.1.4.10.2 Online Inquiry, Search, and Update Capabilities

Team CSC recognizes the importance of timely and accurate field data collection to support the proper functioning of a Health Check solution. Our proposed solution uses the familiar Web browser, online pages, and powerful Web Portal tools to provide quick data capture capability and powerful inquiry functions to serve the local Health County staff needs efficiently and error-free. Through the Web browsers, the local Health County staff can access and update their county-specific information as well as downloading the online information to their local database. The Wiki functionality allows the Health Check staff members to maintain, organize, and update Web-site content at its convenience.

Our proposed Health Check Subsystem provides extensive online inquiry, search, and maintenance capabilities for authorized users to access and update the Health Check database from workstations via a browser. Using the Baseline System's user interface design, all Health Check information inquiries and updates are initiated by activating either the "Recipient" or "Case Management" menu options from the top menu bar on a common home page that is immediately presented after a user has logged on to the system. Web-based functionality includes the ability to access information regarding new eligibles, new screenings and referrals, county-specific data access for Health Check Coordinators, and the use of standard protocols to download data to the desktop. (**40.10.1.16**)

Focus on Improved Health Outcomes
CSC worked with the Norwegian Department of Health to develop an innovative web-based system that provides news and information about treatment and procedures and allows citizens to make better informed decisions about healthcare

(40.10.1.16)

Pages D.1.4.10-5 through D.1.4.10-9 contain confidential information.

and abnormal conditions including dates and indications whether the conditions were treated or referred for treatment. The Health Check Periodicity Schedule Table will be used to establish health screening schedules according to a recipient's demographic data and also used in conjunction with claim information for identifying anomalies and related referrals or treatments. The Case Management Plan Issue Table provides the information for generating monthly notifications for next screenings, missed screenings and abnormal conditions not treated based on State criteria. The Client Notification Table captures all information related to the production of Health Check notifications. Other database tables, relating to case activities, are updated by the local HCC staff through Web browsers as described in the previous sections. (**40.10.1.1, 40.10.1.4, 40.10.1.5**)

(40.10.1.1, 40.10.1.4, 40.10.1.5)

D.1.4.10.4 Health Check Letters

The Health Check solution provides an integrated letter-generation and rule-based workflow component that will be used to generate and manage the Health Check and other notification letters to the Health Check recipients. The solution will provide on-line, updateable letter templates for Health Check monthly notifications, standardized letters and inserts based on the reason for the communication. Health Check letter processing includes the functionality necessary to generate letters to eligible recipients and track and report program participation and is performed on both a weekly and monthly basis.

The purpose of the Weekly Letter Process is to produce correspondence to the parents or guardians of Medicaid eligible children, giving them information about the State's Health Check Program (and encouraging them to participate). Newly Eligible Letters will be produced for each newly eligible Medicaid client under the age of 21 to introduce them to the program. The process will also produce an Annual Letter three months prior to each eligible client's birthday, to remind the parents or guardians of the availability of Health Check services.

The Health Check Weekly Letter Process will access the Recipient Database to extract all current Health Check eligible recipients to produce the following reports and letters:

- Health Check Newly Eligible letters for newly eligible recipients. The letter will capture all clients in the household on one letter, up to 10 clients.
- Health Check Annual Notification letters for recipients within three months of their next birthdays.
- Health Check Newly Eligible Follow-up Worksheet which lists the newly eligible Medicaid clients that were notified of the availability of Health Check services (medical, vision, dental, hearing screenings) through the generation of a Newly Eligible Letter.

The Annual Notification and Newly Eligible Letters will include the Spanish translation on the reverse side for each letter generated. During the implementation effort, Team CSC will collaborate with the State to determine and implement language support for additional languages. (**40.10.1.7)**

(40.10.1.7)

The Health Check Monthly Letter Process will access the Recipient Database to generate the monthly notifications to case heads for next screenings, missed screenings, and abnormal conditions not treated, based on State criteria. (**40.10.1.8)** (40.10.1.8)

The Health Check Subsystem tracks all notifications issued including the case data, recipient ID and date of notice. For each letter generated, the system will update the Health Check Client Notification Table with the type of letter sent, case id, recipient id, and the corresponding date that it was sent. For each newly eligible client identified, a line will be written to the Health Check Newly Eligible Follow-up Worksheet for the client's county of residence. For each Annual Notification letter that is sent to a client, a line will be written to the Health Check Annual Notification Report for the client's county of residence. (**40.10.1.9)** (40.10.1.9)

D.1.4.10.5 Web Portal for Health Check Coordinators

Team CSC acknowledges the State's requirement for a Web-based application to capture and maintain local Health Check staff information for generating management fees, accounting and stewardship reports.

Web-enabled Collaboration
Wiki will enable all Health Check Coordinators to share knowledge through the NC*Tracks* Web portal. Wiki lets users organize, edit, update, and manage web-site content themselves, greatly simplifying and speeding the process of maintaining relevance and currency of web-site content.

We propose to provide the above functionality within a Web Portal solution that includes the innovative Wiki facility, which will allow all Health Check Coordinators to easily create power community websites for use in knowledge management or dissemination of shared insights. We also propose a more supportive user interface environment based on the Rich Internet Application (RIA) interface technology. The RIA technology will be used to provide a desktop computing metaphor that simplifies browser navigation and the integrated display of information collected in the course of various search and inquiry activities.

We will work with the State to design and implement a modern Web-based application to automate the capture of HCC staff and Full-Time Equivalency (FTE) data from the county for the generation of Health Check Coordinator management fees and generation of County Options Change Request (COCR) and Monthly Accounting of Activities Report (MAAR) reports. The information will be used to compute and generate Health Check management fee transactions for the Claims Subsystem to effect payment to the local Health Check offices. To satisfy other new functionality, Team CSC will add a "Comments" table to the Health Check database to convert and capture the HCC comments currently stored in the Fox Pro Data Shell application. Additionally, new database tables will be designed to store HCC staff information, payment support data, and accounting information for processing the Monthly Accounting of Activities Report (MAAR) and County Options Change Request (COCR) reporting functions. In addition, we will work with the State to address Web-based Health Check functionality for the creation, update and management of Health Check Information Notifications and Health Check Recipient Data. (**40.10.1.11, 40.10.1.13, 40.10.1.15, 40.10.1.18**) (40.10.1.11, 40.10.1.13, 40.10.1.15, 40.10.1.18)

D.1.4.10.6 Health Check Reports

Team CSC will work with the State to design and implement the monthly Full-Time equivalent (FTE) report based on the information received on the MAAR and COCR reports, Health Check Activity, and monthly MAAR Summary reports. These reports will be generated from the data submitted by the local HCCs through the new Web-based applications. We will also work with the State to design and implement the EPSDT reports for the primary care providers and administrative entities as well as the report on recipients associated with a particular practice for a State-defined time period which will include the county and statewide participation rates. The EPSDT report will be produced no later than the fifth day of the month for the previous month's data and made available on the Web for providers to download for their practice only.

In addition to the above reports, Team CSC proposes to work with the State to review and implement the Baseline System reports for promoting Health Check enrollments, monitoring program activities, and cost analysis. **Exhibit D.1.4.10.6-1** illustrates some of the Baseline System reports that are available for supporting the State's business needs. (**40.10.1.14, 40.10.1.17, 40.1.19, 40.10.1.20, 40.10.1.21**)

(40.10.1.14, 40.10.1.17, 40.1.19 - 21)

Report Title	Description
Case Management Medicaid Expenditures by Client	This report lists by county and client, the amount of Medicaid expenditures in relation to the client's budget amount. The report is generated for clients with pre-defined Client Restriction Codes such as Care at Home and Traumatic Brain Injury. The report provides the variance percent and variance amount between the actual Medicaid expenditures and the budgeted amount for the case management plan period. Clients will continue to appear on the report for a period of one year.
Case Management Client Reminder Report	This report lists by county and Client Restriction Code, the activities being supervised through the Client Reminder page. The report is sorted by Case Management Agency first, then by county office.
Case Management Clients by County Report	This report lists by Program Type, all active clients and all clients that became inactive within the reporting quarter. The report will provide both county and statewide totals of specific waiver program clients. It is intended to aid the administrative management of the waiver programs.
Case Management Other Client Waiver Programs Report	This report lists all active clients with recipient exception codes/client restriction codes of 64, 65, and 67. The report provides a total of the Medicaid expenditures incurred by the client during the reporting quarter.
Health Check Fact Sheet	This fact sheet is an enclosure that will be included with each Newly Eligible Letter and Annual Letter that is generated for Health Check clients.
Health Check No Medicaid Services Received Report	This report lists all active Fee-for-Service (FFS) Health Check participants who have not received any Medicaid services within the past year.

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Exhibit D.1.4.10.6-1. Baseline EPSDT Reports. *Existing reports provide Health Check reporting functionality that can easily be adapted to reflect North Carolina information.*

D.1.4.10.7 Security and Controls

Team CSC recognizes the importance of maintaining security and controls over all online updates to the Health Check databases. Our proposed solution includes a centralized authentication mechanism coupled with role-based access control to ensure that access to Health Check data are granted only to State-authorized users. Further, our proposed solution makes use of the audit logging facility native to the database to provide a 100 percent complete logging of all updates to the Health Check data. The audit logs are kept online and accessible by State-authorized users. (**40.10.1.10**)

(40.10.1.10)

D.1.4.10.8 Conclusion

Team CSC will adapt existing EPSDT functionality to North Carolina requirements to furnish a robust Health Check capability. Our solution encompasses Web technology and integrated database functionality to make accurate, current information available to Health Check Coordinators and enhance their ability to promote Health Check services and ensure recipient wellness.

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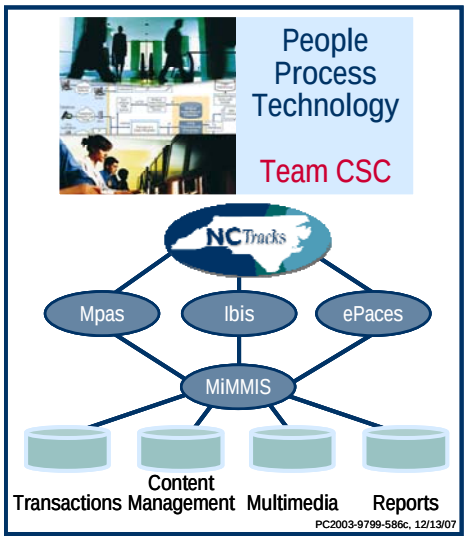
D.1.4.11 Third Party Liability Subsystem

Team CSC will deliver an effective Third Party Liability solution that ensures DHHS programs are the payer of last resort through cost-avoidance and recovery of previous claim payments that should have been reimbursed by other payers.



Budgetary constraints and increased numbers of recipients in North Carolina's Medicaid and other medical assistance programs require prudence in the use of federal and state program dollars to avoid eliminating much needed recipient services. To date, the State's well-defined policies and procedures, interfaces to other systems and vendors, and the support of the administrative capabilities provided by the North Carolina MMIS have been the backbone for developing solid business practices and fiscal integrity, thus stretching the State's medical assistance program dollars.

The North Carolina DHHS Divisions of Medical Assistance (DMA), Mental Health (DMH) and Public Health (DPH) TPL Unit's cost management strategies have resulted in significant program dollar savings. The State has been diligent in enforcing its rules that require providers and recipients to provide or secure third party resource information to ensure that those payers accept responsibility for payment of services prior to DHHS Divisions of Medical Assistance, Mental Health and Public Health dollars being expended, ensuring that the respective DHHS Division is the payer of last resort in all applicable situations. Medicaid and other medical assistance program recipients may have access to other health insurance coverage from employment, Medicare, CHAMPUS, court-ordered medical support or because of a workers compensation incident, automobile or other accident. North Carolina takes advantage of these third party resources through a combination of activities including cost avoidance, post-payment billing by specialized third party resource contractors and State staff, benefit recovery functions in cases where the client's condition is the result of an accident and recovery from deceased clients' estates. **(SOO 10.12.5-14)**

Technology-optimized TPL Management
The TPL solution leverages Web-based access and ease-of-use, rules-based workflow to automate workload processing, user-defined business rules, and comprehensive logging, audit trail and reporting capabilities.

(10.12.5-14)

The NCMMIS aids these efforts through acquiring and maintaining information for Carrier (current and historical), Recipient (resource and invoice data) and Recovery Case Files including both Casualty and Estate. In each case, the NCMMIS requires entry, billing (when applicable), maintenance, collections and reporting functionality to support cost avoidance and/or recoupment efforts.

Team CSC understands the criticality of the State's goal for an enhanced Third Party Liability (TPL) Subsystem that maximizes the collection results derived from the

Page D.1.4.11-2 contains confidential information.

information begins at the State's County Eligibility Offices. The eligibility workers have collateral responsibility for identifying and investigating client third party resource at the time of a recipient's acceptance for medical assistance. Additional information for third party resource availability is conducted through State directed data matches and insurance carriers and public agencies. Third party liability notification can also be obtained through the claim payment process, e.g., the claim has an indicator that an accident was the reason for services provided.

The information that is gathered is entered into the State's Eligibility Information System and passed daily or real-time to the State's MMIS Recipient and TPL Subsystems where it is maintained and used in claims processing. As applicable to the third party resource information, the Recipient Subsystem maintains a TPL indicator, liability and deductible balance, transfer of assets, and cross-referenced records. This data is stored in the MMIS to support other subsystem requirements for recipient third party resource information. **(Comment CSC318)**

In addition, the TPL Subsystem enables the State to manage information about other insurers and identify appropriate opportunities for payments to be made by other entities. Each entity will be entered as a Carrier prior to being billed. Our proposed modifications to our Baseline TPL Subsystem will enable this carrier information to be sent to the Web for viewing by the general public. Recipient resources are Third Party Insurance policies that cover recipients enrolled in any of the covered DMA, DMH, DPH, and ORHCC medical assistance programs. They will be maintained by Carrier ID, Policy Number and Policy Sequence Number to prevent duplicate policies. This information can be entered manually or electronically from the State's Eligibility System (EIS) as an interface, or as a batch file from both the Defense Enrollment Eligibility Reporting (DEERS) and the Child Support Enforcement Interface (CSE). CSE information is pended for verification before the system accepts the data for processing purposes. All updates to carrier and resource information are shared with the Point of Sale (POS) and back to the EIS to ensure TPL data in these systems is current and accurate.

The Baseline TPL Subsystem also supports Health Insurance Premium Payment (HIPP) information which is stored on the TPL recipient resource record. The TPL subsystem will automatically generate HIPP transactions for all eligible recipients. These transactions are stored on the claims database and submitted to the Financial Management and Accounting Subsystem for remittance and payment generation.

The recipient resource information is used by the Claims and POS Subsystems to determine whether a claim will be paid or denied. Edits will be applied to the claim identifying it as a pay and chase claim or a cost-avoided claim. Varying situations can occur in this process and each will have its own hierarchy to follow to ensure maximum benefit dollars are saved.

Specific pay and chase claims are federally mandated for recipients under the Medicaid for Pregnant Women (MPW) program and for Non-Custodial Parents (NCP) with court orders to carry insurance on the non-custodial child. System overrides will be developed in accordance with State defined rules, diagnosis and procedure codes to expedite provider payments for prenatal care.

The Baseline system receives daily TPL extract information from the MMIS and POS Claims Subsystems. This data will be written to billing tables to enable invoice billing either by paper or electronically to the appropriate entities. Team CSC will work with the State to define all of the parameters of the billing and maintenance component to ensure its appropriate links to other MMIS functions including financial and reporting.

Trauma claims will be posted as a result of specific system edits. When these claims are identified, the system will automatically generate a Trauma Questionnaire which will be sent to the recipient. The questionnaire will automatically be logged into the system. These questionnaires enable the State to determine whether a recovery case should be opened and support the reduction of State dollars expended. These cases are managed by the TPR case workers to retain pertinent claim data.

In addition to Trauma recovery cases, the system will also support the establishment of Estate recovery cases. These cases can be invoked by a number of conditions and will be discussed under D.1.4.11.6 in this section.

The Baseline TPL Subsystem will support further reduction of State liability by processing retroactive billings for Medicare and Insurance updates. This occurs when a claim is paid and TPL is identified post payment of that service date. Our approach to managing these billings is discussed under D.1.4.11.6 in this section.

All TPL information is maintained in the reporting repository to enable ad hoc and scheduled report and extract creation. All TPL invoices, letters and reports are systematically formatted based on State-approved design for hard copy production as needed. Each of these communication vehicles are sent to the responsible party (carrier, recipient, attorney, etc.) as well as to our electronic data management system for electronic storage and authorized user access. **(Comment CSC318)**

CSC's most recent experience in providing Third Party Liability Support services is our current contract in the State of New York. CSC's Third Party Subsystem proposed baseline product has supported the State of New York's cost avoidance efforts of more than $7.2 billion and TPL recovery efforts of $142 million in calendar year 2007. With this experience, we are confident in our ability to move North Carolina's Third Party Liability Subsystem into the next generation of MMIS development using MITA and third party resource strategies which will be enhanced by incorporating advanced technologies such as Ibis. **(Comment CSC771)**

The effectiveness of the TPL solution determines the extent to which the State is able to preserve State program benefit funds. Team CSC commits our resources to implementing an optimal TPL solution to further the State's goal of achieving operational efficiencies that translate into monetary savings. The TPL Subsystem is fully integrated with all other components of the Replacement MMIS and is available to stakeholders and users through online pages.

Exhibit D.1.4.11.1-1 illustrates the operating environment for our proposed TPL Subsystem with clear identification of the stakeholders, external systems, and other Replacement MMIS subsystems with which the TPL Subsystem interacts.

Page D.1.4.11-5 contains confidential information.

Exhibit D.1.4.11.1-2 summarizes the high-level inputs, processes, and outputs that comprise the TPL solution.

Inputs	Processes	Outputs
Medicare, Carrier information	Update Medicare and Carrier data	Updated TPL tables.
Employer, other resource Information	Update resource and employer information	Updated TPL tables
Data feeds from various entities (e.g., Defense Enrollment Eligibility Reporting System (DEERS), State agencies, etc.)	Update TPL tales to reflect current information	Updated TPL tables
HIPP information/requests	Maintain accurate HIPP data	Updated HIPP tables, financial transactions to Claims Subsystem to generate HIPP payments
Mass change requests	Apply mass changes	Updated TPL database
Inquiry and update requests	Resolve inquiry, perform updates	Informational response, updated database
Information initiating recovery cases (e.g., notice of death)	Establish and maintain recovery case	Updated recovery data
Tracking and Audit Trail requests	Maintain audit trail, tracking	Audit trail
Report requests	Perform reporting	Reports
Letter and notification requests	Generate letters/notices	Letters, notices

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Exhibit D.1.4.11.1-2. TPL Inputs, Processes, and Outputs. *The TPL capability addresses all the processes necessary to provide accurate processing of information regarding other insurers.*

The capabilities described for the Replacement MMIS TPL solution encompass several subsystem components and tools which we reference in the following discussion. **Exhibit D.1.4.11.1-3** briefly describes each element.

Tool/Component	Function/Description
Reference Subsystem	Maintains coding used in TPL administration
Recipient Subsystem	Maintains recipient demographics and other coverage indicators
Provider Subsystem	Maintains information regarding provider eligibility to furnish services
Prior Approval Subsystem	Interacts with TPL to adjudicate approval requests
Managed Care Subsystem	Interacts with TPL to determine eligibility and coverage
Claims Subsystem	Provides claims-based information about other coverage (e.g., Medicare, other insurer). Claims history provides universe of claims for recoveries. Receives and processes HIPP financial transactions.
Health Check Subsystem	Verifies absence of other coverage to pay for EPSDT services.
Third Party Liability Tables	Determines primacy of other insurers, including Medicare, for coverage of recipient's services.
Automated workflow	Streamlines and controls automated processing and routing of TPL workload

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Exhibit D.1.4.11.1-3. TPL Tools and Components. *The TPL process seamlessly integrates with Replacement MMIS components to provide consistent responses and effective processing.*

D.1.4.11.2 Online Inquiry, Search, and Update Capabilities

Accurate, complete, and timely cost-avoidance and recovery relies on ready access to TPL repository data to support research, validation, and timely entry of TPL resource data. To this end, Team CSC's proposed TPL Subsystem provides extensive State-designated user online inquiry, add, update, and search capabilities to access and maintain the TPL database using the familiar Web browser. The system maintains an online audit trail of all updates to the TPL data. **(40.11.1.19, 40.11.1.21, 40.11.1.51)**

(40.11.1.19, 40.11.1.21, 40.11.1.51)

Using the Baseline System's familiar Web-based user interface design, all TPL information inquiries and maintenance are initiated from a common home page that is immediately presented after a user has logged on to the system. From the

home page, a user may activate the "Third Party" option on a top menu task bar for more menu options such as:

- "Carrier" menu option to research and update information for commercial insurance and Medicare insurance carriers
- "Employer" menu option to research and update benefits and coverage provided by recipient's employer. Authorized users are allowed to add new employer information, track coverage available through employers, and update coverage based on the benefits plan provided by the employer.
- "Resource" menu option to search and maintain a recipient's TPL resource data (e.g., coverage provided by other insurance sources) including commercial insurance, Medicare/Buy-in, and Medicare Part D data. Additionally, users may enter free-form text related to a recipient or commercial insurance policy through a "TPL Notes" page.
- "Mass Change request" menu option that allows mass update of a range of carrier and resource data.

(40.11.1.21, 40.11.1.51)

(40.11.1.21, 40.11.1.51)

Carrier Search

Carrier information is maintained on the TPL Carrier database and represents the people or organizations with which the recipient may have medical assistance financial support such as private insurance carriers, pharmacy benefit managers, lawyers, employers, etc. All such entities are entered into the system as carriers. Entities are classified as health and non-health related carrier resources; non-health resources include attorney, non-custodial parent, administrator and recipient. DMA, DMH, ORHCC, and DPH authorized users will have access to the Carrier file for updates; however, our review indicates that only DMA may add health insurance data to the files. This will be confirmed during DDI. **(Comment CSC771)**

A user may activate the "Carrier" menu option to access the "Carrier Search" page to search for TPL carrier information using the following criteria alone or in combination: carrier code, complete or partial carrier name, postal code, carrier type, city name, state code, telephone number and claims submission address.

Exhibit D.1.4.11.2-1 shows the "Carrier Search" page, accessed via the "Carrier" menu option that allows for research and update information for commercial insurance and Medicare carriers. **(40.11.1.4)**

(40.11.1.4)

Pages D.1.4.11-8 through D.1.4.11-11 contain confidential information.

The TPL Resource Tables are designed to store multiple instances of carrier and recipient third-party resource information. Each instance of third-party payer information is represented by a database row containing the following data elements:

- Resource Type which specifies whether the resource record is Medicare, a commercial insurance coverage, casualty case, or court-ordered absent parent insurance
- Insurance company carrier code
- Policy number
- Policy Sequence Number which provides unique identification of the resource record in case more than one resource has the same resource type, carrier code, and policy number
- Group number in the case of group insurance policy type
- Employment data such as Name of the policyholder's employer, Employer Address: including city, state, ZIP Code, and country code and Employer contact telephone number
- Court-ordered information

(40.11.1.6 40.11.1.8 – 9)

- Begin/end dates for validity of policy. **(40.11.1.6, 40.11.1.8, 40.11.1.9)**

This database will be expanded to include all additional RFP-required data as identified throughout this response, e.g., our response for RFP requirements 40.11.1.1 and 40.11.1.5 on page D.1.4.11-9.

The TPL Resource Tables are maintained by the online means described previously, as well as by periodic (e.g., daily, weekly, semi-monthly, monthly, etc.) batch data feeds from the State for:

- DHHS Eligibility Information System (EIS)
- DHHS Child Support Enforcement Interface (CSE) Automated Collection and Tracking System (ACTS) (**40.11.1.28)**

(40.11.1.28)

- Defense Department's Defense Enrollment Eligibility Reporting System (DEERS).

Once the TPL resource tables are updated, the information is immediately available for claim cost-avoidance and recovery actions, thereby improving processing accuracy. For example, if a new Pharmacy resource is created for a recipient, this information is immediately available to the claims adjudication process for cost-avoiding pharmacy claims at the point of sale using pharmacy policy rather than medical policy. The system also provides access to previously paid claims, at a minimum of three years, for the user to review when TPL resources are identified or verified retroactively. **(40.11.1.23, 40.11.1.24)**

(40.11.1.23, 40.1.1.24)

TPL resource updates involving Non-Custodial Parent (NCP) policyholders are tracked on the TPL resources tables. These tables maintain TPL resource associations with one, some, or all of the individuals covered by the NCP's policy, which could include one or more recipients associated with one or more cases. **(40.11.1.56, Comment CSC47)**

(40.11.1.56)

The TPL Subsystem includes the following controls to enhance data integrity and ensure that certain situations that must be manually reviewed are flagged:

- TPL resource updates from Child Support Enforcement (CSE) are pended until approved by the State **(40.11.1.57, Comment CSC48)** (40.11.1.57)
- TPL resource updates for a recipient covered by the Breast and Cervical Cancer Medicaid (BCCM) or Health Choice programs are pended for final disposition by the State with a notification that the recipient is covered by either of these programs. **(40.11.1.58)** (40.11.1.58)

D.1.4.11.4 Health Insurance Premium Payments (HIPP) Process

(10.12.3-4) **(SOO 10.12.3-4)** The TPL Subsystem provides the HIPP functionality to support DHHS in replacing Medicaid coverage for qualified beneficiaries with other less-costly health insurance options. The TPL HIPP component provides several online pages to facilitate HIPP processing and premium payment management.

Authorized users can retrieve and review HIPP cost-effectiveness data using one of the following search criteria combinations such as Case Number, Case Number and recipient ID combination, recipient ID or full/partial recipient names. Users may add or update HIPP data related to the insurance resource. Other pages are provided to set premium payment amounts. And finally, **to facilitate mass replacements, users may perform mass authorizations of HIPP coverage and premium payment for qualified recipients based on setting basic target criteria for system-wide match and replace activities. The mass adjustment capability reduces manual workload.**

The HIPP database contains HIPP policy information and payments, HIPP cost analysis for policies, and annual Medicaid expenditures used in cost analysis.

Exhibit D.1.4.11.4-1 shows the primary HIPP Tables and their informational content.

HIPP Table	Information Content
TPL Policy HIPP	Premium payment data reflecting what the State is paying for the recipient's health insurance premiums.
TPL HIPP Cost Analysis	Data entered by the authorized users to determine if paying the health insurance premium would be cost-effective for the State
TPL HIPP Cost Analysis Coverage Code	Coverages available to a recipient through a health insurance policy
TPL HIPP Cost Analysis Individual	Recipients covered on a health insurance policy
TPL Policy HIPP Payment	History of the premium payments made
TPL Medicaid Expenditures	Average annual Medicaid expenditures data used into determine cost-effectiveness for the HIPP Program

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Exhibit D.1.4.11.4-1. HIPP Tables. *These tables maintain HIPP information used in premium payment and administration.*

The online, updateable HIPP data accessible to authorized users provides the basis for the generation of financial transactions for payment of insurance policy premiums for all approved HIPP recipients. The payment process involves an initial creation of a preliminary HIPP payment report that lists all HIPP payments for the weekly payment cycle. This report provides the basis for State staff to determine actual payments and perform an online authorization for payments. The system generates and routes the HIPP financial transactions to the Claims Subsystem where they are stored on claims

history and available for online inquiry and reporting. The Financial Subsystem generates payments (checks or EFTs) as well as corresponding remittances for all approved HIPP transactions. **(40.11.1.36)**

(40.11.1.36)

D.1.4.11.5 Cost Avoidance and Pay-and-Chase Processing

(Comment CSC771) Cost-avoidance is affected by business rules that direct the claims adjudication process to deny claims that should rightfully be reimbursed by other third parties. In situations where it is not possible to perform outright cost-avoidance, a user can instead select a pay-and-chase option to pay first and follow through with further review and possible rebilling of the financially-responsible payer.

State users may also set various TPL edit and control criteria to enforce or exempt certain constraints during the claims adjudication process. The business rules will be supplied to the Claims Subsystem in the form of a TPL Cost Avoidance Criteria table that contains the parameters for matching claim data to identify cost-avoidance and pay-and-chase situations. Each incoming claim will process through the claims adjudication function validating any reference or TPL resource information. When there is a match, there are four potential courses of action:

- Pay claim: claim excluded from TPL resource information, enabling the passing through of the cost avoidance edits and allowing the claim to be paid
- Pay and chase: claims are excluded based on the claim information and TPL resource information such as a lawsuit or incident applicable to automobile insurance carrier, workers compensation or other disability claim allowing the claim to be paid and a accrual of paid claims until the execution of any medical coverage settlement for State reimbursement
- Suspended claim: matches occur; however, requires manual intervention to assess the appropriateness of claim adjudication
- Deny claim: claim demonstrates TPL availability; the collection against this resource has not been provided, resulting in automatic claim denial.

When the claims adjudication process is completed, all cost avoided claims (denied and paid will be identified including the dollar amounts associated with these cost-avoided claims. An extract file of the pay-and-chase claims and applicable billing information also will be created. The Replacement System will create “cases” for recipient’s claims that have met a DHHS defined threshold amount. These cases will enter the TPL Recovery Workflow component described below to continue processing and billing to the third-party insurance carrier. **(40.11.1.10, 40.11.1.11, Comment CSC30)**

(40.11.1.10, 40.11.1. 11)

The Cost Avoidance Criteria table will also direct the claims adjudication to identify special processing requirements such as:

- Bypass cost-avoidance for claims involving preventive pediatric services and prenatal care, unless TPL is indicated on the claim **(40.11.1.2)**
- Cost-avoid claims for inpatient hospital stays for pregnant women **(40.11.1.3)**

(40.11.1.2, 40.11.1.3)

- Routing of Durable Medical Equipment (DME) claims to Children's Special Health Service (CSHS) for payment when they are for non-Medicaid DME services for a child who is Medicaid eligible, CHCS eligible, and for whom an approval for the item is on file **(40.11.1.33, Comment CSC45)** (40.11.1.33)
- Process specific Durable Medical Equipment (DME) claims for Medicaid payment only after payments have been made by Children's Special Health Service **(40.11.1.33, Comment CSC45**) (40.11.1.33)
- Develop State rules during DDI to automate a process for identifying those claims that were referred to CSHS for payment to either use as validation for CSHS request for reimbursement or to create an accounts payable (**40.11.1.33, Comment CSC45)** (40.11.1.33)
- Exclude, based on specific dates, third-party insurance on a per-person/per-policy basis including the possibility of having multiple exclusions (**40.11.1.54)** (40.11.1.54)
- Allow claim payments for recipients for specific services even when either Third Party annual or lifetime benefits are exhausted and in accordance with State benefits coverage rules. **(40.11.1.55, Comment CSC46)** (40.11.1.55)

D.1.4.11.6 TPL Cost Recovery Workflow

The TPL Subsystem supports the management of cost-recovery activities through an informational construct called a recovery case as discussed earlier in this section. **Team CSC will enhance the Baseline System with a rules-based workflow component for managing the cost-recovery activities and enhancing revenue collection for the State.** Rules-based capability will enable implementation of processing changes without the need for programming intervention and will greatly speed the implementation process.

To facilitate administrative effort, each recovery case is created to include complete information to support billing, such as claim data involved in a recovery action, generated invoices, case ID, type and status, lien amount and amount of recoveries, policy number, policy name, SSN, recipient name or ID, carrier name or ID, provider name or ID. In addition, the Replacement MMIS will provide the ability for users to enter the attorney name, attorney address, attorney telephone number, attention to line and accident number associated with the case. **(40.11.1.39, 40.11.1.29, 40.8.1.210, Comment CSC178)** (40.11.1.39, 40.11.1.29, 40.8.1.210)

The TPL Subsystem automatically creates potential recovery cases, with related historical claim information from the past three years, when triggered by any of the following events:

- An update of an insurance coverage that may affect previously-paid claims
- Receipt of retro-eligibility notification from the Recipient Subsystem involving a recent update to a recipient's eligibility, including Medicare eligibility, which affected past-period coverage
- Identification of trauma or accident-related service in the weekly adjudicated claims to generate accident inquiry letters and questionnaires/reports for potential cost-recovery

- Receipt of a death notification from the Recipient Subsystem related to a deceased recipient who had a permanently-institutionalized Living Arrangement Code or the recipient had attained age 55 with Personal Care Service (PCS), Long Term Care (LTC), or a Community Alternatives Program (CAP) coverage. For these cases, the TPL Subsystem will extract previously-paid claims to setup the recovery cases. The original historical claims will be flagged for "lifetime" retention

(40.11.1.12, 40.11.1.13, 40.11.1.16, 40.11.1.24, 40.11.1.27, 40.11.1.30)

- Extraction of weekly claims in which the recipient's health insurance carrier or Medicare "denies" payment for a particular service. (**40.11.1.12, 40.11.1.13, 40.11.1.16, 40.11.1.24, 40.11.1.27, 40.11.1.30**)

When any of these events occur, the post-payment process will determine:

- If all claims on the existing invoice are closed,
- If some of the claims on the existing invoice are closed
- If a new invoice is to be created
- If the changes received have no impact on the existing invoice, therefore no modification is necessary
- If there is no impact to claims history, then no invoice will be created

If a new invoice is required, the necessary data for claim development is compiled and moved to the invoice generation process as discussed below.

Invoices are closed when:

- All claims on the invoice have been paid,
- All claims on the invoice have reject reason code, or
- A combination of the above.

Invoices that have not been closed by State-defined time frames will be forwarded to the State TPL vendor. The activities associated with this action will be defined during DDI. **(Comment CSC771)**

The system will extract and store the relevant historical claims within each recovery case. When retroactive Medicare coverage is entered in the Recipient Subsystem, the extraction process will also identify paid historical claims that are paid and are still within the allowed Medicare filing time-limit for those claims.

Team CSC will work with the State to define rules to perform TPL retro-processing to determine if a notice or an invoice should be sent. Recipients with Part B coverage will have their invoice sent to their Medicare carrier and Recipients with Part A coverage will have their invoice sent to the provider. If no responses are received from these entities, we will implement State-defined rules for actions to be taken. An example of such an action may include establishing an accounts receivable against the provider's forthcoming earnings to recoup the invoiced amount. **(Comment CSC771)**

The historical claim information kept within a recovery case is used for tracking and reporting on recovery and invoice statuses and enables the posting of the final recovery status back to the individual history claim stored in the Claims Subsystem.

(40.11.1.14, 40.11.1.15, 40.11.1.18, 40.11.1.25, 40.11.1.32)

Case information also includes invoice data and recovery data. A closed recovery case will be archived after a specified time-period, but a record of the archived case ID will be retained in the TPL database to facilitate retrieval of archived cases. **(40.11.1.14, 40.11.1.15, 40.11.1.18, 40.11.1.25, 40.11.1.32)**

Once a cost-recovery case is created, the TPL workflow component will proactively notify the appropriate TPL staff to review, modify, cancel, or approve recoverable items by placing the case in the TPL staff work queue, initiating recoveries in a time frame specified by DHHS.

Team CSC proposes a Web-based TPL workflow component for an automated post-payment billing module that will be supported by rules-based workflow technology to enhance all DHHS LOB TPL cost-recovery activities and improve operations, as follows:

- Automatic or manual creation of recovery cases with unique case IDs to provide accurate tracking and maintenance of recovery activities. This feature would enable the system to generate a facsimile or electronic bill to third party resources based on the claim's reimbursement amount and related State criteria. **(40.11.1.37, Comment CSC771)**

(40.11.1.37)

- Automatic or manual creation of invoices with supporting claim information to bill for recoverable drug claims from insurance carriers
- Automatic or manual creation of invoices with supporting claim information to bill for Estate recovery. Please refer to discussion below under Establishing State Recovery Cases .**(40.11.1.26, 40.11.1.31, 40.11.1.47)**

(40.11.1.26, 40.11.1.31, 40.11.1.47)

***Checks Received* (Comment CSC771)**

Payment and refund checks from providers, carriers or non-health related entities as noted earlier are received by the state-approved bank lock-box vendor, imaged and deposited in accordance with our Financial operational procedures as discussed in Section D.1.4.14, Financial Management and Accounting. The deposit records enter the MMIS and each one is assigned a financial control number. Team CSC and respective DHHS LOB TPL staff as authorized validate the receipt information and apply the appropriate funds to the appropriate invoice or recovery case. Per State-defined procedures, the funds may be paid against one claim or entered across multiple claims. For example, the total funds received can be applied to one claim or a percentage may be allocated to each claim. All funds received will be assigned a financial reason code. Invoices and recovery cases can remain opened or closed based on State-defined rules. Invoices that remain open can be rebilled based on an established frequency and acceptable response period. Funds applied to an invoice with one or more claims will have a history only mass adjustment request created for each claim. For recovery cases, State rules will be defined during DDI for applying funds and flagging the claim as part of a recovery case.

Invoice and Recovery Case Payment Denials (Comment CSC771)

Team CSC has identified additional functionality required to support the NCMMIS TPL tasks and as such offer a high level overview of our recommendation for the management of invoice and recovery case payment denials as follows: If invoiced entities deny payment the denial is logged against the invoice or recovery case transaction denoting the reason for the denial. It is possible that only part of the payment was denied, and therefore, only that portion of the claim(s) or case that was denied will be denoted. For claims invoiced, if the carrier (health or non-health related) provides sufficient information as to why they would not reimburse for the service, the claim could be set to zero and subsequently removed from "open" status, however, it will allow the residual invoiced claims to remain open until all third party payments can be accounted for, i.e., either receive payment or sufficient documentation to substantiate the denial. Team CSC will apply any methodology defined during the DDI to address these issues and to ensure the maximum collection results available.

Establishing Estate Recovery Cases (Comment CSC771)

Team CSC will also expand our Baseline TPL Subsystem to accommodate the State's need to systematically generate Estate Recovery cases and the identification of all related claims within the case set-up. This will be developed based on State and Federal Medicaid recovery guidelines and DHHS LOB rules. CSC will support this process with paper invoices produced for mailing to the Department of Social Services (DSS) for the county of the recipient. The Estate Recovery Case, including all applicable claims, will remain online and managed by the case manager until authorized closure.

Establishing Casualty Case Information (Comment CSC771)

Team CSC will also expand our Baseline TPL Subsystem to accommodate the State's identification of casualty cases as a result of returned trauma questionnaires or other correspondence. The State will have the capability to approve or cancel trauma questionnaire mailings. The State will have online access to select appropriate claims related to the case and will be able to generate invoices and letters to request payment. All inbound and outbound correspondence will be imaged and accessible for online review as needed. The details and workflow for this function will be defined during DDI.

Managing Recovery Cases (Comment CSC771)

The Web-based TPL workflow component will also provide online facility for State users to manage the case activities including inquiry and maintenance of case records. Authorized-State users can perform online tracking and updating of open cases, type of case, case status, lien amount, and amount of recoveries. Online pages will allow review of invoices generated by CSC by carrier or recipient for prescription drug recovery. The search capability will allow retrieval of recovery case information using various search criteria, separately or in combination, such as recovery case ID, case type, policy number, policy holder name and SSN, claim number, recipient name or ID, carrier name or ID number, provider name or ID, attorney name, and accident number or a combination of these elements. The online facility will also allow State

users to view all TPL receivables including claim detail status and total amount not posted, add or delete claims in a recovery case, add or update TPL threshold amount, and enter free-form text. They can also recall claims and other recovery information to send out by mail, fax, or electronically. State users can also use the online facility to update a recovery case to reflect recoveries received and log recovered funds. **(40.11.1.17, 40.11.1.22, 40.11.1.34, 40.11.1.35, 40.11.1.38, 40.9.1.40, 40.9.1.41, 40.9.1.42, 40.9.1.43, 40.11.1.49)**

(40.11.1.17, 40.11.1.22, 40.11.1.34 – 35, 40.11.1.38, 40.9.1.40 – 43, 40.11.1.49)

The proposed solution will maintain all open recovery cases online until closed by an authorized user. It will allow a recovery case to be closed without full recovery when initiated by an authorized user. The TPL Subsystem will coordinate recovery case initiation with the Recipient Subsystem. When a recovery case is created, the TPL Subsystem will update the recipient's record with the case ID to indicate that the recipient has an open recovery case. The TPL Subsystem will also coordinate recovery case closing with the Claims Subsystem to ensure appropriate retention of historical claims involved in a recovery case. When a recovery case is closed, the TPL Subsystem will update the recipient's historical claim records with the closing date so that the Claims Subsystem will retain these historical claims online for three years from the closing date before archiving them offline. The TPL Subsystem will also monitor preset threshold conditions and flag claims for recipients who have reached a defined threshold. The system can:

(40.11.1.44, 40.11.1.45, 40.11.1.46, 40.9.1.48)

- Recall claim information involved in a recovery case for email or postal dispatch
- Flag recipients who are a TPL/recovery/cost avoidance case and maintain on line for three (3) years after the case is closed before archiving **(40.11.1.44, 40.11.1.45, 40.11.1.46, 40.9.1.48)**

(40.11.1.50)

- Flag recipients who have reached a defined threshold **(40.11.1.50)**

All data created and sent out of the system for response and is returned is received in the mailroom for imaging and stored in our electronic data management system. It is appropriately linked to the specific case and routed through workflow processing to the designated work queue for processing.

Additional proposed Baseline TPL Subsystem modifications for State consideration are presented in the following paragraphs.

Medicare Maximization (Comment CSC771)

The Baseline TPL Subsystem supports the requirements for States to take advantage of the CMS Medicare Maximization Project. The Center of Medicare Advocacy (CMA) investigates certain claims that previously have been paid by Medicaid to determine if Medicare should have been the primary payer. The current project is focused on Skilled Nursing Facilities (SNF), Home Health and Chronic Disease Hospitals (CDH) claims. Other types may be added in the future. This requirement was not stipulated in the RFP requirements; however, in the event the State participates in this program, Team CSC will demonstrate our application and work with the State during DDI to incorporate this functionality as a part of the TPL processing.

Audits (Comment CSC771)

The Baseline TPL Subsystem supports Audit sampling of electronic claims submitted with other insurance and Medicare payments or denials. This sampling is produced on a report that can be used by users for provider notification. The providers will receive the identified audit claims and a letter indicating the action the provider must take. A State-approved response time is established for the provider response with copies of EOBs that match the claims selected for the audit. If the provider submits claims that match to the audit data, the claim is removed from the audit list. If not, a second letter is issued. If there is no response within the second letter's scheduled response time, the State may elect to set up recoupment for each of the ICNs on the report. These receivables are established for those claims with unacceptable documentation. Reports for these A/Rs are prepared in accordance to State-defined criteria for each LOB.

D.1.4.11.7 Collaboration with Other Systems

Team CSC's proposed solution will include advanced rules-based workflow and Web Services technology to simplify the management and operation of the required data exchanges, as well as providing a forward path for the future data and application service-sharing scenario advocated by the CMS MITA initiative. These capabilities reduce implementation timeframes and costs, and add to customer convenience.

Team CSC will work with State to implement both batch file transfer protocol (FTP) and real-time Web Services for the following data sharing requirements:

- Provide carrier update transactions to State entities
- Support access to TPL data from other systems such as EIS, Mental Health Eligibility Inquiry, Client Services Data Warehouse (CSDW), Medical Quality Control, Online Verification, ACTS, Health Information System (HIS), and other Replacement MMIS subsystems using Web Services, FTP, or software application program interface (API) technology and SOA concepts
- Receive and process TPL data transmitted by ACTS from the Division of Information Resource Management (DIRM) electronic File Cabinet
- Provide a daily extract of TPL carrier and recipient resource data to the State including ACTS, CSDW, and EIS

- Provide an extract of TPL recipient resource updates related to Child Support to ACTS.
- Provides capability for batch access to TPL data using API and SOA concepts between EIS, ACTS, and the Replacement MMIS

(40.11.1.20, 40.11.1.52, 40.11.1.62 – 40.11.1.65)

(40.11.1.20, 40.11.1.52, 40.11.1.62, 40.11.1.63, 40.11.1.64, 40.11.1.65)

Team CSC recognizes the importance of ensuring successful transmission in any data exchange operation. **Our quality assurance practice in this area includes logging of all data transmission activities and automatic monitoring of the transmission status to alert our operations staff for corrective actions.** The logging software will produce daily logs of successful transmission of TPL data to DIRM for CSDW, ACTS, and EIS. **(40.11.1.53)**

(40.11.1.53)

D.1.4.11.8 Letter Generation and Reporting

The Baseline System TPL Subsystem has letter generation functionality and automatically produces letters such as notification to CMS to remove a recipient from the Buy-in program upon death, and letters to recipients warning them of impending Medicare eligibility three months prior to their 65th birthdays. Team CSC will augment these existing capabilities to enable production of system-generated letters to providers, recipients, and county offices. We will consult with the State to determine the specific triggers, content, and distribution for such letters. **(40.11.1.66)**

(40.11.1.66)

Team CSC acknowledges the State's requirements for a report of TPL segments that have been updated more than once in 30 days, a Health Choice Recipient Activity report, and a TPL edit/error report(s) for ACTS for State staff access. We will work with the State to develop and implement these three reports in addition to the reports listed in the design documentation; we will jointly assess the State's needs, review proposed formats and content, and obtain State approval for each item. **(40.11.1.59, 40.11.1.60, 40.11.1.61)**

(40.11.1.59 – 40.11.1.61)

D.1.4.11.9 Security and Controls

Team CSC recognizes the importance of maintaining security and controls over all online updates to the TPL databases. Our proposed solution includes a centralized authentication mechanism coupled with role-based access control to ensure that access to TPL data is granted only to State-authorized users. Further, our proposed solution makes use of the audit logging facility native to the database to provide a 100 percent complete logging of all updates to the TPL data. The audit logs are kept online and are accessible by State-authorized users. **(40.11.1.19)**

(40.11.1.19)

D.1.4.11.10 Conclusion

The Replacement MMIS TPL Subsystem offers the State a powerful capability to define and manage third-party liability and maximize the Enterprise's ability to protect North Carolina health care entitlement program funds. The TPL Subsystem is fully integrated with all other components of the solution to enable effective interface with the financial management function and native internal control capabilities that perform comprehensive logging, tracking, and auditing of recovery activities. Using the TPL functionality, the State is assured of accurate and timely processing, financial

accountability, extensive interface and real-time update support, and maximization of revenue preservation.

Pages D.1.4.12-1 through D.1.4.12-2 contain confidential information.

The Drug Rebate Subsystem relies on information furnished from diverse sources and interacts with other Replacement MMIS subsystems, such as Reference. **Exhibit D.1.4.12.1-2** summarizes the high-level inputs, processes, and outputs that comprise the Drug Rebate Subsystem.

Inputs	Processes	Outputs
Claims Data	Load claims data and store	Quarterly claims database
Manufacturer and Drug Information	Maintain Manufacturer data	Updated Manufacturer and Drug information
CMS Data	Maintain CMS data	Updated quarterly CMS data
Reference Subsystem data	Maintain Reference tables	Updated Reference tables
	Generate invoices, labels	Invoices, labels, data feeds
Checks and remittances from drug manufacturers	Maintain Accounts Receivable	Updated Accounts Receivable database
Adjustment Requests	Process adjustment information	Updated database
Inquiries and Disputes	Log inquiries and correspondence	Not applicable
Resolve, document disputes	Inquiry responses, Letters, Dispute resolution information	Not applicable
Report Requests	Generate reports	CMS-64 Report, other reports
Tracking, audit trail information requests	Enable tracking and audit trail	Audit trail, Logs

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Exhibit D.1.4.12.1-2. Drug Rebate Inputs, Processes and Outputs. *The comprehensive Drug Rebate solution efficiently handles all processes to enable effective financial management.*

Easy-to-use pages provide access to Drug Rebate functionality for authorized users. In addition to enabling Drug Rebate processing, these pages also provide standard navigational capabilities so that users may access other parts of the system as needed (for example, to view Reference tables). **Drug Rebate Subsystem data is stored and maintained in an integrated relational database that enables availability of current, accurate Drug Rebate information throughout the system.** The capabilities described for the Replacement MMIS Drug Rebate solution encompass several subsystem components and tools which we reference throughout the following discussion. **Exhibit D.1.4.12.1-3** lists and briefly describes each element.

Tool/Component	Function/Description
Drug Rebate Subsystem	Subsystem performs Drug Rebate calculation, invoicing, reconciliation, reporting, and maintenance of Manufacturer/labeler data
Reference Subsystem	Subsystem houses and maintains NDC-specific Drug data used to perform Drug Rebate functions
Pitney-Bowes Mailer's Choice, Finalist, and StreamWeaver	ZIP Code database, barcoding, and addressing software used in invoice addressing and mailing
Mobius Report Management System	Online report retrieval and storage capability
Claims Subsystem	Claims

9799-999

Exhibit D.1.4.12.1-3. Drug Rebate Tools and Components. *Powerful software components interact seamlessly with Replacement MMIS subsystems.*

Team CSC's Baseline System is a strong, solid platform from which to meet current North Carolina Drug Rebate requirements, as well as any future enhancement needs. We will, therefore, continue to leverage the existing structure and capabilities as this is the most cost-effective and speedy approach to responding to State requirements.

D.1.4.12.2 Drug Rebate Supporting Maintenance

Performing the Drug Rebate function requires that several supporting activities occur, as described below, including:

- Maintaining Treasury Bill rate information
- Maintaining 340B Provider data
- Maintaining Excluded Manufacturer data
- Maintaining a Unit Conversion table.

D.1.4.12.2.1 Treasury Bill Rate Information

CMS provides the weekly Treasury Bill rate information, required for calculating interest, in its regular Program Releases to State Medicaid Directors. Users enter this information using the Treasury Bill Rates Selection and Treasury Bill Rates Detail pages, which update rates in the Replacement MMIS tables. Refer to D.1.4.12.4.2 for a discussion of drug unit rebate and unit measurement data capture. **(40.12.1.2)**

(40.12.1.2)

D.1.4.12.2.2 340B Provider Data

The Health Resources and Services Administration (HRSA) within the Federal Department of Health and Human Services maintain a file of providers participating in the 340B Discounted Drug Program. These providers include disproportionate share providers, federally-qualified health center (FQHC) look-alike providers, federal grantees, and others indicated in section 340B of the Public Health Service Act. The HRSA maintains this downloadable list at www.hrsa.gov/odpp.

A Team CSC Drug Rebate Coordinator downloads this file once per quarter. The Coordinator compares the newly-downloaded file's contents for North Carolina providers to the contents of the last downloaded version of the same file, identifying new providers and changes to existing provider information. The Drug Rebate Coordinator reviews the new/changed provider data and, with the approval of DHHS, updates the 340B provider data using the Replacement MMIS Disproportionate Share Provider Selection and Disproportionate Share Provider Detail pages. The claims selection process assesses this information and excludes 340B provider claims from the rebate process. 340B provider information is also available from the 340B associations and the providers themselves. **(40.12.1.16)**

(40.12.1.16)

D.1.4.12.2.3 Excluded Manufacturer Data

The Replacement MMIS also maintains a list of drug manufacturer IDs for excluded manufacturers. An excluded manufacturer is a drug manufacturer that does not sell any drugs in the State of North Carolina and has signed a statement to that effect. That signed statement is maintained in that manufacturer's drug rebate file. Claims specifying drugs from excluded manufacturers are ignored during drug rebate processing. A Drug Rebate Coordinator maintains the excluded manufacturer list, using the Replacement MMIS Excluded Manufacturer Selection and Excluded Manufacturer Detail pages. **(40.12.1.15)**

(40.12.1.15)

D.1.4.12.2.4 Unit Conversion Table

The unit conversion factors allow for correction of drug unit type mismatches between pharmacy claim data and manufacturer rebate data. An example is when a

pharmacy is reimbursed for a drug in a tablet form and the drug rebate amount applies to milligrams of the drug. A Drug Rebate Coordinator maintains the Unit Conversion table through the Drug Maintenance pages provided in the Replacement MMIS Reference Subsystem (refer to Proposal Section D.1.4.6). The Drug Rebate claims extract process uses this table for unit conversion of units paid per claim to CMS units billed and CMS units billed to units paid per claim. **The Replacement MMIS also provides the Drug Rebate Rebate/Pharmacy Inconsistencies Report to assist in identifying these situations. This report is generated during the Drug Rebate Invoice Creation Process and lists inconsistencies between rebate amount due and amount paid to provider. (40.12.1.3, 40.12.1.20)**

(40.12.1.3, 40.12.1.20)

D.1.4.12.3 Drug Rebate Accounts Receivable

The Drug Rebate Accounts Receivable process enables invoice generation and remittance management. The core of the Accounts Receivable capability is the Accounts Receivable database and pages, described below, complemented by the ability to manually adjust Accounts Receivable data and recover from posting of checks subsequently deemed to be bad.

D.1.4.12.3.1 Accounts Receivable Database

The Replacement MMIS maintains a Drug Rebate accounts receivable database which tracks transactions by National Drug Code (NDC) and original claim paid quarter (NDC/quarter). The initial entry for an NDC/quarter occurs when a line item is generated on a drug rebate invoice. From that point forward, all drug rebate transactions that affect that NDC/quarter are tracked in this database. The database contains a current status section that provides the current status for that NDC/quarter.

Comprehensive Accounts Receivable Management

The Accounts Receivable Database within the Drug Rebate Subsystem supports complete invoice generation and management of all labeler remittances, promoting responsible fiscal administration of this function for the State.

The database is used to track all adjustments and disputes entered by manufacturers on the remittance statement forms**.** This data is collected from the remittance statements entered. Adjusted and disputed units are associated with and kept for each adjustment and dispute reported by a manufacturer.

The database maintains a detailed record of changes made to each NDC/quarter. Manufacturer adjustments, manually-entered adjustments, and manufacturer disputes can all cause changes in the amounts and units invoiced and paid. This detail record begins with the initial transaction where the NDC/quarter is invoiced and tracks events that change invoiced or paid units, invoiced or paid amounts, per-unit rebate amount, number of claims, or reimbursement amounts. The database also tracks declared and resolved disputes from an accounts receivable viewpoint. Through this transaction record, each change to the NDC/quarter is tracked from the initial number of units invoiced and the associated rebate due through all payments received, adjustments made, and/or disputes. A complete history of the units invoiced/paid/adjusted/ disputed and associated interest can be reviewed from the initial invoice through the last transaction entered. When necessary, claim adjustments are submitted using the

Page D.1.4.12-6 contains confidential information.

The Replacement MMIS Invoice History Applied Adjustments page allows for entry of generated adjustments of rebate and interest. A series of adjustment codes exists to adjust Drug Rebate history data for the following reasons:

- Record how a dispute was resolved
- Record a State-approved write-off amount so that collection is not pursued (40.12.1.30) **(40.12.1.30)**
- Restore a written-off amount so that collection is pursued
- Modify the number of units as the result of research.

CSC's Baseline System currently maintains interest at the invoice level by quarter. Team CSC will enhance existing adjustment capabilities to maintain rebate, unit, and interest information at the drug detail/NDC level (40.12.1.23). **(40.12.1.23)**

D.1.4.12.3.3 Bad Check Recovery

Occasionally a drug manufacturer's check is not cashable. The Replacement MMIS provides the ability to record this occurrence and back out of any remittance advice data that has been applied using funds from the bad check. A Coordinator locates the check record for the check that is bad using the Drug

Rebate Check Selection page and sets a flag. A batch process scans the check table and processes all checks that have been flagged as bad. **This process finds all remittance advices that are associated with a bad check and reverses the application of the data on those remittance advices in order to restore the accounts receivable database.** After each remittance advice is re-processed, the remittance advice is returned to a status indicating that the remittance advice has not yet been processed and is available for entry when a replacement check is received. Upon completion of reprocessing all associated remittance advices, the bad check is flagged as having been re-processed. That check record remains available for historical purposes, but can never be used again for processing a remittance advice.

Correction of Bad Check Information

The Drug Rebate Subsystem features the ability easily to back-out bad check data and preserve the integrity of the Accounts Receivable database.

D.1.4.12.4 Drug Rebate Invoice Creation

The process to create Drug Rebate invoices entails multiple sub-processes that, together, ensure the accuracy and validity of requests for rebate remittance. The Replacement MMIS has comprehensive capabilities to calculate invoices and maintain the necessary information and tracking, as described below.

D.1.4.12.4.1 Maintain Drug Manufacturer Data

CMS provides a quarterly drug manufacturer file to each State approximately 45 days after each quarter ends. This file is used to maintain the required drug manufacturer data for the Medicaid/OBRA-90 drug rebate program. When this file is received, a program is run to read in the manufacturer file and update the Drug Rebate manufacturer information, before the quarterly invoice production process begins. Automated information may also be received from the State. Team CSC will work with DMA to determine the format of these updates and develop a conversion process to accommodate this information (40.12.1.34). **(40.12.1.34)**

The Replacement MMIS manages extensive information about manufacturers:

- Manufacturer ID numbers and labeler codes
- Indication of collection media
- Indication of invoicing media
- Contact name, mailing and e-mail address, phone and fax numbers
- Manufacturer (labeler) enrollment, termination and reinstatement dates
- Manufacturer Unit Rebate Amount (URA)
- Manufacturer units of measure

This information is maintained online in the Drug Rebate and Reference tables in the Replacement MMIS. The Replacement MMIS provides pages for retrieving, viewing, and manually updating drug manufacturer data; these pages include the Drug Manufacturer Selection, Information, Contact, and Notes pages, as well as pages associated with the Reference Subsystem (refer to Proposal Section D.1.4.6.)

CSC Knows the Prescription Drug Industry

CSC is one of the original Medicare Part D providers. We have

- Over 6 million prescriptions processed — an average of 30,000 per day
- Nearly 400,000 beneficiaries enrolled, with the number continuing to grow by 200 to 500 a day
- An average of 2,000 calls answered every day from Medicare beneficiaries
- Savings realized by participating Medicare beneficiaries: $34 million (on the discount-only card) and $206 million (on the $600 credit received each year by low-income beneficiaries)

Drug manufacturers may contact Team CSC directly with changes to their contact information. The Drug Rebate Coordinator then updates the manufacturer data through the online Drug Manufacturer pages. **(40.12.1.1)**

(40.12.1.1)

D.1.4.12.4.2 Apply CMS Specified Rebate Changes

CMS also supplies a quarterly file to the State containing Drug Rebate per-unit rebate amounts. The Reference Subsystem processes this file and updates the Reference drug file with the new Unit Rebate Amount (URA) data. The CMS file contains rebate per-unit data for the quarter being processed and also prior period adjustments (updated rebate per-unit data items for a previously-processed quarter).

The Drug Rebate component reads the CMS file to find the changes made to previous quarter per-unit rebate data and makes adjustments to the accounts receivable database, based upon those changed per-unit rebate amounts. **The Reference Subsystem maintains a historical record of each unit rebate entry. Current and historical URA information is available through online pages in the Reference Subsystem** (refer to Proposal Section D.1.4.6). **(40.12.1.70)**

(40.12.1.70)

CMS has specified that when a prior quarter's per-unit rebate amount increases, the associated drug manufacturer is responsible for reviewing previously-received drug utilization reports and sending the additional payment to affected States without the State re-invoicing for the new amount. CMS allows the States to send an informational notice to drug manufacturers that have not paid additional rebates due to increased prior quarter per-unit rebate amounts.

The Replacement MMIS follows this CMS policy by:

- Updating accounts receivable with previous quarter per-unit rebate changes
- Including a line on the next invoice for each changed rebate that resulted in a lesser payment due to the State. If the State has been paid in full, then a credit amount is generated on the invoice.
- Including a line on the next invoice for each changed rebate that resulted in a new balance due from the manufacturer and the manufacturer has not already remitted the new amount due. This new balance due is included on the invoice for the appropriate quarter following a statement that this is a reminder and that the new balance due is not included in the total invoiced amount.

When the Replacement MMIS updates an item on the accounts receivable database, the following occurs:

- Replaces the new per-unit rebate amount over the current per-unit rebate amount applied
- Multiplies the current number of units invoiced by the new per-unit rebate amount resulting in a new current invoiced amount
- Subtracts the current amount received from the current invoiced amount resulting in a new current amount due
- Creates an adjustment transaction and adds it to the database. This transaction contains a code that defines the transaction as a CMS-supplied, per-unit rebate amount change, the date of the transaction, and the difference — derived by subtracting the old current amount due from the new current amount due
- Reviews the open disputes on the NDC/quarter and recalculates any withheld amount by multiplying the units disputed by the new rebate per-unit amount. **(40.12.1.2)**

(40.12.1.2)

CSC's Partners Understand the State's Needs

Memberhealth, Inc….has shown a strong willingness to work creatively with the state regarding multiple funding streams such as Medicare, Medicaid, and North Carolina Seniorcare plan. You have excellent problem solving skills and have always been willing to work with us under tight timeframes and challenging circumstances in the shifting terrain introduced by Medicare Part D.

– Michael Keough, North Carolina Office of Rural Health and Community Care

D.1.4.12.4.3 Summarize Utilization of Pharmaceutical Products

The Replacement MMIS includes a batch process that loads all pharmacy claims to the Drug Rebate area. These claims are accumulated for quarterly extraction. The batch process can be scheduled to occur weekly, or at any other user-specified interval. Team CSC arranges for downloads of claims not paid through the Replacement MMIS system so that they are available for this process, as well as providing comprehensive claims history to the NC Medicaid Enterprise. **(40.12.1.33)**

(40.12.1.33)

After all claims have been adjudicated (original and adjustment) and paid for a given quarter, the Replacement MMIS reviews the claims for the quarter and extracts:

- All pharmacy claims paid during the quarter
- Medical claims with pharmacy codes, including those administered with HCPCS

- All pharmacy claims that were adjusted during the quarter if the adjustment changed the NDC, units reimbursed, reimbursed amount, or Federal payment participation rate. **(40.8.1.199)**

(40.8.1.199)

Both credit and debit claims are extracted.

This claims extraction takes place as soon as all the claims for latest quarter have been finalized. The Replacement MMIS summarizes the claims data by original quarter paid and NDC and applies the unit conversion factors to the claim data affected by those factors. This process includes automated checks at the claim detail and header level to verify that the summarization process has produced a valid result, based on the transaction detail processed. The system processes the following reports so that certain kinds of errors can be spotted and corrected before the invoice run is executed for the quarter. Drug Rebate Coordinators review these reports for consistency and quality. The following reports are produced:

- Drug Rebate Labeler Variance NDC Within Quarter Report
- Drug Rebate Labeler Variance Labeler Summary Report
- Drug Rebate Labeler Variance NDC Across Quarters Report. **(40.12.1.36)**

(40.12.1.36)

The Replacement MMIS retains the extracted claims file for each quarter, thus preserving the original rebate quarter associated with the claim. This file becomes the universe of claims on which that quarter's drug rebate invoices are reported. These retained files are also used for reporting and dispute resolution, thus eliminating the possibility that a reselection of claims for a quarter, even those claims that have been adjusted, might result in a different set of claims. (40.12.1.7) Refer to Proposal Section D.1.4.12.7, Drug Rebate Historical Data, below.

(40.12.1.7)

D.1.4.12.4.4 Determine Appropriate Rebates from Drug Manufacturers

After the claims data is summarized, the Replacement MMIS accesses the drug file to obtain per-unit rebate data. The per-unit rebate data is retrieved by Program Code, NDC and quarter. Once the per-unit rebate amount is determined, the rebate for a specific NDC and quarter is determined by multiplying the number of units reimbursed times the per-unit rebate amount.

CSC's Baseline System Drug Rebate Subsystem does not currently allow for the processing of medical (physician) claims. Team CSC will modify the claims extract process to identify physician claims with drug procedure codes, as well as pharmacy claims that should be included. We will collaborate with the State to ensure we identify all transactions to be included and the appropriate selection parameters and verify that our approach will meet all of the State's requirements. **(40.12.1.5, Comment CSC176)**

(40.12.1.5)

D.1.4.12.4.5 Determine Other Events to Report on the Invoices

Before the Drug Rebate invoices can be generated, the system passes through the accounts receivable history data and identifies other events that should be

Detailed Invoice Generation
Team CSC includes all pertinent information on invoices, including past quarter outstanding balances, interest due, and changes in prior quarter per-unit rebate amounts.

included on the next invoice. A single NDC/quarter record in the accounts receivable history data may result in multiple lines being printed on the next invoice. The following events are extracted for inclusion on the next invoice:

- An NDC/quarter has an outstanding balance that has not yet been paid by the manufacturer. The Replacement MMIS pulls the outstanding balance for inclusion on the next invoice.
- A change in a prior quarter's per-unit rebate amount was received from CMS on the latest file and the manufacturer has not already reported the change to the State. If the per-unit amount increased and the manufacturer has not yet sent a new payment, a line is printed on the invoice reminding the manufacturer that they have submitted a change to CMS but not submitted any additional payment to the State. If the per-unit amount decreased, and the manufacturer had previously been paid more than the newly calculated amount due for this NDC/quarter, then a credit is printed on the invoice for the amount previously overpaid by the manufacturer
- The manufacturer has previously informed the State of a change in a per-unit amount for a previously invoiced NDC/quarter. The manufacturer included a check or request for credit that will not be recognized until the corresponding per-unit rebate amount change has been received from CMS. A line is printed on the invoice to inform the manufacturer that CMS confirmation of the change has not yet been received.
- A Drug Rebate Coordinator inputs a manual adjustment to an NDC/quarter since the last invoice. That adjustment resulted in an increase/decrease in the rebate due.
- A Drug Rebate Coordinator inputs a dispute resolution. That resolution resulted in an increase or decrease in the amount due plus, possibly, an interest estimate.
- A dispute is still unresolved on an NDC/quarter.
- The non-rebateable drug claims are reviewed to determine if any of the NDC/quarter combinations on the file have become rebateable. When an NDC/quarter has been found to been made rebateable retro-actively, that data is reported on the appropriate quarter of the drug rebate invoice being compiled. Non-rebateable data is kept for three years in case the NDC involved is made rebateable retroactively. **(40.12.1.4)**

(40.12.1.4)

D.1.4.12.4.6 Create Invoices to the Manufacturers

Invoices are currently generated by manufacturer, by quarter. Since the Program Code is retained in the Drug Rebate tables, invoices can also be generated by Program Code to enable separate identification of rebate and interest amounts by labeler/quarter/program. The definition of this code can be expanded to include additional North Carolina multi-payer programs.

The Drug Rebate invoice design meets CMS's requirements for reporting current and prior period drug utilization data to the drug manufacturers.

A new report section is generated for each new labeler/quarter combination. As an example, when the second quarter of 2007 invoice is created for labeler 12345, several items may be re-invoiced for previous quarters. Only previous quarters for

which reportable items have occurred appear on the latest invoice. The final invoice for the second quarter, 2007 for labeler 12345 may contain the following sections:

- Second Quarter, 2007 — Drug Utilization report drawn from new claims data.
- First Quarter, 2007 — Drug Utilization report drawn from first quarter, 2007 claims that were adjusted during the second quarter of 2007. The report also lists several first quarter 2007 per-unit rebate increases that were received from CMS but for which the manufacturer has not submitted further payment. These prior period rebate amount adjustments are reported on this report but the increase in amount due is not included in the overall invoice due amount.
- Fourth Quarter, 2006 — Drug Utilization report drawn from fourth quarter, 2006 claims that were adjusted during the second quarter of 2006. The report lists outstanding balances due on fourth quarter, 2006, NDCs for which the manufacturer has not yet made full payment. Interest charges have been estimated against the balance due on this report
- Second Quarter, 2006 — Several outstanding disputes are listed. Two dispute resolutions are recorded. Interest charges have been estimated against the closed dispute items that resulted in balances due the state.
- Invoice — Grand total of the balance recorded for each of the quarters listed above. An interest estimate is calculated against each quarter and is reported separately from the rebate amount due total.

CMS-approved Invoice Format
Team CSC produces invoices that meet CMS requirement for format and content, breaking out billing by labeler/quarter.

Note that no section was created for the Third Quarter of 2006 because no reportable items were generated for that quarter.

Following each quarterly section of a Drug Rebate invoice is a total page detailing the dollars recorded on that section of the invoice. This balance may be due the State or the manufacturer. Following the oldest quarter reported is a total page that summarizes all the individual quarters' balances and presents a final amount due for payment by the manufacturer. It is conceivable that this final amount due could be a credit balance in which case Team CSC would follow State policy regarding including a refund check for that balance with the invoice.

If the final balance due on the invoice is greater than zero and less than a specific dollar amount, and the total of the claims reimbursement for the current quarter's claims is less than a threshold amount, then the Replacement MMIS can include a statement on the invoice informing the manufacturer that they may delay paying the amount due and they will not incur any interest charges if they do not make the payment in response to this invoice.

CSC's Baseline System currently does not have a capability to freeze invoices; rather, staff would handle this need procedurally. Team CSC will develop an online capability to freeze invoices when deemed appropriate, and collaborate with the State to confirm that our proposed design meets the State's intent. **(40.12.1.38, Comment CSC727)**

(40.12.1.38)

(40.12.1.6, 40.12.1.8 40.12.1.26)

The Replacement MMIS generates delivers drug rebate invoices via paper. Mailing labels are generated for each invoice, or on request. Invoices can be regenerated, either individually, or in total, through existing batch processes or selection of specific invoices through online pages. **(40.12.1.6, 40.12.1.8, 40.12.1.26)**

D.1.4.12.4.7 Generate Letters

(40.12.1.10 – 12)

The Replacement MMIS uses automated letter generation software for maintaining and producing letters. Letter templates will allow Team CSC to create and maintain invoice cover letters, collection letters, and follow-up letters. Templates will be updatable online and have the ability to accommodate free-form text entries. Team CSC will create letters that meet the State's requirements and implement a workflow to image, index, retain, and retrieve these letters. **(40.12.1.10, 40.12.1.11, 40.12.1.12)**

D.1.4.12.4.8 Report Utilization Data to CMS

As part of the process to create drug rebate invoices for the manufacturers, the Replacement MMIS creates a drug utilization file that is transmitted to CMS. The system also produces the quarterly CMS-64 report in the required format.

(40.12.1.37)

Team CSC will develop a process to transmit invoice data and detail history to CMS and the State. We will determine the formats approved by each entity and develop automated processes to transmit the data in compliance with these requirements. **(40.12.1.37)**

D.1.4.12.4.9 Automatically Calculate Interest

The Replacement MMIS automatically calculates interest estimates on late payments and resolved disputes according to the rules provided by CMS. Interest estimates are calculated using weekly U.S. Treasury Bill rates and are calculated at the quarterly invoice level and tracked at the manufacturer level. Interest estimates are calculated during the quarterly invoicing process. The need to calculate an interest estimate is based on the data contained in the accounts receivable table.

An interest estimate is calculated for the following situations:

- A prior period quarterly invoice is not paid-in-full — an interest estimate for the manufacturer is created after reducing the amount due by the amount withheld for any unresolved disputes that originated in the quarter being processed
- A prior period quarterly invoice shows a credit balance (overpayment) and this overpayment is not due to a prior period rebate-per-unit amount change — an interest estimate for the State is created
- All disputes on a specific NDC/quarter have been settled and the resulting amount due has not been paid within the CMS mandated timeframe — an interest estimate for the manufacturer is created
- All disputes on a specific NDC/quarter have been settled and the resulting credit amount has not been refunded within the CMS mandated timeframe — an interest estimate for the State is created.

Automatic, Accurate Interest Calculation
The Drug Rebate Subsystem automatically calculates interest using the US Treasury Bill rates and maintains business rules to identify specific situations in which interest is and is not billed.

Interest is not calculated for the following situations:

- Unresolved manufacturer declared disputes
- A credit balance exists because the State just received, on the latest data file from CMS, a prior period adjustment to a rebate-per-unit amount
- The total due on the entire invoice is greater than zero and less than a specified dollar amount and the total claim reimbursement amount for the currently-invoiced quarter is less than a specific threshold amount.
- The Charge-Interest indicator located on the Drug Manufacturer Information page is set to do-not-charge-interest for the manufacturer being processed.

The beginning date for interest estimating for the conditions specified occurs as follows:

- Dispute resolutions — the mail date of the invoice for the paid quarter of the amount being disputed, modified by the parameter provided for specifying a grace period.
- Past-due amounts whose paid quarter is equal to the immediate prior quarter — the date the last invoice was mailed, modified by the parameter provided for specifying a grace period.
- Past-due amounts whose paid quarter is not equal to the immediate prior quarter — the date the last invoice was mailed (without applying the grace period).

The ending date of all interest estimate calculations is the current date. Following the CMS-prescribed formula, interest is estimated according to the average Treasury Bill rate for the number of days between the calculated start and end dates. Interest estimates are totaled for a manufacturer and printed on each quarter's billing summary page as "Interest Estimated." A grand total of interest for all the quarters appears as "Interest Estimated" on the invoice. **(40.12.1.31)**

(40.12.1.31)

D.1.4.12.5 Drug Rebate Remittance Advice

The Drug Rebate Remittance Advice processing occurs monthly and includes the entry and maintenance of the drug manufacturers' checks and remittance advice data. Team CSC collects payments and enters data on online pages.

D.1.4.12.5.1 Collect Payments

Team CSC receives the remittance advices and checks from the drug manufacturers. These checks are logged and photocopied prior to deposit. Once logged, copies of the drug rebate checks and corresponding remittance statements are forwarded to a Drug Rebate Coordinator. The Coordinator prepares the check information and remittance advices for entry. Part of that preparation is to record the check number on each of the associated remittance statements and ensure that the check balances to the sum of the amount paid on the associated remittance statements. Team CSC uses the Replacement MMIS Drug Rebate Check Selection and Drug Rebate Check Maintenance pages provided to record the receipt of the check including the check number and date received by NDC. **(40.12.1.28)**

(40.12.1.28)

Pages D.1.4.12-15 through D.1.4.12-16 contain confidential information.

CSC will develop a letter template to issue a collection letter for the disputed NDCs to the drug manufacturer. We will confer with the State to determine the appropriate language and format for this letter.

Team CSC will work with the State to develop the capabilities for an automatic tickler file to flag, track, or report on responding and non-responding manufacturers. Additionally, Team CSC will integrate the imaging and contact logging/tracking features of our solution with the Drug Rebate function to enable recording of telephone conversations, letters, inquiries, and other correspondence actions taken by manufacturers. We will collaborate with the State to confirm that our proposed approach meets the State's intent.

(40.12.1.24 – 25) **(40.12.1.24, 40.12.1.25)**

D.1.4.12.6.1 Record Resolved Disputes

The Replacement MMIS provides an adjustment code that can be manually entered by the Drug Rebate Coordinator to record the resolution of a dispute. This adjustment code is entered through the Invoice History Applied Adjustment page. The adjustment code allows a Coordinator to enter the final number of rebateable units agreed to between with the drug manufacturer for a specific NDC and quarter. The Coordinator enters the dispute resolution date into the Invoice History Applied Adjustment page.

D.1.4.12.7 Drug Rebate Historical Data Access

Team CSC maintains Drug Rebate data online in accordance with customer requirements. All databases, including the Accounts Receivable file and manufacturer data, enable complete online tracking and audit trails as described throughout this section. Static files such as invoices, claims summarization files, and claims detail files will be retained online. Additionally, Team CSC performs weekly copying and retention of various Drug Rebate informational tables that support the Drug Rebate process. **(40.12.1.27)**

(40.12.1.27)

Online Data Access
Team CSC will maintain Drug Rebate data online and develop the appropriate pages and capabilities to retrieve and view claims-level detail and invoice balancing information.

Team CSC will maintain Drug Rebate data online for five years to furnish historical access to invoices and summary-level information which will be made available through a new online page. We will implement additional functionality to view supporting claims-level detail for all claims and adjustments with selection criteria by labeler, quarter, NDC, or any combination of these fields; this detail data will balance to each manufacturer invoice by North Carolina program (i.e., State entity). Team CSC will develop a new inquiry page to enable these searches and display of data. We will also provide links for the user to view associated provider, drug, and recipient information related to the selected claim. Also, we will implement the capability to maintain units paid (as used to calculate claims pricing) and CMS units billed for Drug Rebate on the claims history detail records. We will collaborate with the State to confirm our solution meets all requirements. **(40.12.1.18, 40.12.1.21, 40.12.1.35)**

(40.12.1.18, 40.12.1.21, 40.12.1.35)

Team CSC's Replacement MMIS will have a near-line archival storage approach for retaining Drug Rebate information — including invoice, payment, CMS drug, claim, and operational comments data — indefinitely. Once retrieved from archive, data will be viewable through the existing online pages, in the same manner as more current online data. **(40.12.1.14)**

(40.12.1.14)

D.1.4.12.8 Mandatory Reports

The Replacement MMIS produces a wide variety of reports to support Drug Rebate processing. The following table lists the mandatory reports identified in the RFP for the Drug Rebate function. In instances where the Baseline System has an existing report to meet the State's requirements, Team CSC will review these reports with the State to determine any format or content changes necessary. We will modify all reports to reflect North Carolina headings, identifiers, and State-specific information. Team CSC expects such changes to be minor. For instances where no report currently exists, Team CSC will work with the State to define the format, content, distribution, and frequency of each report and develop the required reporting capability. **Exhibit D.1.4.12.8-1** responds to Drug Rebate reporting requirements.

Req. #		Team CSC Response/Approach
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	Drug Rebate financial and drug information is available in the relational database and Drug Rebate tables, with audit trails to track changes. The Replacement MMIS, therefore, has the capability to generate total expenditure reports for multiple source and other drugs, annually, tri-annually, or on any frequency desired by the State. Team CSC will work with the State to determine the timing, content, and format desired. The Replacement MMIS maintains drug pricing parameters in the Drug Rebate tables. These tables can be modified and enhanced to support pricing changes. Team CSC will collaborate with the State to determine the specific statistical computations, comparisons, or other processing necessary to support a specific change. We will apply the required calculations in the table update programs of the Drug Rebate Subsystem. We will work closely with the State to ensure we understand the requirement and that our proposed approach meets State requirements.
40.12.1.32	Provides capability to perform end-of-month balancing process	The Replacement MMIS produces comprehensive reports that can be run monthly to reflect the exact status Drug Rebate activities; the primary reports are: • Drug Rebate Manufacturer Accounts Receivable Report • Drug Rebate Interest Billed and Collected Report • Drug Rebate Cumulative A/R Balances Report • Drug Rebate Monthly Reconciliation Report. If desired by the State, Team CSC will develop a consolidated month-end balancing report that reflects the information in the above reports, plus any other program parameters that the State determines should be reported.
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	Team CSC will develop reports to list all invoices beneath a specific threshold, and invoices for a specific quarter and program.
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	To meet this requirement, the Replacement MMIS produces the Drug Rebate CMS-64 Report in the required format.

Req. #		Team CSC Response/Approach
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	The Replacement MMIS produces the following reports that meet this requirement: • Drug Rebate Interest Billed and Collected Report — This report lists the interest billed and collected, as well as the total collected for the current month. • Drug Rebate Manufacturer Accounts Receivable Report — This report lists drug rebate amounts disputed and/or outstanding by manufacturer. • Drug Rebate Monthly Reconciliation Report — This report lists the amounts recorded as paid on remittance advices during the month.
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	Team CSC will develop a 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	The Replacement MMIS produces the following reports that meet this requirement: • Drug Rebate Cumulative A/R Balances Report — This report lists the drug manufacturers with accounts receivable balances. • Drug Rebate Manufacturer Accounts Receivable Report — This report lists drug rebate amounts disputed and/or outstanding by manufacturer.
40.12.1.44	Provides capability to produce the NDC Detail Report to give summary data by quarter for selected NDCs	The Baseline System currently has an NDC Detail Report that provides summary data by quarter for all NDCs. Team CSC will modify this report to enable reporting of only 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	Team CSC will develop an 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	Team CSC will develop a 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	Team CSC will modify 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	Team CSC will develop an 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	Team CSC will develop an 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	Team CSC will develop 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	To meet this requirement, the Replacement MMIS produces the Drug Rebate DSE Exclusion Report which lists the drug rebate information for drugs dispersed by disproportionate share providers.
40.12.1.52	Provides capability to produce Excluded Provider Listing, displaying the claims paid for providers not subject to rebate	Team CSC will develop an 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	To meet this requirement, the Replacement MMIS produces the Medicaid Drug Rebate/Pharmacy Inconsistencies Report which lists potential drug unit type mismatches between pharmacy claim and manufacturer rebate data when the rebate/reimbursement ratio is above a set threshold.

Req. #		Team CSC Response/Approach
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	To meet this requirement, the Replacement MMIS produces the Medicaid Drug Rebate Invoice which details the drug utilization for each labeler for claims received during the last quarter. The utilization is reported by paid claim quarter. The report also functions as the invoice to the manufacturer requesting the drug rebate payment.
40.12.1.55	Provides capability to produce a Balance Due Report listing the top ten (10) credit balances at run time	Team CSC will develop 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	Team CSC will develop 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	Team CSC will develop 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	Team CSC will develop 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	To meet this requirement, the Replacement MMIS produces the following reports that meet this requirement: • Drug Rebate Adjustment/Dispute Report — report will list the adjustments and disputes entered on the drug rebate remittance advices that were processed during the previous week. • Drug Rebate Adjustment Codes G and I Report — report will list drug rebate adjustments/disputed amounts if adjustment code G or I specified.
40.12.1.60	Provides capability to produce an Interest Activity Report to display all interest overrides	Team CSC will develop an Interest Activity Report displaying all interest overrides.
40.12.1.61	Provides capability to produce an Interest Detail Report to display all interest for a labeler and quarter	To meet this requirement, the Replacement MMIS produces the Drug Rebate Interest Billed and Collected Report which lists the interest billed and collected as well as the total collected for the current month. In addition to a monthly run, this report is also run quarterly.
40.12.1.62	Provides capability to produce a report of invoiced amounts greater than the sum of claim reimbursement amounts	Team CSC will develop 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	To meet this requirement, the Replacement MMIS produces the Drug Rebate Manufacturer Accounts Receivable Report which lists drug rebate amounts disputed and/or outstanding by manufacturer.
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	Team CSC will develop 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. The Baseline System does not currently process medical claims for Drug Rebate purposes; the reporting process will extract claims with the appropriate codes for this report. The inconsistency identified in the State Requirements Matrix has been resolved. (Comment CSC244)
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	To meet this requirement, the Replacement MMIS produces the Drug Rebate Cumulative A/R Balances Report which lists the drug manufacturers with accounts receivable balances.
40.12.1.66	Provides capability to produce a report of payments received for drugs with CMS URA of zero	Team CSC will develop 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.	Team CSC will develop a Recapitulation Report that notifies manufacturers of corrected balances after dispute resolution procedures have been completed for one or more quarters.

Req. #		Team CSC Response/Approach
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	Team CSC will develop 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.	Team CSC will develop a 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. The Replacement MMIS will contain a page that enables users to enter specific criteria for reports.

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Exhibit D.1.4.12.8-1. Drug Rebate Reporting Requirements. *The Drug Rebate Subsystem offers robust reporting that can be expanded and customized to meet the State's needs.*

D.1.4.12.9 Conclusion

The Replacement MMIS provides a comprehensive capability to administer the Drug Rebate function. The Drug Rebate component is fully-automated and maintains all financial, claims, and manufacturer information in relational databases that provide current and accurate information and powerful reporting and inquiry capability. Reference and drug information is maintained in tables that can be easily updated through online pages, allowing control over the rebate function without the need for programming intervention. Native workflow capabilities optimize drug rebate processing and ensure timeliness. These automated capabilities will enable us to conduct the Drug Rebate program in the most effective manner possible and maximize the revenue collected for the State of North Carolina.

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Page D.1.4.13-1 contains confidential information.

To support the automation of people and efficient system interaction, Team CSC's technical approach includes automated methods for achieving routine business processes. For example, we will implement a Web portal, NC*Tracks*, which is based upon the dynamic functionality of Microsoft Windows SharePoint. Our NC*Tracks* Web portal will provide the ability to customize forms, create dashboards for online access, notify users of new reports, and other event triggers to automate business processes. This dashboard solution supports North Carolina management with a single source of information to serve multiple agencies across the enterprise. It will provide North Carolina the flexibility to view and analyze data as soon as it is available. The MARS solution architecture is designed to be readily configurable to accommodate business changes. MARS functionality is streamlined to enable efficient report generation that has resulted in minimal human intervention.

Online Data Access
The MARS reports are viewable online via a customized dashboard to assist in planning, directing, monitoring, and controlling the various functions involved in the Medicaid and other state healthcare programs.

The North Carolina MARS solution will support business objectives such as:

- Timely information and report data for review, evaluation, and decision-making
- Support for ongoing financial planning processes and the efficiency of cost control measures with accurate expenditure report data
- Analysis, development, and improvement of program policies, procedures, and guidelines with accurate and timely information and report data
- Evaluation of the quality of provider participation and performance, service delivery, and provider interaction with enrolled populations
- Federal reporting and CMS system certification
- Review and analysis of State and county participation in the Medicaid share of cost
- NC DHHS analysis of effectiveness and efficiency of program management and administration with current data and statistics.

The following sections provide detail of Team CSC's Management and Administrative Reporting Subsystem and our ability to generate required reports accurately for multiple programs through this system. We have organized the sections as follows:

- Management and Administrative Reporting Subsystem Overview
- Administrative Reporting
- Operations Reporting
- Provider Relations Reporting
- Recipient Relations Reporting
- Federal Reporting
- Ad Hoc Reporting Capabilities
- Online Access
- Additional Features

D.1.4.13.1 Management and Administrative Reporting Subsystem Overview

A comprehensive set of State and federal required MARS reports is used to provide financial, administrative, and operational data from the Replacement MMIS to support monitoring and administrative functions of the NC DHHS and its divisions. Our MARS reports were designed to support our current Medicaid customer's management needs and will be modified to provide DMA, DMH, DPH, and ORHCC managers, policy makers, and other system users with timely and meaningful information to assist in planning, directing, monitoring, and controlling the various functions involved in Title XIX and other state healthcare programs. These reports assist the State in monitoring eligibility and program utilization, evaluating performance indicators, overseeing the program budget, and initiating program changes in response to regulatory developments or trends identified through data analysis.

In the Baseline System, MARS reports are created to support five traditional functional areas of healthcare program monitoring:

- Administration
- Operations
- Provider Relations
- Recipient Relations
- Federal Reporting.

Reported information from each of the functional areas may be current or historical and range from status level reports consisting of concise summary data to detailed level reports reflecting specific detail information generated for use by a given functional area.

D.1.4.13.1.1 MARS Data Stores

The primary source of information for MARS reports are the data extracted from the various subsystems within the Replacement MMIS. Our solution maintains source data from all other functions within the Replacement MMIS including the Claims Processing, Recipient, Provider, and Financial Subsystems. The accuracy and content of the MARS reports are heavily dependent upon the data made available from these data sources. Team CSC will create the report at frequencies defined by the State. **(40.13.1.1)**

(40.13.1.1)

During the DDI Phase, Team CSC will work closely with NC DHHS staff to identify all data elements required for accurate MARS reporting and ensure that our MARS database includes the following types of data:

- Adjudicated claims data
- Adjustment and void data
- Financial transactions for the reporting period
- Reference data for the reporting period
- Provider data for the reporting period

- Recipient data (including Long-Term Care (LTC), Health Check, cost of care, co-pays, benefits used, and insurance information) for the reporting period
- Budget data from the North Carolina Accounting System (NCAS)
- Financial data, for the reporting period

We will work with the State to define the detail data required for NCAS, Medco, and Health Check and any other inputs not available from or through the Replacement MMIS claims financial function. **(40.13.1.21)**

(40.13.1.21)

Through this data identification process, Team CSC will make sure we maintain the data elements required to support State and federal budget forecasts, tracking, and modeling. We will include data for charges, expenditures, programs, recipient eligibility, and utilization to support reporting such as:

- Participating and non-participating eligible recipient counts and trends by program and category of eligibility
- Utilization patterns by program, recipient medical coverage groups, provider type, and summary and detailed category of service
- Charges, expenditures, and trends by program and summary and detailed category of service
- Lag factors between date of service and date of payment to determine billing and cash flow trends
- Any combination of the above. **(40.13.1.10)**

(40.13.1.10)

To accomplish this reporting we rely on an existing statistically valid trend methodology that will be approved by NC DHHS for generating MARS reports. As data extracts are generated and the MARS data store is built for each reporting period, Team CSC uses a cutoff for cost audit data with standard date of service or date of procedure being used to establish the cutoff. Once the data is captured, we maintain data in such a manner that we are able to report prior year data separately from current year data, and develop summary data for all claims. **(40.13.1.9, 40.13.1.20)**

(40.13.1.9, 40.13.1.20)

While many items reflected throughout the MARS reports are uniquely defined for reporting purposes, the above-mentioned data sources provide input that is critical to the MARS reporting derivations. All of the data element sources used by the MARS reporting function are maintained with controls, balances, and quality review, to ensure the integrity and integration of the data used for the MARS analysis so all State and federal reports can be generated at frequencies defined by the NC DHHS or its divisions. Team CSC captures and maintains the data necessary to meet all federal and State requirements for MARS, and identifies and provides all federal MARS reports required to meet and maintain CMS certification. **(40.13.1.15, 40.13.1.22)**

(40.13.1.15, 40.13.1.22)

D.1.4.13.1.2 Controls, Balancing, Audits, Continuous Quality

Team CSC recognizes that it is important to maintain uniformity, comparability, and balance among all data and reports produced by MARS. The Team CSC solution incorporates system checkpoints and balancing routines throughout all process steps for MARS reporting to ensure MARS data is balance and that it is comparable to other reports from other MMIS functional areas including the ability to reconcile

financial reports with claims processing reports. Similar reports are compared and a variance report is produced to assist authorized-personnel in assessing the appropriateness of the variances or making applicable corrections to ensure the accuracy and consistency of data. We monitor all system changes and ensure that during the change control process that we identify changes to programs and category of service are reflected as appropriate changes to MARS reports. In addition, the Replacement MMIS produces an Audit Trail Report that shows dollar and record amounts from the control file for each cycle of a given month, which benefits audit and operations for end-of-month control balancing. During the DDI Phase, Team CSC will work closely with NC DHHS staff to develop any additional required reporting capability in response to specific MARS requirements to provide uniformity, comparability, and balancing of data. **(40.13.1.7, 40.13.1.16, 40.13.1.18, 40.13.1.19)**

(40.13.1.7, 40.13.1.16, 40.13.1.18 – 19)

Team CSC understands and accepts the responsibility to ensure that all MARS reports are timely and accurate. MARS provides complete audit trail and tracking capability. Any out of balance condition immediately halts processing and reports on the out of balance conditions as soon as they occur. In addition, we will review the Audit Trail Report after every MARS report production cycle for balance reporting and deliver a balance report to the State. In the event that we discover any audit, control, or balancing discrepancies, we will notify the State and indicate a Corrective Action Plan. When the correction is in place, follow-up reporting will be provided to the State. **(40.13.2.1)**

(40.13.2.1)

D.1.4.13.1.3 Report Formats and Schedules

MARS parameters are stored in DB2 tables and are easily updateable by authorized users with online pages, allowing changes to report processing and report formats with few coding modifications. Team CSC will collaborate with the State during the DDI Phase to determine the specific statistical computations, comparisons, or other processing necessary to support subtotals, totals, averages, variances, and percents of items and dollars on all reports. In addition, we will ensure that all MARS reports are sorted and produced by program, plan, county, and population group. Data elements are captured and maintained in the MARS data store to allow Team CSC to generate reports sorted and broken out for these categories. **(40.13.1.2, 40.13.1.25)**

(40.13.1.2, 40.13.1.25)

The Baseline System produces a wide variety of MARS reports that are specific to Medicaid programs. In instances where the Baseline System has an existing report to meet the NC DHHS requirements, Team CSC will meet with the State to determine the timing, content, and format desired. We will modify all reports to reflect North Carolina headings, identifiers, and State-specific information. Based on our initial review, Team CSC expects such changes to be minor. Where no report currently exists such as reports for other State programs, Team CSC will work with the State to define the format, content, distribution, and frequency of each report and develop the required reporting capability. We will respond to State requests for information concerning the reports in addition to providing a Data Element Dictionary that describes the codes and values included on the reports. **(40.13.1.11, 40.13.1.25, 40.13.2.2)**

(40.13.1.11, 40.13.1.25, 40.13.2.2)

Current report formats allow us to generate MARS reports with detailed and summary-level counts of services by service, program, and eligibility category based on State-specified units such as days, visits, and prescriptions. We will work with NC DHHS during the DDI Phase to incorporate other units that are needed. Our reports also provide counts of claims, unduplicated paid, participating, and eligible recipients, and counts of providers. Our design work with NC DHHS will ensure that all counts are according to State-specified categories. **(40.13.1.8)**

(40.13.1.8)

The Replacement MMIS currently produces MARS reports at monthly, quarterly, and annual intervals. Team CSC will work closely with NC DHHS to schedule the MARS reports at required intervals including semiannually and bi-annually, as specified by the State and Federal requirements and will ensure the data is accurately accumulated and available at these intervals. We will establish guidelines for generating user-identified reports and generate those reports on a State-specified schedule. When establishing the schedule for MARS reports, Team CSC sets transaction processing cutoff points to ensure all data required for a reporting period is available for the appropriate report production cycle. This ensures that reports contain consistent data and are comparable across functions. **(40.13.1.3, 40.13.1.17, 40.13.1.23)**

(40.13.1.3, 40.13.1.17, 40.13.1.23)

D.1.4.13.1.4 Report Storage and Retrieval

Team CSC uses Mobius, an enterprise report viewing and distribution system to store reports. Mobius is a user-friendly, easy-to-use navigational tool for locating documents, with the ability to display documents of diverse formats simultaneously, and the ability to annotate, move, freeze, zoom, and scale document elements as needed. With Mobius, users can export documents, in whole or in part, to other desktop applications such as spreadsheets, word processors, and analytical tools. Mobius also improves the access to the Replacement MMIS reports by providing access to documents via our **NC***Tracks* Web portal.

Four years of MARS reports will be maintained online and five years of MARS annual reports will be archived by rolling five years of MARS reports to tape. These reports will be made available to users for print on a high-speed printer within twenty-four hours of the request. **(40.13.1.13)**

(40.13.1.13)

D.1.4.13.2 Administrative Reporting

The Administrative Reporting Module supports overall management control, planning, and reporting processes, including policy planning and evaluation, fiscal planning and control, and federal and State reporting. Administrative reporting presents budgeted and actual expenditures based on eligibility category, money code, and category of service. Categorized summary totals are available for providers, recipients, paid claims, denied claims, and suspended claims.

The Administrative Module generates the following standard federal reports:

- Medical Assistance Financial Status
- Claims Processing Performance Analysis
- Claims Processing Throughput Analysis by Category of Service
- Provider Claim Filing Analysis

- Recipient Cost Sharing Summary
- Medicaid Program Budget Report: Average Number of Eligibles
- Medicaid Program Expenditures Report
- Home and Community-Based Services Waivers

Because the source data includes information extracted from the Financial Subsystem, the Team CSC MARS solution provides the capability to generate reports that include the results of all State-initiated financial transactions with claim specific and non-claim specific transactions or other State-specified categories. The system also can identify, separately or in combination as requested by the State, various types of recoupments and collections using reason codes maintained within the Financial Subsystem. Report modifications and additional reports may be required to fully satisfy these requirements after all the State financial data elements have been reviewed. **(40.13.1.4, 40.13.1.5)**

(40.13.1.4, 40.13.1.5)

Other reports that are produced by the Administrative Reporting module include:

- **Retro Rate Request Summary Report.** The Retro Request Summary report details the number of claims and the total Federal, State and Local share amounts of retroactive rate adjustments transactions by provider id, provider location and rate code. It also details the previous and new rate amount and the begin and end dates of service for claims affected by the adjustment.
- **Rate Adjustment Summary Report.** This report presents a listing by county of the various fields used for rate adjustment for every retroactive rate adjustment summary record.
- **Medical Systems Expenditures by Source of Funds.** This report shows the expenditures and Federal, State and Local Shares for the current month, current 12-month period, previous 12-month period, dollar variance from year to year and percentage variance by detailed category of service.
- **Analysis of Assistance Payments.** This report presents Medicaid expenditures by type of service and lists a breakdown of the total expenditures into non-reimbursable and reimbursable amounts. The reimbursable amount is then separated into Federally Participating and Federally Non-Participating amounts. Federally Participating and Federally Non-Participating are then broken down in Screening, Family Planning Sterilization, Family Planning Other, and All Other. The report is also separated into sections based upon various demographic sub-sets. This report carries both provider submitted claims, adjustments and voids, and Retroactive Rate Adjustments
- **Rate Adjustment Report —** The purpose of this report is to provide details of retroactive rate adjustments based on information provided by the State. It provides details of those providers who have rate adjustments. The report lists, by county, the provider type, the provider, the period of the adjustment, the rate variance, patient days, adjustment amount, and Federal, State, and local Shares. If a provider rendered services in more than one county, the provider will be reported under each applicable county. Provider totals (adjustment amount, Federal Share, State Share, and Local Share) are displayed under each applicable county, along

with grand totals for all counties relating to adjustment amount, Federal Share, State Share, and Local Share.

- **Weekly Computation of Federal, State and County Share.** The purpose of this report is to summarize the Federal, State, and Local participation and respective shares for all counties.

D.1.4.13.3 Operations Reporting

Operational performance reports provide data to support the monitoring and control of claims processing functions. These reports provide a practical basis for improving the effectiveness and efficiency of claims processing. By providing reliable and timely information on claims receipt, review, adjudication, payment, and error statistics, these reports assist with the analysis of claims inventory and display production backlog. The operations reporting module generates the following standard federal reports:

- Operational Performance Summary
- Error Distribution Analysis
- Provider Error Frequency Analysis

D.1.4.13.4 Provider Relations Reporting

The Provider Reports support activities associated between providers and the Medicaid program, including enrollment and certification, audit and cost settlement, utilization evaluation, payment advisement, claim filing analysis, and provider evaluation and education. The provider reporting module allows the evaluation of provider participation, indicates provider billing characteristics, and monitors billing irregularities where actual or potential problems may exist. The provider module generates the following standard federal reports:

- Provider Participation Analysis
- Cost Settlement Details and Summaries
- Provider Claim Filing Details
- Third Party Payment Analysis
- Provider Ranking List
- Provider 1099 Annual Earnings

D.1.4.13.5 Recipient Relations Reporting

The Recipient Reports allow NC DHHS to review and analyze recipient participation, eligibility, activity, and service usage to enhance the efficiency and effectiveness of the program. The Replacement MMIS Recipient Reporting Module generates both scheduled reports and ad-hoc reports that show administrative and recipient directed activities including recipient eligibility; summary totals by age, race, and specific program code; and unduplicated counts of recipients on a monthly basis for the past year. The recipient module generates the following standard federal reports:

- Recipient County Expenditure Analysis
- Expenditure, Units of Service and Beneficiary Counts by Aid category
- Title XIX Category and Service

- Service and Current Month, Previous Month, Same Month Last Year and Current and Previous Fiscal Year to Date
- Eligibility Counts.

D.1.4.13.6 Federal Reporting

The Federal Reporting Module generates outputs necessary to meet federal MMIS reporting requirements, in the format specified by Federal requirements. These reports and extracts are used for analytical research, planning, budgeting, and policy analysis. All MARS reports that will be sent to CMS are generated in the format specified by Federal requirements and include those reports specific to CMS certification. In addition, these reports will be modified, as needed, to reflect county and State Medicaid cost participation breakdowns in the MARS reporting. The federal reporting module generates the following standard federal reports and extracts: **(40.13.1.14, SOO 10.12.9-1, SOO 10.12.9-2)**

(40.13.1.14, 10.12.9-1, 10.12.9-2)

- MSIS Extract Files (using only Medicaid data)
- CMS 2082 Sections A through N

Drug usage reports present analysis for several classifications including frequency, dollars paid, times filled, drug identification, and eligibility data. Drug usage reporting provides specific, targeted information necessary for program management when reviewing and developing medical assistance policy and regulations. The drug module generates the Drug Usage Analysis report.

The Recipient Subsystem will create a monthly Medicare Part D Enrollment file to be transmitted to CMS and will also accept and process the CMS Medicare Enrollment Response file transmitted through a Division of Information Resource Management (DIRM) interface. Both successful and failed response transactions are stored for online administrative review and reconciliation. Based on these interfaces, Team CSC will ensure all Medicare Modernization Act (MMA) file and MMA State Response File reports are generated. **(40.13.1.24)**

(40.13.1.24)

D.1.4.13.7 Ad Hoc Reporting Capabilities

Ad hoc features allow users to develop tailored reports to specific questions or to follow up on issues identified in the standard management reports. The system produces outputs in a variety of formats including reports, graphs, and charts, as well as files in many standard formats. It supports analyses and a wide range of reporting requirements from very simple to very complex, in a convenient and easy to use, yet extremely powerful solution.

During the DDI Phase, Team CSC will work closely with NC DHHS and its division to establish specific selection, summarization, and un-duplication criteria to use for requesting claim detail reports. Upon implementation of the Replacement MMIS, authorized users will be able to request claim detail reports using the State-defined selection criteria via online pages. The Replacement MMIS will generate all claim detail reports each evening during a batch cycle and reports will be posted to Mobius for retrieval by the requester via our **NC***Tracks* Web portal. **(40.13.1.12)**

(40.13.1.12)

Team CSC will work with SAS to create business intelligence ad hoc reporting as required by NC DHHS to increase the effectiveness of MARS business functions.

SAS — A Leader in Business Intelligence

SAS has been positioned by Gartner, Inc. in the Leaders Quadrant in the "Magic Quadrant for Business Intelligence Platforms, 1Q07"

To support a successful MMIS transition, we offer NC DHHS the SAS Enterprise Intelligence Platform, which addresses business intelligence and analytics from a fully integrated platform. Our solution not only reports past and current activity—it can apply predictive analytics to this historical information to prepare NC DHHS for future requirements.

A business intelligence layer will enable NC DHHS to:

- Reduce risk by generating needed intelligence at all stages before, during, and after system replacement
- Integrate data from multiple systems and platforms, both internal and external to the agency
- Perform advanced analytics, such as predicting outcomes, identifying trends, and detecting fraud, without impacting operational system performance
- Enable all levels of users to quickly and easily get the information they need to respond to requests from management, legislators, the press, recipients, and other stakeholders.

UNC School of Public Health Sheps Center Research and Analysis Excellence

The Sheps Center has been designated an "Evidence-based Practice Center" (EPC) by the federal Agency for Healthcare Research and Quality.

University of North Carolina School of Public Health Sheps Center is recognized for research and analysis excellence, whose talents NC DHHS can leverage to improve health outcomes and lower cost. The Sheps Center in partnership with Research Triangle International conducted over fifty systematic reviews on topics ranging from pharmacotherapy of alcoholism to treatment of rheumatoid arthritis as well as topics such as screening for prostate cancer. They also participated in the "Drug Effectiveness Review Project (DERP) consortium and conducted drug class reviews specifically for state Medicaid Programs. The Sheps Center has evaluated over twenty classes of medication using state of the art systematic review processes to identify specific actions and information for providers.

Team CSC and The Sheps Center will develop the following:

- Initial business intelligence analysis
- Dashboard information display requirements
- Related library content recommendations for initial personalized stakeholder portals
- Provide a continuing education / announcement program via the portals and complete special studies as approved by NC DHHS.

The Sheps Center, with its library services and evidence-based practice staff, will conduct horizon-scanning surveillance for high quality comparative effectiveness

Pages D.1.4.13-11 through D.1.4.13-13 contain confidential information.

- **Abortion Reports** — The Abortion Reports provide detailed information on the number of abortion procedures performed, expenditures for abortion procedures, number of clients who have received abortion procedures, demographic characteristics of abortion recipients and expenditures for services ancillary to an abortion procedure. The Abortion Report process is executed monthly, but certain reports and files are only created during the quarter ending months.
- **Graduate Medical Education Statistical Report** — This report provides information to management on expenditures for Graduate Medical Education claims submitted by hospitals for recipients enrolled in Managed Care plans which no longer pay the GME portion of Inpatient claims
- **Family Planning Exception Reports** — The Family Planning Exception report is a summary of record-specific listings of the county code, detailed category of service, MARS aid category, Title XIX aid category and special aid category for Family Planning records that are exceptions to normal Family Planning processing.

D.1.4.13.10 Conclusion

The Replacement MMIS provides timely and accurate reporting of Medicaid expenditures, participation, and eligibility metrics, allowing the users to query and access MARS specific data efficiently. The MARS automated functionality is streamlined to enable efficient report generation minimizing human intervention. The base Replacement MMIS brings powerful features that support the business needs for each of the divisions, DMA, DMH, DPH, and ORHCC.

Team CSC is committed to working with the North Carolina DHHS and its divisions during the DDI Phase to design, develop, and implement a new MARS Subsystem that meets or exceeds the RFP requirements to monitor and administer a multi-payer system.

D.1.4.14 Financial Management and Accounting Subsystem

Team CSC's Financial Management and Accounting subsystem will provide the state with accurate and timely Financial and Accounting processes within a multi-payer, multi-benefit plan environment. Our solution is easily adaptable to meet new regulatory and legislative mandates.

D.1.4.14.1 Introduction

Financial management and accounting is a key component of any MMIS. After carefully reviewing your requirements and our baseline system functionality we are able to offer you an exceptional solution. This section of our proposal describes how we will take the baseline capabilities and modify them for your Replacement MMIS.

The Financial Management and Accounting Subsystem is fully integrated with all other aspects of the proposed Replacement MMIS, enabling application of Team CSC's technical innovations and capabilities to financial and accounting processing.

(40.1.1.1, 40.1.1.6, 40.1.1.7, 40.1.1.9, 40.1.1.10, 10.12.6-1)

Multi-payer Processing

Team CSC understands the complexity of the State's multi-payer environment. We understand that there are multiple benefit programs with program specific funding sources, goals, requirements, policies and procedures. **(40.1.1.1, 40.1.1.6, 40.1.1.7, 40.1.1.9, 40.1.1.10, SOO 10.12.6-1)**

Multi-payer features of our solution include:

- Checkwrite schedule flexibility allows different financial payers to establish their own checkwrite schedule. This will ensure timely generation of payments according to the schedule required by each respective program.
- Business rules reflecting eligibility and service hierarchy. This ensures that payment is made from Medicaid if it originates from a DMH provider for a client that is Medicaid eligible.
- Funding calculation based on the recipient and provider eligibility, as well as automated benefit package look-ups, selecting the most appropriate financial payer based on the hierarchy rules defined by DHHS. Funding programs are designed to provide accurate calculation and allocation of program costs among the broad DHHS payment entities such as federal, State, local government entities, and other sources. The funding source matrix for DHHS medical services is complex and dynamic and must be able to respond to legislative, budget and grant changes timely and accurately.
- Historical retention of funding source allocation for each detail service at the time of claim payment so provider and system generated adjustments can accurately adjust funding source allocations when claims are adjusted or recouped. This point-in-time historical trail of funding sources will also be used in managing accounts receivable (AR) balances when cash is posted to specific claims and detail services.
- Associate all balances and transactions with the appropriate line of business or benefit program as well as responsible funding sources, and benefit periods. This association is enabled by the fact that AR processing occurs at the most detail level possible. For example, accounts receivable balances arising from provider overpayments are normally tied to the related claim line that was overpaid. Our accounts receivable process will also provide the capability to properly adjust the provider and claims history detail when necessary.

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In a multi-payer environment each financially responsible payer has unique budgetary constraints. Each payer needs to manage budgets for different benefit plans for which they are fiscally responsible. Our system offers features that help manage these constraints, and ensure that cycle payment amounts are within budgetary limits.

Ease of Modification to Accommodate New Financial Requirements

Team CSC's baseline system provides end users with a high degree of flexibility and functionality. This **flexibility allows authorized users to make immediate changes and apply updates to the system through our NC*Tracks* Web portal. Allowing users to effect changes through NC*Tracks* eliminates the need for system maintenance or development work to activate updates.** Ease-of-Modification benefits include:

- General Ledger account codes, compliant with NCAS, can be added to the system using a standard screen, allowing the system to easily adapt to the changing accounting needs of each different benefit program
- Codes used in ongoing processing, such as recoupment reason codes, can be added, deleted, or changed to quickly accommodate changing needs
- Financial transactions are available for online keying of provider adjustments, write-offs, and accounts receivable case transactions.

Team CSC's Replacement MMIS will ensure the integrity of these system updates.

Users authorized to make such updates will be limited, the Replacement MMIS will ensure accountability for updates, by automatically logging information about all update transactions, retaining the time, date, and user ID of the staff person who entered the update.

Checking of Budget Allocations

In a multi-payer environment, each benefit program has its distinct budgetary constraints that need to be honored as claim payments are processed. Team CSC's Replacement MMIS will have the ability to check budgetary allocations during financial payment cycle processing before the payment cycle is finalized. In situations where budget allocations are not adequate to cover the final paid amount for the claim, the system will have the ability to either pend or deny the claim, or check for additional funding sources in accordance with DHHS specifications.

Funding Capabilities

Our Financial Management and Accounting Subsystem will allow for dynamic configuration of claim criteria that ties payment of that service to the appropriate budget and funding source. One important element in Medicaid is Category of Service (COS) which must include criteria from eligibility attributes from both the recipient and the provider tables and from claim service detail information. The system will be built to accommodate criteria fields that are not used currently but may be considered for use in the future.

In cases where there are multiple funding sources for the benefit plan/service combination, the system will process the claim to access each respective payment source, starting with the primary source, until funds are exhausted. We will access funding in the order of the payment hierarchy to the extent that State or other coverage funds are still available.

When multiple budgets cover a service, and the primary budget does not have enough funds, the system will allow additional budgets from the benefit plan/service combination to be used to cover the balance of the claims paid amount. All funding sources and accompanying amounts used will be stored on the claim record and used for reporting, shares calculation, online inquiry, and system balancing.

However, based on configurable rules as set by DHHS, a single claim line cannot fund from payment sources that span multiple benefit plans. For example, a claim is assigned multiple benefit plans and is assigned a reimbursement amount of $100 for the primary benefit plan(s). Funding sources assigned to the primary benefit plan show only $75 available. The claim would be denied for the primary plan during financial payment processing and re-adjudicated using the next available benefit plan as dictated by the hierarchy. All funding for the claim would be decremented from funding sources assigned to the new benefit plan even if it pays for the same dollar amount as before.

Reporting

In order to ensure timely system-generated reports, Team CSC's offers online access to all report through the NC*Tracks* Web portal. Standard reports will be generated automatically per a schedule and posted to a repository. Reports in the repository are available to authorized NC*Tracks* users. This process eliminates reporting delays that can be counterproductive and frustrating. It is especially valuable in the Financial Management Subsystem, where timely sharing of information will greatly simplify the weekly approval process with DHHS and the DHHS Controller's office. Having reports available immediately will allow State staff to know the total value of claims processed, and total funding required by each funding entity within each benefit program.

Compliance with HIPAA and NPI Standards

The Baseline System is fully compliant with all current HIPAA requirements, including the ability to accept incoming claim and encounter records using the X12 837 transaction. Claims status transactions are processed using the X12 276 and 277 transactions; eligibility requests use the standard X12 270 and 271 formats. Remittances are accommodated using the X12 835 and 820 formats, and the baseline system also supports a non-standard supplemental remittance record format that offers providers even more detailed information on the reasons claims pend or deny.

The Baseline System will be compliant with National Provider Identification (NPI) requirements when the Design and Development phase begins.

Compliance with Government Regulations and Accounting Standards

Team CSC's Replacement MMIS Financial Management Subsystem will comply with applicable laws and governmental regulations, including all of the following:

- IRS regulations
- State and Federal laws
- CMS regulations
- North Carolina DHHS Cash Management Plan and Procedures (**40.14.1.84**)

(40.14.1.84)

In addition, all financial transactions and financial statements will be conducted and recorded in a manner that is consistent with the requirements of Generally Accepted Accounting Principles.

In order to ensure ongoing compliance, Team CSC will actively follow developments in the legislative and regulatory environment, and will proactively track all potential changes, including new IRS regulations, CMS requirements, and NC regulatory requirements as they are under discussion. In this way, Team CSC will be able to anticipate new requirements before their implementation date. Team CSC will be able to review current table-driven configurations to assure they can handle new regulations, and allow system enhancements to be developed, if needed, to fully accommodate each new requirement.

Medicaid Information Technology Architecture (MITA) Alignment

The MITA standard is still unfolding and, as one of the authors of MITA, CSC is carefully tracking these developments. Because of our intimate MITA knowledge our baseline system design has the flexibility to be MITA aligned today and tomorrow. Many of the MITA-endorsed development features, such as the use of modular and reusable code, structured coding standards, and system security features, are already integrated into the base line systems. Other key MITA objectives, such as enhanced data sharing, effective update procedures for data warehouse/data mart systems, and the use of open architecture are also current features of the Baseline System.

Security and Integrity of Processing

An essential component of any application used to process billions of dollars in transactions is that it be controlled at all times by strong internal controls and security procedures to ensure the integrity of processing. **We will control user access by function as well as by data field and/or window. Additional security and integrity features include:**

- Comprehensive logging of all table changes at the field level
- Comprehensive logging of all system access attempts – successful and failed.
- Balancing features that help ensure the accuracy and completeness of processing. Batch applications include internal balancing procedures to ensure that processing is complete, and record counts balance to totals established by trusted sources, prohibiting insertion of data from non-authorized entities. Records input to a jobstream must balance to records read out, and any out-of-balance condition initiates an iterative escalation process. These controls are very effective in enforcing the integrity of processing, ensuring that disbursements are based upon legitimate system-generated transactions.

Task Scheduling Tool

The complex, multi-payer/user environment will require extensive coordination to ensure data is managed appropriately. In order to achieve this goal, Team CSC will use an automated schedule application to allow for appropriate initiation of automated processing, while ensuring that critical path applications are fully exercised in the proper time sequence. Our plan will be to:

- Run catalogued job streams, reports, or other tasks at specific pre-programmed times
- Provide problem intervention, requiring automated processing interruption, in the case of abnormal job cancellation of other processing problems. In the rare cases when such processing anomalies do occur, a system alert is initiated, along with an iterative escalation procedure that brings top management into the resolution process according to a pre-established schedule. Top management remains involved until the issue is resolved and normal processing can be rescheduled. These procedures translate into a much

higher quality of processing, avoiding processing delay and enduring that critical deliverables, such as payment checks, are consistently generated on time.

- Team CSC's automated scheduler is an important processing tool, helping to ensure that all applications are fully processed on time, and in the proper sequence.

Electronic Document Management Support (EDMS)
All inbound faxes and written documents will be imaged and stored for DHHS and Team CSC authorized-user viewing.

It should be noted that electronic images of check copies and provider remittances are also generated during each payment cycle, and can be easily accessed to facilitate research activities. These documents are indexed by provider ID, making retrieval of a provider's profile over a designated time period easy to accomplish.

Batch and Real Time Online Access
The base Replacement MMIS can provide batch and real time online data access between authorized DHHS external systems and designated system functions. Online web pages enable authorized users to easily access each LOB's recipient, provider, encounter and reference data. Search pages enable multiple inquiry key criteria as applicable to the search, including name, identification/financial transaction numbers, and payment dates.
(40.8.1.282) **(40.8.1.282)**

Comprehensive Functionality to Meet all RFP Requirements
Team CSC's proposed Financial Management and Accounting Subsystem will meet DHHS' business and technical requirements. The Replacement MMIS will have capability for fully integrated financial operations, including general ledger, accounts receivable, claims payment/accounts payable, cash receiving, receipts dispositioning, and apportionment functions streamlining operations, improving provider and recipient
(40.14.1.7) services, and reducing administrative costs. **(40.14.1.7)**

D.1.4.14.2 Subsystem Technical Functionality

The preceding discussion highlights some of the more important advantages of Team CSC's Baseline System. We believe our solution is an excellent fit for the NC DHHS' ongoing processing needs and represents the best solution available for a full-featured, flexible, and compliant system. In order to fully convey the advantages of Team CSC's baseline system, the following section presents a more detailed view of the Financial Management Subsystem, including a description of many of its operational features, as well as actual images of some of the screens used to achieve financial processing. This section presents descriptions of functionality for each of the following categories:

- Establishment and Control of Accounting codes
- General Ledger Processing
- Payment Functions
- Remittance Advices
- Cash Control and Bank Accounts
- Accounts Payable
- Accounts Receivable
- General Account Receivable/Accounts Payable Requirements
- Funds received
- Fiscal Transactions

- Recoupments
- Recipient Functionality
- 1099 and Related Reporting
- NCAS and Data Warehouse Interface
- Financial Accounting and Reporting Requirements
- Additional Functionality For Financial Management

D.1.4.14.2.1 Establishment and Control of Accounting Codes

Team CSC understands that the Replacement MMIS must be able to produce reports that can detail expenditures and receipts for multiple LOB's and associated programs, and reports that summarize the financial activities of the entire entity across all funds. Given that each LOB will require its own general ledger reporting, the system accounting is designed to accommodate the respective financial coding appropriate to specific program funds.

Team CSC's Baseline System supports accounting codes that allow transactions and balances to be associated with the appropriate general ledger account. Use of these codes provides the 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. These codes allow for the accurate accumulation of program expenditures by benefit program, and also creation of a detailed balance sheet for each program, showing all assets, liabilities, and residual balances. During DDI the system will be adapted to fully accommodate any accounting codes currently required by any of the existing LOB systems. **(40.14.1.11, 40.14.1.62, SOO 10.12.6-5)**

(40.14.1.11, 40.14.1.62, 10.12.6-5)

The system allows codes to be added or deleted by an authorized user facilitating immediate change to the chart of accounts as the need arises. Accounting code updates do not require a change to a copy library or data processing table that traditionally required a development project or support of systems development or other technical staff. Team CSC will work with DHHS to establish codes for each benefit program during the DDI, and any subsequent updates will be user controlled.

Codes can be developed with specific effective and end dates and may coincide specifically with DHHS' budget year where budgeted dollars may be required for several program categories of claims. User-defined criteria will ensure accurate reporting in accordance with DHHS report specifications. **Exhibit D.1.4.14-1**, Financial Reason Code Page, illustrates screen layout for this functionality, depicting some of the data which should be entered to establish or modify codes used in the system.

Pages D.1.4.14-7 through D.1.4.14-8 contain confidential information.

(40.8.1.249, 40.8.1.250, 40.14.1.91, 40.8.1.303, 40.8.1.334, 40.8.1.215)

General Ledger Pend Process

(40.8.1.249, 40.8.1.250, 40.14.1.91, 40.8.1.303, 40.8.1.334, 40.8.1.215, Comment CSC61, Comment CSC206) Our Baseline System can link the detail financial transaction to the claim detail level activity. Because of this association, the system has the capability to pay claims according to an established budget hierarchy. To ensure Team CSC accommodates the budget hierarchy process, the Baseline system's General Ledger/Fiscal Pend Process will be modified to maintain unlimited funding source balances at the service level for each benefit plan for each DHHS LOB. A customized table that can be updated online will be used to determine the action to take when insufficient funding is not available for a specified General Ledger Code. This will include the ability for DMH funding sources to support multiple General Ledger Codes that can be accessed via an established sub-hierarchy. Thus a payment can be derived from one or an accumulation of funds available during that checkwrite cycle.

The process to achieve this funding allocation is initiated through the Claims Processing System. It will perform the applicable editing on a claim and assign an initial status of "pending to pay", 'pended' or 'denied'. A 'pend' status is re-processed and is eventually updated to 'pay' or 'deny' while a 'deny' status is final.

All claims with a 'pending to pay' status are examined during initial Financial processing to ensure that there is appropriate funding available to pay that claim as described above. Claims that do not have sufficient funding available are either updated to a 'Pend' status, permanently 'Denied', or allocated funds from an associated General Ledger Code as described above. In the event that there are insufficient funds available under the primary DMH benefit plan, the system will be able to recycle the claim through the Claims Processing system to automatically bypass the primary plan and advance to the subsequent benefit plan as designated in the established budget hierarchy. The Claims Processing system will perform the associated edits and audits with the subsequent benefit plans prior to the Financial processing. The re-adjudication using the new benefit plan will take place during the current pay cycle to avoid holding up payment for the claim. An audit trail illustrating each source evaluated for payment will be maintained in the claim history record.

Working with DHHS, we will develop criteria for proper selection of budget and funding source to include date of service, category of service, type of service and other criteria to be defined during the detail design stage. This will include criteria to support the suspension of claims due to insufficient funding available.

- Based on the criteria to be developed, the General Ledger Fiscal Pend Process prevents claims from being paid when the budgeted amount of their funding source(s) has been exhausted. A claim fiscally pends if its reimbursement amount is greater than the Available Balance and the Bypass Indicator is not set. Claims that meet the above criteria can do any of the following:
  - Auto-deny,
  - Switch and check new or related program based on a hierarchy or preset indicator
  - Suspend, recycle and check for funding from the same funding source at a later date.
  - Fiscally pended claims continue to recycle through the weekly Financial Subsystem until sufficient funds are made available by increasing the Starting Balance on the General Ledger Code for which the claims are fiscally pending or turning on the

Bypass Indicator for that General Ledger Code. **The Replacement MMIS will ensure that fiscally pended claims from previous cycles are always processed prior to all claims from the current cycle.** In addition, the sort criteria will ensure that all adjustments and credits are processed against the appropriate LOB budget prior to processing any new day claims. All sort criteria will be defined during DDI to ensure that it meets each DHHS LOB requirements. **All claims that are fiscally pended at the end of a financial cycle are documented on Provider Remittance Statements. (Comment CSC753)**

D.1.4.14.2.3 Payment Functions

Our Baseline System offers a very high level of automation and efficiency in the processing of provider payments. In our New York State Medicaid project, CSC processes on an annual basis 450 million claims and 25 million encounter transactions; the payment processing is responsible for correctly paying over $40 billion worth of claims per year on behalf of New York's 3.5 million Medicaid clients.

Payments Based on Legitimate Claims

(40.8.1.30, 40.8.1.295, 40.8.1.313, 40.8.1.273)

(40.8.1.30, 40.8.1.295 40.8.1.313, 40.8.1.273) Our Financial Management and Accounting subsystem is fully integrated with the Claims Processing Subsystem. The Claims Processing Subsystem, described in Section D.1.4.8, implements extensive checks to ensure that only valid disbursements are passed to the Financial Management and Accounting Subsystem. The Baseline System incorporates a number of features that work together to ensure the legitimacy of payments:

Authorized masterfiles are used for Recipients, Providers, and Pricing information, including the Financial Participation Rate table. These files are tightly controlled and include time segments to identify appropriate values and eligibility statuses over time. File updates normally occur on a daily basis. The Baseline Systems allows for any update schedule that DHHS requires. The use of these masterfiles is a very effective control to ensure that payments are made only to enrolled providers, and on the behalf of recipients who are eligible on the date of service. Masterfiles also facilitate the capability to create provider, recipient, reference, and account data and other important functionality:

- Receivable/payout data is created
- The recipient eligibility file includes information to identify and assign the financially responsible payer and benefit program applicable to each service rendered in the claim
- 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.
- The use of masterfiles facilitates extensive data validity edits and clearly defined pricing methodologies in the adjudication of claims and adjustments to further ensure the validity of claim payments.

During the claims adjudication process, the system performs edits, audits, pricing and payment-related calculations, ensuring the appropriateness of the system payment decision for each claim and adjustment. This editing is an important control which ensures accurate balances for each checkwrite in accordance with State-approved policy and procedures. The system is able to perform multiple pricing methodologies in accordance with DHHS LOB policy and procedures. Pricing methodologies are linked to payer, program, benefit plan, and applicable coding and are applied to services listed on the claim. **(40.8.1.267)**

(40.8.1.267)

Payment Processing

Team CSC's baseline system supports a wide range of functionality to support payment processing, and includes many features that are of significant value to DHHS's multi-payer environment.

LOB Checkwrite Scheduling

(40.8.1.227, 40.8.1.228, 40.8.1.229, 40.8.1.242, 40.8.1.257)

(40.8.1.227, 40.8.1.228, 40.8.1.229, 40.8.1.242, 40.8.1.257) (Comment CSC725) The Baseline System can generate separate checkwrites for each DHHS LOB, according to a schedule to be chosen by the individual benefit program. The system scheduling feature supports production of all outputs of a claims payment cycle to be dated with the same system date for each DHHS LOB individual cycle run. In addition, it provides the ability to override that date through a system parameter at the discretion of the DHHS LOB. The system checkwrite scheduling can be modified at the discretion of the DHHS LOB. We will use the Thursday following the processing date as the last payment cycle for the month.

Initiation of Payments

(40.8.1.51, 40.8.1.247, 40.8.1.248, 40.8.1.252, 40.8.1.253, 40.8.1.304, 40.8.1.333, 40.14.1.27, 40.14.1.92, 40.8.1.224)

(40.8.1.51, 40.8.1.247, 40.8.1.248, 40.8.1.252, 40.8.1.253, 40.8.1.304, 40.8.1.333, 40.14.1.27, 40.14.1.92, 40.8.1.224) (Comment CSC147, Comment CSC149) The Financial subsystem initiates the payment process each cycle when the system accumulates provider net reimbursement dollars at the conclusion of the claim financial processing. These claims will be placed into a "pending to pay" status with the exception of those claims that have been excluded from payment as directed by any DHHS LOB and those claims for providers in "hold" status. The system will use the DMH budget data contained on the DMH file during fund determination processing. In addition, the system produces balancing reports at detail and summary levels aligned to program budgeted dollars including the budget data received directly from DMH. All claim details can be tracked back to the original claim.

The Baseline system currently produces a "Fiscal Pend Report that lists all "Fiscally Pended" claims by General Ledger Code. CSC will add a 'Fiscal Pend Deny Report' for claims that are 'denied' for lack of available funding and provide a corresponding extract file(s) for this report, specifically for DHHS DMH, and any of the other divisions if required. DHHS will be able to dictate the format of this file(s) and where the file(s) are to be routed.

The system will validate the status of each provider, i.e., active, suspended, inactive prior to issuing any payments or processing refund checks and voided checks.

Prior to the execution of the checkwrite, Team CSC obtains approval from NC DHHS for the amount required for payment.

Accumulation of Paid Claims

(40.8.1.220, 40.8.1.382)

(40.8.1.220, 40.8.1.382) Claims adjudicated in a "pending to pay" claim status are subjected to processing of any additional financial transactions such as adjustments and other payable/receivable transactions described previously. Payments may be increased or decreased accordingly. In addition, the system applies recipient deductibles as appropriate based on their plan participation.

For those LME or similar status claims that are submitted as supporting information for manually paid claims, the Baseline system will adjudicate them as a "zero" pay in accordance with rules defined during DDI. These claims are adjudicated as any other claim, i.e., through applicable edits and audits. In those instances in which the State wants the NC MMIS to generate a LME or similar service type payment, the claim is treated as any other claim, including source funding availability. CSC will provide the State with reporting that supports payment justification in either instance.

(40.8.1.215, 40.8.1.235, 40.8.1.243, 40.8.1.277, 40.8.1.382, 40.8.1.316)

Adjustments to Initial Payment Balances

(40.8.1.215, 40.8.1.235, 40.8.1.243, 40.8.1.277, 40.8.1.382, 40.8.1.316.) The Financial Management and Accounting subsystem computes a final net amount for each detail in a claim and for the claim across detail lines. It computes a net amount to be paid to each provider by each financial payer across the benefit programs in which the provider participates. A total paid to each provider by each benefit program is also computed. If the net payment amount is positive, the system applies all or a portion of the payment amount to any outstanding account receivable balances. Any remaining positive payment amount specific to a single DHHS LOB or as accumulated across multiple DHHS LOBs is paid to the provider in the form of a paper check or an Electronic Funds Transfer (EFT) for all claims in the current checkwrite cycle.

The system will support each LOB's banking choice.

Lump Sum Payment

A Lump Sum Payment transaction is used to generate a non-claim related payment to a provider. Lump Sum Payment transactions act as a direct payment to the provider and are not recouped. The amount indicated in the transaction is paid to the indicated provider via their current method of payment and is added to the 1099 Amount. The Lump Sum/Cash Advance Payouts Report lists all providers who have been issued a lump sum or cash advance payout during the weekly payment cycle.

(40.8.1.330)

Cash Advance

(40.8.1.330) A Cash Advance transaction results in both a Lump Sum Payment and Recoupment transaction being issued. A Cash Advance transaction issues a payment to the indicated provider in the amount approved, and then automatically places that amount into an accounts receivable to be recouped in accordance with DHHS LOB policies and procedures. Like Lump Sum Payment transactions, a Cash Advance transaction must contain pre-assigned shares percentages, a Program, County Code, and a Category of Service. All payments issued through a Cash Advance transaction are added to the 1099 amount and are automatically recouped through accounts receivable processing. Recoupment amounts collected from a Cash Advance transaction are not added to the 1099 amount since the initial lump sum payment was previously recorded.

The Lump Sum/Cash Advance Payouts Report lists all providers who have been issued a lump sum or cash advance payout during the weekly payment cycle.

Public Goods Pool Processing

The Replacement MMIS Lump Sum Payment capability accommodates DHHS's uncompensated services payment process for disproportionate -share hospitals for uncompensated services in four (4) quarterly payments. The baseline system is designed to

support Public Goods Pool processing by providing automated reporting to summarize claims paid to disproportionate-share hospitals. These aggregated claim payments become the basis for the Disproportionate Share lump sum payment by applying a State-specified percentage to the total. The resulting total supplemental payment can be issued in a Public Goods Pool check run through a manual check process or as paper/EFT payment as directed by DHHS. These payments would be shown on the providers' remittance advice statements with appropriate identification.

We understand that the actual disbursement of this type of payment is currently done directly from NCAS by the DHHS Controller's Office. Our system is capable of taking over this payment function if directed by the State.

Like all other forms of payment, Public Goods Pool data for each provider is available online for inquiry.

Processing of System Generated Checks, Check Registers, EFT's

(40.8.1.222, 40.8.1.223, 40.8.1.230, 40.8.1.240, 40.8.1.312)

(40.8.1.222, 40.8.1.223, 40.8.1.230, 40.8.1.240, 40.8.1.312) The Replacement MMIS will produce system-generated checks, remittance advices, voucher statements, and other documentation for each DHHS LOB or across multiple DHHS LOBs as defined by the State. Based on the LOB and the respective provider's signed agreement in the selection of media to receive reimbursement, the system can generate a single paper check or an EFT. In addition, a corresponding ANSI 835 or paper remittance will be generated for every provider with claim activity for that payment cycle by single DHHS LOB or across multiple LOBs. An EFT register is also generated and can be used to easily identify providers who are receiving EFT transactions for a particular payment cycle.

(40.8.1.222)

(40.8.1.222) After all approved claims and other financial transactions have been summarized by each DHHS LOB, the system calculates a total payment amount across multiple DHHS LOBs payment amount for each provider. This payment amount will be entered in either a check file or to an EFT file to be transferred to our disbursement bank.

Check Processing

All new checks are created with an initial status of 'Uncleared' and have an Issue Date, Payment Send Date, and Status date associated with them. The Issue Date contains the cycle date that the check was created in. The Status Date displays the date of the last time the check status was updated.

Check numbers are pre-printed on the paper check stock. Entry of pre-printed check numbers in the system is done by keying the check number ranges from all printed checks into the Checks Printed/Retro Fit Page. This program then matches the check number to its corresponding check information and updates the Payment Number field with the correct check number. System balancing requires that the number of check numbers entered equals the number of checks printed, ensuring that every check number is assigned to the correct check information.

Manual Checks

(40.8.1.276, 40.8.1.314)

(40.8.1.276, 40.8.1.314) Our Financial Subsystem provides the capability to issue manual checks under specific conditions, and enter the manual check data into the system upon check generation. The Manual Check Entry Page allows authorized users to enter manual check information into the system. Users enter the Provider ID, Check Number, Major

Page D.1.4.14-14 contains confidential information.

application. This “pre-note” test offers providers confirmation that their data has been properly entered, and that the actual transfer of funds is operating properly.

If a provider is ending their EFT enrollment, the EFT End Date of their current segment is assigned the date the EFT Enable Code is deactivated or set to ‘No’. A history of all EFT enrollment information is available online via the EFT/Payment Control Page.

EFT failures

(40.14.1.25) **(40.14.1.25)** In some circumstances, EFT transactions do not process correctly, often because a provider has closed its bank account in favor of a new account without notifying the Fiscal Agent. Under such circumstances, an issued EFT transaction cannot post to the closed bank account, and will be returned to us on an “ACH return” file by the disbursing bank. When this occurs, the baseline system will support the following resolutions steps:

- For each rejected EFT transaction, the effort code causing the reject will be entered to the system by our Transaction Accounting staff
- Transaction Accounting staff then create a manual paper check to be forwarded to the provider at the official “pay-to” address on the Provider Masterfile
- The provider is notified of the error, and asked to submit an EFT enrollment form with the correct account information to be re-input.

Transaction accounting staff then accesses the Remit Payment Control screen to disable EFT payment until the provider has responded with a new application and the corrected data has been updated to the system.

Generation of Check Registers

The Final MMIS Payment Register Report is generated during each payment cycle and provides a detail listing of all checks and EFTs that were created during that cycle as well as summary information about the total value of cycle payments. Check registers are comprehensive, in that they include all disbursements whether made by paper check or EFT.

Provider’s Payment Data

(40.8.1.262, 40.8.1.302, 40.8.1.307, 40.8.1.236, 40.8.1.383) **(40.8.1.262, 40.8.1.302, 40.8.1.307, 40.8.1.236, 40.8.1.383)** The system supports all provider payment data and also provides the capability to update online financial files and claims history with provider payment data according to approved DHHS LOB rules. This includes the capability to store and display all DHHS LOB’s eligible benefit plans and associated claim payment detail lines. The system benefit plan funding decision audit trail will also be viewable. During DDI we will review data requirements to ensure any additional data fields and related processing are added to the system to support DHHS LOB’s specific requirements.

Provider Earnings File

(40.8.1.221, 40.8.1.298) **(40.8.1.221, 40.8.1.298)** At the conclusion of the payment cycle, a Claims Adjudication File is created and used for the posting of paid claims to the Provider Earnings file based on each LOB and applicable checkwrite payment amounts.

File Transfers for Disbursement Transactions

Our Financial Management and Accounting Subsystem will create several control files to support file transfer. The first of these files is an EFT file with authorized transactions to be

transferred to providers' accounts according to an established schedule. The second file is the Bank Checks Issued File, with an entry for every paper check generated during the disbursement cycle. This file includes a number of relevant data elements including check number, check date, provider name, and approved payment amount. All checks on the LOB Bank Checks Issued File initially have an 'Uncleared' status.

These files are used by the disbursing banks to execute EFT transactions, and to provide authorization to clear paper checks, which are matched by the bank against the authorizing file as they clear. It should be noted that any paper checks presented to the disbursement bank which do not exactly match the Banks Checks Issued File will not be allowed to proceed through the clearing process, and will be dishonored by the disburement bank. This control is very effective in ensuring the validity of check disbursements.

Prior to the last payment cycle of a month, the Disbursing Bank sends the Bank Account Reconciliation File to us. This file contains a complete listing of all paid checks, as well as other information, such as the payment date. The LOB Bank Account Reconciliation File is processed against the Replacement MMIS check data and updates the checks with their current status.

Changes to Disbursement Transactions

(40.14.1.6, 40.8.1.279)

(40.14.1.6, 40.8.1.279, Comment CSC208) In certain circumstances, the need may arise to stop, hold or void a disbursement transaction. The Baseline System offers the ability to initiate these changes using the Financial Claims Payment Display Group. The following transactions can control payments once they have been generated:

- Stop/Void Check Transaction
- Stop/Void and Reissue Check Transaction
- Hold/Release Electronic Funds Transfer (EFT) Transaction
- Stop Electronic Funds Transfer (EFT) Transaction
- Debit EFT Transaction
- Override EFT transaction and create paper checks
- Check Retrieval

The Check Retrieval Page, as shown in **Exhibit D.1.4.14-3a**, is used to generate check 'stubs' that are inserted by a Fiscal Agent financial team member in place of a pulled check. Modifications will be made to the Financial Claims Payment Display Group to support automated check and EFT overrides for a specified date range.

Support for Positive Pay

An authorized check file is transferred to the bank containing an entry for every paper check printed during the disbursement cycle. This file includes a number of relevant data elements including check number, check date, provider name, and approved payment amount.

The authorized check file is loaded to the disbursement bank's internal system and is accessed during the check clearing process every night. As checks presented during the day are processed, each check is compared to the corresponding entry on the authorized check file. If presented items do not match, the funds are not disbursed, and follow-up action is initiated by the bank and Team CSC. This control, Positive Pay, is very effective, and has

Page D.1.4.14-17 contains confidential information.

will include payment information that indicates whether payments calculated exceed the budgeted amount and provides budget variances by LOB program and other DHHS approved criteria. **(40.8.1.319, 40.8.1.334)**

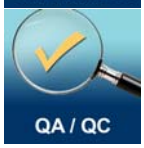
(40.8.1.319, 40.8.1.334)

Additional reporting will be made available online that identifies any financial exception reporting related to un-reconciled balances or account missing from the chart of accounts. We will work with DHHS to define the required specifications during DDI. **(40.14.1.93)**

(40.14.1.93)

The financial reports also capture the appropriate FFP rate based upon the recipients program and benefit plan eligibility and their associated category of service. **(SOO 10.12.3-5)**

(10.12.3-5)



(40.8.1.239)

Cycle Reprocessing

We are proud of the fact that all cycles have been processed on time and accurately throughout our tenure as New York Medicaid fiscal agent. We have never needed to reprocess a single payment cycle. We are confident that we can establish a similar record for North Carolina. In the unlikely event that any one or all of the DHHS LOB's determine that the original cycle for payment is unacceptable, CSC will rerun the payment cycle before the next regularly scheduled cycle and within eight clock hours of the LOB's notification. (40.8.1.239)

D.1.4.14.2.4 Remittance Advices

Team CSC's baseline Financial Subsystem includes a very robust and flexible capability for producing provider Remittance Advices. For providers, the system can generate the HIPAA compliant 835 transaction, as well as the 820 transaction used by pharmacies. Remittance advices and EOB's are also available in hardcopy for those who wish to receive payment information in that format. **(40.8.1.234, 40.8.1.297)**

(40.8.1.234, 40.8.1.297)

Remittance Advices

(40.8.1.318, 40.8.1.225, 40.8.1.320) Checkwrite reporting and remittance advices are produced at the end of the payment cycle by single DHHS LOB and across multiple DHHS LOBs. Upon receipt of the State Controller's Register file, the Replacement MMIS will perform an update to Claims History denoting the remittance advice number and issue date. In addition, Team CSC produces a monthly file of all claims adjudicated and other financial transactions by LOB.

(40.8.1.318, 40.8.1.225, 40.8.1.320)

(40.8.1.270, 40.8.1.299, Comment CSC215) Remittance Advice data includes the itemization of submitted claims that have been paid, pended, denied, or adjusted, and also depicts any other detailed financial transactions, such as suspended claims listing by DHHS LOB or across multiple DHHS LOBs when requested by the provider. Each Remittance Advice detail line provides the claim control number, recipient name and identification number, provider patient account number, service codes, tooth number and surface information, billed, allowed and paid amounts associated with the claim, summary information, and error message listing. The DHHS-LOB approved explanation codes are applied based on claim adjudication, e.g., cutback, denied due to TPL coverage, adjustment/recoupment reason codes, etc. The remittance advices include weekly, monthly and annual year-to-date earnings information by program regarding the number of claims paid, denied, suspended, adjusted, in process, and financial transactions for the current payment period.

(40.8.1.270, 40.8.1.299)

Remittance statements contain information necessary for providers to resolve issues concerning the adjudication and payment of their claims. A remittance statement is created for each provider with activity in a payment cycle regardless of whether a check or EFT is produced for that provider. These processes also provide reports and data feeds related to Remittance Processing.

The Remittance Media Indicator is defaulted to "electronic" for all providers and is available for both inquiry and update via the Remit Media field on the Remit/Payment Control Page as illustrated above in **Exhibit D.1.4.14-3**.

The Remittance Sequence Indicator gives providers the option of choosing the order in which claims appear on their remittance statements. This indicator has a default setting of Claim Status followed by Client Id and Date of Service but can be changed to any of the following sort options: TCN, Client Id, and Date of Service. If the non-default sort option is used, the secondary sorts are by Claim Status followed by Client Id and Date of Service. The Remittance Sequence Indicator is updateable online using the Remit Seq field on the Remit/Payment Control Page.

Due to limitations in their computer systems, some providers cannot handle electronic remittances over a certain size. The Maximum Line Count contains the maximum number of lines that can be contained on an electronic remittance statement for a given provider. This field is updateable online via the "Max Remit Claim Ct" field on the Remit Payment Control Page and provides the Replacement MMIS the flexibility needed to control the size of electronic remittances. The Maximum Line Count is defaulted to the maximum value of 999,999,999 and is only lowered if specifically requested by a provider.

(40.8.1.301, 40.8.1.305)

Remittance Suppression

(40.8.1.301, 40.8.1.305, Comment CSC210) Our Financial Management and Accounting Subsystem will provide the capability to suppress generation of remittances in certain circumstances.

- The system also provides the ability to suppress the generation of check or EFT (both zero pay and pay) but allow the generation of the corresponding remittance for any provider or provider type.
- The system will also provide the ability to suppress the generation of remittances and their subsequent payment for a certain cycle.
- The system provides capability to suppress the print of a remittance advice when the only thing that is being printed is related to a credit balance
- At the State's option, a remittance can also be suppressed when it contains only pended claims that were input during the current payment cycle.

The Print Suspense Code can be updated online and can be used to set any of the selection criteria set forth above.

Exhibit D.1.4.14-4, Provider Payment History Page, illustrates how the user can view and maintain provider payment history. Detailed information is provided on a provider's payment, including remittance number, payment number, and payment type. Authorized users may stop, stop and reissue, void, or void and reissue a check, or stop, debit, hold or release an EFT. Users may capture notes on the history of a payment.

Pages D.1.4.14-20 through D.1.4.14-21 contain confidential information.

The EDMS enables authorized users to view cash receipts documents, including images of checks, money orders, electronic fund transfers and any support documentation. The cash receipts will be indexed by transaction to the appropriate business unit. The information will be retained throughout the life of the contract online. **(40.14.1.86, 40.14.1.88, 40.14.1.89, 40.14.1.90)**

(40.14.1.86, 40.14.1.88, 40.14.1.89, 40.14.1.90)

When a deposited check is received and cannot be associated with a specific receivable, the transaction will be processed by a receipts dispositioning team. We will assign a unique transaction control number, the date of the 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.

Applicable reporting will be defined during DDI to ensure accounting of all receipts and adjustments within the month of receipt. Audit trails will be maintained and provide before and after images of each transaction and any subsequent corrections. The system captures the user, date and time of each transaction. Please refer to our discussion below under the heading for Funds Received, section D.1.4.14.2.9, for additional discussion on cash receipt processing.

D.1.4.14.2.6 Accounts Payable

(40.14.1.19) **(40.14.1.19)** Team CSC will provide a financial component which addresses the specific accounts payable needs of North Carolina's DHHS multiple service programs. The Replacement MMIS supports general accounts payable functionality and enables:

- Interface and online screen access based on MMIS authorized user entities to provide initial and updated financial transactions and query capabilities
- The ability for DHHS to track each program's expenditures with analytical querying tools to perform "what ifs."
- Online reports that can be created as claims and financial processes are completed.

(40.14.1.28) **(40.14.1.28)** The Baseline System enables the processing of a State Payout Authorization Form with an authorized signature in the existing Accounts Payable functionality. The payable will be scheduled for payment processing as directed by DHHS LOB. The payable will have its own Financial Transaction Code and be managed according to DHHS LOB accounts payable policies and procedures. Reporting will be defined during the Requirements Analysis and Design Phases.

(40.14.1.31) **(40.14.1.31)** Our solution enables payable transactions for issuing non-provider specific payments. Adjustment to the financial reporting will be made, as appropriate, to the type of transaction. Allocation of these types of payments is made in accordance with DHHS-defined policy and procedures.

(40.14.1.21) **(40.14.1.21)** Our solution will provide the ability to process transactions for checks from outside systems establishing a Claims History record. This functionality can be easily added to Team CSC's baseline system by creating a new history record type which will capture the amount of the check generated by the outside system, along with the provider ID, date, and other relevant information to be stipulated by DHHS. We will work closely with DHHS during the DDI to be certain that the new class of history record captures all required data elements.

(40.8.1.311, 40.14.1.20) **(40.8.1.311, 40.14.1.20)** Based on DHHS-specified rules, the proposed Replacement MMIS will generate reports to identify providers with specific program credit balances and no claim activity, by program, within DHHS-specified periods.

(40.14.1.22) **(40.14.1.22)** Based on authorization rules, DHHS-users will be able to use the **NC***Tracks* Web portal to access financial information such as check vouchers and reconciliation data.

(40.14.1.23, 40.14.1.24, 40.14.1.26) **(40.14.1.23, 40.14.1.24, 40.14.1.26)** The payables function will include the ability for authorized users to perform online updates to DHHS-designated updateable fields, such as stop payment, canceling of transactions, funding sources, etc. The system captures before and after images of changes to data, and identifies the user making the change, date and time.

D.1.4.14.2.7 Accounts Receivable

Team CSC's baseline system provides a very comprehensive and function-rich Accounts Receivable module, which will greatly enhance the operational activities associated with establishing and tracking receivable transactions.

(40.14.1.35, 40.14.1.49) **(40.14.1.35, 40.14.1.49**) The Baseline system provides the 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). DHHS will also have the capability to control the portion of payments made against each account receivable, using DHHS-defined A/R financial codes.

(40.14.1.2) **(40.14.1.2)** In the Provider Accounts Receivable Process, there is no limitation on the number of accounts receivable a provider may have for any and all DHHS LOB's. The system is able to create an accounts receivable for transactions such as withholds, advance payments and recovery of advance payments by DHHS LOB by provider tax ID number and/or by a single provider number associated with a tax ID. The Baseline system currently assigns an entity number to each specific FEIN in the system. All claims for providers with the same FEIN are assigned the entity number for that FEIN. The entity number is used for security purposes so that the provider FEIN is not maintained on the claim record. The Baseline system uses the entity number to link all provider numbers together that are under the same FEIN. The Baseline Accounts Receivable process will be modified to use the entity number for all recoupment activity as defined in DDI.

The priority associated with a Financial Reason Code dictates the order in which money is recouped when a provider has multiple accounts receivables. Team CSC will apply available claims dollars as appropriate to each receivable and in accordance with DHHS LOB policy and procedures. For example, DHHS may required the provider paid dollars be applied to the one with the earliest effective date, or if there are multiple with the same establishment date, then the one with the highest dollar value may be recouped first. Team CSC will work with DHHS during the design and Development stage to fully define these hierarchies.

The Provider Accounts Receivable sub-process tracks and retrieves money owed by providers. The process supports three types of accounts receivable:

- **Negative Claim Accounts Receivable** — Contains negative balances resulting from claim activity.

- **Negative Retro Accounts Receivable** — Contains negative balances resulting from Retroactive Rate Adjustments.
- **Recoupment Accounts Receivables** — Contains balances resulting from Recoupment or Cash Advance fiscal transactions.

Following is a detailed description of these three types of accounts receivables:

Negative Claim Accounts Receivable

(40.14.1.35) **(40.14.1.35)** Negative Claim Accounts Receivables are used to track and collect negative balances brought about by claim activity such as adjustment or void processing. A Negative Claim Accounts Receivable balance is automatically established by the system when a provider's total claim amount is negative. A Negative Claims Accounts Receivable is established with a priority code defined by DHHS and an associated recoupment methodology.

The Financial Negative Claim Detail Page is used to view Negative Claims Accounts Receivable information. An override recoupment percentage or amount can be assigned by updating the Percentage or Installment fields located on this page.

Negative Retro Accounts Receivable

(40.14.1.35) **(40.14.1.35)** A Negative Retro Accounts Receivable is used to track and collect negative balances brought about by retroactive rate adjustments. During every cycle, a total retroactive amount is computed for every provider that has had retroactive rate adjustment activity. If the total retro amount is negative, the system automatically creates a Negative Retro Accounts Receivable and, in accordance with DHHS LOB rules, assigns the appropriate recoupment methodology and priority. The Financial Recoupment Detail Page is used to view a Negative Retro Accounts Receivable balance from a specific cycle. The Weekly Amount to Recoup, Weekly Percentage to Recoup, and Effective Date can be updated on this page by using the Installment, Percentage, and Effective Date fields.

Recoupments Accounts Receivable

(40.14.1.44) **(40.14.1.44)** Recoupment transactions may be established to recover advances to providers, garnishments, or other funds recoveries authorized by DHHS, ordered by a court, the NC Department of Revenue or US Internal Revenue Service. Recoupment Accounts Receivables are used to track and collect these types of balances. Recoupment accounts receivable balances are not system generated, they are entered online or via batch processed fiscal transactions.

The Financial Recoupment Detail Page is used to view Recoupment Accounts Receivable balances. The Weekly Amount to Recoup, Weekly Percentage to Recoup, and Effective Date can be updated from this page using the Installment, Percentage, and Effective Date fields.

Interest Accruals

The Accounts Receivable Process calculates, stores, and recoups interest for accounts receivable that contain Financial Reason Codes that are designated for interest accrual. A list of Financial Reason Codes eligible for interest accrual is maintained and available for online viewing.

The rate used for interest calculations is stored via a system parameter and can be updated from week to week using the System Parameter Search and System Parameter Detail

pages. The same rate is used for all accounts receivable interest calculations for a given cycle. Interest is calculated weekly based on the current balance of an accounts receivable.

Accounts Receivable Reporting

(40.14.1.36) **(40.14.1.36)** All current accounts receivable information is available online. Authorized users can use the Financial Accounts Receivable Search Results Page to search for accounts receivables. Once a specific accounts receivable has been selected, the user is automatically navigated to one of the following Pages depending on the Financial Reason Type Code assigned to that receivable:

- Financial Recoupment Detail Page
- Financial Negative Claim Detail
- Financial Payout Detail Page
- Financial Receipt Detail Page

In addition to online search capabilities, the system provides a number of standard reports that can easily be accessed by authorized users. The following reports and data feeds are generated both weekly and monthly providing both detail and summary information for accounts receivables:

- Accounts Receivable Detail Report
- Summary of Accounts Receivable by Reason Code Report
- Accounts Receivable Aging Report
- Provider Past Due Amounts Datafeed File

(40.14.1.39, 40.14.1.50, 40.14.1.12) **(40.14.1.39, 40.14.1.50, 40.14.1.12) (Comment CSC282)** Existing monthly reporting will provide notification to DHHS when an account receivable has reached one year of account inactivity. DHHS will be to access online Accounts Receivable web pages to make appropriate determinations as to whether individual balances should be subject to adjustment or write off. The Fiscal Agent Financial Team may also make recommendations to the DHHS based on stale accounts receivables indentified via standard system reports. Providers owing written-off receivables are flagged in the provider tables to prevent receipt of additional payments.

In accordance with CMS requirements, we will support the reduction of program expenditures associated with the accounts receivable function within 60 days of the date they are discovered. The advanced reporting capabilities discussed above will greatly facilitate attainment of this important objective.

Liens and Levies

(40.14.1.3) **(40.14.1.3)** The Baseline System has the capability to record and collect liens and levy assessments. In order to recognize these liens, we will establish an Accounts Receivable financial transaction which follows processing steps as outlined under Accounts Receivable discussion above.

Accounts Receivable Collection Letters

(40.14.1.37) **(40.14.1.37)** Through the Provider Notification Letter Process, the Replacement MMIS can automatically trigger the generation of provider notification letters. Provider notification letter templates are stored in the system and are identified by a unique Letter Code which is associated with each fiscal transaction. The presence of a letter code automatically generates a copy of the appropriate letter, which is printed and mailed to the

provider. In addition, the system provides the capability for Team CSC or DHHS staff to generate collection letters manually, based on a review of provider account activity.

State Controller Check Voucher Status Transactions

(40.8.1.280, 40.8.1.317) **(40.8.1.280, 40.8.1.317)** We will work with the State Controller's Office to establish policy and procedures for the development and management of transactions of check voucher status during the Requirements Analysis and Design Phase. Our early assessment of this requirement is that it can be accommodated in the Accounts Receivable functionality.

D.1.4.14.2.8 General Account Receivable/Accounts Payable Requirements

The Replacement MMIS will support transactions from any other program management or external entity interface permitted by DHHS LOB policy and procedures.

(40.14.1.95) **(40.14.1.95)** The system also provides the 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. Team CSC has reviewed DHHS Approved "AR-AP Requirements and Business Rules – Updated 12-19-06" to ascertain what the requirements will be for the proposed Replacement MMIS and DHHS case management software integration. Our architectural solution and software applications already satisfy many of these requirements, reducing customization requirements.

D.1.4.14.2.9 Funds Received

(40.14.1.42) **(40.14.1.42)** Our Replacement MMIS will have the capability to receive and process cash receipts arising from a number of different sources:

- Provider
- Carrier
- Recipient
- Drug manufacturer

These incoming funds can result in claim-specific and gross recoveries, regardless of submitter. Our system provides the capability to apply gross recoveries to providers or recipients as identified.

Funds Received from Providers

Provider Funds received transactions are used to enter payments that are received from providers into the system. These payments can originate in the form of a personal check or a returned system check. Funds received transactions are entered online via the Funds Received Detail Page as shown in **Exhibit D.1.4.14-6,** or enter Ibis workflow from the bank lock box vendor's daily cash receipt transaction file. During DDI we will work with DHHS to configure rules for application of payments via automation.

The Financial Receipt Disposition Page, as illustrated in **Exhibit D.1.4.14-7**, may be used to disperse existing funds received balances. The Financial Reason Code Page is used for inquiry and for updating the descriptions, type, priority, and indicators associated with a Financial Reason Code.

Once in the system, the Financial Receipt Disposition Page **(Exhibit D.1.4.14-7)**, can be used to disposition the balance in a number of different ways. These include refunding the

Pages D.1.4.14-27 through D.1.4.14-28 contain confidential information.

Fiscal transactions are used, but not limited to, the controlling of refunds, recoupments, liens/levies, withholds, advance payments, advance payment recoveries, receivable corrections, sanctions, and claim specific and non-claim specific recoveries. The system provides online access to summary-level provider accounts receivable and payable data as previously described and pending recoupment amounts that are automatically updated after each claims payment cycle with summary level data consisting of week-to-date, month-to-date, year-to-date, State and Federal fiscal year-to-date totals. This includes updating of the Claims History and Provider paid claims summary. **(40.8.1.205, 40.8.1.269, 40.8.1.275, 40.8.1.308, 40.14.1.16, 40.14.1.33, 40.14.1.34, 40.14.1.73)**

(40.8.1.205, 40.8.1.269, 40.8.1.275, 40.8.1.308, 40.14.1.16, 40.14.1.33, 40.14.1.34, 40.14.1.73)

Authorized users may add new fiscal transactions by choosing the appropriate transaction type and selecting the “Add” button on the Financial Accounts Receivable Search Results Page. Existing accounts receivables can be reversed or closed out by simply assigning them a zero balance. In order to ensure the highest level of security over fiscal transactions, the number of users authorized to perform these functions will be kept to a minimum. **(40.8.1.309)**

(40.8.1.309)

(40.14.1.64) The system supports the capability to prepare fiduciary statements in accordance with GAAP to account for all program funds received and disbursed by Team CSC.

(40.14.1.64)

D.1.4.14.2.11 Recoupments

Recoupment transactions are used to collect money that a provider owes to DHHS by creating an accounts receivable in the amount to be recovered. An accounts receivable is used to track and retrieve money owed to any of the DHHS LOBs. Recoupments of a receivable can be established by percentage, dollar amount or total amount during one (1) payment cycle. **(40.8.1.258)**

(40.8.1.258)

Every recoupment transaction is identified by a Financial Reason Code, which indicates the type of transaction, total amount of dollars per check and the priority associated with it such as receivable/recoupment for provider services dated after a recipient’s death, IRS penalty withholds, advance payments, TPL recoveries, drug rebate, medical refunds, sanctions, FADs recoveries, write-offs, overpaid or claims paid in error, and other program overpayments. The amount indicated on the transaction is the amount that needs to be recouped by the appropriate LOB. The system also manages cash receipts as described in Section D.1.4.14.2.5, Cash Control and Bank Accounts. **(40.8.1.210, 40.8.1.215, 40.8.1.255, , 40.8.1.256, 40.8.1.265, 40.8.1.321, 40.8.1.322, 40.8.1.323, 40.8.1.324, 40.8.1.325, 40.14.1.2, 40.14.1.5, 40.14.1.7, 40.14.1.43, 40.14.1.38, 40.14.1.40, 40.14.1.44, 40.14.1.45, 40.14.1.46, 40.14.1.48, 40.14.1.51)**

(40.8.1.210, 40.8.1.215, 40.8.1.255, 40.8.1.256, 40.8.1.265, 40.8.1.321, 40.8.1.322, 40.8.1.323, 40.8.1.324, 40.8.1.325, 40.14.1.2, 40.14.1.5, 40.14.1.7, 40.14.1.43, 40.14.1.38, 40.14.1.40, 40.14.1.44, 40.14.1.45, 40.14.1.46, 40.14.1.48, 40.14.1.51)

(40.14.1.10) The Financial Management and Accounting Subsystem will provide the capability to set up multiple open accounts receivable items including provider sanctions for recoupment against provider claims payable in the financial system, subject to a hierarchy table. The financial system provides the capability to deduct or add appropriate amounts and/or percentages from processed payments, regardless of origin of the transaction, with online and inquiry access as previously discussed. The system can withhold the money from provider claims payable for all receivable items meeting recoupment criteria until the provider payable balance for all receivables has been fully recouped.

(40.14.1.10)

A user can specify an amount or percentage of approved current cycle claims to recoup each week that is related to that specific accounts receivable or let the system use the Default Percentage to Recoup, which is associated with the Financial Reason Code itself. The amount or percentage indicated is then taken from the provider's current claim payment total each cycle and applied to the accounts receivable balance until the balance is paid off. If there are multiple receivables, the recoupment can be applied to those receivables as well. This can be established on a hierarchy based on fund codes or recoupment types as approved by DHHS. The function allows recoupment processing without specifying a LOB credit balance. Overpayment recoupment transactions will be linked to the original claim. The provider may also submit payment by check or use a combination of payment mechanisms.

(40.14.1.47) **(40.14.1.47)** As system-generated payments are posted to the receivable, required fields will be completed indicating the Remittance Advice data, number and amount. Manual payment entries as a result of a provider check will also require date of receipt, check number and provider number. This information is available online through **NC***Tracks* to authorized users.

(40.8.1.251) **(40.8.1.251) (Comment CSC207)** Often, it is necessary to prevent claim payments to providers under varying conditions. Some of these payments, either for the checkwrite total or for a specific claim need to be withheld in full while others are only partially withheld. In all cases, a claim's payment(s) can be held for a period of time to be specified by DHHS.

The Baseline system currently supports a post adjudication pend process enabling authorized users to enter specific criteria, resulting in the suspension of claims satisying one of more conditions during weekly Financial processing. These pended claims are held until they are either released for re-adjudication or denied by the authorized user.

As an alternative means, DHHS can also create an accounts receivable using a Financial Reason Code with a Special Processing Code setting of "Automatic." Financial Reason Codes with a Special Processing Code value of "Automatic" are required to contain a zero balance but will recoup the desired amount or percentage from the provider's claim pay each week. This special type of recoupment gives DHHS great flexibility in collecting payments and does not create auditing issues by inflating accounts receivables balances.

(40.14.1.29) **(40.14.1.29)** The Replacement MMIS will manage the Cost Settlement transactions that may include disbursement of tentative, final, or other funds to provides upon State request, recoupment of receivable dollars, or receipt and dispositioning of cash receipts. We will establish appropriate payable/receivable financial transactions as previously discussed in the related sections of this document. All DHHS LOB and DMA Audit Section required reporting will be defined and developed during DDI.

(40.8.1.216, 40.8.1.373, 40.8.1.374, 40.8.1.375, 40.8.1.376, 40.8.1.377, 40.8.1.378, 40.14.1.53, 40.14.1.54, 40.14.1.55, 40.14.1.56)

D.1.4.14.2.12 Recipient Functionality

Recipient Premium Payments

(40.8.1.216, 40.8.1.373, 40.8.1.374, 40.8.1.375, 40.8.1.376, 40.8.1.377, 40.8.1.378, 40.14.1.53, 40.14.1.54, 40.14.1.55, 40.14.1.56) Our Baseline System will be enhanced to support recipient premium invoicing, collections, notices of non-payment as well as recipient premium receipts and refund processing and cancellation notices when appropriate. The Baseline System already supports this functionality, including system-

generated correspondence in required recipient languages and associated accounts payable/accounts receivable transactions.

Cost Sharing

(40.14.1.57, 40.14.1.58, 40.14.1.59, 40.8.1.378)

(40.14.1.57, 40.14.1.58, 40.14.1.59, 40.8.1.378) Our Baseline System supports cost sharing, co-insurance deductibles and co-pay requirements during claims adjudication for recipient services. The system ensures that each recipient's cost sharing does not exceed the threshold for the family group. This is managed within the system, and is monitored using system reporting. In the event the threshold is exceeded, manual adjustments approved by the authorizing entity can be made to correct the excess. This process will be reviewed with DHHS during the General and Detailed Design phases to ensure all North Carolina criteria are met.

EOB Processing and Ad hoc Messages

Team CSC's Replacement MMIS incorporates full capabilities for generating Explanation of Medical Benefits (EOB's) by LOB. These statements are normally prepared and mailed to recipients as confirmation of services rendered by providers who have billed the system for medical treatment. Team CSC's baseline system provides all of the processing needed to prepare these statements on a recurring basis. Depending on the needs of each specific payer or benefit program, the system can generate these statements using a statistical sampling procedure to send them to a subset of recipients during a particular month or other time period, or they can be generated on a 100% basis if the LOB has such a requirement. The EOB processing module includes the ability to generate free form recipient messages in a manner similar to the creation of messages for provider Remittance Advices described earlier. **(40.8.1.237)**

(40.8.1.237)

(40.8.1.381, 40.14.1.60)

(40.8.1.381, 40.14.1.60) Our Baseline System produces recipient communications, i.e., letters and notices based on line of business, in the recipient's preferred language as indicated from the Eligibility Information System file and maintained in the Recipient Subsystem. Team CSC will work with DHHS during the DDI to develop standard letter formats.

Recipient Explanation of Benefits

(40.8.1.231, 40.8.1.232)

(40.8.1.231, 40.8.1.232) The Baseline system provides the capability to produce beneficiary Recipient Explanation of Medicaid Benefits (REOMBs) and Recipient Explanation of Benefits by LOB. These can be produced in the recipient's preferred language or as designated by the State during the DDI phase.

D.1.4.14.2.13 1099 and Related Reporting

(40.14.1.80, 40.14.1.81, 40.14.1.82, 40.14.1.83)

(40.14.1.80, 40.14.1.81, 40.14.1.82, 40.14.1.83) The 1099 Claim Amount is the financial year-to-date accumulation of total monies received by a provider and reportable as earned revenue to the IRS and the North Carolina Department of Revenue. The 1099 reporting includes all providers who meet IRS criteria for issuance, including receipt of payments in excess of the IRS minimum annual payment threshold for 1099 generation. This threshold, currently set to $600, can be easily updated in the Financial Subsystem should the IRS elect to change the threshold at some future date. Our Baseline System is able to provide 1099's based on the specific line of business, reflecting the value of processed claims or other payment data including appropriate financial adjustments and related transactions.

Re-issued and manual checks are not added to the 1099 Claim Amount because they are replacing payments that have already been sent to the provider.

The 1099 information is updated after each processing cycle, and displayed on the lower portion of the Payment Summary page as shown at **Exhibit D.1.4.14-8**.

When appropriate, the 1099 Claim Amount for each provider can be adjusted to reflect nonclaim or lump sum payments, based on restricted entry by authorized users.

In addition to the 1099 Adjustment, every provider also has a Suppress 1099 Indicator. This indicator is used to control the creation of the provider's end of year 1099 and is available for online inquiry and update using the Remit/Payment Control Page as illustrated in **Exhibit D.1.4.14-3**. The 1099 is not generated for a provider if their Suppress 1099 Indicator is set. The Suppress 1099 Indicator is initially turned off for all providers.

It should be noted that providers are informed of their cumulative 1099 amount at the close of each processing cycle, as the 1099 value is included as a reported item on each Remittance Advice issued during the year.

Page D.1.4.14-33 contains confidential information.

specifications, including such items as date incurred, penalty assessed, collection approach, dollars collected per checkwrite period and completion data. A system-generated letter will be issued to the provider when the payment penalty is satisfied and a new 1099 will be issued with the corrected information.

All related correspondence is imaged and maintained in the EDMS and is accessible to authorized users. The correspondence will be maintained to ensure compliance with IRS procedures and to provide an audit trail of all activity relating to the B Notice issue.

D.1.4.14.2.14 NCAS and Data Warehouse Interface

NCAS Interface

(40.8.1.246, 40.14.1.13, 40.14.1.17)

(40.8.1.246, 40.14.1.13, 40.14.1.17, Comment CSC-267) We will provide an interface to North Carolina's Accounting System (NCAS) that will enable exchanges of data between NCAS and Team CSC. Through this interface, the Replacement MMIS will be able to retrieve budget and available balance data from NCAS. Procedures will be established to enable alerting of the appropriate DHHS LOBs when available funding is not sufficient for LOB checkwrite requirements. In addition, we will be able to provide NCAS with details of the checkwrite process, as well as other accounts payable/receivable data using this interface. Our current assessment of the interface requirements is that our Baseline functionality supports the data exchange requirements for both directions, however, if changes are determined during the DDI Phase, CSC is prepared to make the necessary modifications.

(40.14.1.18)

DMH Client Data Warehouse Extract

(40.14.1.18, Comment CSC280) Team CSC will provide a DMH extract for the Data Warehouse by using a DB2 database unload utility. This utility requires the input of the specific tables and columns needed for the extract. We will refine the DMH Client Data Warehouse Extract specifications during DDI and develop the extract and interface accordingly.

D.1.4.14.2.15 Financial Accounting and Reporting Requirements

Team CSC's baseline Financial subsystem includes a wide range of reporting to support processing activities, and to offer current information on claims expenditures, accounts receivable, and other important financial results.

(40.14.1.65)

(40.14.1.65) The GL Budget Balance Report is produced weekly and provides both detail and summary information for General Ledger Codes and Appropriation Codes to correspond to the checkwrites over the State's fiscal year including adjusted account balances that are incurred between the last June checkwrite and June 30th. This approach also supports the development of DHHS' general expenditure reports for each LOB on a year-to-date basis and within ten (10) days of the State's fiscal year end on June 30th.

(40.14.1.68, 40.14.1.72)

(40.14.1.68, 40.14.1.72) The reports are cross-checked against other Replacement MMIS reporting to ensure they balance to other reports using the same information. The system will generate all program reporting required on a weekly, monthly, quarterly an annual basis in accordance to DHHS specifications, basis of accounting and reporting due dates.

(40.14.1.8, 40.14.1.9)

(40.14.1.8, 40.14.1.9) The MARS share process provides computation of financial participation for each government entity, i.e., county, State and Federal and any other entities designated by DHHS. It should be noted that assignment of financial participation

shares is very precise and accurate, allocating shares not only to the specific federal grant or other funding source, but also to the specific grant year during which the liability was incurred. Reporting to CMS and the State is produced accurately and on time and in accordance with the DHHS-designated schedule, media and format. Please refer to Section D.1.4.13 MARS Subsystem Requirements for our approach to this process. **(SOO 10.12.6-8)**

(10.12.6-8)

(40.8.1.328, 40.8.1.329, 40.8.1.241)

(40.8.1.328, 40.8.1.329, 40.8.1.241) The base Replacement MMIS produces all required LOB balanced-checkwrite reporting, tying all provider financial transactions to the appropriate LOB provider history. In addition, the system generates appropriate balancing reports by LOB for weekly, monthly, quarterly and annual financial reporting. The financial reporting is produced in accordance with each DHHS LOB policy, procedures, frequency, and media following the checkwrite.

D.1.4.14.2.16 Additional Functionality for Financial Management

In presenting the unique advantages of our Financial Management and Accounting Subsystem, we have deliberately highlighted certain topics where our solution closely matches the unique needs of the North Carolina multi-payer environment. We would like to underscore the fact that our solution is also comprehensive, and provides all of the functionality that the RFP requires. Team CSC's offers a most efficient support for all the Financial Management activities required by DHHS. The following section describes these additional functionalities that our system will provide:

(40.14.1.74)

External Authorized DHHS System Data for Accounting and Record Keeping
(40.14.1.74) Team CSC will work with DHHS and the Replacement MMIS payer entities to define data accounting and record keeping requirements during the Requirements Analysis phase, including the ability to incorporate data from State-approved automated systems. Processes and sub-processes to support these requirements will be identified and incorporated into the customization tasks during DDI.

(40.14.1.4)

Retroactive Financial Transactions
(40.14.1.4) The system enables processing retroactive changes to deductible, TPL retroactive changes, and retroactive changes to program codes (such as State-funded to Title XIX). Daily detailed and summary reporting will enable us to monitor the integrity of the changes. **We will work with DHHS to establish procedures to ensure the appropriate management of this requirement.**

(40.14.1.63)

Fund Years/Sources
(40.14.1.63) Claims and other financial transactions are assigned to Federal and State fund years and funding sources in accordance with DHHS designated rules and end-period dates that are programmed into the system. Established reporting and ad hoc querying can provide DHHS LOBs with information regarding to program expenditures within specified time periods.

(40.8.1.327)

Change Transactions
(40.8.1.327) The Replacement MMIS can apply any change transactions received for corrections to checks by each LOB. Accounts payable and receivable policy and procedures are applied to these types of transactions in accordance with DHHS-approved rules.

Payment Error Processing

If a claim is determined to have been paid at the wrong payment amount, the system's adjustment and void functionality enables an adjustment to the original claim. In many cases, adjustment/void transactions are submitted by providers using the same input path they use for original claims. In other cases, we prepare voids or adjustments using a process called "special input processing." Special inputs are often adjustments to large numbers of claims that experienced a common error or other submission problem.

For all adjustments, the original claim remains in claims history as is. The system creates a new copy of the original claim called the adjustment. The adjustment reflects the new payment. Please refer to Section D.1.4.8 Claims Processing Subsystem for additional discussion on Special Input Processing.

Financial Transaction and Summary Reporting

(40.14.1.61, 40.14.1.71)

(40.14.1.61, 40.14.1.71) Our Baseline System includes automated cycle balancing functions to verify that claim counts and dollar amounts remain in balance throughout the claims payment processing cycles and that the cumulative results of each of the daily claims adjudication cycles balances with the payment cycle results. Financial transactions outside claims adjudication are cycled during the payment processing function to produce "net" results. Reports are generated to provide an audit trail of claims and other financial transactions passing throughout the payment cycle. These reports are used to investigate and reconcile any variances that may be detected by the automated processing. Month-end checkwrite reporting is provided via interface files and DHHS user-defined reporting. All financial reporting ties back to the individual provider history.

Recipient Profiles

(40.8.1.331, 40.8.1.332)

(40.8.1.331, 40.8.1.332) The base Replacement MMIS supports online and/or ad hoc requests/reporting for authorized users to retrieve paid claim data, buy-in payment and adjustment, or any other LOB recipient profile reporting as the information is retrievable from the system database.

Provider Audits by LOB

(40.8.1.238)

(40.8.1.238, Comment CSC134) The system supports ad hoc querying tools that can be used to extract data to produce statistically valid sampling reports that may be required for provider audits by LOB. These same reports can be developed as a standard report and issued in a frequency and media as required by the LOB.

Participation Rate Tables

(40.14.1.1)

(40.14.1.1) Team CSC will review the approach for updating the Financial Participation Rate Tables used for services provided by DMA, DMH, DPH, and the Migrant Health Program during the General and Detailed Designed Phases. We will perform this task at a DHHS required frequency.

Financial Related Issues Call Tracking

(40.8.1.281, 40.14.1.15)

(40.8.1.281, 40.14.1.15) Team CSC has provided a description of our Customer Call Center our Client Services Operation section. Our Financial business unit has access to the tracking functionality to enter call information as a result of calls with providers or other DHHS call-logging customer requirements. Critical call details can be entered in the tracking screen notes field.

Accounting Processes

(40.8.1.226, 40.8.1.284) **(40.8.1.226, 40.8.1.284)** Our Baseline System supports a consolidated accounting function for each payer's program, type, and provider as required by the RFP. During the DDI we will obtain the information requirements from each entity that supports all transaction activity and status for the time period the consolidated reporting is generated.

(40.14.1.94) **(40.14.1.94)** Team CSC has reviewed DHHS "Approved MAS Requirements and Business Rules — Updated 12-6-06" to assess the requirements for interfacing the Medicaid Accounting System to our proposed Replacement MMIS. Our Replacement MMIS will provide the capability for integration of all Medicaid Accounting System(MAS) legacy system functionality, processes, data, reports and interfaces. We are confident that the architectural solution and software applications will support a smooth integration, and Team CSC will work with DHHS to define the detailed specifications required to support this effort during DDI. **(SOO 10.12.6-3)** (10.12.6-3)

(40.8.1.259, 40.8.1.260, 40.8.1.283, 40.8.1.294) **(40.8.1.259, 40.8.1.260, 40.8.1.283, 40.8.1.294)** The Financial Management and Accounting Subsystem processes all claims, credits, adjustments (increases/decreases), recipient deductibles and patient monthly liability based on claim type or specific claims, voids, and fiscal transactions through the final payment process, producing provider checks and electronic fund transfer (EFT) transactions and accompanying remittance advice statements. The system has update capability and produces a system-generated log that tracks all change requests displaying relevant information in appropriate data fields.

With the implementation of the CMS 60 Day Refund Rule, Team CSC enhanced the system reporting to capture reporting data for provider overpayments based on program external recoveries or payment errors. Report data is displayed to include all of the necessary information that establishes the overpayment based on DHHS-approved criteria, e.g., third party liability identification, third party payments, coordination of benefits, drug rebate recoveries, system payment errors and so forth. From the time the overpayment is identified in the daily reporting, the "clock" begins and operational tasks are initiated to complete validation of the overpayment, notification to the provider, establishing an account receivable financial transaction within the MMIS to recoup the dollars and to ensure that the overpayment dollars are refunded to CMS as reflected on the CMS 64 report.

The Financial Subsystem accepts both batch and online entered fiscal transactions that are applied to provider accounts receivables and calculates provider payments according to DHHS-approved payment source hierarchy. The system accepts and processes both automated and manually entered updates.

(40.8.1.24) **(40.8.1.24)** The Replacement MMIS 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

(40.8.1.245, 40.8.1.244) **(40.8.1.245, 40.8.1.244)** Our solution can accommodate the withholding of adjudicated claims from the payment cycle based on payment source, and can also combine POS and MMIS claims payment processing cycles

Capitation Payments

(40.8.1.263, 40.8.1.264, 40.8.1.285, 40.8.1.286) **(40.8.1.263, 40.8.1.264, 40.8.1.285, 40.8.1.286)** The Baseline System supports capitation payment functionality that includes the ability to apply a set amount or percentage to the withhold against the capitation payment. The system will allow such withholding for

providers not submitting their encounters to the system and also for providers with high error rates in the data. It will also enable release of the withhold when the withhold has been satisfied or as directed by the appropriate DHHS LOB.

Provider Incentives

(40.8.1.266) **(40.8.1.266)** Working with DHS during the Requirements Analysis and Design Phases, Team CSC will modify the base Replacement MMIS to accommodate the ability to apply management incentives to specific management fee claims.

Encounter Processing

(40.8.1.291, 40.8.1.292) **(40.8.1.291, 40.8.1.292) The Baseline System currently processes over 25 million managed care encounter transactions a year**. Encounter data is submitted by managed care entities using submission methodologies similar to those used for rate-based and fee-for-service claims. Encounters are input into the Claims Subsystem, and are subjected to numerous data validity and master file edits/audits that result in approved, pended, or denied status and are reported accordingly.

Encounters are listed on the Remittance Advice reflecting the appropriate status. Encounters that are listed with an approved status do not receive any reimbursement, as the services are covered under the provider's capitation fees. An output extract of encounter data (Encounter Remittance Advice) will be developed in accordance with DHHS LOB specifications during the Requirements Analysis and Design Phases.

(40.14.1.14) **(40.14.1.14, Comment CSC268)** Our Baseline system provides the capability to initiate State-approved special timely filing edits in accordance with DHHS policy as it relates to the State's fiscal year end. The Baseline system allows the use of table updateable system parameters to override existing edits such as timely filing edits to provide for exception processing. Related reporting will be generated in accordance with DHHS specifications.

Pharmacist Professional Fee

(40.8.1.293) **(40.8.1.293)** At DHHS direction, we will create an output extract to accommodate Pharmacist Professional Fees on the Pharmacy Remittance Advice. When the processing is complete and the provider payment data is updated, users can access the payment history using appropriate search criteria.

Retroactive Changes to Deductibles

(40.8.1.274) **(40.8.1.274)** Through the Mass Adjustment functionality in the base Replacement MMIS, Team CSC can support retroactive changes to deductibles and if appropriate, system-generated adjustments of those claims affected by the adjustment. Adjustment processing is discussed in Section D.1.4.8 Claims Processing Subsystem Requirements.

Drug Rebate Procedures

(40.8.1.199, 40.8.1.211, 40.8.1.268) **(40.8.1.199, 40.8.1.211, 40.8.1.268)** The Replacement MMIS provides the ability to capture rebateable NDCs for all pharmaceuticals administered in the DHHS Program, including those drugs administered with HCPCS codes that are submitted on professional and institutional claims. Drug rebate recoveries are applied to the appropriate claim detail lines. Please refer to Section D.1.4.12 Drug Rebate Subsystem for additional discussion.

Team CSC Administrative Billing

(40.14.1.70) **(40.14.1.70)** We will provide accurate, easy to comprehend administrative billing statements, supported by source documents that provides a complete audit trail. These source documents will be retained and made available for DHHS to review in order to ascertain the validity of fiscal agent billings. We also have developed an automated reporting function for the itemization of approved-administrative costs incurred for the management of our MMIS clients. Administrative billings will be tailored for the North Carolina Replacement MMIS to ensure DHHS receives maximum Federal Financial Participation (FFP) as it relates to our services. Team CSC will provide accurate monthly invoices to NC DHHS reflecting services performed and detailing individual cost by DHHS payer, program, and budget code reflecting any Federal Financial Participation (FFP) splits.

(10.12.1-27) **(SOO 10.12.1-27)**

Deficit Reduction Act of 2005 (DRA)

CSC's financial reporting capabilities include the identification of providers who have received a minimum of $5 million in Medicaid claims reimbursement , individually or by group Tax-Id, or as defined by the State. This report will be the impetus for the September 30th annual notification to Medicaid providers advising of the amount paid to them and requesting the return of an executed Letter of Attestation.

The notification letter can be generated through mass email and/or hardcopy mailings. A provider's response can be returned either via email, fax/hardcopy or over the provider web portal. Hardcopy and electronic images will enter through our electronic data management system where a workflow process is invoked to update the annual notification status provider indicator housed in the Provider Master Database. Our proposed process includes electronic signature and the development of action codes which may require modifying the system depending on whether they are the trigger for suspending a provider until the Attestation has been received. Our approach will be thoroughly reviewed with the State during DDI and implemented in accordance with the approved State decisions**.**

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Pages D.1.5-1 through D.1.5-3 contain confidential information.

Pages D.1.6-1 through D.1.6-7 contain confidential information.

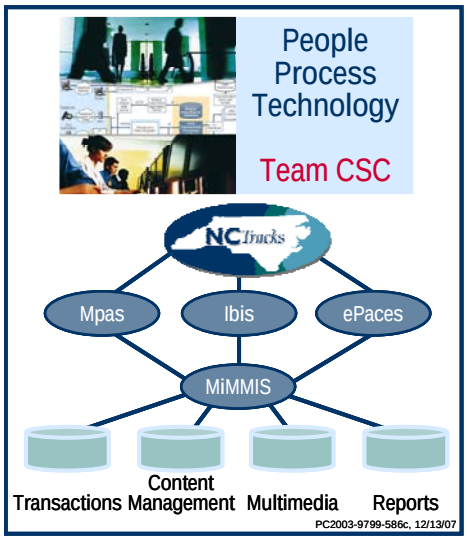
Pages D.1.7-1 through D.1.7-6 contain confidential information.

Pages D.1.8-1 through D.1.8-9 contain confidential information.

D.1.9 WORK SITES FOR DDI PHASE

We selected our DDI work sites to permit easy, personal interaction with the State and to minimize single points of failure.

Team CSC understands the importance of having our operational facility within the prescribed 15 mile radius of the North Carolina DHHS facilities to facilitate communications with the DHHS staff and foster the long-term relationships necessary to accomplish the task of developing, designing, and implementing the Replacement MMIS successfully.



During the DDI phase of the project it is critically important that the Team CSC subject matter experts (SMEs) and technicians as well as the North Carolina DHHS technical and functional staff have a close working relationship. We believe that such a relationship is facilitated when we are in a location convenient to you. **(50.2.4.1.1, 40.1.2.1)**

(50.2.4.1.1, 40.1.2.1)

Our initial work site for development and Fiscal Agent operations of the Replacement MMIS will be at one of our CSC locations within the required 15 miles radius of the Dorothea Dix Campus facilities**.** Depending on timing, we may remain in that facility and expand our space as we transition into the Operations phase, or relocate to another permanent facility, where we will remain for the duration of the contract. **(SOO 10.10-11)**

(10.10-11)

Our DDI Facility Approach
We selected our work locations with two objectives in mind: First to provide easy access by DHHS staff and second to maximize use of existing facilities to minimize cost and risk.

Team CSC's primary worksite will house the following functions:

(40.1.2.3) • Fiscal Agent local facility (DDI and Operations phases) **(40.1.2.3)**

(40.1.2.4) • Fiscal Agent Key Personnel (DDI and Operations phases) **(40.1.2.4)**

(40.1.2.4) • Fiscal Agent Business Units (DDI and Operations phases) **(40.1.2.4)**

(40.1.2.4) • Fiscal Agent Mailroom (DDI and Operations phases) **(40.1.2.4)**

- Software development activities, Design, Systems Integration Testing (SIT), User Build Acceptance Testing (UBAT), Production Simulation Testing (PST), and User Acceptance Testing (UAT) will be conducted in the dedicated test facility in our North Carolina operations building
- Software maintenance activities (Operations phase)
- Data and Imaging Center (DDI and Operations phases)
- Storage of physical Medicaid files (DDI and Operations phases)

(10.10-12) • Requirements analysis staff **(SOO 10.10-12)**

Some limited activities will be conducted at other locations:

- During the DDI phase of the contract limited software design and development will be accomplished in NY
- Our primary Data Center will be in our New York Medicaid Operations Center
- Limited network operations
- Disaster recovery operations
- Network Operations Center

During the DDI phase, we will use some subject matter experts and developers located in our Albany, NY facility to ensure that you have true experts in the CSC baseline system to support the project. Overall, more than 85% of our Fiscal Agent Operations and software maintenance workforce will be physically located in our North Carolina facility.

Our New York Medicaid Operations Center will serve as the primary computing facility and will support a portion of the network operations. By taking advantage of in-place New York resources we are able to reduce your total cost of ownership (TCO) and offer the systems reliability enjoyed by our eMedNY customer.

During requirements analysis, we will provide remote access to the baseline system for all State and Fiscal Agent team members. **(SOO 10.9-8)**

(10.9-8)

Exhibit D.1.9-1 provides a more detailed listing of where our functions supporting the Replacement MMIS will be located.

Function	Location
Adjustment Processing	Raleigh
Bulk printing of checks, remits, EOMB, letters	Albany
Claim Medical Review	Raleigh
Claims Processing	Raleigh
Claims Resolution	Raleigh
Clinical Services	Raleigh
Complex System Resolution	Raleigh
Contact Center	Raleigh
Data Center Operations	Albany
Data and Imaging Center	Raleigh
Distribution	Raleigh
Electronic Claims Intake	Albany Data Center
Enrollment	Raleigh
Financial Management	Raleigh
Fiscal Agent Business Units	Raleigh
Fiscal Agent Key Personnel	Raleigh
Fiscal Agent Local Facility	Raleigh
Fiscal Agent Mailroom	Raleigh
Health Program Services	Raleigh
IT Services	Raleigh
Managed Care	Raleigh
Medical Director	Raleigh
Medical Policy Support	Raleigh
Network Operations Center	Marlton, NJ
OCI Compliance	Raleigh
On-demand/low volume printing of checks & letters	Raleigh
Outreach/Training	Raleigh
Paper Intake	Raleigh
PMO	Raleigh
Provider Services	Raleigh
Quality Assurance	Raleigh
Security	Raleigh
Simple System Resolution	Albany Data Center
Software Development	Raleigh
Software Maintenance	Raleigh
Technical Services	Raleigh
Utilization Management	Raleigh

9799-08-999

Exhibit D.1.9-1 Team CSC Support Locations. *Team CSC's support to Replacement MMIS is centered in North Carolina.*

D.1.9.1 CSC Team North Carolina Facility

Team CSC's Raleigh, North Carolina facility will have ample room for DDI activities, work space for the State and large meeting facilities. Additional space will be acquired as needed. **(SOO 10.10-13)**

(10.10-13)

Establishing the Team CSC Program Management Office will be our first priority after contract award. We will begin by locating all key personnel assigned to the North Carolina Replacement MMIS effort, in space dedicated to the contract. Our facility will have all necessary office space, conference rooms, training room, and an

area for the IT and communications equipment that will be supporting the Program Management Office. Our NC operations will also house our Systems Architects, Senior Software Engineers, and Business Analysts. **During the DDI Phase specifically, Team CSC recognizes that there will be multiple meetings to define the requirements, design and develop the software, and conduct meetings with the State, therefore, we will ensure that there are sufficient conference rooms and training facilities during this critical phase to facilitate the requirements. In addition, space will also be provided in the initial allocation for the three State employees as requested.** We will include space identified above in the planning for the size and location of the initial DDI Phase Facility. (**40.1.2.5)**

(40.1.2.5)

Our North Carolina facility will comply with the facility requirements for State employees stated in the RFP to provide Carolina private office space for three (3) state employees (see **Exhibit D.1.9.1-1**). Team CSC will also provide assistance and access to operations, information, and data set elements necessary. The office space will include: secure, private, appropriately securable desks and file cabinets. Team CSC will provide IBM-compatible PCs, monitors, and printers with appropriate connection to the contractor's WAN/LAN for Internet and email services. Telephone service as well as office supplies will also be provided. Team CSC will, for the length of the contract, provide and maintain all equipment as well as upgrade both equipment and software for State employees operating at our site. We will also provide copier, scanner, and fax services to State employees operating at our location. (**40.1.2.5, 40.1.2.6, 40.1.2.7-8, 40.1.2.9, SOO 10.9-25)**

Exhibit D.1.9.1-1. Team CSC's Raleigh Offices. *Locating near Dorothea Dix Campus Promotes Partnership.*

(40.1.2.5 – 9, 10.9-25)

The NC facility will be expanded and/or augmented to fully support the Operations Phase approximately 6 months prior to Implementation. As the Operations Phase begins, those functions no longer required to be performed in our NY facility will be reduced and transferred to North Carolina. Only personnel necessary for the operations of the primary processing facility or for base system expertise in support of the North Carolina staff will remain located in the NY Operations Center.

D.1.9.2 Conclusion

We will operate our facilities in accordance with North Carolina's specific requirements and in accordance with all appropriate local, State, and Federal regulations. In preparing and operating our work locations, **Team CSC will ensure that all facilities documentation is in order should auditors from DHHS or the Federal Government request to review any applicable permits, blueprints/floor plans, and leases. We will also ensure that all build-outs and renovations meet DHHS requirements.** We realize that DHHS may also perform onsite inspections to monitor renovation, expansion, or construction progress. **Team CSC will consult DHHS if there are any changes in regard to the facilities approach or plans during the implementation. In addition, we will ensure that the design for our**

operational workplace meets DHHS requirements regarding access and security for certain functional areas such as program integrity. We will take into account the confidential storage of Medicaid files and records when considering facility options.

(40.1.2.2)

As we transition into the Fiscal Agent (Operations Phase), Team CSC understands that we shall perform all operations, systems maintenance, and modifications and other work performed under this contract at locations prior-approved by DHHS. (40.1.2.2)

Pages D.1.10-1 through D.1.10-21 contain confidential information.

Pages D.1.11-1 through D.1.11-2 contain confidential information.

Pages D.1.12-1 through D.1.12-9 contain confidential information.

Pages D.1.13-1 through D.1.13-3 contain confidential information.

North Carolina Replacement Medicaid Management Information System (MMIS)

RFP Number: 30-DHHS-1228-08

Prepared for:
North Carolina Department of Health and Human Services

Office of Medicaid Management Information System Services

Prepared by:
Computer Sciences Corporation

30 May 2008
Volume I — Technical Proposal

Book 2 of 4
Sections D.1.14-D.4

Best and Final Offer

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List of Exhibits

List of Abbreviations

AARP	American Association of Retired Persons
ABEND	Abnormal Ending
ABTC	Asia Pacific Economic Council Business Travel Card
ACCP	American College of Clinical Pharmacy
ACD	Automatic Call DistributionDistributor
ACH	Automated Clearing House
ACII	Allergy and Clinical Immunology International
ACTS	Automated Collection and Tracking System
ACWP	Actual Cost of Work Performed
ADA	American Dental Association, American Diabetes Association, Americans with Disabilities Act of 1990 (US), American Dietetic Association
ADAO	Adult Developmental Disability Assessment and Outreach
ADC	Application Development Completion
ADCEP	Adult Developmental Disability Community Enhancement Program
ADD	Application Detailed Design
ADP	Application Design and Prototyping
AEDC	After Effective Date of Contract
AFTP	Anonymous File Transfer Protocol
AHF	American Hospital Formulary
AHFS	American Hospital Formulary Service
AHIC	American Health Information Community
AHIMA	American Health Information Management Association
AHIP	America's Health Insurance Plan
AIAN	American Indian Alaskan Native
AIDS	Acquired Immune Deficiency Syndrome
AIM	Application Implementation
AINS	Automated Information Notification System
ALM	Application Life-Cycle Management
AMCP	Academy of Managed Care Pharmacy
ANSI	American National Standards Institute
AP	Area Program, Accounts Payable

AP	Accounts Payable
APC	Application Preliminary Design
APEC	Asia-Pacific Economic Cooperation
API	Application Program Interface
AQT	Application Qualification Testing
AR	Accounts Receivable
ARA	Application Requirements Analysis
ASAO	Adult Substance Abuse Assertive Outreach and Screening
ASC	Accredited Standards Committee, Ambulatory Surgery Center
ASCDR	Adult Substance Abuse IV Drug User/Communicable Disease
ASCP	American Society of Consultant Pharmacists
ASHP	American Society of Health Systems Pharmacists
ASP	Automated Support Package
AV	Actual Value
AVRS	Automated Voice Response System
AVRU	Automatic Automated Voice Response Unit
AWP	Average Wholesale Price
BA	Business Analysis, Business Analyst
BAC	Budget at Completion
BCBS	Blue Cross Blue Shield
BCCM	Breast and Cervical Cancer Medicaid
BCP	Business Continuity Plan
BCWP	Budgeted Cost of Work Performed
BCWS	Budgeted Cost of Work Scheduled
BENDEX	Beneficiary Data Exchange
BI	Business Intelligence
BIA	Business Impact Analysis
BPEL	Business Process Execution Language
BPM	Business Process Management
BPMO	Business Process Management Office
BPMS	Behavioral Pharmacy Management System
BPO	Business Process Outsourcing

BRIDG	Biomedical Research Integrated Domain Group
BSD	Business System Design
BV	Budget Variance
C&A	Certification and Accreditation
C&KM	Collaborative and Knowledge Management
C&SI	Consulting and System Integration
CA	Computer Associates, Control Accounts
CA	Control Accounts
CAFM	Computer-Aided Facilities Management
CAM	Control Account Managers
CAP	Community Alternatives Program, Competitive Acquisition Program, Corrective Action Plan
CAP	Community Alternatives Program
CASE	Computer-Aided Software Engineering
CAT	Contingency Assessment Team
CBT	Computer-Based Training
CCAS	Certified Clinical Addiction Specialist
CCS	Certified Clinical Supervisor
CCB	Change Control Board , Configuration Control Board
CCB	Change Control Board
CCI	Correct Coding Initiative
CCM	Child Case Management
CCNC	Community Care of North Carolina
CCSP	Claims Customer Service Program
CDAO	Child Developmental Disability Assessment and Outreach
CDHP	Consumer Driven Healthcare Plan
CDHS	California Department of Health Services
CDISC	Clinical Data Interchange Standards Consortium
CDR	Critical Design Review
CDRL	Contract Data Requirements List
CDS	Controlled Dangerous Substance
CDSA	Children's Developmental Services Agencies

CDW	Client Data Warehouse
CEO	Chief Executive Officer
CERT	Comprehensive Error Rate Testing, Computer Emergency Readiness Team
CERT	Computer Emergency Readiness Team
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CHECK	NC State Departments of Health and Office of State Controller
CI	Configuration Item
CICS	Customer Information Control System (IBM)
CIO	Chief Information Officer
CISSP	Certified Information Systems Security Professional
CLIA	Clinical Laboratory Improvement Amendments, Clinical Laboratory Improvement Act
CLIN	Contract Line Item Number
CM	Configuration Management
CMM	Capability Maturity Model , Center for Medicare Management
CMM	Capability Maturity Model
CMMI	Capability Maturity Model Integration
CMOS	Configuration Memory Operating System
CMP	Change Management Plan
CMS	Call Management System, Centers for Medicare and Medicaid Services
CMS	Centers for Medicare and Medicaid Services
CNDS	Common Name Data System or Service
CNS	Comprehensive Neuroscience
CO	Contracting Officer
COB	Coordination of Benefit
COCC	Certificates of Creditable Coverage
COCR	County Options Change Request
COE	Center of Excellence
COOP	Continuity of Operations
COR	Contracting Officer's Representative
CORI	Criminal Offender Record Information

COS	Category of Service
COTR	Contracting Officer's Technical Representative
COTS	Commercial Off-the-Shelf
CP	Claims Processor, Communication Plan
CPA	Certified Public Accountant
CP	Claims Processor
CPAF	Cost Plus Award Fee
CPAR	Customer Performance Assessment Review
CPAS	Claims Processing Assessment System
CPE	Current Production Environment
CPFF	Cost Plus Fixed Fee
CPI	Cost Performance Index
CPM	Critical Path Methodology
CPR	Contract Performance Reporting, Cost Performance Report
CPR	Cost Performance Report
CPSW	Claims Processor Switch
CPT	Current Procedural Terminology
CPU	Central Processing Unit
CR	Change Request
CRIS	Clinical Research Information System
CRM	Customer Relationship Management
CRNA	Certified Registered Nurse Anesthetist
CROWD	Center for Research on Women with Disabilities
C-RUP	Catalyst Extended RUP
CRP	Conference Room Pilot
CS	Commercial Service
CSC	Computer Sciences Corporation
CSDW	Client Services Data Warehouse
CSE	Child Support Enforcement
CSIRT	Computer Security Incident Response Team
CSR	Customer Service Representative, Customer Service Request
CSSC	Customer Support and Service Center

CSV	Comma Separated Value
CTI	Computer Telephony Integration
CV	Cost Variance
CWBS	Contract Work Breakdown Structure
CWF	Common Working File
DA	Delivery Assurance
DAL	Data Accession List
DASD	Direct Access Storage Device
DAW	Dispense As Written
DB2	IBM Relational Database Management SsytemSystem
DBA	Database Administrator
DBAR	Disaster Backup and Recovery
DBMS	Database Management System
DCEU	Data Cleansing and Entry Utility
DCMWC	Division of Coal Mine Workers' Compensation
DCN	Document Control Number
DD	Developmental Disabilities
DDC	Drug Discount Card
DDI	Design, Development, and Implementation
DEA	Drug Enforcement AdministrationAgency
DEC	Developmental Evaluation Centers
DED	Data Element Dictionary
DEERS	Defense Enrollment Eligibility Reporting System
DEP	Release Deployment
DERP	Drug Effectiveness Review Project
DESI	Drug Efficacy Study Implementation
DHH	Department of Health and Hospitals
DHHS	Department of Health and Human Services
DHMH	Department of Health and Mental Hygiene
DHSR	Division of Health Service and Regulation
DIACAP	DOD Information Assurance Certification and Accreditation Process
DIRM	Division of Information Resource Management

DLP	Derived Logical Process
DMA	Division of Medical Assistance
DME	Durable Medical Equipment
DMECS	Durable Medical Equipment Coding System
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
DMERC	Durable Medical Equipment Regional Carrier
DMH	Division of Mental Health
DMH/DD/SAS	Division of Mental Health, Developmental Disabilities, and Substance Abuse Services – May be referred to as DMH
DMZ	Demilitarized Zone
DNS	Domain Name Server
DOB	Date of Birth
DoD	Department of Defense
DOH	Department of Health
DOJ	Department of Justice
DOL	Department of Labor
DOORS	Data Object Oriented Repository System
DOR	Department of Revenue
DPH	Division of Public Health
DPM	Deputy Program Manager
DR	Disaster Recovery
DRG	Diagnosis-Related Group
DSD	Detailed System Design
DSH	Disproportionate Share Hospital
DSR	Daily Service Review
DSS	Division of Social Services (organization within NC DHHS)
DSS	Decision Support System, Department of Social Services (as part of county government), Division of Social Services (organization within NC DHHS)
DSS	Decision Support System
DUR	Drug Utilization Review
EA	Enterprise Architecture
EAC	Estimate at Completion
EBM	Evidence-Based Medicine

EBP	Elementary Business Process
ECS	Electronic Claims Submission
EDB	Enrollment Database
EDI	Electronic Data Interchange
EDITPS	Electronic Data Interchange Transaction Processing System
EDMS	Electronic Document Management System
EDP	Electronic Data Processing
EDS	Electronic Data Systems
EEOICP	Energy Employees Occupational Illness Compensation Program
EFT	Electronic Funds Transfer
EHR	Electronic Health Record
EI	External Input , External Inquiry
EI	External Input
EIA	Electronic Industries Alliance
EIN	Employer Identification Number
EIS	Eligibility Information System
ELA	Enterprise License Agreement
EMC	Electronic Media Claim
eMedNY	New York MMIS
EMEVS	Electronic Medicaid Eligibility Verification System
EMR	Electronic Medical Record
ENM	Enterprise Network Management
ENV	Environment
EO	External Output
EOB	Explanation of Benefits
EOMB	Explanation of Medicaid(Medicare)(Medical) Benefits
EPA	Environmental Protection Agency
ePACES	Electronic Provider Automated Claims Entry System
EPAL	Enterprise Privacy Assertion Language
EPC	Evidence-based Practice Center
EPMO	Enterprise Program Management Office
EPMR	Executive Level Project Management Review

EPS	Energy Processing System
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment (Aaka Health Check)
EQ	External Query
ER	Emergency Room
ERA	Electronic Remittance Advisory
ERE	Estate Recovery Evaluation
ESRD	End Stage Renal Disease
ETC	Estimate to Completion
ETIN	Electronic Transmitter Identification Number
ETL	Extract, Transform, Load
ETN	Enrollment Tracking Number
EV	Earned Value
EVMS	Earned Value Management System
EVS	Eligibility Verification System
FA	Fiscal Agent
FADS	Fraud and Abuse Detection System
FAO	Fiscal Agent Operations
FAQ	Frequently Asked Questions
FARO	Finance and Reimbursement OfficerOrganization
FAS	Fiscal Agent Staff
FBI	Federal Bureau of Investigation
FBLP	Federal Black Lung Program
FCA	Functional Configuration Audit
FCAPS	Fault Management, Configuration, Accounting, Performance, and Security Management
FCN	Financial Control Number
FDA	Food and Drug Administration
FDB	First DataBank
FDDI	Fiber Distributed Data Interface
FedEx	Federal Express
FFP	Federal Financial Participation, Firm Fixed Price

FFP	Firm Fixed Price
FFS	Fee-For-Service
FFY	Federal Fiscal Year
FIFO	First-In/First-Out
FIPS	Federal Information Processing Standards
FISMA	Federal Information Security Management Act of 2002
FMAP	Federal Medical Assistance Percentage
FMC	Federal Management Center
FP	Function Point
FTE	Full-Time Equivalent
FTP	File Transfer Protocol
FUL	Federal Upper Limit
FYE	Fiscal Year Ended
GAAP	Generally Accepted Accounting Principles
GAO	General Accounting Office
GC3	Generic Classification Code
GCN	Generic Code Number
GEMNAC	Graduate Medical Education National Advisory Committee
GHS	Government Health Services
GIAC	Global Information Assurance Certification
GIS	Global Infrastructure Services
GUI	Graphical User Interface
GL	General Ledger
GMC	Global Management Center
GME	Graduate Medical Education
GMENAC	Graduate Medical Education National Advisory Committee
GMP	General Management Process
GNN	Generic Name
GSS	Global Security Solutions
GTEDS	GTE Data Services
H.E.A.T.	Hydra Expert Assessment Technology
HCC	Health Check Coordinator

HCCR	Health Check Coordinator Reporting
HCCS	Health Check Coordinator System
HCFA	Health Care Financing Administration (predecessor to CMS)
HCPCS	Healthcare Common Procedure Coding System
HCPR	Health Care Personnel Registry
HCSC	Health Care Service Corporation
HETS	HIPAA Eligibility Transaction System
HFMA	Healthcare Finance Financial Management Association
HHA	Home Health Aide
HIC	Health Insurance Claim
HICL	Health Insurance Contract Language
HIE	Health Information Exchange
HIGLAS	Health Integrated General Ledger and Accounting System
HIM	Health Information Management
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIPDB	Healthcare Integrity and Protection Data Bank
HIPP	Health Insurance Premium Payment
HIS	Health Information System
HIT	Healthcare Information Technology
HIV	Human Immunodeficiency Virus
HL7	Health Level 7 (Format and protocol standard)
HMA	Health Management Academy
HMO	Health Maintenance Organization
HP	Hewlett Packard
HPII	High Performance Image Import
HRSA	Health Resources and Services Administration
HSIS	Health Services Information System
HUB	Historical Underutilized Business
HW	Hardware
I/O	Input/Output
IA	Information Assurance
IAD	Incremental Application Development

IAVA	Information Assurance Vulnerability Alert
IAW	In Accordance With
Ibis	Integrated Business Information System
IBR	Initial Baseline Review
IBS	Integrated Business Solution
ICD	International Classification of Diseases , Iterative Custom Development
ICD	International Classification of Diseases
ICF-MR	Intermediate Care Facilities for the Mentally Retarded
ICR	Intelligent Character Recognition
ID	Identification
IDS	Intrusion Detection System
IEEE	Institute of Electrical and Electronics Engineers
IFPUG	International Function Point Users Group
IGN	Integrated Global Network
IIHI	Individually Identifiable Health Information
ILM	Information Life-Cycle Management
IM	Information Management
IMP	Integrated Master Plan
IMS	Integrated Master Schedule
Ind HC	Independent Health Care
IOM	Institute of Medicine
IP	Internet Protocol
IPGW	Internet Protocol Gateway
IPL	Initial Program Load
IPMD	Integrated Program Management Database
IPR	In-Progress Review
IPRS	Integrated Payment and Reporting System
IPT	Integrated Product Team
IRS	Internal Revenue Service
ISO	International Standards Organization
ISPTA	International Security, Trust and Privacy Alliance
ISVM	Information Security Vulnerability Management

IT	Information Technology
ITIS	Integrated Taxonomic Information System
ITF	Integrated Test Facility
ITIL	Information Technology Infrastructure Library
ITIS	Integrated Taxonomic Information System
ITS	Information Technology Solutions
IV&V	Independent Verification and Validation
IVR	Interactive Voice Response
JAD	Joint Application Development
JCL	Job Control Language
KE	Knowledge Engineer
KFI	Key From Imaging
KM	Knowledge Management
KPI	Key Performance Indicator
KPP	Key Performance Parameter
LAN	Local Area Network
LDAP	Lightweight Directory Access Protocol
LDSS	Local Department of Social Services
LEP	Limited English Proficiency
LHD	Local Health Department
LME	Local Managing Entity
LMFT	Licensed Marriage and Family Therapist
LOB	Line of Business
LOE	Level of Effort
LPA	Licensed Psychological Associates
LPC	Licensed Professional Counselors
LMFT	Licensed Marriage and Family Therapists
LPN	Licensed Practical Nurse
LST	Legacy Systems Transformation
LTC	Long-Term Care
MA	Medicare Advantage
MAAR	Monthly Accounting of Activities Report

MAC	Maximum Allowable Cost
MAR	Management and Administrative Reporting
MARS	Management and Administrative Reporting Subsystem
MARx	Medicare Advantage Prescription Drug Program
MAS	Medicaid Accounting System
MA-SHARE	Massachusetts — Simplifying Healthcare Among Regional Entities
MCE	Medicare Code Editor
MCHP	Maryland Children's Health Program
MCO	Managed Care Organization
MDCN	Medicare Data Communications Network
MDME	Medicare Durable Medical Equipment
MEQC	Medicaid Eligibility Quality Control
MES	Managed Encryption Service
MEVS	Medicaid Eligibility Verification System
MIME	Multipurpose Internet Mail Extensions
MiMMIS	Multi-Payer Medicaid Management Information System
MIP	Medicare Integrity Program
MIS	Management Information System
MITA	Medicaid Information Technology Architecture
MM	Meeting Minutes
MMA	Medicare Modernization Act
MMCS	Medicare Managed Care System
MMIS	Medicaid Management Information System
MOAS	Medicaid Override Application System
MOF	Meta Object Facility
MPAP	Maryland Pharmacy Assistance Programs , Medical Procedure Audit Policy
MPAP	Maryland Pharmacy Assistance Programs
Mpas	Multi-Payer Administrator System
MPLS	Multi-Protocol Label Switching
MPP	Media Processing Platform
MPW	Medicaid for Pregnant Women

MS	Microsoft
MSIS	Medicaid Statistical Information System
MSMA	Monthly Status Meeting Agenda
MSP	Medicare Secondary Payer
MSR	Monthly Status Report
MT	Management Team
MTBF	Mean Time Between Failures
MTF	Medical Treatment Facility
MTQAP	Master Test and Quality Assurance Plan
MTS	Medicare Transaction System
NAHIT	National Association for Health Information Technology
NAS	Network Authentication Server
NASMD	National Association of State Medicaid Directors
NAT	Network Address Translation
NATRA	Nurse Aide Training and Registry
NC	North Carolina
NCAMES	North Carolina Association for Medical Equipment Services
NCAS	North Carolina Accounting System
NCHA	North Carolina Hospital Association
NCHC	North Carolina Health Choice for Children
NCHCFA	North Carolina Health Care Facilities Association
NCID	North Carolina Identity Service
NCMGMA	North Carolina Medical Group Manager's Association
NCMMIS+	North Carolina Medicaid Management Information System (Legacy system)
NCP	Non-Custodial Parent
NCPDP	National Council for Prescription Drug Programs
NCQA	National Committee on Quality Assurance
NCSC	North Carolina Senior Care
NCSTA	North Carolina Statewide Technical Architecture
NC*Tracks*	North Carolina Transparent Reporting, Accounting, Collaboration, and Knowledge Management System
NDC	National Drug Code

NDM	Network Data Mover
NEDSS	National Electronic Disease Surveillance System
NEHEN	New England Healthcare EDI Network
NGD	Next Generation Desktop
NHA	North Carolina Hospital Association
NHIN	National Health Information Network
NHSCHP	National Health Service Connecting for Health Program
NIACAP	National Information Assurance Certification and Accreditation Process
NIH	National Institutes of Health
NIST	National Institute of Standards and Technology
NNRP	Non-Network Retail Pharmacy
NOC	Network Operations Center
NPDB	National Practitioner Data Bank
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
NPS	North American Public Sector
NSC	National Supplier Clearinghouse
NYeC	New York eHealth CollabortaiveCollaborative
NYS	New York State
O&M	Operations and Maintenance
O&P	Orthotics and Prosthetics
OAC	Office of Actuary
OBRA-90	Omnibus Budget Reconciliation Act of 1990
OBS	Organizational Breakdown Structure
OCI	Organizational Conflict of Interest, Organizational Change Implementation
OCR	Optical Character Recognition
OCSQ	Office of Clinical Standards and Quality
ODS	Operational Data Store
OIG	Office of the Inspector General
OLAP	Online Analytical Processing
OLTP	Online Transaction Processing
OMB	Office of Management and Budget

OMMISS	Office of MMIS Services
ONC	Office of the National Coordinator
ONCHIT	Office of the National Coordinator for Health Information Technology
OP	Operations Management Plan
OPA	Ohio Pharmacists Association
ORDI	Office of Research and Development
ORHCC	Office of Rural Health and Community Care
OS	Operating System
OSC	Office of the State Comptroller
OSCAR	Online, Survey, Certification, and Reporting
OTC	Over the Counter
OWCP	Office of Workers' Compensation Programs
P&L	Profit and Loss
PA	Prior Approval
PAC	Pricing Action Code
PAL	Prescription Advantage List
PASARR	Pre-Admission Screening and Annual Resident Review
PBAC	Policy-Based Access Control
PBC	Performance-Based Contract, Package Design and Prototyping
PBD	Package-Based Development
PBM	Pharmacy Benefits Management
PBX	Private Branch Exchange
PC	Personal Computer
PCA	Physical Configuration Audit
PCCM	Primary Care Case Management
PCP	Primary Care Physician , Primary Care Provider
PCP	Primary Care Physician
PCS	Personal Care Service
PDA	Personal Digital Assistant
PDC	Package Development Completion
PDF	Portable Document Format
PDP	Prescription Drug Plans

PDTS	Pharmacy Data Transaction System or Service
PDTS	Pharmacy Data Transaction Service
PEND	Slang for suspend
PERM	Payment Error Rate Measurement
PES	Package Evaluation and Selection
PHI	Protected Health Information
PHSS	Population Health Summary System
PIHP	Pre-Paid Inpatient Mental Health Plan
PIM	Personal Information Management
PIR	Problem Investigation Review , Process Improvement Request
PIR	Problem Investigation Review
PMB	Performance Measurement Baseline
PMBOK	Project Management Body of Knowledge
PMI	Project Management Institute
PML	Patient Monthly Liability
PMO	Project Management Office
PMP	Project Management Plan, Project Management Professional
PMP	Project Management Professional
PMPM	Per Member Per Month
PMR	Performance Metrics Report, Program Management Review, Project Management Review
PMR	Program Management Review
PMR	Performance Metrics Report
POA&M	Plan of Action and Milestones
POMCS	Purchase of Medical Care Services
POP	Point of Presence
POS	Point of Sale (Pharmacy), Point of Service
POS	Point of Service
PPA	Prior Period Adjustment
PQAS	Prior Quarter Adjustment Statement
PRE	Release Preparation
PreDR	Preliminary Design Review

PREMO	Process Engineering and Management Office
PRIME	Prime Systems Integration Services
PrISMS	Program Information Systems Mission Services
ProDR	Production Readiness Review
ProDUR	Prospective Drug Utilization Review
PRPC	Pega Rules Process Commander
PSC	Program Safeguard Contractor
PSD	Package System Design
PST	Production Simulation Test or Testing
PST	Production Simulation Testing
PV	Planned Value
PVCS	Polytron Version Control System
QA	Quality Assurance
QAP	Quality Assurance Plan
QASP	Quality Assurance Surveillance Plan
QC	Quality Control
QCP	Quality Control Plan
QIC	Qualified Independent Contractor
QMB	Qualified Medicare Beneficiary
QMO	Quality Management Organization
QMP	Quality Management Plan
QMS	Quality Management System
R&A	Reporting and Analytics
RA	Remittance Advice
RACI	Responsibility, Accountability, Coordination, and Informing Requirements
RADD	Rapid Application Development and Deployment
RAID	Redundant Array of Inexpensive Disks
RAM	Responsibility Assignment Matrix
RAS	Remote Access Server
RBM	Release-Based Maintenance
RBRVS	Resource-Based Relative Value Scale
RCA	Root Cause Analysis

RDBMS	Relational Database Management System
REMIS	Renal Management Information System
REOMB	Recipient Explanation of Medicaid Benefits
Retro-DUR	Retroactive Drug Utilization Review
RFI	Request For Information
RFP	Request for Proposals
RHH&H	Regional Home Health and Hospice
RHHI	Regional Home Health and Hospice Intermediaries
RHIO	Regional Health Information Organization
RIA	Rich Internet Application
RICE	Reports, Interfaces, Conversions, and Extensions
RIMP	Risk and Issue Management Plan
RM	Risk Manager
RMP	Risk Management Plan
RN	Registered Nurse
ROI	Return on Investment
ROSI	Reconciliation of State Invoice
RPN	Retail Pharmacy Network
RPO	Recovery Point Objective
RRB	Railroad Retirement Board
RSS	Really Simple Syndication
RTM	Requirements Traceability Matrix
RTO	Recovery Time Objectives
RTP	Return to Provider
SA	System Architect
SADMERC	Statistical Analysis Durable Medical Equipment Carrier
SAN	Storage Area Network
SANS	System Administration, Networking and Security Institute
SAP	Systems Acceptance Plan
SAS	Statement on Auditing Standards, Statistical Analysis Software
SCC	Security Control Center
SCHIP	State Children's Health Insurance Program

SD	Software Development, System Development
SD	Software Development
SDB	Small Disadvantaged Business
SDEP	Service Delivery Excellence Program
SDLC	Software Development Life Cycle
SDM	Service Delivery Manager
SE	Software Engineering, System Engineering
SE	Software Engineering
SEC	IT Security
SEI	Software Engineering Institute
SEPG	Software Engineering Process Group
SFY	State Fiscal Year
SIMS	Security Information Management Systems
SIT	Systems Integration Testing
SIU	Special Investigations Unit
SLA	Service Level Agreement
SMAC	State Maximum Allowable Charge
SME	Subject Matter Expert
SMR	Senior Management Reviews
SMTP	Simple Mail Transfer Protocol
SNIP	Strategic National Implementation Process
SOA	Service-Oriented Architecture
SOAP	Simple Object Access Protocol
SOB	Scope of Benefit
SOC	Security Operations Center
SOCC	Secure One Communications Center
SOO	Statement of Objectives
SP	Security Plan
SPAP	State Pharmacy Assistance Plan
SPI	Schedule Performance Index
SPOE	Service Point of Entry
SRR	System Readiness Review

SRT	Service Restoration Team
SRTM	Security Requirements Traceability Matrix
S*S	Sure*Start
SSA	Social Security Administration
SSL	Secure Socket Layer
SSN	Social Security Number
SSO	System Security Officer
SSP	System Security Plan
STD	Standard
STA	Statewide Technical Architecture
STD	Standard
STest	String Test
STP	Staffing Plan
SURS	Surveillance and Utilization Review Subsystem
SV	Schedule Variance
SW	Software
T&M	Time and Materials
TBD	To Be Determined
TCE	Training Center of Excellence
TCN	Transaction Control Number
TCO	Total Cost of Ownership
TCP	Transmission Control Protocol
TDD	Technical Design Document, Telecommunication Device for the Deaf
TDD	Technical Design Document
TED	TRICARE Encounter Data
TES	Time Entry System
TIA	Technical Infrastructure Acquisition
TMA	TRICARE Management Activity
TMOP	TRICARE Mail Order Pharmacy
TOA	Threshold Override Applications
TP	Turnover Plan
TPA	Third Party Administrator

TPAR	Transactional Performance Assessment Review
TPCI	To Complete Performance Index
TPL	Third-Party Liability
TRR	Test Readiness Review
TRRx	TRICARE Retail Pharmacy
TRScan	Transform Remote Scan
TSN	Transmission Supplier Number
TTY	Text Telephone
TxCL	Therapeutic Class Code
UAT	User Acceptance Test
UBAT	User Build Acceptance Test
UDDI	Universal, Description, Discovery, and Integration
UI	User Interface
UPC	Universal Product Code
UPIN	Unique Provider Identification Number
UPS	Uninterruptible Power Supply, United Parcel Service
UPS	United Parcel Service
UR	Utilization Review
URA	Unit Rebate Amount
USB	Universal Serial Bus
US-CERT	United States Computer Emergency Readiness Team
USD	Unicenter Service Desk
USI	User-System Interface
USPS	United States Postal Service
UT	User Testing
V&V	Verification and Validation
VAC	Variance at Completion
VAF	Value Adjustment Factor
VAN	Value Added Network
VAR	Variance Analysis Report
VAT	Vulnerability Assessment Tools
VoIP	Voice Over Internet Protocol

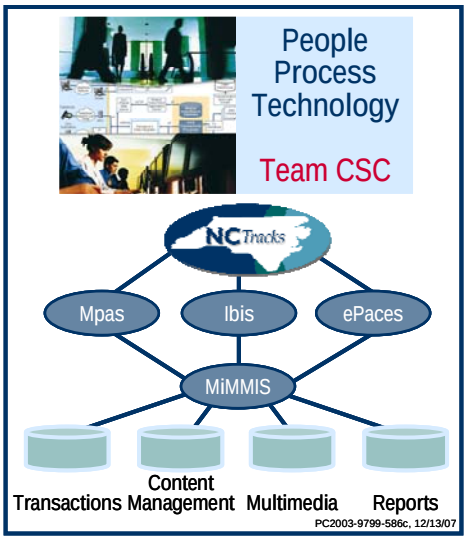
VP	Vice President
VPMS	Voice Portal Management System
VPN	Virtual Private Network
VSAM	Virtual Storage Access Method
WAN	Wide Area Network
WBS	Work Breakdown Structure
WEDI	Workgroup for Electronic Data Interchange
WFM	Workflow Management
WSDL	Web Services Description Language
WSMF	Web Services Management Framework
XAD	Accelerated Application Development
XAP	Accelerated Application Prototyping
XBD	Accelerated Business Process Design
XML	Extensible Markup Language
XPDL	XML Process Definition Language
XTC	Accelerated Timebox Completion

Pages D.1.14-1 through D.1.14-49 contain confidential information.

D.1.15 DATA CONVERSION AND MIGRATION APPROACH

Team CSC recognizes the importance of a carefully executed data conversion effort. We will ensure success through: a combination of legacy analysis to ensure the business rules are extracted and the processing context is mapped; a set of industry-leading tools to profile, scrub and automate the mapping of data; and an engineering approach the team has applied to many similar projects.

D.1.15.1 Approach



Many organizations implementing large-scale system replacement projects discover that the data conversion and migration aspects of the project are often fraught with risk and uncertainty because of the difficulties in working with legacy platforms and cleansing and converting legacy data sources. Because the legacy systems have evolved over many years, the underlying data typically suffers from inconsistencies and other quality problems. In addition, documentation is often missing or incomplete, business rules are embedded deep within application source code, and personnel with in-depth knowledge of the system have changed over time – all leading to a system that is increasingly difficult to support and in need of replacement. If multiple legacy systems are being converted and integrated, these issues are compounded exponentially. Therefore, Team CSC will lead the coordination with the State and the incumbent fiscal agent to perform activities required for the successful transfer and conversion of legacy data for the DDI Phase and ongoing operations. **(40.1.2.13)**

(40.1.2.13)

Because of these issues, Team CSC has developed a comprehensive plan for migrating and converting legacy data that identifies risks early and mitigates those risks. This plan will be coordinated with NC DHHS prior to execution. We couple our approach with state-of-the-art technology and methodology to ensure that the data migration effort is a well-planned and well-executed activity that does not place the project schedule or budget in jeopardy. We have detailed the benefits of our approach in **Exhibit D.1.15.1-1**.

How the Team CSC Data Conversion Methodology Benefits DHHS
• Identifies legacy data issues early in the process, mitigating the risk of project delays and cost overruns
• Provides a structured and iterative framework for converting each source, allowing data migration to progress over time
• Extracts legacy program structure and business rules to ensure completeness of data and knowledge transfer
• Recognizes that some manual data conversion may be necessary and provides tools and processes to facilitate this, as required, ensuring that all data gets properly converted
• Utilizes state-of-the-art tools and technologies that automatically capture and retain valuable metadata, reducing the time and resources required and providing audit trails of converted data.
• Provides a framework for ongoing data quality, allowing business rules developed in the conversion process to be leveraged by the new system to ensure that data generated by the replacement system remains clean.

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Exhibit D.1.15.1-1. Benefits of Our Data Conversion Approach

Team CSC's approach to design and deployment of the Replacement MMIS is to divide the system into a number of sub-system builds that are deployed in a phased manner. Corresponding to each build phase is a matching data conversion and migration phase. The Integrated Master Schedule shows the specific data conversion tasks and the proposed submission date for each build. While each system build requires its own data conversions, the same overall conversion methodology is uniformly applied for all data conversion.

Dividing the data conversion into separate builds reduces risks by containing the scope. Furthermore, knowledge gained from data conversion for earlier builds can be used for subsequent system builds.

Team CSC recognizes that NC DHHS has already made substantial investments in analyzing and mapping the existing legacy system. Therefore, our approach incorporates a full review and validation of the existing Detailed System Design (DSD) documentation to ensure that all of the knowledge previously captured is validated and is fully leveraged in our approach.

(40.1.2.19)

CSC recognizes that the data to be converted includes not only legacy data from NC DHHS, but also legacy data from DMA, DMH, DPH, and the Migrant Health Agency in the ORHCC. **(40.1.2.19)**

D.1.15.1.1 Methodology

The Team CSC Data Conversion and Migration Methodology is a structured and iterative framework that breaks the conversion and migration process down into a set of manageable steps that can be applied in an iterative manner to different sets of legacy data. The data conversion tasks and activities are governed by CSC's Catalyst 4D Methodology structure. The Catalyst 4D methodology consists of four stages that define the progress of a project: Discover; Design; Develop; and Deploy. Stages are used to group work products, activities, and roles. **Exhibit D.1.15.1.1-1** shows CSC's Catalyst 4D methodology for data conversions and migrations.

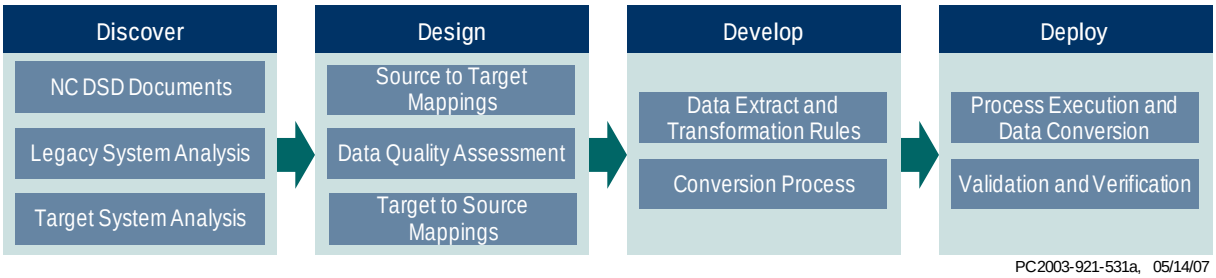

Exhibit D.1.15.1.1-1. Team CSC Catalyst 4D Methodology for Data Conversion and Migration. *Our migration model is provable and ensures successful conversion.*

The Catalyst 4D methodology defines project activities at a level that balances the need for detail with the desire for simplified, high-level abstraction. It organizes project activities into activity blocks that reflect the types of activities performed across stages. For example, the Source to Target / Target to Source Mappings block identifies the business solution and the services required to implement that solution. This level of detail: **(Comment CSC42)**

- Supports standardization across activity blocks. A relatively simple, repeatable pattern of activity makes the methodology easy to remember, follow, and adapt.
- Facilitates visual representation of the methodology. Methodology diagrams help practitioners understand the arrangement and flow of project activities.

The methodology allows the source data systems to be assessed based on business functions, volume, criticality, timeliness and cleanliness to determine the appropriate order in which various data sources or subsystems should be converted. The iterative approach also facilitates data subsetting and volume load management to ensure that conversion routines are both complete (i.e., addresses all possible data anomalies) and are scalable (i.e., can process small subsets or the entire file).

Our methodology provides a structured, flexible, and iterative approach to data migration and conversion – allowing the data conversion activities to be effectively integrated into the overall project tasks and Build schedule. The methodology is designed to fit well within the context of the overall Integrated Master Plan (IMP), and will be utilized as the framework for creating the Data Migration and Conversion Plan CDRL.

D.1.15.1.2 Tools and Technology

To implement the Data Conversion and Migration Methodology, Team CSC will use Commercial Off-the-Shelf (COTS) integration tools provided by our teammate SAS. These SAS Data Integration tools are the accepted standard for the State of North Carolina and the State has entered into an enterprise license agreement with SAS to provide these tools to State projects. SAS provides integrated Extract, Transform, Load (ETL) capabilities that enable organizations to extract, transform, and load complex relational data. The SAS tools address significant data migration challenges facing DHHS.

DHHS Migration Challenge	Benefit of Using the SAS Tool Set
Potential project delays and cost overruns caused by having to use disparate data integration toolsets or create custom code to access legacy data	SAS is the only vendor who offers a data integration solution that is fully integrated with data quality. This alleviates problems caused by using several tools or custom code. The use of the SAS tool set significantly decreases the total cost of ownership (TCO) in terms of maintenance, training, and time lost in regaining familiarity with a rarely used non industry standard tool.
Business and technical problems caused by inaccurate, contradictory, and inconsistent data from the legacy systems	The SAS tools can transform and combine disparate data, remove inaccuracies, standardize on common values, parse values, and cleanse dirty data to create consistent, reliable information. SAS data profiling tools allow data consistency and quality issues to be discovered very early in the process so that mitigation strategies and cleansing rules can be adequately developed.
Maintaining adherence to the Statewide Technical Architecture and IT standards	SAS is a State of North Carolina standard for data integration including the extract, transform, and load processes, business intelligence, and advanced analytics. By maintaining adherence to the statewide standards, the MMIS Data Migration will be consistent with other data integration projects throughout the State. This allows the Replacement MMIS to leverage current State infrastructure and expertise in developing, supporting, and maintaining these systems, and leverages the existing architecture that is already in place at DHHS further reducing the TCO.

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Exhibit D.1.15.1.2-1. Benefits of using SAS tools. *The SAS tool set offers powerful capabilities for data integration compliant with State standards.*

In addition, the SAS tool set provides the following advantages:

- A single platform to manage the entire Data Conversion and Migration Process

- Robust Metadata Facility to capture and manage data attribute information and business rules in one place, reducing time, resources, and project risk
- Integrated Data Quality facilities, to include Data Profiling, Standardization, Deduplication, Parsing, and Cleansing ensures that converted data is clean prior to entering the Replacement MMIS database
- Intuitive graphical user interface (GUI) interface for all aspects of the Conversion and Migration process allows developers to be more efficient by limiting the amount of manual programming required
- Integrated Scheduling Facility to allow processes to be run interactively or scheduled as batch jobs, providing flexibility to run conversion processes as needed or on a regular schedule to keep the data appropriately refreshed
- Native connectivity to mainframe systems and data sources, as well as virtually all server-based database systems, allows data to be directly accessed and converted from any source.

In addition, Team CSC understands that it is unlikely that all data needed for the Replacement MMIS can be converted from the existing legacy systems. To mitigate this risk, Team CSC has developed a semi-automated tool called DCEU (Data Cleansing and Entry Utility) that allows users to manually review and enter data into the system. This tool will be used to enter any paper based records that are not currently stored in the system, or manually add or correct data that cannot be automatically converted from the legacy systems for whatever reason. This may include data elements that have embedded business intelligence in the Legacy system that are required to be parsed into separate data elements in the Replacement MMIS. **(SOO 10.9-16)**

(10.9-16)

D.1.15.2 Discovery Phase

The first step in the Data Conversion and Migration process will be to perform a structural analysis of both the legacy and target systems. This analysis will identify and document the data structures that exist in the legacy systems and in the Replacement MMIS to facilitate the mapping process that occurs later. The types of information captured will include:

- Subsystem Names
- Table or File Names
- Column Names, and
- Column Attributes (Description, Data Type, Length, etc.).

A combination of techniques will be used to facilitate the collection of information about candidate source systems, including meetings with key personnel and functional experts, review of data and process models, and supporting documentation.

The main outputs from this activity will be:

- Source System Data Definition Document
- Replacement System Data Definition Document, and
- Data transformation rules.

D.1.15.2.1 Source System Analysis

The legacy MMIS+ contains embedded knowledge in the form of business rules that are applied in specific business processing contexts. Since NC DHHS has already made a substantial investment in analyzing the existing legacy systems' data structures, the Source System Analysis will begin with a comprehensive review of the information already captured in the DSD. All source system information in the DSD will be validated for completeness and accuracy to ensure that all relevant information is captured, and that the information is up-to-date. An output is the inventory of all source system data and tables that must be converted.

Team CSC will convert all legacy data from the legacy MMIS+ in addition to data from DMA, DMH, DPH and the Migrant Health Program in the ORHCC to maintain benefit plans and data relationships in a multi-group aspect. **(40.1.2.20)**

(40.1.2.20)

For areas where the DSD is either incomplete or out of date, a full analysis of the corresponding legacy subsystem will be completed to capture the necessary structural information. The analysis will consist of reviewing existing system documentation and documented data models or copybooks, as well as using the SAS tools to actually connect to the legacy system and extract structural information about the legacy data where possible.

D.1.15.2.2 Legacy Systems Analysis

The legacy system contains embedded knowledge in the form of business rules that are applied in specific business processing contexts. These are not typically visible to either the State or Incumbent vendor's subject matter experts and are not available in system design documentation. A failure to identify these often results in missing key business rules and important data files that are not surfaced until later in testing potentially lead to schedule delays.

For that reason, Team CSC will use specialized tools to extract the system design and business rules. These business rules will be externalized into a rules engine for validation by State SMEs and later use in the Replacement MMIS. This analysis will ensure that all business rules and required data are surfaced with sufficient time to be incorporated into the design and construction activities. This approach provides the State and the CSC Team assurance that the data conversion and development effort is complete and accurate. We believe our tool set is unique in the IT marketplace, in including legacy data analysis capability as a regular component of our data conversion tasks. With this unique advantage, completeness and accuracy of business knowledge and data from a legacy to a replacement system is substantially improved. **(40.1.2.21)**

(40.1.2.21)

Team CSC will transfer or convert existing legacy MMIS+ reports and report-related data, including reports in legacy MMIS+ and/or stored in Report2Web. **(40.1.2.18)**

(40.1.2.18)

While performing due diligence for this proposal, the CSC legacy analysis team identified a number of business rules that appear to be missing and are not found in the DSD. Our approach, including working closely with the State, helps to identify and close potential gaps.

D.1.15.2.3 Target System Analysis

The Team CSC solution provides a robust, flexible, and extensible MMIS data model. The model has been successfully deployed in a functional MMIS application and is extensively documented. As such, most of the work for Target System Analysis is already complete.

Gartner identifies the SAS tools as industry leaders...

- SAS' DataFlux is in the Leader's Quadrant for Data Quality Tools
- SAS Data Integration is in the Leader's Quadrant for Data Integration Tools

Since the data model is flexible and extensible, it is expected that modifications to the standard model will be easily accommodated to meet the unique requirements of the North Carolina DHHS implementation. Many of these changes will be identified during overall systems requirements and design, but some may result from the Source to Target / Target to Source Mapping step of the Data Conversion and Migration process. For example, during the mapping process, it is possible that some data elements from the legacy system do not have corresponding elements in the replacement system. Once these are identified and documented during the mapping process, decisions can be made about how to address them to include the creation of new data elements in the Replacement MMIS. **(Comment CSC42)**

Exhibit 1.15.2.3-1 shows how the SAS tools can be utilized to attach to and collect structural information on source and target data stores:

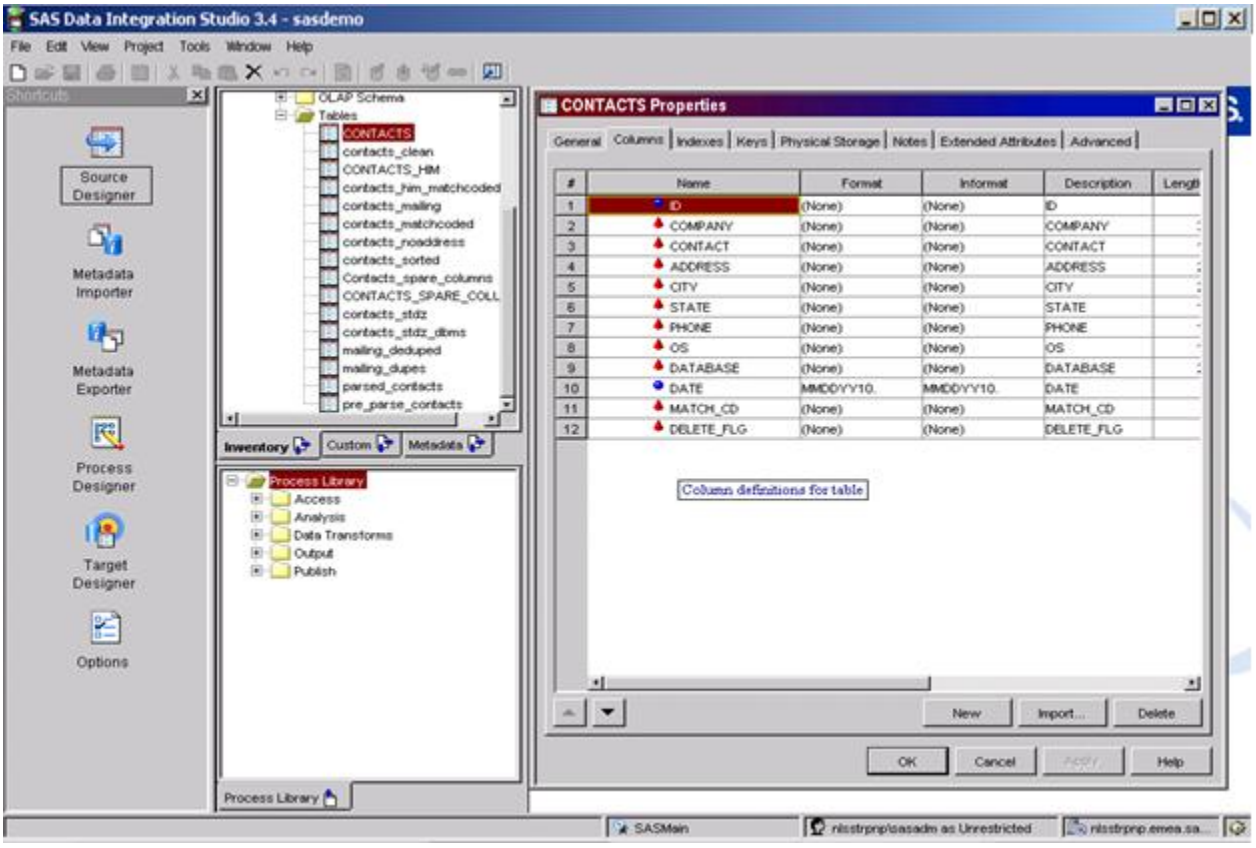

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Exhibit D.1.15.2.3-1. Source Mapping via SAS Data Integration tools. *The SAS tool set enables the CSC Team to easily connect to source data and extract metadata.*

D.1.15.3 Design Phase

During the Design phase, the CSC Team will accomplish two major processes. First will be the High Level Source to Target / Target to Source Mapping where we will identify discrepancies between the source and target systems. The second will accomplish a Data Quality Assessment where we will evaluate the data for completeness, consistency, and accuracy. Details of these two processes are outlined below. **(Comment CSC42)**

D.1.15.3.1 High Level Source to Target / Target to Source Mapping

Identifying discrepancies between the source and target early (prior to design and construction phases of the project) limits the need for the rework that often occurs if these discrepancies are not discovered in the early stages of the project. Once the structural analysis of the source and target systems is complete, a high level mapping will be completed that shows the relationship between data elements in the legacy MMIS+ and those in the Replacement MMIS.

At this point, the intent is merely to map which source data elements map to which target data elements, not to establish the business rules for converting the data. In addition to mapping the common data elements, this process will also identify any data elements from the legacy system that do not have corresponding elements in the replacement system, and vice-versa. SAS tools will be used to collect and enter the data mapping information. Using the SAS tools provides the following benefits:

- Easy-to-use GUI that can directly import source and target data structures
- Mapping information is stored as metadata which can later be leveraged by the same tools for implementing the conversion rules
- Can easily collect additional information about mappings (1:1 vs. derived, formulas, rules, notes, etc.) if available.

Exhibit 1.15.3-1 illustrates the extensive Mapping capabilities of SAS Data Integration Studio™.

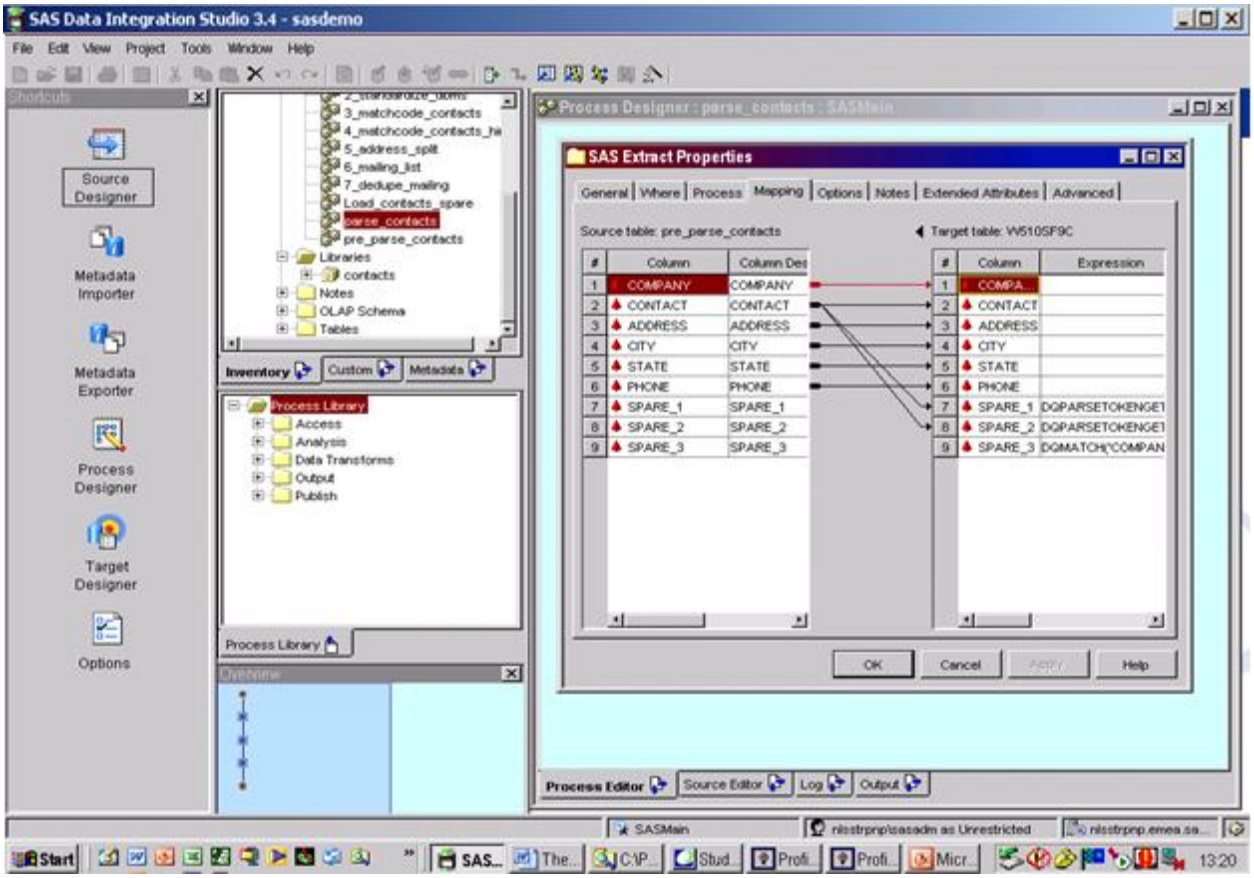

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Exhibit D.1.15.3-1. Source to Target / Target to Source Mapping via SAS Data Integration tools. *Data can be quickly and easily mapped from source to target via the SAS tools.*

The SAS Data Integration Studio interface supports both direct (1:1) and indirect (custom business rule based) mappings.

The outputs from this phase are expected to be:

- Source to Target / Target to Source High Level Mapping Document
- Extracted Business Rules and Data Files, and
- Non-Matched Mappings Document.

(Comment CSC42)

D.1.15.3.2 Data Quality Assessment

If existing data problems are allowed to pass through from the legacy MMIS+ to the Replacement MMIS, it will undermine the credibility of the Replacement MMIS. Determining and addressing data quality issues as part of the conversion and migration process is imperative in producing a Replacement MMIS that is accepted by the State and its stakeholders.

Team CSC methodology places a substantial emphasis on the Data Quality Assessment phase, in which the actual data values in the legacy MMIS+ begin to be evaluated for completeness, consistency, and accuracy. During this phase, each

legacy subsystem data source will be evaluated and profiled to determine the completeness, consistency, and accuracy of the underlying data.

Team CSC proposes to use the SAS Data Profiling tools during this activity, as they provide the following capabilities to allow data anomalies to be quickly and easily identified:

- Easy-to-use GUI Interface
- Completeness Analysis (record counts, null counts, blank counts, etc.)
- Consistency Analysis (pattern analysis, uniqueness, etc.)
- Distribution Analysis (min, max, percentile, outliers, frequency distributions, etc.)
- Cross-table analysis (primary/foreign key analysis, redundant data analysis, Venn diagrams, etc.)
- Automated Reporting, and
- Track Quality Changes Over Time.

Exhibit 1.15.3.2-1 illustrates the data profiling that can be accomplished using SAS tools. In this case, variables in two different tables are being compared to determine how much overlap there is in the values. This analysis is used for determining the consistency of data across different sources or for determining whether there is a strong primary: foreign key relationship between the two sources.

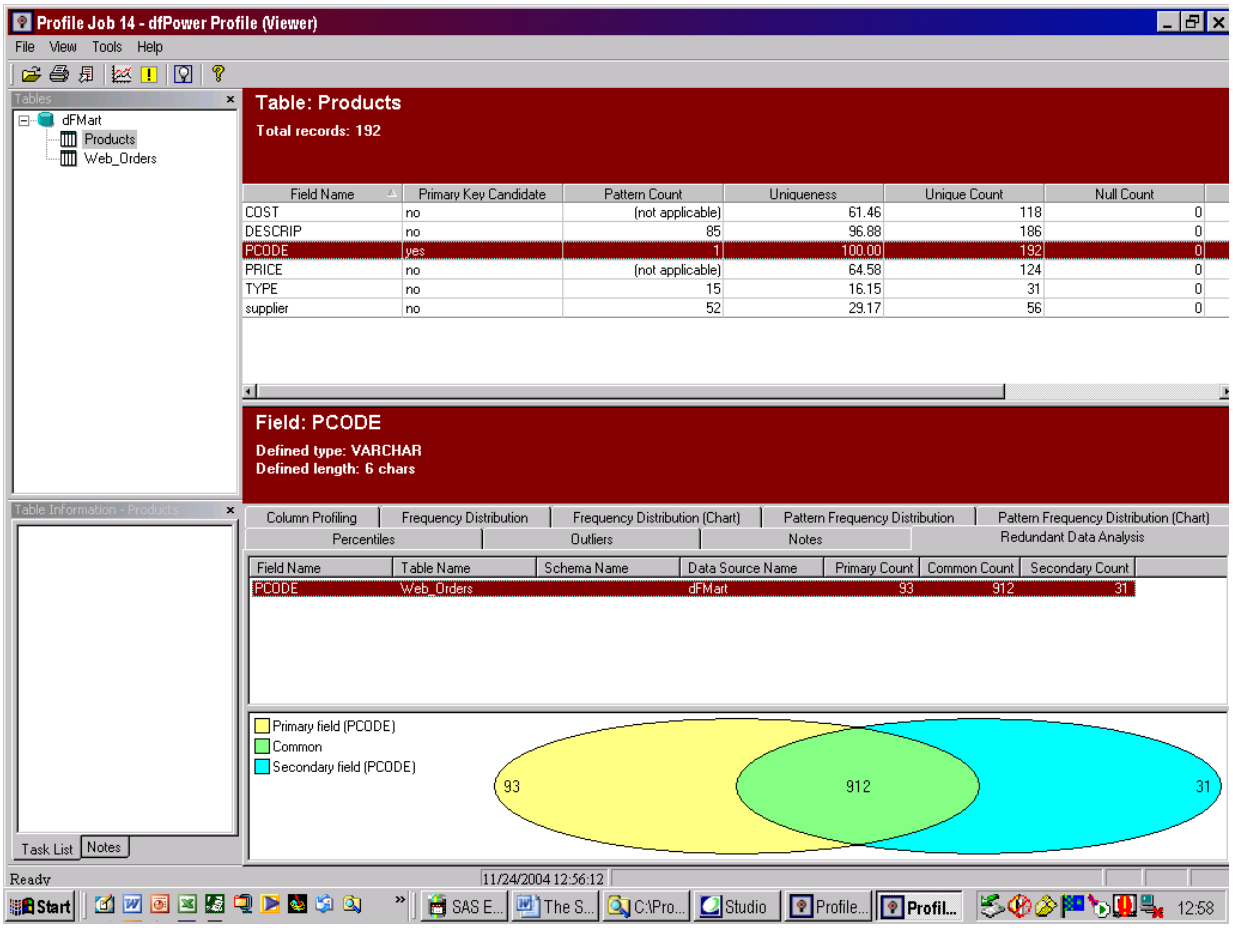

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Exhibit D.1.15.3.2-1. Data Profiling via the SAS Data Integration tools. *SAS tools data profiling capabilities make it easy to check for data consistency across different sources.*

Once the data profiling has been completed, experts will evaluate the results and produce the Data Quality Assessment Document. In addition to providing the profiling results for each data element, this document will also include the team's assessment of each data quality issue identified, noting its criticality, impact, and possible solutions for cleansing. This analysis includes input from legacy system experts, legacy analysis team, and domain subject matter experts familiar with the source systems and business rules.

The output from this process will be the Data Quality Assessment Document.

(10.9-16) **(SOO 10.9-16)**

D.1.15.4 Develop Phase

During the Develop phase, the CSC Team will accomplish two major processes. First will be the Data Extraction and Conversion Rule Development stage where the CSC Team will develop the conversion rules. During the second process, the CSC Team will actually build the transformation processes to populate the Replacement MMIS database. Details of these two processes are outlined below.

D.1.15.4.1 Data Extraction and Conversion Rule Development

Data Extraction and Conversion Rule Development is the stage where the bulk of the conversion rules are developed for data translation and where the results from Legacy Analysis are mapped into an externalized business rule engine. During this stage, documents previously produced (i.e., Structural Analysis, Legacy Analysis, High Level Mapping, and Data Quality Assessment) are analyzed in Joint Application Design-type (JAD) sessions to determine the appropriate business rules for converting the data. In addition to the actual conversion rules and formulas, this phase also produces a running "Issues Log" for data discrepancies that are not easily addressed by standardized rules and need to be addressed through an escalation or other decision making process. **(40.1.2.21)**

(40.1.2.21)

The SAS tools can be used in the JAD-type sessions to interactively build the transformation rules, or rules can be collected by other means and entered into the tool later. Utilizing the tool for the collection and storage of the rules allows the knowledge to be captured as metadata in the tool and then directly leveraged within the tool during the Conversion Construction phase. This saves time and increases the accuracy, as the capture process is actually building the rule that can be directly inserted into a process flow, as opposed to capturing the rule in one place (e.g., Word or Excel) and then having to implement it in some other tool or programming language.

Some examples of common business or transformation rules are:

- Data Standardization Rules
- De-duplication Rules
- Formatting Transformations
- Parsing Rules
- Numeric Conversion Rules
- Data Validation Rules
- Recovered Business Rules
- Cross-Source Entity Relationship Rules, and
- Database Conversion Rules.

Exhibit 1.15.4.1-1 illustrates using the SAS tools for building data standardization business rules.

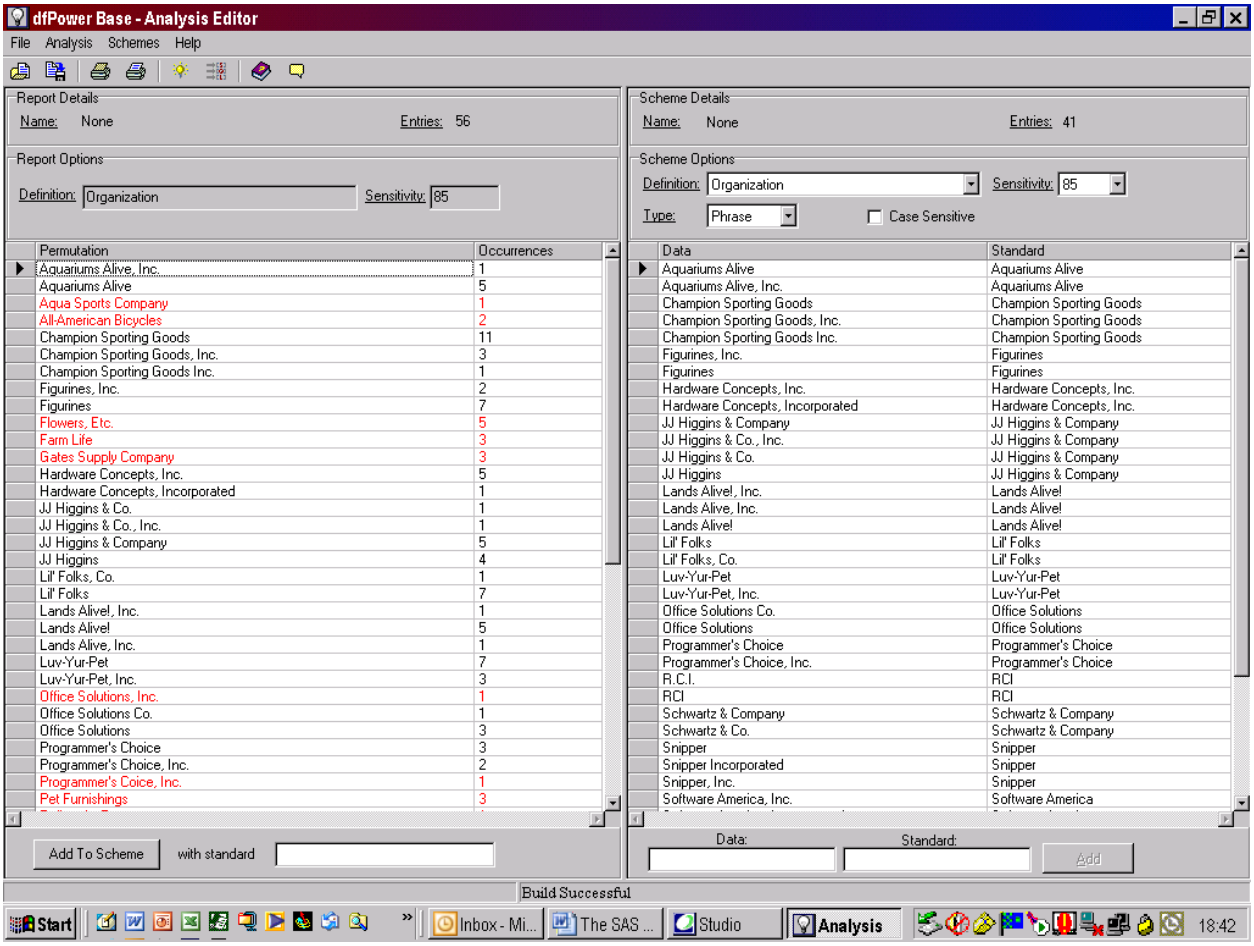

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Exhibit D.1.15.4.1-1. Data Standardization via the SAS Data Integration tools. *Data Standardization tools facilitate data mapping for applications.*

This screen shows how non-standardized values can be mapped to a single standardized value. A "Quick Map" feature quickly assesses all values and attempts to map those that appear similar. This is also the foundational element for assuring that target to source mappings are preserved and there are no unresolved elements. The analyst can then override those or add additional mappings based on the unmapped values (those highlighted in red). The mappings can then be saved as a business rule and included in one or more conversion process flows.

The output from this process will be the Data Quality Assessment Document.

D.1.15.4.2 Conversion Construction

Conversion construction is where all of the information previously collected is utilized to actually build the transformation processes that are necessary to populate the Replacement MMIS database.

Typically, data will first be extracted from a legacy system to a staging area. This allows the Construction Team to work with a static, point-in-time snapshot of the data to better facilitate building and testing the processes. In addition, it minimizes impact on the legacy systems, which are still operational during this time.

The extracted data is then fed into process flows that apply the business and transformation rules previously defined. Because the rules were captured as metadata in the SAS tools, they are simply inserted into the process flow and applied to the appropriate data elements.

In April 2007, SAS and Sun Microsystems Inc. set a new world-record benchmark for ETL of massive volumes of data – processing and loading 1.25TB in under 2 hours 36 minutes.

The output data structures from the process flows can either be the actual target tables in the Replacement MMIS, or load files that the Replacement MMIS can pick up and load based on existing utilities available in the Replacement MMIS.

(40.1.2.17) Data to be converted will include all claim TIFF images with claim numbers and all associated claim electronic files and related index information from the legacy MMIS+ in an indexed and retrievable format on the FileNet system. **(40.1.2.17)**

Exhibit 1.15.4.2-1 illustrates the SAS Data Integration Studio GUI that will be used to construct and manage the conversion processes:

This screen shows how the Process Designer wizard in the SAS Data Integration tool can be used to construct a data conversion process via a drag-and-drop, non-programming user interface. Once jobs are created, they can be run interactively from within the tool, or can be scheduled to run at a later time or on a recurring basis.

(40.1.2.16) We will provide the capability for storing all conversion-related artifacts in an easily retrievable format for access by the State for the life of the contract or the commencement of processing by a subsequent contractor. **(40.1.2.16)**

(10.9-16) The output from this process will be the Completed Data Conversion and Migration Routines. **(SOO 10.9-16)**

D.1.15.5 Deploy Phase

During the Deploy phase, the CSC Team will accomplish two major processes. First will be the actual Process Execution where we will actually produce a set of Populated Replacement System Database Tables. The second will be where we will accomplish Data Validation and produce a Validation Report to be approved by NC DHHS.

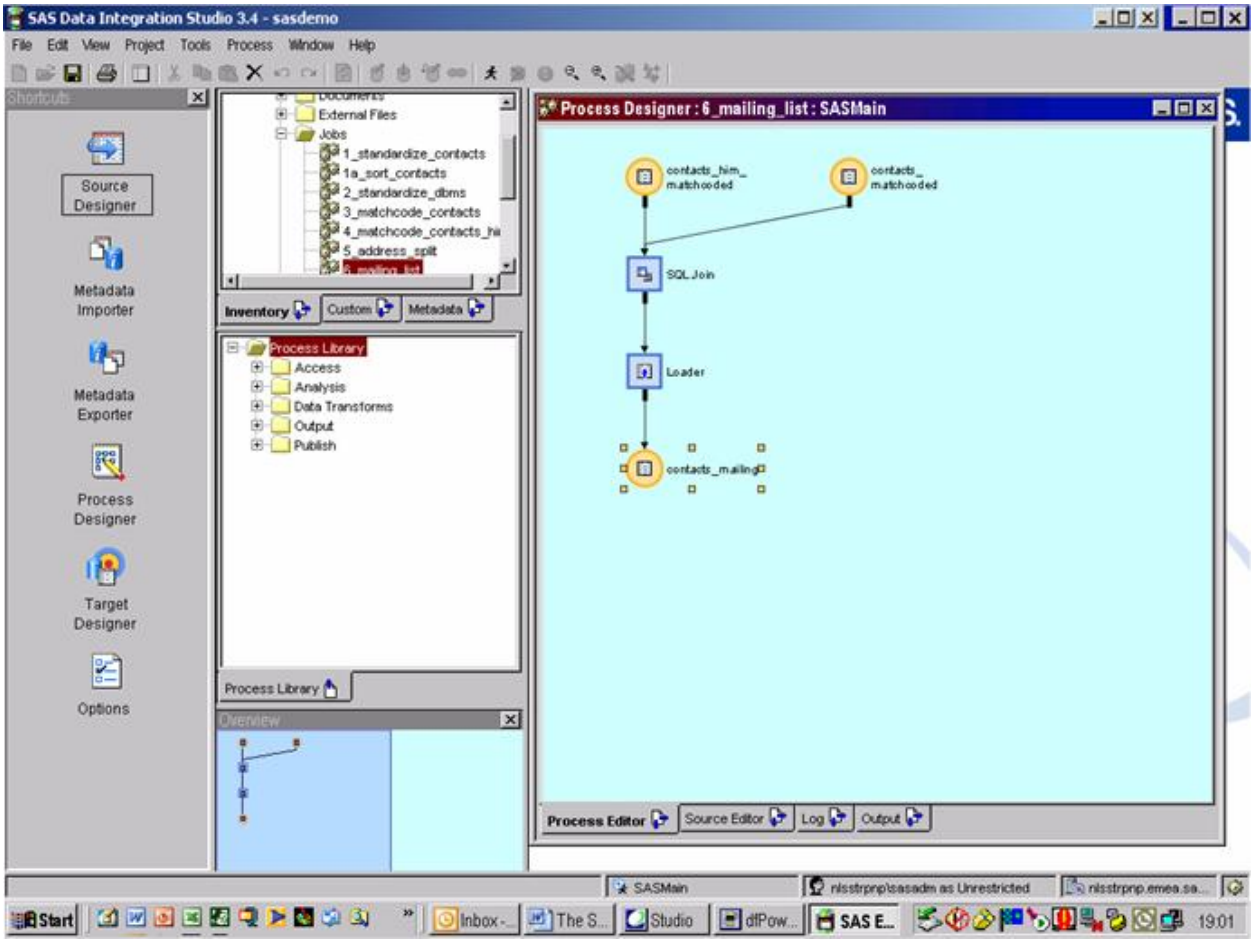

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Exhibit D.1.15.4.2-1. Construction of a Conversion Process via SAS Data Integration tools.
SAS provides an easy to use graphics interface to build data conversion processes rapidly.

D.1.15.5.1 Process Execution

Once the conversion routines are developed and tested, they can be run interactively or scheduled and run in batch. This allows for an iterative approach whereby subsets of data can be converted and validated – making the tasks more manageable. Over time, larger subsets of data can be processed.

In addition, Team CSC understands that it is unlikely that all data needed for the Replacement MMIS can be converted from the existing legacy MMIS+. To mitigate this risk, Team CSC has developed a semi-automated tool called Data Cleansing and Entry Utility (DCEU) that allows users to manually review and enter data into the system. This tool will be used to enter any paper-based records that are not stored in the system, or manually add or correct data that cannot be converted from the legacy systems. This may include data elements that have embedded business intelligence in the Legacy MMIS+ that are required to be parsed into separate data elements in the Replacement MMIS.

The Execution phase will be carefully planned as part of the overall Implementation Master Plan. During the design and construction phases for the overall system, data

will be needed to build and test the various components. Through careful planning and execution, the Data Conversion and Migration process will ensure that data is available in sufficient type, quantity, and quality to support the other design and development activities at the appropriate time. By utilizing state-of-the-art tools and structured methodologies, the process will also be flexible to allow for changes to the data requirements throughout the DDI process. Team CSC will also apply its Quality Assurance Process to validate baseline results from each conversion and identify opportunities to improve results and eliminate potential defects.

The output from this phase will be Populated Replacement System Database Tables.

One distinct benefit to NC DHHS and other State users and/or vendors will be a thoroughly validated database that will be made available for their use. Once populated, Team CSC will continue to validate the database to ensure data integrity.

(40.1.2.14) **(40.1.2.14)**

D.1.15.5.2 Data Validation

It is particularly important to validate the data conversion results. Team CSC will design a structured validation process that will ensure all data is correctly converted. One of the most common problems with conversion is that exceptions are not followed up on and that all data is not accounted for in the reconciliation process of conversion. Frequently, control totals and balancing are only performed for a few key data fields in the conversion. Control totals and balancing are basically summarizing the converted data and comparing the summary values to what is being reported by the existing system. If the summary numbers match, then you could infer that the detail data is also correct.

The process designed will be a combination of automated and manual balancing and tracking. Each data field will be tracked through the conversion process and verified that it is actively being converted, or that it has a problem and cannot be converted any further. Reports that show the conversion tracking and balancing will be designed. Procedures for tracking the conversion processes will be designed and documented to ensure that automated and manual conversion tracking and balancing is adequately managed.

The other major component of validation is the physical comparison of source data to converted data. The conversion process will be designed to automate the comparison of source data with converted data when possible, to use business rules to verify that data was converted successfully, and to perform visual inspection on an exception basis. Automated tools can assist in this process by reviewing records counts, value distributions, summaries and other statistics.

Team CSC will provide hardware, software and data support for the State during all phases of conversion and testing for the entire contract period. The State will have the same access to the data as does Team CSC. **(40.1.2.15)**

(40.1.2.15)

The output from this phase will be an approved Validation Report.

(10.9-16) **(SOO 10.9-16)**

D.1.16 Deployment/Rollout Approach

Team CSC's Deployment/Rollout approach is designed to provide early functionality for some components, tools to evaluate data conversion and data that is manipulated by the new system, and most importantly, confidence for the NC DHHS that Team CSC is developing and implementing a Replacement MMIS that meets or exceeds all defined requirements and the agreed schedule with low risk.

Deployment is the culminating event of the DDI Phase, and Team CSC emphasizes hard work, planning, and risk mitigation in preparation for the event. Two major objectives of the Deployment Phase are to implement the Replacement MMIS and assume fiscal agent operations from the incumbent. This cutover to Team CSC must be accomplished in a timely, efficient and accurate manner, without adversely effecting day-to-day operations, and without disrupting the NC DHHS, the recipient community, or provider services.

Team CSC achieves the successful deployment of the Replacement MMIS and the transition of operations using extensive planning and preparation, a knowledgeable staff, thorough training, and extensive quality control measures — all of which follow our Catalyst® Project Management Methodology.

We have assembled a project team that includes individuals who have vast experience with healthcare system implementations and the transition of business functions from another contractor. Led by the Account Executive Director, John Singleton, **our proposed leadership team, which includes the Deputy Account Director, Project Management Office (PMO) Director, Implementation Director, Lead Business Architect, and the Claims Processing Manager, brings over 225 years of cumulative experience in managing large-scale projects and MMIS/healthcare claims processing business operations.** John brings more than 30 years in Medicaid, Medicare, and managed care with a primary focus on Medicaid to this position. His excellent blend of skills, knowledge, and expertise in both the technical and management arenas complements the range and depth of his health care experience. John has worked on multiple systems designed for and operated in a multi-payer environment. His skills have been developed in eleven healthcare system implementations across Medicaid, Medicare Part B, and Medicaid managed care. In fact, John led the systems engineering team at EDS in the early 1980s when the current North Carolina claims processing subsystem was designed, developed, tested, and implemented. His knowledge and understanding of multiple management information systems across the public sector market offer valuable experience to the team.

In addition, CSC has recent experience with the design, development, and implementation a new MMIS for the State of New York. This project was deployed in two phases over several years and included the implementation of a new eligibility verification system, service authorizations, and real time pharmacy claim adjudication in 2002 as phase one. The full replacement MMIS, including claim adjudication for all other claim types, was finalized in 2005 as part of phase two. Phase one implementation occurred without any unplanned interruption or loss of functionality for the real time transactions that were part of this critical deployment activity. **It is**

clear from this experience that we understand what it takes to implement a large-scale Medicaid project including multi-payer functionality.

In addition, CSC has **a strong, proven record within the federal and private sectors that amply demonstrates expertise in the planning, execution, monitoring, and control of project transitions**. This experience has provided invaluable knowledge and lessons learned that coalesce in the 'next practices' for system transitions. The following examples supply evidence of our ability to provide extensive transitioning services:

- **U.S. Air Force Arnold Engineering Development Center (AEDC) Support.** CSC provided comprehensive IT services encompassing operation and maintenance of all computers, communications, and other support services, including system engineering, analysis, and integration; network management; data and voice; management information systems (MIS); financial and resources management; project planning; facility/equipment maintenance; test support operations; data acquisition; business process reengineering; user training; and safety, supply, and purchasing services. Our 60-day transition plan clearly identified tasks and milestones to accomplish the phase-in efficiently and without interruption to ongoing AEDC activities. The plan addressed transition of personnel and IT infrastructure; it identified potential risks and steps to mitigate them. A phase-in team supplemented our management team with specialists in completing phase-in activities of similar size and complexity. The team mobilized 1,000 people (98.4 percent incumbent employees) in 60 days, with no disruption to services, providing full continuity of mission support and contract performance on the start date.
- **NASA Program Information Systems Mission Services (PrISMS).** CSC is the primary IT mission contractor for the Office of the CIO, providing management of service delivery for contract functions across the customer base of more than 6,000 employees and contractors. CSC currently operates and maintains 18 WANs, 12 LANs, and hundreds of network components. PrISMS required a stable transition without interruption of mission-critical services. CSC collaborated with NASA to complete the 45-day phase-in on schedule and without service interruption. CSC accomplished startup, subcontract negotiation, property inventory and transfer, facilities startup, personnel staffing, transfer of ongoing work, and control of related work (including seven high-visibility, critical projects).
- **Securities and Exchange Commission (SEC) Infrastructure Support Services (SEC ISS).** This $168 million, performance-based 125-person task order under the GSA Millennia contract, supports some 5,000 users nationwide in the Securities and Exchange Commission by providing computer operations and maintenance, network engineering, and other services in support of a heterogeneous IT environment consisting of client-server systems connected by a high-speed nationwide switched network.
- Our resourcefulness and effectiveness at recovering from catastrophic situations is illustrated by the events that occurred during the contract period. Originally scheduled for 60 days, CSC completed the transition in just 45 days, hiring 19 staff

members for network operations in the first two weeks and 100 percent of targeted incumbent personnel. On September 11, 2001, SEC lost the New York regional office with the collapse of the World Trade Center. This resulted in a total loss of IT infrastructure and equipment supporting 333 people.

In addition to responding to this crisis, CSC needed to continue the transition of this contract. In mid-October, after the SEC acquired replacement office facilities in lower Manhattan, CSC engineers installed servers, workstations, and telecommunications for the new office and brought them back on-line. The SEC was the first U.S. Government agency returned to full service in the Manhattan area after this devastating event. We completed transition ahead of schedule with no loss of continuity despite this unexpected, additional task.

- **Information Technology Solutions Environmental Protection Agency (ITS-EPA).** This $876 million, performance-based 550-person task order under the GSA Millennia contract, was implemented to support the Environmental Protection Agency (EPA). The task order specified a full range of IT solutions, including the national network, national computing center, desktop hardware and software support, call center / help desk, web application development, database services, change management, configuration management, and other services needed for a complex IT infrastructure of approximately 400 servers and 8,000 desktops. CSC transitioned the contract in 60 days, performing in parallel with some transformation tasks. To ensure continuity of service, we prepared comprehensive checklists that identified activities, responsible parties, and deliverable schedules. We retained 100 percent of the targeted incumbent staff and achieved a 93 percent transition performance rating by implementing immediate improvements to increase customer satisfaction.

CSC's Relevant Transition/Deployment Experience		
Program	**Requirements**	**Relevance to NC SOO**
USAF AEDC	• Transition of personnel and IT infrastructure • Identification of potential risks • Development of comprehensive mitigation strategies	• Demanded the integration of a risk and issue management system in which the Client was integrated as a partner (SOO 10.8-1) • Tailored highly qualified workforce to support operations (SOO 10.10-3)
NASA PrISMS	• Maintenance of service-performance levels and system-availability goals • Transition of operational responsibilities and resources for desktop computing support, wide area network (WAN) operations, and data-reduction operations functions	• Retained organizational structure capable of successfully executing operations scope (SOO 10.10-14) • Sustained life-cycle support (SOO 10.9-2) • Adhered to IFPUG software size functionality where applicable (SOO 10.5-4)
SEC ISS	• Stringent adherence to set deadlines • Ability to respond to disaster recovery	• Executed quick deployment of replacement strategies (SOO 10.3.1-1) • Managed the master plan to achieve a successful project (SOO 10.8-3)
ITS-EPA	• Installation of new technology • Transformation of key operations into managed services • Collaborative decision making • Transformation to performance based contract with service levels agreements met or exceeded	• Improved operations for stakeholders by increasing the level of automation (SOO 10.7-1) • Ensured that the EPA received a reasonable return on all performance standards by meeting/exceeding service level agreements (SOO 10.12.1-7)

9799-999

Exhibit D.1.16-1. Team CSC Deployment Experience on Similar, Complex Programs. *CSC brings successful deployment experience to the NC Replacement MMIS project that is relevant to the State's requirements and will help to meet NC's SOO.*

Pages D.1.16-4 through D.1.16-18 contain confidential information.

producing system documentation deliverables, according to function. For example, designated project analysts and specialists jointly develop the disaster recovery plan.

A structured documentation methodology parallels our structured system design so that our documentation evolves with the project as changes or refinements to the system are made. This methodology helps to ensure that deliverables are consistent in format, appearance, and content.

Each succeeding design document incorporates and builds upon all previous documents. Based upon feedback from the NC DHHS review, walk-throughs, and any other discussions, meetings, or requests, Team CSC revises the documentation and submits the final deliverable to the NC DHHS for review and approval. **Because a draft of the deliverable has already been reviewed by the State and all outstanding issues resolved, this review usually consists of the NC DHHS verifying that all agreed-upon revisions have been incorporated into the final document.**

Keeping Replacement MMIS documentation up-to-date and following the documented processes and procedures are vital to achieving day-to-day accuracy and efficiency. Prior to the full implementation of the system, Team CSC updates all pertinent systems documentation, user manuals, procedure manuals, and operating procedure documents. Along with the NC DHHS input, documentation updates result from integration testing, user acceptance testing, and operational readiness testing, as well as correction of any deficiencies found in the system. **We maintain security and file back-up safeguards for all documentation created and maintained by Team CSC.**

Documentation maintenance continues during the Operations Phase. We review and prepare updated copies of the appropriate documentation to reflect any modifications, corrections, or enhancements to the system and deliver them to the NC DHHS in a timely manner.

Team CSC's formal change control process is the key to maintaining systems and user documentation. We use proven project management practices to identify errors, make accurate and timely updates, track changes, schedule walk-throughs and approval, and notify users of updates. We also review the changes with the user groups that rely upon the documentation to perform their jobs. Reviewing existing documents is a regular part of our change control process. Over time, if the NC DHHS' goals and priorities are modified, policies and procedures must reflect these changes. We commit to ensuring high quality, complete systems and user documentation for the Replacement MMIS in accordance with the required tasks, deliverables, and approved project schedule.

D.1.16.3.7 Develop Deliverables

To support CMS Certification of the Replacement MMIS, Team CSC will provide the required draft deliverables to the NC DHHS Project Manager in the required formats. As part of the delivery, **Team CSC provides an overview walk-through of the contents and answers any questions that the NC DHHS Project Manager,** the MMIS Project Team, or other members of the review panel may have about the

organization and contents of the draft deliverable. The NC DHHS reviews the draft deliverables and provides feedback to Team CSC within the agreed to timeframe. We then modify the deliverable based upon the review panel's feedback.

Each final deliverable is submitted to the NC DHHS Project Manager for review and approval in writing to signal completion. Once approved in writing by the NC DHHS, the deliverables, such as the Final Deployment Plan and Deployment Contingency/Back-out Plan, along with the IMP, guide all of our activities.

D.1.16.3.8 Obtain Approval from DHHS to Deploy the System

It is only upon receipt of approval from the NC DHHS that Team CSC moves forward with actual deployment of the Replacement MMIS.

The deployment of the Replacement MMIS is the final step of the DDI Phase and the major tasks and milestones are documented and presented for the NC DHHS' review and approval prior to deployment of the system and assumption of business functions. We carefully plan, schedule, and then execute the deployment activities in a coordinated and manner with the NC DHHS' assistance and approval, guided by the Final Deployment Plan.

D.1.16.3.9 Deploy the System

Members of the development and conversion teams are onsite to monitor the deployment of the Replacement MMIS. This team acts as a "quick response" team to identify critical system issues and coordinate timely, expedient responses. For ease of contact and effective communication between team members, the team will work from a central location. Team CSC will conduct morning meetings to communicate the status of the deployment process and to discuss any issues and upcoming activities.

Team CSC acknowledges the NC DHHS' assistance is required during the Deployment Phase, and works closely with designated the NC DHHS staff to ensure an efficient and timely deployment of the system as well as an orderly transition from the incumbent fiscal agent to Team CSC for fiscal agent business functions. Coordination of file and record transfers, including archived data, and final conversion monitoring are critical to assuring appropriate timing of the cutover. Clear communication with the provider community and the NC DHHS helps to eliminate issues that can result in confusion regarding the cutover schedule.

The NC DHHS must coordinate and monitor final conversion activities, review and approve the final provider notifications. During all of these activities, the NC DHHS staff must also participate in documentation walk-throughs and training sessions so that they can bridge the transition and continue to perform their work effectively.

During the Deployment Phase, Team CSC accepts all new files from the incumbent fiscal agent. These files may be magnetic tape, disk, optical, diskette, or paper. We accept claim-related receipts and pended claim records, and convert the appropriate data. Control totals are kept and compared to the State's totals to ensure that all necessary data is transferred. We correct any problems identified in the conversion process or notify the State of any problems from the originating systems with the

transferred data. We submit the results of the final file conversions to the NC DHHS for review and approval.

Team CSC acknowledges its responsibility for processing all claim records not adjudicated as of the date of the last payment cycle. Following this date, claim records are accepted from all enrolled providers, and processing of all types of claims takes place. We activate online access by authorized staff and providers. Additionally, we accept and arrange for storage and backup of archive files in the manner specified by the State.

D.1.16.3.10 Ensure Optimal Processing of the Replacement MMIS

After implementing the Replacement MMIS, **Team CSC monitors and audits systems data to verify that the system is performing according to specifications.** We report our post-implementation results to the NC DHHS. Part of this process includes conducting a status review session with the NC DHHS to evaluate our deployment processes.

As this phase begins, Team CSC moves into an operations role and ensures a smooth-running, efficient Replacement MMIS. An important support effort for Team CSC is to help the State use our new and effective automated management tools to monitor and review performance information.

D.1.16.4 Conclusion

Team CSC has planned a controlled approach to the deployment of the Replacement MMIS. Our deployment schedule and project management methodology define the process required to bring up the Replacement MMIS, ensure that it is functioning properly, and to monitor and tune the operation of the system. The Deployment Plan and schedule also include the tasks required to assume all fiscal agent business functions from the incumbent.

We are keenly aware of the complexity involved with implementing the Replacement MMIS. The successful coordination of the numerous steps in association with the NC DHHS that lead up to the system and operational cutover requires the synchronization of an immense number of tasks.

A Final Deployment Checklist is based on the Deployment Plan and IMP. In particular, the Deployment Plan details all of the tasks, procedures, documentation, and other relevant activities that must be implemented down to the minutest level. In many instances, we have broken tasks down to the hour-by-hour level of detail. This extraordinary attention to detail and the capture of all phase minutiae are critical to the success of the deployment.

Following the checklist, there is an accurate accounting for all systems elements leading up to the final rollout of the Replacement MMIS, which leads into the warranty period, followed by the ongoing maintenance and systems support period. **(SOO 10.10-1)**

(10.10-1)

(50.2.4.1.5)

D.1.17 Required Matrices (50.2.4.1.5)

As an experienced Medicaid fiscal agent, CSC understands the scope and objectives of the North Carolina functional requirements. CSC offers a modern, web-enabled, configurable solution that provides a high degree of compatibility with the RFP-specified functional requirements.

CSC is offering North Carolina a configurable, integrated MMIS solution that is highly compatible with the State's requirements. Analysis of the completed matrix indicates that ***only 10 percent of the requirements necessitate new functionality*** be added to the baseline system. The remaining 90 percent of the functionality requirements are available within our baseline system, as it exists today or with configuration and modification to existing functionality.

D.1.17.1 State Requirements Matrix (50.2.4.1.5)

To populate this matrix, CSC performed in-depth reviews of each RFP requirement by an engineering team comprising System, IT and Operational personnel – all of whom have extensive knowledge of Medicaid and the baseline system. Our first level review was conducted to earmark gaps within the baseline. While we determined that the baseline system and team capabilities could satisfy the vast majority of requirements, we identified the need for third-party applications and staffing solutions for such capabilities as provider credentialing services, single sign-on and expanded workflow functionality. To fill these gaps, CSC sought partnerships with established, highly regarded solution providers and applied this third-party product information as input into the appropriate entries in the State Requirements Matrix.

For those requirements where third-party support was not needed, the CSC engineering team assigned each requirement to one of three groupings:

1. **Requirement was understood as stated.** (No additional research was required to understand the meaning and scope.) The CSC engineering determined the work, if any, that would be required to modify the baseline system to fully satisfy the requirement. Documentation was captured to support the estimate as well as define the approach.
2. **Clarification needed.** (Basic framework understood, but more follow up was necessary to fully understand the scope.) For the requirements where clarification was needed, the engineering team utilized the information provided in the North Carolina Detailed System Design (DSD) to determine the scope of the requirement and the impact to the baseline MMIS.
3. **Functionality all new.** (Full extent of requirement not known.) For these requirements, the engineering team consulted the DSD to understand the direction North Carolina was taking previously. This provided the engineering team with a basis of understanding to properly define a solution and assess the effort.

As a result of this activity, the CSC engineering team developed an initial approach and level of effort required to satisfy each requirement. These initial findings were then formally reviewed by a core group of senior CSC Systems and Operations staff. This review provided an opportunity to vet each approach and confirm the level of

effort assigned. Refinements were made as necessary. The final approaches were then used to populate the State Requirements Matrix and ultimately create our "Build" strategy and implementation schedule.

For the BAFO submission, we have verified the entries in columns A, B, C and E in the State Requirement Matrix are accurate and definitive . Furthermore, we have deleted the Gap Analysis from our proposal, which reflected our preliminary assessment and generated confusion in the review of State Requirement Matrix. (**Comment CSC202**)

Additionally, CSC has revised column D of the State Requirements Matrix to include accurate proposal section and page references for all entries. (**Comment CSC116**)

D.1.17.2 Matrix Entries

CSC has populated Appendix 50, Attachment C, Exhibit 1, State Requirements Matrix according to the directions provided in RFP Section 5.2.4.1.5. Specifically, all requirements with system implications (whether listed within Systems or Operational requirements sections) have entries in columns A – E. Operational requirements with no system implications only reflect entries for Columns D and E.

For ease of reference, we formatted the section numbers in Column D in bold, blue font to distinguish them from the corresponding page numbers.

As indicated by our entries in Column E of the matrix, CSC agrees to meet all requirements stated in the State Requirements Matrix and we pledge to work collaboratively with NC DHHS to deliver the Replacement MMIS.

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
	Multi-Payer Requirements					
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	N	Y	N	**D.1.4.1.2;** D.1.4.1-4 **D.1.4.8.1;** D.1.4.8-3 **D.1.4.8.5.1;** D.1.4.8-29	Y

Requirement #	Requirement Description	A	B	C	D	E
					D.1.4.8.5.2; D.1.4.8-29 **D.1.4.14.1;** D.1.4.14-1	
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	N	Y	N	**D.1.4.1.2; D.1.4.1-4** **D.1.4.1.2;** D.1.4.1-5 **D.1.4.8.5.1;** D.1.4.8-25	Y
40.1.1.3	Provides capability to allow recipients and providers to enroll in one (1) or more benefits plans	N	Y	N	**D.1.4.1.2;** D.1.4.1-5 **D.1.4.2;** D.1.4.2-2 **D.1.4.5.2.4;** D.1.4.5-13	Y
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	N	Y	N	**D.1.4.1.2.3;** D.1.4.1-7 **D.1.4.6.1;** D.1.4.6-4	Y
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	N	Y	N	**D.1.4.1.2.2;** D.1.4.1-6 **D.1.4.6.1;** D.1.4.6-4	Y

Requirement #	Requirement Description	A	B	C	D	E
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	N	Y	N	**D.1.4.1.2.3;** D.1.4.1-7 **D.1.4.8.5.1;** D.1.4.8-26 **D.1.4.14.1;** D.1.4.14-1	Y
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	N	Y	N	**D.1.4.1.2.3;** D.1.4.1-7 **D.1.4.8.5.1;** D.1.4.8-29 **D.1.4.8.5.2;** D.1.4.8-29 **D.1.4.14.1;** D.1.4.14-1	Y
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	N	Y	N	**D.1.4.1.2.3;** D.1.4.1-8 **D.1.4.8.5.5;** D.1.4.8-49	Y
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	N	Y	N	**D.1.4.1.2.3;** D.1.4.1-8 **D.1.4.1.2.3;** D.1.4.1-9 **D.1.4.8.5.1;** D.1.4.8-24 **D.1.4.14.1;** D.1.4.14-1	Y

Requirement #	Requirement Description	A	B	C	D	E
40.1.1.10	Provides capability to track and report current and historical claims detail and associated funding sources	N	N	Y	**D.1.4.8.10;** D.1.4.8-89 **D.1.4.14.1;** D.1.4.14-1	Y
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	N	N	N	**D.1.4.1.4;** D.1.4.1-10	Y
40.1.1.12	Provides capability to track, report, reproduce, and/or forward recipient mail that is undeliverable	N	N	N	**D.2.1.1.3.5;** D.2.1.1-7	Y
40.1.1.13	Fiscal Agent shall shred recipient correspondence that is returned to the Fiscal Agent as non-deliverable				**D.2.1.1.3.5;** D.2.1.1-7	Y
40.1.1.14	Provides capability for data validation editing for all online and Web entry views	N	N	N	**D.1.4.1.6;** D.1.4.1-12	Y
	Data Transfer and Conversion					
Requirement Deleted 40.1.1.15	~~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~~					
	Interfaces					
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	N	N	N	**D.1.4.1.4;** D.1.4.1-10	Y

Requirement #	Requirement Description	A	B	C	D	E
	Security					
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				**D.1.4.1.5;** D.1.4.1-11 **D.2.1.5.1.5;** D.2.1.5-6 **H.1.2;** H.7 **H.1.2.2;** H-12	Y
40.1.1.18	Provides capability for initial batch loading of security records and profiles prior to implementation					
	User Access Authentication and Authorization					
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 *DHHS Application Integration with NCID* in the Procurement Library.	N	Y	N	**D.1.4.1.5;** D.1.4.1-11 **H.1.3.2;** H-22	Y
40.1.1.20	Provides capability to adhere to the role-based access control model in compliance with NC DHHS Security policies Refer to *Replacement MMIS Security Business Rules* in the Procurement Library.	N	N	N	**D.1.4.1.5;** D.1.4.1-11 **H.1.3.2;** H-22	Y
	Architecture Reference *Appendix 40, Attachment B, DMA Network Diagram* and *Appendix 40, Attachment C, DMH Network Diagram* of this RFP for information purposes only.					
40.1.1.21	**Goal**: Provides capability for the architecture to be:	N	N	N	**D.1.10;** D.1.10-1	Y

Requirement #	Requirement Description	A	B	C	D	E
	▪ Adaptable ▪ Available ▪ Extensible ▪ Interoperable ▪ Manageable ▪ Redundant ▪ Resilient ▪ Scalable ▪ Securable					
40.1.1.22	**Goal**: Provides capability for the architecture to align with the principles and practices in the North Carolina Statewide Technical Architecture (STA)	N	N	N	**D.1.10;** D.1.10-1	Y
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.	N	N	N	**D.1.10;** D.1.10-1 **D.1.10;** D.1.10-2	Y
40.1.1.24	**Goal**: 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	N	N	N	**D.1.10;** D.1.10-1 **D.1.10;** D.1.10-2	Y
40.1.1.25	**Goal**: 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	N	N	N	**D.1.10;** D.1.10-1	Y
	System Software Controls					
40.1.1.26	Provides capability to update records to reflect changes such as merging or decoupling of recipient and provider IDs	N	N	N	**D.1.4.2.4;** D.1.4.2-12 **D.1.4.5.2.4;** D.1.4.5-18	Y

Requirement #	Requirement Description	A	B	C	D	E
	User Interface and Navigation					
40.1.1.27	Provides capability for standard user interface characteristics, data accessibility, and navigation across all Replacement MMIS business areas	N	N	N	**D.1.4.1.6;** D.1.4.1-12	Y
40.1.1.28	Provides capability for compliance with language and accessibility requirements as defined in the Regulatory Compliance Section	N	Y	N	**D.1.4.1.6;** D.1.4.1-12	Y
40.1.1.29	**Goal**: 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	N	N	N	**D.1.4.1.6;** D.1.4.1-12	Y
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	N	N	N	**D.1.4.1.6;** D.1.4.1-12	Y
40.1.1.31	Provides capability for real-time interaction with all business areas, enabling routine inquiries	N	N	N	**D.1.4.1.6;** D.1.4.1-12	Y
40.1.1.32	Provides capability for multiple business area views to be displayed concurrently and to facilitate interaction between business area views	N	N	N	**D.1.4.1.6;** D.1.4.1-12	Y
40.1.1.33	Provides capability for consistency in displaying view/file/report titles, dates, times, and other business area-specific requirements	N	N	N	**D.1.4.1.6;** D.1.4.1-12	Y
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	N	N	N	**D.1.4.1.6;** D.1.4.1-12	Y
	Document Management and Correspondence Tracking					
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	N	N	N	**D.1.4.1.7;** D.1.4.1-13	Y

Requirement #	Requirement Description	A	B	C	D	E
	MMIS					
40.1.1.36	Provides capability for integrated document management and correspondence tracking across all Replacement MMIS business areas	N	N	N	**D.1.4.1.7;** D.1.4.1-13	Y
40.1.1.37	Provides capability for online access to Replacement MMIS and document management and correspondence tracking with a single log-on	Y	N	N	**D.1.4.1.7;** D.1.4.1-13	Y
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	Y	N	N	**D.1.4.1.7;** D.1.4.1-13	Y
40.1.1.39	Provides capability to receive, electronically store, and retrieve intraoral/extraoral photographs, digital radiographs, and digital versions of orthodontic models (casts)	Y	N	N	**D.1.4.1.6;** D.1.4.1-12 **D.1.4.1.7;** D.1.4.1-13	Y
40.1.1.40	Provides capability to link incoming documents, correspondence, and supporting documentation to related documents and correspondence already on file	N	N	N	**D.1.4.1.7;** D.1.4.1-13	Y
40.1.1.41	Provides capability to assign a unique document identifier to each document	N	N	N	**D.1.4.1.7;** D.1.4.1-13	Y
40.1.1.42	Provides capability to retrieve all linked documents with one (1) request	N	N	N	**D.1.4.1.7;** D.1.4.1-13	Y
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	N	N	N	**D.1.4.1.7;** D.1.4.1-13	Y
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	N	N	N	**D.1.4.1.7;** D.1.4.1-14	Y

Requirement #	Requirement Description	A	B	C	D	E
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	N	N	N	**D.1.4.1.7;** D.1.4.1-14	Y
40.1.1.46	Provides capability for data retrieved from offline storage to be retained online for ten (10) business days, unless otherwise requested	N	N	N	**D.1.4.1.7;** D.1.4.1-14	Y
40.1.1.47	Provides capability to print hard copies of electronically stored documents	N	N	N	**D.1.4.1.7;** D.1.4.1-13	Y
40.1.1.48	Provides capability to print and fax documents	N	N	N	**D.1.4.1.7;** D.1.4.1-13	Y
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	N	N	N	**D.1.4.1.7;** D.1.4.1-14	Y
40.1.1.50	Provides capability to make all documents available to the State within two (2) business days of creation	N	N	N	**D.1.4.1.7;** D.1.4.1-13	Y
40.1.1.51	Provides capability to accept input in frequencies as defined in business areas and from multiple sources, types, and formats, including: ▪ Required electronic transaction formats, (e.g., X12) ▪ Scanners (e.g., paper claims/written correspondence) ▪ Electronic text (e.g., e-mail, e-fax, voice media files) ▪ Paper documents (e.g., correspondence, claims forms, faxes) ▪ Portable media (e.g., magnetic tapes, 3.5” floppy drives, CD/DVD drives)	N	Y	N	**D.1.4.1.7;** D.1.4.1-14	Y
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	Y	N	N	**D.1.4.1.7;** D.1.4.1-14	Y
40.1.1.53	Provides capability to protect all stored images and electronic copies from direct	N	N	N	**D.1.4.1.7;** D.1.4.1-14	Y

Requirement #	Requirement Description	A	B	C	D	E
	access while allowing authorized copies to be used for further processing					
	Audit Trail					
40.1.1.54	Provides capability to track through audit trail data with date/time stamps: ▪ All access, activity, and system identifier of users or persons making adds, changes, deletes, or queries ▪ All activity that causes any additions, changes, deletions, or queries ▪ 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	N	N	N	**D.1.4.1.8;** D.1.4.1-14	Y
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	N	N	N	**D.1.4.1.8;** D.1.4.1-14	Y
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	N	N	N	**D.1.4.1.8;** D.1.4.1-14	Y
	Online Help					
40.1.1.57	Provides capability for selectable online help views for user functionality that duplicate or link to system documentation	N	N	N	**D.1.4.1.6;** D.1.4.1-12 **D.1.4.1.9;** D.1.4.1-14	Y
40.1.1.58	Provides capability for online help for all features, functions, and data element fields as	N	Y	N	**D.1.4.1.6;** D.1.4.1-12	Y

Requirement #	Requirement Description	A	B	C	D	E
	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				**D.1.4.1.9;** D.1.4.1-15	
40.1.1.59	Provides capability for context-sensitive help to view, window, or dialog	Y	N	N	**D.1.4.1.6;** D.1.4.1-12 **D.1.4.1.9;** D.1.4.1-15	Y
	Search and Query					
40.1.1.60	Provides capability to allow all records to be selectable and searchable by record elements, as specified within business areas	N	N	N	**D.1.4.1.10;** D.1.4.1-15	Y
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	N	N	N	**D.1.4.1.10;** D.1.4.1-15	Y
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	N	N	N	**D.1.4.1.10;** D.1.4.1-15	Y
40.1.1.63	Provides capability for users to query via parameterized standard reports and view online production data	N	Y	N	**D.1.4.1.10;** D.1.4.1-15	Y
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	Y	N	N	**D.1.4.1.10;** D.1.4.1-15	Y
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	Y	N	N	**D.1.4.1.10;** D.1.4.1-15	Y
40.1.1.66	Provides capability to govern queries so that run time does not exceed defined limits	N	N	N	**D.1.4.1.10;** D.1.4.1-15	Y

Requirement #	Requirement Description	A	B	C	D	E
	Correspondence and Letters					
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	N	N	N	**D.1.4.1.11;** D.1.4.1-15	Y
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 area requirements and to electronically store saved images of each letter produced from the templates in an easily accessible, searchable format	Y	N	N	**D.1.4.1.11;** D.1.4.1-15	Y
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	Y	N	N	**D.1.4.1.11;** D.1.4.1-15	Y
40.1.1.70	Provides capability to create and manage stakeholder correspondence, clinical policy documentation, bulletins/publication, business rules, and business forms	N	N	N	**D.1.4.1.11;** D.1.4.1-16	Y
40.1.1.71	Provides capability to perform desktop publishing of documents for all stakeholders	N	N	N	**D.1.4.1.11;** D.1.4.1-16	Y
40.1.1.72	Provides capability for on-demand and batch-driven correspondence creation and mailing	N	N	N	**D.1.4.1.11;** D.1.4.1-16	Y
40.1.1.73	Provides capability for letter-generation solution that has the flexibility to use form letters and/or on-demand text generation	N	N	N	**D.1.4.1.11;** D.1.4.1-16	Y
40.1.1.74	Provides capability for all stakeholders to create and electronically store correspondence templates for private and community use	N	N	N	**D.1.4.1.11;** D.1.4.1-16	Y
40.1.1.75	Provides capability to use spellchecker functionality	N	N	N	**D.1.4.1.11;** D.1.4.1-16	Y
40.1.1.76	Provides capability to use business rules intelligence to determine the best choice for	N	Y	N	**D.1.4.1.11;** D.1.4.1-16	Y

Requirement #	Requirement Description	A	B	C	D	E
	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	N	Y	N	**D.1.4.1.11;** D.1.4.1-16	Y
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	N	N	N	**D.1.4.1.11;** D.1.4.1-16	Y
40.1.1.79	Provides capability to send correspondence through workflow management for approval, where business rules require secondary approval	N	Y	N	**D.1.4.1.11;** D.1.4.1-16	Y
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)	N	N	N	**D.1.4.1.11;** D.1.4.1-16	Y
40.1.1.81	Provides capability to track the correspondence creator, date, recipient, and time stamp and maintain this information historically	N	N	N	**D.1.4.1.11;** D.1.4.1-16	Y
40.1.1.82	Provides capability to enclose attachments to meet recipient's language requirements	N	Y	N	**D.1.4.1.11;** D.1.4.1-16	Y
40.1.1.83	Provides capability to create and distribute documents to multiple addresses	N	N	N	**D.1.4.1.11;** D.1.4.1-16	Y
40.1.1.84	Provides capability to redistribute static letters	N	N	N	**D.1.4.1.11;** D.1.4.1-16	Y
40.1.1.85	Provides capability to create performance reporting associated with correspondence	N	N	N	**D.1.4.1.11;** D.1.4.1-16	Y
40.1.1.86	Provides capability to allow user to designate address to be used	N	N	N	**D.1.4.1.11;** D.1.4.1-16	Y
40.1.1.87	Provides capability to enforce security rules to control who issues each type of letter	N	N	N	**D.1.4.1.11;** D.1.4.1-16	Y

Requirement #	Requirement Description	A	B	C	D	E
	and to designate and enforce a chain of review for certain letters				**H.1;** H-2	
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.	N	Y	N	**D.1.4.1.11;** D.1.4.1-16	Y
	Reports					
40.1.1.89	Provides capability for system-generated reporting to include, without limitation: ▪ Federal- and State-required report and distribution ▪ Reports identified in Appendix 40, Attachment G of this RFP ▪ Fiscal Agent operations and system performance ▪ Contract compliance ▪ Cost allocation ▪ Contract invoicing ▪ Standard pre-formatted reports with parameters selection criteria	N	N	N	**D.1.4.1.12;** D.1.4.1-17	Y
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	N	N	N	**D.1.4.1.12;** D.1.4.1-17 **H.1.2.2;** H-12	Y
40.1.1.91	Provides capability to maintain all reports that cannot be regenerated to reflect the report contents as originally represented	N	N	N	**D.1.4.1.12;** D.1.4.1-17	Y
	Workflow Management					
40.1.1.92	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	N	N	N	**D.1.4.1.13;** D.1.4.1-18 **D.1.4.1.13;** D.1.4.1-19	Y

Requirement #	Requirement Description	A	B	C	D	E
	Provides capability to support: ▪ Documentation retrieval (link to imaged documentation) ▪ Alert agent on events such as work item creation, assignment, work item updates, and status changes ▪ Assignment tracking and retrieval ▪ Aging report(s) ▪ Work item monitoring ▪ Work item reassignment				**D.1.4.1.13;** D.1.4.1-20 **D.1.4.1.13;** D.1.4.1-21 **D.1.4.1.13;** D.1.4.1-22	
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	N	N	N	**D.1.4.1.13;** D.1.4.1-21	Y
40.1.1.94	Provides capability to move requests to the next work queue based on expertise required for completion	N	N	N	**D.1.4.1.13;** D.1.4.1-22	Y
40.1.1.95	Provides capability to allow the assignment or routing of tasks by the user	N	N	N	**D.1.4.1.13;** D.1.4.1-18	Y
40.1.1.96	Provides capability for tickler and/or to-do list capability	Y	N	N	**D.1.4.1.13;** D.1.4.1-21	Y
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	N	N	N	**D.1.4.1.13;** D.1.4.1-19	Y
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	N	N	N	**D.1.4.1.13;** D.1.4.1-19	Y
40.1.1.99	Provides capability to designate certain notes as confidential and restrict access to notes to authorized users	Y	N	N	**D.1.4.1.13;** D.1.4.1-19	Y

Requirement #	Requirement Description	A	B	C	D	E
40.1.1.100	Provides capability for automated work load balancing	N	N	N	**D.1.4.1.13;** D.1.4.1-21	Y
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	Y	N	N	**D.1.4.1.13;** D.1.4.1-22 **D.1.4.1.18;** D.1.4.1-38	Y
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	N	N	N	**D.1.4.1.13;** D.1.4.1-22	Y
40.1.1.103	Provides capability to use user-defined templates that support various workflow processes	Y	N	N	**D.1.4.1.13;** D.1.4.1-23	Y
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	N	N	N	**D.1.4.1.13;** D.1.4.1-23	Y
40.1.1.105	Provides capability of integrating with a rules engine	N	N	N	**D.1.4.1.13;** D.1.4.1-18	Y
40.1.1.106	Provides capability to allow State access to work queue to assist in evaluation and disposition of work queue items	N	N	N	**D.1.4.1.13;** D.1.4.1-23	Y
	Rules Engine					
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					

Requirement #	Requirement Description	A	B	C	D	E
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					Y
40.1.1.112	Provides capability to allow for rules to be tested against production data prior to installation	N	N	N	**D.1.4.1.14;** D.1.4.1-24	Y
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	N	N	N	**D.1.4.1.14;** D.1.4.1-25	Y
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	N	N	N	**D.1.4.1.14;** D.1.4.1-24	Y
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					
New Requirement 40.1.1.120	Provides capability to apply Procedure Code Pricing (PR) File Cleanup business rules against current Procedure Code Pricing (PR) File					

Requirement #	Requirement Description	A	B	C	D	E
	Integrated Test Facility					
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	N	N	N	**D.1.4.1.15;** D.1.4.1-30	Y
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	N	N	N	**D.1.4.1.15;** D.1.4.1-30	Y
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	N	N	N	**D.1.4.1.15;** D.1.4.1-30	Y
40.1.1.124	Provides capability for the automated migration of new business areas and application fixes between the ITF environments and production environment	N	N	N	**D.1.4.1.15;** D.1.4.1-31	Y
40.1.1.125	Provides capability to perform assessments without affecting production and/or data	N	N	N	**D.1.4.1.15;** D.1.4.1-30	Y
40.1.1.126	Provides capability for State access to all test system files	N	N	N	**D.1.4.1.15;** D.1.4.1-30	Y
40.1.1.127	Provides capability for version control in the ITF	N	N	N	**D.1.4.1.15;** D.1.4.1-31	Y
40.1.1.128	Provides capability to synchronize the ITF with the production environment when updating the Replacement MMIS production system	N	N	N	**D.1.4.1.15;** D.1.4.1-31 **D.4.4.2;** D.4-11	Y

Requirement #	Requirement Description	A	B	C	D	E
	Training					
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)	N	N	N	**D.4.6.3;** D.4-16	Y
40.1.1.130	Provides capability for online CBT courses for all Replacement MMIS application systems	N	N	N	**D.4.6.3;** D.4-16	Y
40.1.1.131	Provides capability for proficiency testing, quality reviews, and retraining, as needed, for Fiscal Agent staff				**D.4.6.1;** D.4-15	Y
40.1.1.132	Provides capability to deliver provider training through Web-based services and electronic media	Y	N	N	**D.4.5.1;** D.4-13 **D.4.5.2;** D.4-13	Y
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	Y	N	N	**D.4.5;** D.4-12 **D.4.6.3;** D.4-16	Y
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	Y	N	N	**D.4.5;** D.4-12	Y
40.1.1.135	Provides capability for Web-accessible downloads of training documentation that will be synchronized with provider policy and billing updates	Y	N	N	**D.4.5;** D.4-13	Y
40.1.1.136	Provides capability for a training evaluation tool to analyze and report to the State on training effectiveness	N	N	N	**D.4.6.8** D.4-19	Y

Requirement #	Requirement Description	A	B	C	D	E
	Call Center Services					
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	N	N	N	**D.1.4.1.17;** D.1.4.1-31	Y
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	N	N	N	**D.1.4.1.17;** D.1.4.1-33	Y
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.	N	N	N	**D.1.4.1.17;** D.1.4.1-33	Y
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	N	N	N	**D.1.4.1.17;** D.1.4.1-33	Y
40.1.1.141	Provides capability to support requirements of Civil Rights Act for Persons of Limited English Proficiency (LEP) and Hearing Impaired	N	N	N	**D.1.4.1.17;** D.1.4.1-31	Y
40.1.1.142	Provides capability for call monitoring by supervisors and State monitors	N	N	N	**D.1.4.1.17;** D.1.4.1-36	Y
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	N	N	N	**D.1.4.1.17;** D.1.4.1-33	Y
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	N	N	N	**D.1.4.1.17;** D.1.4.1-33	Y

Requirement #	Requirement Description	A	B	C	D	E
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	Y	N	N	**D.1.4.1.17;** D.1.4.1-32	Y
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	Y	N	N	**D.1.4.1.17;** D.1.4.1-32	Y
40.1.1.147	Provides capability to transfer calls, along with all related documentation that was collected	N	N	N	**D.1.4.1.17;** D.1.4.1-33	Y
40.1.1.148	Provides capability for callers to interact with an automated attendant or speak to a customer service representative	N	N	N	**D.1.4.1.17;** D.1.4.1-32	Y
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				**D.1.4.1.17;** D.1.4.1-33	Y
	System Availability					
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	N	N	N	**D.1.4.1.19;** D.1.4.1-45	Y
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	N	N	N	**D.1.4.1.19;** D.1.4.1-45	Y

Requirement #	Requirement Description	A	B	C	D	E
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: ▪ Ninety (90) percent of transactions to occur in four (4) seconds or less ▪ Ninety-five (95) percent of transactions to occur in five (5) seconds or less ▪ Ninety-seven (97) percent of transactions to occur in six (6) seconds or less ▪ Ninety-nine (99) percent of transactions to occur in seven (7) seconds or less	N	N	N	**D.1.4.1.19;** D.1.4.1-45	Y
	Customer Service Request Tracking System					
40.1.1.153	Provides capability for online tracking and workflow management of requests for service	N	N	N	**E.9.5;** E.9-12 **E.9.6:** E.9-13	Y
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				**E.9.5;** E.9-12 **E.9.6:** E.9-13	Y
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				**E.9.5;** E.9-12 **E.9.6:** E.9-13	Y
40.1.1.156	Provides capability for tracking CSR status by multiple data elements consistent with the Change Management Process				**E.9.5;** E.9-12 **E.9.6:** E.9-13	Y

Requirement #	Requirement Description	A	B	C	D	E
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				**E.9.5;** E.9-12 **E.9.6:** E.9-13	Y
40.1.1.158	Provides capability to maintain accessibility to all completed project requests for analytical purposes throughout the life of the Contract				**E.9.5;** E.9-12 **E.9.6;** E.9-13	Y
	Web Portal					
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	N	N	N	**D.1.4.1.18;** D.1.4.1-37	Y
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	N	N	N	**D.1.4.1.18;** D.1.4.1-37	Y
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	N	N	N	**D.1.4.1.18;** D.1.4.1-37	Y
40.1.1.162	Provides capability to post announcements or alerts that are displayed at user sign-on	N	N	N	**D.1.4.1.18;** D.1.4.1-38	Y
40.1.1.163	Provides capability to maintain archives of posted announcements and non-provider specific alerts, including the date and message	N	N	N	**D.1.4.1.18;** D.1.4.1-38	Y
40.1.1.164	Provides capability to access, complete, and submit online surveys	N	N	N	**D.1.4.1.18;** D.1.4.1-38	Y
40.1.1.165	Provides capability to link to CBT course presentations	N	N	N	**D.1.4.1.18;** D.1.4.1-38	Y
40.1.1.166	Provides capability to create, organize by topic, and post FAQs and responses online	N	N	N	**D.1.4.1.18;** D.1.4.1-38	Y

Requirement #	Requirement Description	A	B	C	D	E
40.1.1.167	Provides capability to maintain version history of previous forms, user manuals, etc.	N	N	N	**D.1.4.1.18;** D.1.4.1-38 **D.1.4.1.18;** D.1.4.1-40	Y
40.1.1.168	Provides capability to create configurable Web pages of Replacement MMIS functions	N	N	N	**D.1.4.1.18;** D.1.4.1-38	Y
40.1.1.169	Provides capability to view and download standard Replacement MMIS reports in a readable format	N	N	N	**D.1.4.1.18;** D.1.4.1-38	Y
40.1.1.170	Provides capability to request and view parameter-driven standard formatted reports	N	N	N	**D.1.4.1.18;** D.1.4.1-38	Y
40.1.1.171	Provides capability to link to stakeholder Web sites	N	N	N	**D.1.4.1.18;** D.1.4.1-38	Y
40.1.1.172	Provides capability to populate user/security profile-related data for Web Portal access prior to implementation				**D.1.4.1.18;** D.1.4.1-40 **H.1.1;** H-3	Y
	Data Integrity					
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	N	N	N	**D.1.4.1.20;** D.1.4.1-46	Y

40.1.2 General Operational Requirements

Requirement #	Requirement Description	A	B	C	D	E
	Fiscal Agent Data Center and Offices					
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.				**D.1.9;** D.1.9-1 **D.2.2;** D.2.2-1	Y
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.				**D.1.9.2;** **D.1.9-4** **D.2.2;** D.2.2-1	Y
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.				**D.1.9;** D.1.9-1 **D.2.2;** D.2.2-2 **H.1.1.2;** H-5	Y
40.1.2.4	Fiscal Agent (DDI and Operations Phases) shall locate key personnel, business units, and the mailroom at the local site.				**D.1.9;** D.1.9-1 **D.2.2;** D.2.2-2	Y
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: ▪ Lockable desks				**D.1.9.1;** D.1.9-3 **D.2.2;** D.2.2-3 **H.1.1.2;** H-5	Y

Requirement #	Requirement Description	A	B	C	D	E
	▪ Ergonomically correct chairs ▪ IBM-compatible PCs, monitors, and printers with appropriate LAN/WAN connections, Internet access, and e-mail access, at a minimum meeting State standards ▪ Lockable file cabinets ▪ Telephones ▪ Office supplies.					
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.				**D.1.9.1;** D.1.9-3 **D.2.2;** D.2.2-3	Y
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.				**D.1.9.1;** D.1.9-3 **D.2.1.5.1.6;** D.2.1.5-8 **D.2.2;** D.2.2-3	Y
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.				**D.1.9.1;** D.1.9-3 **D.2.1.5.1.4;** D.2.1.5-6 **D.2.2;** D.2.2-3	Y
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.				**D.1.9.1;** D.1.9-3 **D.2.2;**	Y

Requirement #	Requirement Description	A	B	C	D	E
					D.2.2-3	
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.				**D.2.1.5.1.5;** D.2.1.5-6 **D.2.2;** D.2.2-3 **H.1.1.2;** H.1-5	Y
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.				E.1.2.13 E.1-28	Y
	Regulatory Compliance					
D0.1.2.12	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 personally identifiable information and/or financial information. Regulations, statutes, and policies include, without limitation: ▪ 45 CFR Parts 160, 164 (Health Insurance Portability and Accountability Act) ▪ 42 U.S.C. 1320(d) (Public Health, Approval of Special Projects) ▪ 42 CFR Parts 2, 51, 431 (Confidentiality of Mental Health and Substance Abuse information) ▪ 42 CFR Parts 430-502 (Applicable to Medicare/Medicaid) ▪ 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act. ▪ Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d et. seq. ▪ Title XIX, Section 1903 (42 U.S.C. 1396b) Social Security: Payment to States ▪ Title XIX, Section 1927 (42 U.S.C. 1396r-8) Social Security: Payment for covered outpatient drugs	N	N	N	**D.1.4.1;** D.1.4.1-3 **D.1.4.1.6;** D.1.4.1-12 **H.1;** H-2	Y

Requirement #	Requirement Description	A	B	C	D	E
	▪ Federal MMIS certification standards ▪ Financial Accounting Standards Board Generally Accepted Accounting Principles (GAAP) ▪ Part 11 of the State Medicaid Manual ▪ North Carolina State Plans for Medicaid, Mental Health, Developmental Disabilities, and Substance Abuse, and Public Health ▪ US DHHS Title VI Language Access Policy ▪ Recipient eligibility policies from the NC DHHS Eligibility Information System (EIS) and the Common Name Data Service (CNDS) ▪ NC State Law S 1048 (Identity Theft Protection Act) ▪ 10A NCAC Chapters 21 & 22, Medical Assistance ▪ 10A NCAC 26B (Confidentiality Rules For Mental Health, Developmental Disabilities, and Substance Abuse Services) ▪ 10A NCAC Chapter 45, DPH Payment Programs ▪ NC DHHS OSP. 2005. DHHS Application Security Policy. ▪ NC OSCIO. 2004. Application Security Policy with Guidelines, Statewide Information Technology Policy. ▪ N.C.G.S. §126: State Personnel System ▪ N.C.G.S. § 131D: Inspection and Licensing of Facilities ▪ N.C.G.S. §131E: Health Care Facilities and Services ▪ N.C.G.S. § 132: Public Records ▪ The Privacy Act of 1974 5 U.S.C. § 552a ▪ NCAC 10A Chapter 13 - NC Medical Care Commission					

Requirement #	Requirement Description	A	B	C	D	E
	▪ NCAC 10 A Chapter 14 - Division of Facility Services ▪ NCAC 10A Chapter 26 - Mental Health, General ▪ NCAC 10A Chapter 27 - Mental Health, Community Facility and Services ▪ NCAC 10A Chapter 28 - Mental Health, State Operated Facilities ▪ Government Auditing Standards (http://www.gao.gov/govaud/yb2003.pdf) ▪ Information Systems Audit Standards (http://www.isaca.org/stand1.htm). ▪ NC DHHS Privacy and Security policies ▪ Federal Section 508(http://www.section508.gov)					
	Data Transfer and Conversion					
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.				**D.1.4.1.3;** D.1.4.1-9 **D.1.15.1;** D.1.15-1	Y
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.				**D.1.4.1.3;** D.1.4.1-9 **D.1.15.5.1;** D.1.15-15	Y
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.				**D.1.4.1.3;** D.1.4.1-9 **D.1.15.5.2;** D.1.15-15	Y
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	N	N	N	**D.1.4.1.3;** D.1.4.1-9 **D.1.15.4.2;** D.1.15-13	Y

Requirement #	Requirement Description	A	B	C	D	E
	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.				**D.1.4.1.3;** D.1.4.1-9 **D.1.15.4.2;** D.1.15-13	Y
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).				**D.1.4.1.3;** D.1.4.1-9 **D.1.15.2.2;** D.1.15-5	Y
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.				**D.1.4.1.3;** D.1.4.1-9 **D.1.15.1;** D.1.15-2	Y
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.				**D.1.4.1.3;** D.1.4.1-9 **D.1.15.2.1;** D.1.15-5	Y
40.1.2.21	Fiscal Agent (DDI Phase) shall convert and configure all business rules data into a rules engine.				**D.1.4.1.3;** D.1.4.1-9 **D.1.15.2.2;** D.1.15-5 **D.1.15.4.1;** D.1.15-11	Y
	Interfaces					
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.				**D.1.4.1.4;** D.1.4.1-10	Y

Requirement #	Requirement Description	A	B	C	D	E
					D.2.1.5.3; D.2.1.5-11	
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.				**D.1.4.1.4;** D.1.4.1-10 **D.2.1.5.3;** D.2.1.5-12	Y
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.				**D.1.4.1.4;** D.1.4.1-10 **D.2.1.5.3;** D.2.1.5-12	Y
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.	N	N	N	**D.1.4.1.4;** D.1.4.1-10 **D.2.1.5.3;** D.2.1.5-12	Y
	Security					
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.				**D.2.1.5.1.7;** D.2.1.5-8 **F.4.7;** F.4-6 **H.1.2;** H-7 **H.1.2.1;** H-11 **H.1.6;** H-25	Y
40.1.2.27	Fiscal Agent (DDI Phase) shall assess and document the security threats and				**H.1.2.1;** H-11	Y

Requirement #	Requirement Description	A	B	C	D	E
	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.	N	N	N	**H.1.2.2;** H-12	Y
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.				**H.1.2.1;** H-11 **H.1.7;** H-26	Y
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.				**H.1.2.1;** H-11 **H.1.2.4;** H-17	Y
.	**Data Protection Assurance**					
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.	N	N	N	**H.1.2.2;** H-12	Y
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.	N	N	N	**H.1.2.2;** H-12	Y

Requirement #	Requirement Description	A	B	C	D	E
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.				**H.1.2.2;** H-12	Y
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.				**H.1.2.2;** H-12	Y
	Enterprise Security Approach					
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).				**H.1.2;** H-7	Y
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.				**D.4.4.1;** D.4-8 **H.1.2;** H-7	Y
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.				**H.1.2.1;** H-11	Y
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.				**D.2.1.5.1.7;** D.2.1.5-8 **F.4.3;** F.4-3 **H.1.6;** H-25	Y

Requirement #	Requirement Description	A	B	C	D	E
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.				**H.1.2.2;** H-12	Y
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.				**H.1.2.4;** H-17 **H.1.5;** H-23	Y
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.				**H.1.2.4;** H-17	Y
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.				**F.4.7;** F.4-6 **H.1.2;** H-7 **H.1.6;** H-25	Y
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.				**H.1.2.5;** H-18	Y
	Facility Access					
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.				**D.2.2.1;** D.2.2-3 **H.1.3;** H-18	Y

Requirement #	Requirement Description	A	B	C	D	E
40.1.2.45	Fiscal Agent (DDI and Operations Phases) shall provide accountability control to record facility access.				**D.2.2.1;** D.2.2-3 **H.1.3;** H-18	Y
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.				**D.2.2.1;** D.2.2-3 **H.1.3;** H-18	Y
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.				**D.2.2.1;** D.2.2-3 **H.1.3;** H-18	Y
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.				**D.2.2.1;** D.2.2-3 **H.1.3;** H-18	Y
New Requirement 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.				**H.1.2.2;** H-12 **H.1.3;** H-19 **H.1.3.2;** H-22	Y

Requirement #	Requirement Description	A	B	C	D	E
	User Access Authentication and Authorization					
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.	N	N	N	**D.1.4.1.5;** D.1.4.1-11 **D.2.1.5.1.5;** D.2.1.5-6 **H.1.3;** H-18 **H.1.3.2;** H-22	Y
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.	N	N	N	**D.1.4.1.5;** D.1.4.1-11 **H.1.3.2;** H-22 **H.1.4;** H-23	Y
	Application Systems Change Control					
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.				**H.1.3;** H-18 **H.1.4;** H-22	Y
.	**System Software Controls**					
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				**H.1.4;** H-22	Y

Requirement #	Requirement Description	A	B	C	D	E
	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.				**H.1.5;** H-23	Y
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.	Y	N	N	**H.1.5;** H-23	Y
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.				**H.1.7;** H-26	Y
	Logging and Reporting					
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.				**H.1.7;** H-26	Y
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.				**H.1.7;** H-26	Y
	Service Continuity Controls					
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				**H.1.7;** H-26	Y

Requirement #	Requirement Description	A	B	C	D	E
	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				**H.1.2.2;** H-12	Y
.	**Data Backup and Recovery**					
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.	N	N	N	**D.1.4.1.20;** D.1.4.1-45 **H.1.2.2;** H-12	Y
40.1.2.62	The Fiscal Agent (Operations Phase) shall ensure that individual files, collections of files, 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.	N	N	N	**D.1.4.1.20;** D.1.4.1-45 **D.2.1.5.3;** D.2.1.5-12	Y
.	**Records Retention**					
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.	N	N	N	**D.1.4.1.20;** D.1.4.1-46 **D.2.1.5.3;** D.2.1.5-12	Y

Requirement #	Requirement Description	A	B	C	D	E
	User Interface and Navigation					
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.				**D.1.4.1.6;** D.1.4.1-12 **D.2.1.5.3;** D.2.1.5-12	Y
40.1.2.65	Fiscal Agent (DDI and Operations Phases) shall standardize all views, windows, and reports, including: ▪ Format and content of all views ▪ All headings and footers ▪ Current date and time. Zip codes shall display nine digits. All references to dates shall be displayed consistently throughout the system (MM/DD/YYYY). All data labels and definitions used shall be consistent throughout the system and clearly defined in user manuals and data element dictionaries. All Replacement MMIS-generated messages shall be clear, user-friendly, and sufficiently descriptive to provide enough information for problem correction. All Replacement MMIS views shall display the generating program identification name and/or number. The display shall be consistent from view to view.				**D.1.4.1.6;** D.1.4.1-12 **D.2.1.5.3;** D.2.1.5-12	Y
	Workflow Management					
40.1.2.66	Fiscal Agent (Operations Phase) shall perform manual workload balancing.				**D.1.4.1.13;** D.1.4.1-21 **D.2.1.5.3;** D.2.1.5-12	Y

Requirement #	Requirement Description	A	B	C	D	E
40.1.2.67	Fiscal Agent (Operations Phase) shall perform work item reassignments.				**D.1.4.1.13;** D.1.4.1-21 **D.2.1.5.3;** D.2.1.5-12	Y
.	**Rules Engine**					Y
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.				**D.1.4.1.14;** D.1.4.1-24 **D.2.1.5.3;** D.2.1.5-12	Y
40.1.2.69	Fiscal Agent (Operations Phase) shall maintain up-to-date business rule documentation.				**D.1.4.1.14;** D.1.4.1-24 **D.2.1.5.3;** D.2.1.5-12	Y
40.1.2.70	Fiscal Agent (Operations Phase) shall perform business rule changes on a release basis.				**D.1.4.1.14;** D.1.4.1-24 **D.2.1.5.3;** D.2.1.5-12	Y
	Integrated Test Facility					
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.	N	N	N	**D.1.4.1.15;** D.1.4.1-30 **D.2.1.5.3;** D.2.1.5-13	Y
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.	N	N	N	**D.1.4.1.15;** D.1.4.1-30	Y
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				**D.1.4.1.15;** D.1.4.1-30	Y

Requirement #	Requirement Description	A	B	C	D	E
	State applications throughout the life of the Contract.				**D.2.1.5.3;** D.2.1.5-13	
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.				**D.1.4.1.15;** D.1.4.1-30 **D.2.1.5.3;** D.2.1.5-13	Y
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.				**D.1.4.1.15;** D.1.4.1-30 **D.2.1.5.3;** D.2.1.5-13	Y
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.				**D.1.4.1.15;** D.1.4.1-30 **D.2.1.5.3;** D.2.1.5-13 **D.4.4.2;** D.4-10 **D.4.5;** D.4-12	Y
	Training					
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.				**D.2.1.3.3;** D.2.1.3-23 **D.4.5;** D.4-12	Y
40.1.2.78	Fiscal Agent (DDI and Operations Phases) shall develop State-approved training materials for all users and make them available online.				**D.2.1.3.3;** D.2.1.3-24 **D.4.1;**	Y

Requirement #	Requirement Description	A	B	C	D	E
					D.4-3 **D.4.5;** D.4-12 **D.4.6;** D.4-13	
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.				**D.4.4;** D.4-8 **D.4.6;** D.4-13 **D.4.6;** D.4-14	Y
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.				**D.2.2.2;** D.2.2-5 **D.4.4.1;** D.4-9	Y
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.				**D.2.2.2;** D.2.2-5 **D.4.2.1;** D.4-6 **D.4.4.1;** D.4-8 **H.1.2;** H-7	Y
40.1.2.82	Fiscal Agent (DDI and Operations Phases) shall monitor, track, and evaluate effectiveness of training using training industry standard methodologies.				**D.2.1.3.5;** D.2.1.3-32 **D.4.4.1;**	Y

Requirement #	Requirement Description	A	B	C	D	E
					D.4-9 **D.4.4.2;** D.4-11	
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.				**D.4.4.1;** D.4-8	Y
40.1.2.84	Fiscal Agent (Operations Phase) shall report to the State monthly on Fiscal Agent staff training and proficiencies.				**D.4.4.1;** D.4-9 **H.1.2;** H-7	Y
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.				**D.2.1.3.3;** D.2.1.3-23 **D.4.5.1;** D.4-13	Y
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.				**D.2.1.3.3;** D.2.1.3-23 **D.4.6;** D.4-14	Y
40.1.2.87	Fiscal Agent (Operations Phase) shall participate in semi-annual Finance and Reimbursement Officers (FARO) conferences as requested by the State.				**D.2.1.3.4;** D.2.1.3-24 **D.4.6;** D.4-15	Y
40.1.2.88	Fiscal Agent (Operations Phase) shall plan, organize, and conduct the annual Medicaid Fair.				**D.2.1.3.4;** D.2.1.3-29 **D.4.6;**	Y

Requirement #	Requirement Description	A	B	C	D	E
					D.4-15	
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.				**D.2.1.3.2;** D.2.1.3-17 **D.4.6.3;** D.4-16	Y
	Call Center Services					
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.				**D.1.4.1.17;** D.1.4.1-31 **D.2.1.3.2;** D.2.1.3-17	Y
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.				**D.1.4.1.17;** D.1.4.1-31 **D.2.1.3.2;** D.2.1.3-17	Y
40.1.2.92	Fiscal Agent (Operations Phase) shall provide technical Help Desk support during all hours of system availability.				**D.1.4.1.17;** D.1.4.1-33 **H.1.1.3;** H-6	Y
	LAN/WAN Management Operational Requirement					
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.				**D.2.1.5.1.2;** D.2.1.5-4	Y
	Audit					
40.1.2.94	Fiscal Agent (Operations Phase) shall provide assistance to the State, or any				**H.1.2.4;** H-17	Y

Requirement #	Requirement Description	A	B	C	D	E
	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.				**H.1.2.4;** H-17	Y
	System/Software Maintenance					
40.1.2.96	Fiscal Agent (Operations Phase) shall be required to perform system maintenance to the Replacement MMIS based on State-approved CSRs.				**D.1.4.1.21;** D.1.4.1-47 **D.2.1.5.3;** D.2.1.5-13 **D.1.13.2;** D.1.13-3	Y
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.				**D.1.4.1.21;** D.1.4.1-47 **D.2.1.5.3;** D.2.1.5-13	Y
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.				**D.1.4.1.21;** D.1.4.1-47 **D.2.1.5.3;** D.2.1.5-13	Y

Requirement #	Requirement Description	A	B	C	D	E
40.1.2.99	Fiscal Agent (Operations Phase) shall perform maintenance to include, without limitation: ▪ activities necessary for the system to meet the requirements described in the RFP; ▪ activities related to file growth and partitioning; ▪ support of updates to all files and databases; ▪ software and hardware updates, as directed by the State; ▪ RDBMS routine activities; ▪ LAN/WAN administration and maintenance to ensure performance standards are met; ▪ activities necessary to ensure that all data, files, programs, utilities, and system and user documentation are current and that errors found are corrected; ▪ file maintenance, including manual table entry and programming, to support file maintenance changes, performance tuning, capacity planning, backup and recovery tasks, and archival tasks; ▪ 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; ▪ changes to tables for edit criteria; ▪ activities in support of updates to all files and databases, including the rules engine; ▪ add new values or changes to existing values found within internal program				**D.1.4.1.21;** D.1.4.1-47 **D.2.1.5.3;** D.2.1.5-13	Y

Requirement #	Requirement Description	A	B	C	D	E
	tables; ▪ 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; ▪ process improvements; ▪ 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 ▪ Rules engine configuration and maintenance.					
	System Modifications					
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.				**D.1.4.1.21;** D.1.4.1-47	Y
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.				**D.1.4.1.21;** D.1.4.1-47	Y
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.				**D.1.4.1.21;** D.1.4.1-47	Y
40.1.2.103	Fiscal Agent (Operations Phase) shall allocate system modification tasks against productive hours.				**D.1.4.1.21;** D.1.4.1-47	Y

Requirement #	Requirement Description	A	B	C	D	E
40.1.2.104	Fiscal Agent (DDI and Operations Phases) shall manage system modification activities using the change management process.				**D.1.4.1.21;** D.1.4.1-47	Y
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.				**D.1.4.1.21;** D.1.4.1-47	Y
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.				**D.1.4.1.21;** D.1.4.1-47	Y
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.				**D.1.4.1.21;** D.1.4.1-47	Y
	Data Integrity					
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				**D.1.4.1.20** D.1.4.1-46 **H.1.2.2;** H-12	Y

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.				**H.1.2.3;** H-15	Y

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	N	N	N	**D.1.4.2.2;** D.1.4.2-6	Y
40.2.1.2	Provides capability for access to recipient data using any recipient ID number or SSN without other qualifiers	N	N	N	**D.1.4.2.2;** D.1.4.2-6	Y
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	N	N	N	**D.1.4.2.2;** D.1.4.2-6	Y
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	N	N	N	**D.1.4.2.12;** D.1.4.2-19	Y
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	N	Y	N	**D.1.4.2.3;** D.1.4.2-7	Y

Requirement #	Requirement Description	A	B	C	D	E
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	N	Y	N	**D.1.4.2.4;** D.1.4.2-10	Y
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	N	N	N	**D.1.4.2.4;** D.1.4.2-10	Y
40.2.1.8	Provides capability to identify and report on exact duplicate and potential duplicate recipient records within and across lines of business	N	Y	N	**D.1.4.2.4;** D.1.4.2-11	Y
40.2.1.9	Provides capability for maintenance of current and historical recipient identification numbers	N	N	N	**D.1.4.2.3;** D.1.4.2-8	Y
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	N	Y	N	**D.1.4.2.4;** D.1.4.2-12	Y
40.2.1.11	Provides capability to use Enrollment Database (EDB) information to detect Medicare and Medicare HMO entitlement for use in claims processing	N	Y	N	**D.1.4.2.6;** D.1.4.2-14	Y
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	N	Y	N	**D.1.4.2.3;** D.1.4.2-9	Y
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	N	N	N	D.2.1.3.2; D.2.1.3-18	Y

Requirement #	Requirement Description	A	B	C	D	E
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	Y	N	N	**D.1.4.2.10;** D.1.4.2-18	Y
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	N	Y	N	**D.1.4.2.3;** D.1.4.2-8	Y
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	N	Y	N	**D.1.4.2.4;** D.1.4.2-10	Y
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	N	Y	N	**D.1.4.2.4;** D.1.4.2-10	Y
40.2.1.18	Provides capability for State staff to enter online recipient-specific overrides to the timely billing edit for claims processing	N	N	N	**D.1.4.2.2;** D.1.4.2-7	Y
40.2.1.19	Provides capability to receive and process State entities' Eligibility History data from DIRM or ITS prior to operational startup	N	N	N	**D.1.4.2.3;** D.1.4.2-9	Y
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	N	Y	N	**D.1.4.2.3;** D.1.4.2-8	Y
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	N	N	N	**D.1.4.2.3;** D.1.4.2-8	Y

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	N	N	N	**D.1.4.2.3;** D.1.4.2-8	Y
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	N	N	N	**D.1.4.2.3;** D.1.4.2-8	Y
40.2.1.26	Provides capability for online updates of fields not updated through the State’s eligibility update	N	Y	N	**D.1.4.2.4;** D.1.4.2-10	Y
40.2.1.27	Provides capability to receive and process deductible information from the recipient eligibility record and make it available for claims processing	N	N	N	**D.1.4.2.3;** D.1.4.2-9	Y
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.) (**Comment CSC82**)	N	Y	N	**D.1.4.2.4;** D.1.4.2-9	Y
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	N	Y	N	**D.1.4.2.3;** D.1.4.2-8	Y
40.2.1.30	Provides capability to process and reconcile the full file of EIS and the Replacement MMIS recipient eligibility records	N	N	N	**D.1.4.2.4;** D.1.4.2-10	Y
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	N	N	N	**D.1.4.2.6;** D.1.4.2-15	Y

Requirement #	Requirement Description	A	B	C	D	E
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	N	N	N	**D.1.4.2.6;** D.1.4.2-15	Y
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	N	N	N	**D.1.4.2.6;** D.1.4.2-15	Y
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)	N	N	N	**D.1.4.2.6;** D.1.4.2-15	Y
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.	N	N	N	**D.1.4.2.6;** D.1.4.2-15	Y
40.2.1.36	Provides capability to process buy-in updates from CMS via DIRM interface in accordance with CMS Redesign practices	N	N	N	**D.1.4.2.6;** D.1.4.2-15	Y
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	N	N	N	**D.1.4.2.6;** D.1.4.2-15	Y
40.2.1.38	Provides capability to void eligibility segments	N	Y	N	**D.1.4.2.3;** D.1.4.2-9	Y
40.2.1.39**	Provides capability for State staff to enter an online request for a recipient ID card	N	N	Y	**D.1.4.2.5;** D.1.4.2-14	Y
40.2.1.40	Provides capability for system notification from MMIS Recipient business area to MMIS Managed Care business area whenever retroactive managed care					

Requirement #	Requirement Description	A	B	C	D	E
	enrollment/disenrollment occurs					
40.2.1.41	Provides capability to notify TPL electronically whenever retroactive Medicare enrollment occurs	N	N	N	**D.1.4.2.4;** D.1.4.2-11	Y
40.2.1.42	Provides capability to notify claims electronically whenever retroactive Medicaid eligibility occurs for a recipient eligible in another health benefit program	N	N	Y	**D.1.4.2.4;** D.1.4.2-11	Y
40.2.1.43	Provides capability to create claim financial transactions for each CMS buy-in update record	N	N	N	**D.1.4.2.6;** D.1.4.2-15	Y
40.2.1.44	Provides capability to allow adjustments to buy-in claim financial transactions	N	N	N	**D.1.4.2.6;** D.1.4.2-15	Y
40.2.1.45	Provides capability to run the final buy-in cycle for receipt by CMS no later than the 25th of each month Date of final monthly cycle runs shall be directed by the State.	N	N	N	**D.1.4.2.6;** D.1.4.2-15	Y
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	N	N	N	**D.1.4.2.6;** D.1.4.2-15	Y
40.2.1.47	Provides capability to accept and process updates to the EDB from CMS via DIRM interface	N	N	Y	**D.1.4.2.6;** D.1.4.2-14	Y
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	N	Y	N	**D.1.4.2.6;** D.1.4.2-14	Y
40.2.1.49	Provides capability to edit online recipient update transactions for completeness, consistency, and valid values	N	Y	N	**D.1.4.2.4;** D.1.4.2-10	Y
40.2.1.50	Provides capability to identify the correct eligibility group and associated premium	N	N	Y	**D.1.4.2.7;** D.1.4.2-17	Y

Requirement #	Requirement Description	A	B	C	D	E
	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	N	N	Y	**D.1.4.2.7;** D.1.4.2-17	Y
40.2.1.52	Provides capability to collect recipient premium payments	N	N	Y	**D.1.4.2.7;** D.1.4.2-17	Y
40.2.1.53	Provides capability to produce refunds of recipient premiums	N	N	Y	**D.1.4.2.7;** D.1.4.2-17	Y
40.2.1.54	Provides capability to process financial accounting records for premium payments and refunds	N	N	Y	**D.1.4.2.7;** D.1.4.2-17	Y
40.2.1.55	Provides capability to produce reports for recipient premium payment and cost-sharing processes	N	N	N	**D.1.4.2.7;** D.1.4.2-17	Y
40.2.1.56	Provides capability to apply cost-sharing	N	N	N	**D.1.4.2.7;** D.1.4.2-17	Y
40.2.1.57	Provides capability to ensure cost-sharing does not exceed threshold for the family group	Y	Y	N	**D.1.4.2.7;** D.1.4.2-17	Y
40.2.1.58	Provides capability to associate multiple cases in a family together to ensure cost-sharing does not exceed threshold	N	Y	N	**D.1.4.2.7;** D.1.4.2-17	Y
40.2.1.59	Provides capability to send recipient notices and Explanations of Benefits (EOB) in recipient's preferred language	N	Y	N	**D.1.4.2.7;** D.1.4.2-17	Y
40.2.1.60	Provides capability to produce a Certificate of Creditable Coverage (COCC) for each recipient deleted/terminated from specified Medicaid coverage	N	N	Y	**D.1.4.2.9;** D.1.4.2-18	Y
40.2.1.61	Provides capability to produce a COCC for a specific period if requested by the	N	N	Y	**D.1.4.2.9;** D.1.4.2-18	Y

Requirement #	Requirement Description	A	B	C	D	E
	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	N	N	Y	**D.1.4.2.9;** D.1.4.2-18	Y
40.2.1.63	Provides capability to produce a Monthly Summary Report indicating all COCCs mailed to recipients per month that includes: ▪ Total number of COCCs mailed ▪ Total number of COCCs mailed within five (5) days of date of termination/request ▪ Total number of COCCs mailed later than five (5) days from the date of termination/request	N	N	N	**D.1.4.2.9;** D.1.4.2-18	Y
40.2.1.64	Provides capability to use transfer of assets data on the Medicaid recipient record in claims processing	N	N	Y	**D.1.4.2.3;** D.1.4.2-9	Y
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	N	N	N	**D.1.4.2.10;** D.1.4.2-19	Y
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	N	N	N	**D.1.4.2.10;** D.1.4.2-19	Y
40.2.1.67	Provides capability to create a report of individuals with a transfer of assets sanction	N	N	N	**D.1.4.2.10;** D.1.4.2-19	Y
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	N	N	N	**D.1.4.2.10;** D.1.4.2-19	Y
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	N	N	N	**D.1.4.2.8;** D.1.4.2-18	Y

Requirement #	Requirement Description	A	B	C	D	E
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	N	Y	N	**D.1.4.2.8;** D.1.4.2-18	Y
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	N	N	N	**D.1.4.2.8;** D.1.4.2-18	Y
40.2.1.72	Provides capability to transmit the MMA Enrollment File to DIRM for transmission to CMS	N	N	N	**D.1.4.2.8;** D.1.4.2-18	Y
40.2.1.73	Provides capability to process the MMA Enrollment Response File from CMS transmitted via DIRM interface	N	N	N	**D.1.4.2.8;** D.1.4.2-18	Y
40.2.1.74	Provides capability to produce a report of all records transmitted on the MMA Enrollment File	N	N	N	**D.1.4.2.8;** D.1.4.2-18	Y
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	N	N	N	**D.1.4.2.8;** D.1.4.2-18	Y
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	Y	N	N	**D.1.4.2.8;** D.1.4.2-18	Y
40.2.1.77	Provides capability for online access to a summary of the recipient's MMA Enrollment and Response File records	N	N	N	**D.1.4.2.8;** D.1.4.2-18	Y
40.2.1.78	Provides capability for online access to the MMA record selected from the summary	N	N	N	**D.1.4.2.8;** D.1.4.2-18	Y
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 (**Comment CSC14**)	N	N	N	**D.1.4.2.11;** D.1.4.2-19	Y

Requirement #	Requirement Description	A	B	C	D	E
40.2.1.80	Provides capability to accept and process Medicaid/Medicare coverage data from EIS and make it available for claims processing (**Comment CSC14**)	N	N	N	**D.1.4.2.11;** D.1.4.2-19	Y
40.2.1.81**	Provides capability for online access to add, update, and inquire into Medicare data for DMH and DPH recipients	N	N	N	**D.1.4.2.6;** D.1.4.2-15	Y
40.2.1.82	Provides capability to produce eligibility extracts for contractors with whom DMA does business	N	N	N	**D.1.4.2.11;** D.1.4.2-19	Y
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	N	Y	N	**D.1.4.2.3;** D.1.4.2-8	Y
40.2.1.84	Provides capability for multiple types of recipient addresses per line of business (LOB)	N	Y	N	**D.1.4.2.3;** D.1.4.2-8	Y
40.2.1.85	Provides capability for a Client Services Data Warehouse (CSDW) extract of recipient data	N	N	N	**D.1.4.2.11;** D.1.4.2-19	Y
40.2.1.86	Provides capability to produce letters/notices to applicants/recipients	N	N	N	**D.1.4.2.10;** D.1.4.2-18	Y
40.2.1.87	Provides capability to send, receive, and update Provider data between DHSR and the Replacement MMIS for placement of eligible recipient	N	N	N	**D.1.4.2.11;** D.1.4.2-19 **D.1.4.5.1;** D.1.4.5-6	Y
	DPH Online Enrollment					
40.2.1.88**	Provides capability to accept Web-submitted and hard copy financial eligibility applications (DHHS 3014) for program participation	N	N	N	**D.1.4.2.5;** D.1.4.2-12	Y
40.2.1.89**	Provides capability for enrollment instructions and guidelines for supporting functions	N	N	N	**D.1.4.2.5;** D.1.4.2-12	Y

Requirement #	Requirement Description	A	B	C	D	E
	by selected enrollment options					
40.2.1.90**	Provides capability to accept Web-submitted and hard copy supporting documentation for financial eligibility applications	Y	Y	N	**D.1.4.2.5;** D.1.4.2-12	Y
40.2.1.91**	Provides capability to upload attachments electronically and associate attachments with submitted financial eligibility applications	Y	Y	N	**D.1.4.2.5;** D.1.4.2-12	Y
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	N	N	N	**D.1.4.2.5;** D.1.4.2-12	Y
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	N	N	Y	**D.1.4.2.3**; D.1.4.2-8	Y
40.2.1.94**	Provides capability for State DPH staff to enter the status of the application as either complete or incomplete	Y	N	N	**D.1.4.2.5;** D.1.4.2-13	Y
40.2.1.95**	Provides capability to place all applications in an online work queue for State DPH eligibility staff to review	Y	N	N	**D.1.4.2.5;** D.1.4.2-13	Y
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	Y	N	N	**D.1.4.2.5;** D.1.4.2-13	Y
40.2.1.97**	Provides capability for State DPH staff to indicate if an application is complete and ready for disposition	Y	N	N	**D.1.4.2.5;** D.1.4.2-13	Y
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	N	Y	N	**D.1.4.2.5;** D.1.4.2-13	Y

Requirement #	Requirement Description	A	B	C	D	E
40.2.1.99**	Provides capability to electronically store and maintain DPH eligibility data in the Recipient business area	N	Y	N	**D.1.4.2.5;** D.1.4.2-13	Y
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	Y	Y	N	**D.1.4.2.5;** D.1.4.2-13	Y
40.2.1.101**	Provides capability to electronically store and maintain the name, mailing address, and agency of the application interviewer	N	N	Y	**D.1.4.2.5;** D.1.4.2-13	Y
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	N	N	Y	**D.1.4.2.5;** D.1.4.2-13	Y
40.2.1.103**	Provides capability to produce system-generated letters/notices of approvals or denials	N	Y	N	**D.1.4.2.5;** D.1.4.2-13	Y
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	N	Y	N	**D.1.4.2.5;** D.1.4.2-13	Y
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: ▪ Application/case number ▪ Applicant name (partial or complete) ▪ Applicant name phonetic (partial or complete) ▪ CNDS ID, ▪ SSN ▪ Date of birth	N	N	Y	**D.1.4.2.5;** D.1.4.2-13	Y
40.2.1.106**	Provides capability to store abandoned or incomplete applications indefinitely	N	N	N	**D.1.4.2.5;** D.1.4.2-12	Y

Requirement #	Requirement Description	A	B	C	D	E
40.2.1.107**	Provides capability to store and maintain all applications for program participation	N	N	N	**D.1.4.2.5;** D.1.4.2-12	Y
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	N	N	N	**D.1.4.2.12;** D.1.4.2-20	Y
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	N	N	N	**D.1.4.2.12;** D.1.4.2-20	Y
40.2.1.110**	Provides capability to document date and time of receipt of supporting documentation for applications	N	N	N	**D.1.4.2.5;** D.1.4.2-13	Y
40.2.1.111**	Provides capability to produce a weekly aging report that lists work queue status	N	N	N	**D.1.4.2.5;** D.1.4.2-13	Y
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	N	N	Y	**D.1.4.2.5;** D.1.4.2-14	Y
40.2.1.113	Provides capability for recipient lock-in/lock-out to a specific pharmacy and/or primary care provider and/or prescriber	Y	Y	N	**D.1.4.2.5;** D.1.4.2-14	Y
40.2.1.114	Provides capability for recipient lock-in/lock-out from a specific pharmacy and/or primary care provider and/or prescriber	Y	Y	N	**D.1.4.2.5;** D.1.4.2-14	Y
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	N	Y	N	**D.1.4.2.5;** D.1.4.2-14	Y
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	Y	Y	N	**D.1.4.2.5;** D.1.4.2-14	Y

Requirement #	Requirement Description	A	B	C	D	E
40.2.1.117	Provides capability for an unlimited number of lock-in/lock-out segments per recipient	Y	Y	N	**D.1.4.2.5;** D.1.4.2-14	Y
40.2.1.118	Provides capability for multiple concurrent active lock-in/lock-out segments of any type	Y	Y	N	**D.1.4.2.5;** D.1.4.2-14	Y
40.2.1.119	Provides capability for online inquiry and update into lock-in/lock-out segments	Y	Y	N	**D.1.4.2.5;** D.1.4.2-14	Y
40.2.1.120	Provides capability to maintain an audit trail of all changes to lock-in/lock-out segments	N	N	N	**D.1.4.2.12;** D.1.4.2-20	Y
40.2.1.121	Provides capability for online inquiry into audit trail	N	N	N	**D.1.4.2.12;** D.1.4.2-20	Y
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.	N	Y	N	**D.1.4.2.5;** D.1.4.2-14	Y
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	N	Y	N	**D.1.4.2.5;** D.1.4.2-14	Y

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.	N	N	N	**D.2.1.3.7;** D.2.1.3-42	Y

Requirement #	Requirement Description	A	B	C	D	E
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.	N	N	N	**D.2.1.3.7;** D.2.1.3-42	Y
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.	N	Y	N	**D.2.1.3.7;** D.2.1.3-43	Y
40.2.2.4	Fiscal Agent shall coordinate with the applicable State entity to resolve Medicare enrollment problems.				**D.2.1.3.7;** D.2.1.3-43	Y
40.2.2.5	Fiscal Agent shall perform buy-in functions for the North Carolina Medicaid Program using automated and manual operating procedures.	N	N	N	**D.2.1.2.3;** D.2.1.2-13	Y
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.				**D.2.1.3.4** D.2.1.3-25	Y
40.2.2.7	Fiscal Agent shall communicate with recipients and employers regarding COCCs verbally and in written correspondence.				**D.2.1.3.7;** D.2.1.3-41	Y
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.	N	N	N	**D.2.1.3.7;** D.2.1.3-42	Y

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.	N	N	N	**D.2.1.3.7;** D.2.1.3-42	Y
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.	N	N	N	**D.2.1.3.7;** D.2.1.3-42	Y
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.	N	N	N	**D.2.1.3.7;** D.2.1.3-43	Y
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.	N	N	N	**D.2.1.3.7;** D.2.1.3-41	Y

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	N	N	N	**D.1.4.3.2;** D.1.4.3-4	Y
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	N	Y	N	**D.1.4.3.2;** D.1.4.3-5	Y

Requirement #	Requirement Description	A	B	C	D	E
40.3.1.3	Provides capability for ensuring safeguards in responses via ASC X12N 271 transactions, including: ▪ Limiting access to eligibility information to authorized medical providers, VANs, and authorized State personnel only; and ▪ Protecting the confidentiality of all recipient information	N	N	N	**D.1.4.3.3;** D.1.4.3-7	Y
40.3.1.4	Provides capability for access to eligibility verification inquiry to inquire for dates of service within the preceding twelve (12) months	N	N	N	**D.1.4.3.3;** D.1.4.3-7	Y
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	N	N	N	**D.1.4.3.4;** D.1.4.3-8	Y
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	N	Y	N	**D.1.4.3.4;** D.1.4.3-8	Y
40.3.1.7	Provides capability to uniquely identify and track each EVS recipient eligibility verification inquiry and response	N	N	N	**D.1.4.3.4;** D.1.4.3-8	Y
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	N	N	Y	**D.1.4.3.4;** D.1.4.3-8	Y

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.				**D.2.1.3.6;** D.2.1.3-41	Y

Requirement #	Requirement Description	A	B	C	D	E
40.3.2.2	Fiscal Agent shall provide necessary file specifications and testing assistance to VANs on how to access EVS.				**D.2.1.3.6;** D.2.1.3-40	Y
40.3.2.3	Fiscal Agent shall provide the necessary instructions to State and VANs in how to use the EVS. *Note: The VANS are responsible for training the providers who contract with them.*				**D.2.1.3.6;** D.2.1.3-41	Y

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.	N	N	N	**D.2.1.3.10;** D.2.1.3-55	Y
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.				**D.2.1.3.6;** D.2.1.3-40 **D.2.1.3.10;** D.2.1.3-55	Y
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.	N	N	N	**D.2.1.3.10;** D.2.1.3-55	Y

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	N	N	N	**D.1.4.4.1;** D.1.4.4-5	Y
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	N	N	N	**D.1.4.4.3;** D.1.4.4-7	Y
40.4.1.3	Provides capability for eligibility verification inquiry by recipient identification number, or SSN and DOB, and date of service	N	Y	N	**D.1.4.4.2;** D.1.4.4-6	Y
40.4.1.4	Provides capability for access to eligibility verification for dates of service within the preceding 365 days	N	N	N	**D.1.4.4.2;** D.1.4.4-6	Y
40.4.1.5	Provides capability for access to eligibility verification for dates of service not greater than the current date for Medicaid recipients	N	N	N	**D.1.4.4.2;** D.1.4.4-6	Y
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	N	N	Y	**D.1.4.4.2;** D.1.4.4-6	Y
40.4.1.7	Provides capability for system-generated monthly reporting of AVRS daily system availability checks	N	N	N	**D.1.4.4.3;** D.1.4.4-7	Y
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	N	N	N	**D.1.4.4.1;** D.1.4.4-6	Y

Requirement #	Requirement Description	A	B	C	D	E
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	N	N	Y	**D.1.4.4.1;** D.1.4.4-5	Y
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	N	N	Y	**D.1.4.4.1;** D.1.4.4-5	Y
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)	N	N	N	**D.1.4.4.4;** D.1.4.4-7	Y
40.4.1.12	Provides capability to process inquiries made by Medicaid recipients entering the recipient's Medicaid ID number, DOB, and SSN	N	N	Y	**D.1.4.4.5;** D.1.4.4-10	Y
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.)	N	Y	N	**D.1.4.4.3;** D.1.4.4-7	Y
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	N	N	Y	**D.1.4.4.4;** D.1.4.4-9	Y
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	N	Y	N	**D.1.4.4.1;** D.1.4.4-5	Y
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	N	N	Y	**D.1.4.4.1;** D.1.4.4-6	Y
40.4.1.17	Provides capability to switch from English to other languages for all Medicaid recipient inquiry options	N	N	Y	**D.1.4.4.5;** D.1.4.4-10	Y

Requirement #	Requirement Description	A	B	C	D	E
40.4.1.18	Provides capability to refer or transfer recipient calls for information about additional translator services	N	N	N	**D.1.4.4.5;** D.1.4.4-11	Y
40.4.1.19	Provides capability for providers to enter real-time requests for prior approval adjudication via AVRS	N	N	Y	**D.1.4.4.4;** D.1.4.4-9	Y
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	N	N	Y	**D.1.4.4.4;** D.1.4.4-9	Y
40.4.1.21	Provides capability for providers to request printed copies of their Remittance Advice (RA) statements	N	N	Y	**D.1.4.4.4;** D.1.4.4-8	Y
40.4.1.22	Provides capability for call flows for the following provider inquiry types: ▪ Claim status ▪ Checkwrite ▪ Drug coverage ▪ Procedure code pricing ▪ Modifier verification ▪ Procedure code and modifier combination ▪ Procedure code pricing for Medicaid Community Alternatives Program services ▪ Prior approval for procedure code ▪ Medicaid dental benefit limitations ▪ Medicaid refraction and eyeglass benefits ▪ Medicaid prior approval for durable medical equipment (DME), orthotics, and prosthetics ▪ Prior Approval for DPH benefits ▪ Recipient eligibility, enrollment, and Medicaid service limits ▪ Sterilization consent and hysterectomy statement inquiry ▪ Referrals	N	N	Y	**D.1.4.4.4;** D.1.4.4-8	Y

Requirement #	Requirement Description	A	B	C	D	E
	▪ Medicaid Carolina ACCESS Emergency Authorization Overrides					
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	N	N	Y	**D.1.4.4.4;** D.1.4.4-8	Y
40.4.1.24	Provides capability for call flows for responses for the following Medicaid recipient inquiry types: ▪ Medicaid eligibility ▪ Managed care enrollment information, including the primary care provider name, address, and daytime and after-hours phone numbers ▪ Third party liability ▪ Medicare coverage ▪ Well child checkup dates ▪ Hospice eligibility	N	Y	N	**D.1.4.4.5;** D.1.4.4-10	Y
40.4.1.25	Provides capability to uniquely identify and track each AVRS recipient eligibility verification inquiry and response	N	N	N	**D.1.4.4.3;** D.1.4.4-7	Y
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	N	N	Y	**D.1.4.4.3;** D.1.4.4-7	Y
40.4.1.27	Provides capability for Web-accessible downloads of AVRS training documentation that will be synchronized with application system updates	N	N	Y	**D.1.4.4.6;** D.1.4.4-12	Y
	Web Inquiry					
40.4.1.28	Provides capability for an online, HIPAA-compliant inquiry of all information available via the AVRS	N	Y	N	**D.1.4.4.6;** D.1.4.4-11	Y

Requirement #	Requirement Description	A	B	C	D	E
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	N	N	Y	**D.1.4.4.6;** D.1.4.4-11	Y
40.4.1.30	Provides capability for Medicaid recipient access to recipient eligibility and enrollment information, including: ▪ Medicaid eligibility ▪ Carolina ACCESS enrollment information to include the primary care provider name, address, and daytime and after-hours phone numbers ▪ Third party liability ▪ Medicare coverage ▪ Well child checkup dates ▪ Hospice eligibility	N	N	Y	**D.1.4.4.6;** D.1.4.4-12	Y
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	N	N	Y	**D.1.4.4.6;** D.1.4.4-12	Y
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	N	N	Y	**D.1.4.4.6;** D.1.4.4-12	Y
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	N	N	Y	**D.1.4.4.6;** D.1.4.4-12	Y
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.)	N	Y	N	**D.1.4.4.3;** D.1.4.4-7	Y

Requirement #	Requirement Description	A	B	C	D	E
40.4.1.35	Provides capability to uniquely identify and track each online recipient eligibility verification and nurse aide verification inquiry and response	N	N	N	**D.1.4.4.6;** D.1.4.4-11	Y
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	N	N	Y	**D.1.4.4.6;** D.1.4.4-12	Y
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.)	N	Y	N	**D.1.4.4.3;** D.1.4.4-7	Y

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.	N	N	N	**D.2.1.3.2;** D.2.1.3-18	Y
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.	N	N	N	**D.2.1.3.2;** D.2.1.3-18	Y
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.	N	N	N	**D.2.1.3.2;** D.2.1.3-18	Y
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)	N	N	N	**D.2.1.3.4;** D.2.1.3-29	Y

Requirement #	Requirement Description	A	B	C	D	E
	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.	N	N	N	**D.2.1.3.10;** D.2.1.3-55	Y
40.4.3.2	Fiscal Agent shall provide system checks to the AVRS daily and log the findings.	N	N	N	**D.2.1.3.10;** D.2.1.3-55	Y
40.4.3.3	Fiscal Agent shall provide monthly AVRS logs within five (5) State business days from the end of the previous month.	N	N	N	**D.2.1.3.10;** D.2.1.3-55	Y
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.	N	N	N	**D.2.1.3.10;** D.2.1.3-55 **D.2.1.5.1.3;** D.2.1.5-6 **D.2.1.5.3;** D.2.1.5-14	Y

40.5 Provider Requirements

40.5.1 Provider System Requirements

Requirement #	Requirement Description	A	B	C	D	E
	Provider Enrollment					
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	N	N	Y	**D.1.4.5.1;** D.1.4.5-6	Y
40.5.1.2	Provides capability to generate and accept electronic and hard copy supporting documentation for enrollment and re-enrollment or verification functions	N	N	N	**D.1.4.5.2;** D.1.4.5-8	Y
40.5.1.3	Provides capability for provider access to online and batch enrollment functionality	N	N	N	**D.1.4.5.2;** D.1.4.5-8 **D.1.4.5.2.3;** D.1.4.5-10	Y
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	N	Y	N	**D.1.4.5.2.1;** D.1.4.5-9	Y
40.5.1.5	Provides capability for a provider to download application for paper submission	N	N	N	**D.1.4.5.2; D.1.4.5-8**	Y
40.5.1.6	Provides capability to edit against duplicate provider record during enrollment, addition, or change processes	N	N	N	**D.1.4.5.2.3;** D.1.4.5-10 **D.1.4.5.2.3;** D.1.4.5-11	Y
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	N	N	N	**D.1.4.5.2.2;** D.1.4.5-10 **D.1.4.5.2.3;** D.1.4.5-11	Y

Requirement #	Requirement Description	A	B	C	D	E
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	N	N	N	**D.1.4.5.2.4;** D.1.4.5-12	Y
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	N	Y	N	**D.1.4.5.2.4;** D.1.4.5.17	Y
40.5.1.10	Provides capability to capture and maintain Medicare numbers and crossover information	N	N	N	**D.1.4.5.2.4;** D.1.4.5-11	Y
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	N	Y	N	**D.1.4.5.2.1;** D.1.4.5-9	Y
40.5.1.12	Provides capability to receive, image, and link hard copy attachments, executed contracts, and signatory documentation to the provider application	N	N	N	**D.1.4.5.2.2;** D.1.4.5-10 **D.1.4.5.2.3;** D.1.4.5-11	Y
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	N	Y	N	**D.1.4.5.2.4;** D.1.4.5-11	Y
40.5.1.14	Provides capability to electronically store multiple historic provider identifiers	N	N	N	**D.1.4.5.2.4;** D.1.4.5-11	Y
40.5.1.15	Provides capability to accept and electronically store multiple occurrences of provider demographic information, including e-mail	N	N	Y	**D.1.4.5.2.4;** D.1.4.5-13	Y
40.5.1.16	Provides capability to capture information on provider billing agents	N	N	N	**D.1.4.5.2.4;** D.1.4.5-11 **D.1.4.5.2.4;** D.1.4.5-17	Y
40.5.1.17	Provides capability to present customized enrollment application options	N	N	N	**D.1.4.5.2.1;** D.1.4.5-9	Y

Requirement #	Requirement Description	A	B	C	D	E
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	N	Y	N	**D.1.4.5.2.3;** D.1.4.5-11 **D.1.4.5.2.4;** D.1.4.5-19	Y
40.5.1.19	Provides capability to present enrollment instructions and guidelines for supporting functions by selected enrollment options	N	N	N	**D.1.4.5.2.1;** D.1.4.5-9	Y
40.5.1.20	Provides capability to system-generate application attachments based on required criteria and affirmative responses	N	N	Y	**D.1.4.5.2.3;** D.1.4.5-11	Y
40.5.1.21	Provides capability to identify and enroll providers classified as special, atypical, State-funded, or funded by other assistance programs	N	N	Y	**D.1.4.5.2.4;** D.1.4.5-11	Y
40.5.1.22	Provides capability to identify and assign unique identifiers to providers	N	N	N	**D.1.4.5.2.4;** D.1.4.5-11 **D.1.4.5.2.4;** D.1.4.5-19 **D.1.4.5.3;** D.1.4.5-22	Y
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	N	N	Y	**D.1.4.5.2.4;** D.1.4.5-17	Y
40.5.1.24	Provides capability to capture the requestor, sender, and status for all hard copy provider enrollment form requests	N	N	Y	**D.1.4.5.2;** D.1.4.5-8 **D.1.4.5.2.4;** D.1.4.5-18	Y

Requirement #	Requirement Description	A	B	C	D	E
40.5.1.25	Provides capability to capture all enrollment events	N	N	N	**D.1.4.5.2.4;** D.1.4.5-18 **D.1.4.5.3;** D.1.4.5-22	Y
40.5.1.26	Provides capability to accept and electronically store electronic funds transfer (EFT) information	N	N	N	**D.1.4.5.2.4;** D.1.4.5-17	Y
40.5.1.27	Provides capability to flag provider records to support operational activities	N	N	N	**D.1.4.5.2.4;** D.1.4.5-18	Y
40.5.1.28	Provides capability to capture and validate nine-digit (9-digit) zip code to geographic location	N	Y	N	**D.1.4.5.2.4;** D.1.4.5-13	Y
40.5.1.29	Provides capability to store abandoned or incomplete applications for ninety (90) days	N	N	N	**D.1.4.5.3;** D.1.4.5-21 **D.2.1.3.1.2;** D.2.1.3-5	Y
40.5.1.30	Provides capability to capture provider eligibility, program eligibility, and participation status codes with associated affiliations, effective dates, and end dates	N	Y	N	**D.1.4.5.2.4;** D.1.4.5-11	Y
40.5.1.31	Provides capability to capture the providers' preference to use electronic submittal of claims, remittance, and/or EFT	N	N	N	**D.1.4.5.2.4;** D.1.4.5-17	Y
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	N	Y	N	**D.1.4.5.2.4;** D.1.4.5-16	Y
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	N	Y	N	**D.1.4.5.2.4;** D.1.4.5-16	Y
40.5.1.34	Provides capability to capture, verify, and cross-reference provider ownership information	N	N	N	**D.1.4.5.2.4;** D.1.4.5-16	Y

Requirement #	Requirement Description	A	B	C	D	E
40.5.1.35	Provides capability to recognize predefined events requiring State determination or intervention	N	N	N	**D.1.4.5.2;** D.1.4.5-8	Y
40.5.1.36	Provides capability to accommodate NPI and multiple associated taxonomies	N	N	N	**D.1.4.5.2.4;** D.1.4.5-18	Y
40.5.1.37	Provides capability to validate all NPIs	N	N	N	**D.1.4.5.2.4;** D.1.4.5-18	Y
40.5.1.38	Provides capability for option selection for a provider to indicate preference to receive a paper RA	N	N	N	**D.1.4.5.2.4;** D.1.4.5-17	Y
40.5.1.39	Provides capability for the system to capture electronic signatures	N	N	Y	**D.1.4.5.2.1;** D.1.4.5-9	Y
40.5.1.40	Provides capability to use workflow functionality to forward a completed application for credentialing/re-credentialing or verification	N	N	N	**D.1.4.5.3;** D.1.4.5-20	Y
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 Replacement MMIS using API and SOA concepts	N	Y	N	**D.1.4.5.3;** D.1.4.5-21	Y
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	N	N	Y	**D.1.4.5.1;** D.1.4.5-6	Y
	Provider Credentialing					
40.5.1.43	Provides capability to conduct provider credentialing and source verification of provider participation criteria and requirements	N	N	N	**D.1.4.5.3;** D.1.4.5-20	Y
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	N	Y	N	**D.1.4.5.3;** D.1.4.5-21	Y

Requirement #	Requirement Description	A	B	C	D	E
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	N	N	N	**D.1.4.5.3;** D.1.4.5-21	Y
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	N	N	N	**D.1.4.5.2.4;** D.1.4.5-11	Y
40.5.1.47	Provides capability to send and receive electronic communications to support credentialing data verifications	N	N	N	**D.1.4.5.3;** D.1.4.5-21	Y
40.5.1.48	Provides capability to exclude a provider from licensure requirements based on provider type or category	N	N	N	**D.1.4.5.2.4;** D.1.4.5-18	Y
40.5.1.49	Provides capability to generate notification to providers of status, changes, enrollment, termination, credentialing, re-verification, penalties, and termination	N	N	N	**D.1.4.5.3;** D.1.4.5-22	Y
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	N	N	N	**D.1.4.5.3;** D.1.4.5-20	Y
40.5.1.51	Provides capability to share licensure, endorsement, and accreditation information with issuing agencies, authorized State entities, and users	N	N	N	**D.1.4.5.3;** D.1.4.5-21	Y
40.5.1.52	Provides capability to send notification to a provider of impending renewal	N	N	N	**D.1.4.5.3;** D.1.4.5-22	Y
40.5.1.53	Provides capability to send notification to providers who failed to respond to renewal information requests	N	N	N	**D.1.4.5.3;** D.1.4.5-22	Y
40.5.1.54	Provides capability to send, receive, and update data between DHSR and the Replacement MMIS in support of provider credentialing functionality	N	N	N	**D.1.4.5.3;** D.1.4.5-21	Y

Requirement #	Requirement Description	A	B	C	D	E
	Provider Maintenance					
40.5.1.55	Provides capability to present to the provider selected data for verification and update	N	N	Y	**D.1.4.5.4.3;** D.1.4.5-25	Y
40.5.1.56	Provides capability to support different business rule definitions by program and services to be provided	N	N	Y	**D.1.4.5.4.3;** D.1.4.5-25	Y
40.5.1.57	Provides capability to make State-approved forms available online	N	N	N	**D.1.4.5.4.5;** D.1.4.5-26	Y
40.5.1.58	Provides capability to process online requests for generation and distribution of provider contracts	Y	N	N	**D.1.4.5.4.5;** D.1.4.5-26	Y
40.5.1.59	Provides capability to accept and process online requests for additions and changes to the provider data	Y	N	N	**D.1.4.5.4.7;** D.1.4.5-27	Y
40.5.1.60	Provides capability to capture, identify, and report suspected duplicate provider identification numbers and applicable expiration dates	N	N	N	**D.1.4.5.4.2;** D.1.4.5-24	Y
40.5.1.61	Provides capability to capture, update, and maintain Clinical Laboratory Improvement Amendments (CLIA) information for providers	N	N	N	**D.1.4.5.4.1;** D.1.4.5-24	Y
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	N	N	N	**D.1.4.5.4.3;** D.1.4.5-25	Y
40.5.1.63	Provides capability to systematically suspend and notify providers who do not meet enrollment or participation criteria	N	N	N	**D.1.4.5.4.3;** D.1.4.5-24	Y
40.5.1.64	Provides capability to cross-reference all provider identifiers that correspond to the providers' tax identification/reporting number	N	N	N	**D.1.4.5.4.1;** D.1.4.5-24	Y
40.5.1.65	Provides capability for online access of providers to training materials, training	N	N	N	**D.1.4.5.4.5;** D.1.4.5-26	Y

Requirement #	Requirement Description	A	B	C	D	E
	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	N	N	N	**D.1.4.5.4.6;** D.1.4.5-27	Y
40.5.1.67	Provides capability to enter and maintain tax and financial information, including budget codes for accessing State funds	N	Y	N	**D.1.4.5.4.1;** D.1.4.5-24	Y
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	N	Y	N	**D.1.4.5.4.1;** D.1.4.5-24	Y
40.5.1.69	Provides capability to capture the providers who participate in the Competitive Acquisition Program with begin and end dates by program	N	N	Y	**D.1.4.5.4.1;** D.1.4.5-24	Y
40.5.1.70	Provides capability to suspend, sanction, or terminate providers	N	N	N	**D.1.4.5.4.1;** D.1.4.5-23	Y
40.5.1.71	Provides capability to identify and report on out-of-state provider claims denied for non-enrollment	N	N	N	**D.1.4.5.4.3;** D.1.4.5-26	Y
40.5.1.72	Provides capability to maintain 1099 and associated payment summary data	N	N	N	**D.1.4.5.4.1;** D.1.4.5-24	Y
40.5.1.73	Provides capability to identify and reference ownership across multiple occurrences and entities	N	N	N	**D.1.4.5.4.1;** D.1.4.5-24	Y
40.5.1.74	Provides capability to generate provider notifications of licensure, certification, accreditation, and endorsement renewals or expirations and monitor all response activity	N	N	N	**D.1.4.5.4.3;** D.1.4.5-25	Y
40.5.1.75	Provides capability for providers to enter requested updates to data and identify instances that require operational review	N	N	N	**D.1.4.5.4.5;** D.1.4.5-26	Y

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	N	N	N	**D.1.4.5.4.3;** D.1.4.5-25	Y
40.5.1.77	Provides capability to identify providers for whom mail has been returned and suppress all printing and claims activity	N	N	N	**D.1.4.5.4.3;** D.1.4.5-26	Y
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	N	N	N	**D.1.4.5.4.5;** D.1.4.5-26	Y
40.5.1.80	Provides capability for online access by State-authorized users to view and update information on sanctioned providers by LOB	N	N	N	**D.1.4.5.4.3;** D.1.4.5-25	Y
40.5.1.81	Provides capability to perform manual and automated updates to provider data	N	N	N	**D.1.4.5.4.1;** D.1.4.5-23	Y
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	N	N	N	**D.1.4.5.3;** D.1.4.5-21	Y
40.5.1.83	Provides capability for a daily provider table extract	N	N	N	**D.1.4.5.1;** D.1.4.5-4	Y
40.5.1.84	Provides capability for online, real-time responses to EIS and DIRM applications for all provider data processing transactions	N	N	N	**D.1.4.5.4.4;** D.1.4.5-26	Y
40.5.1.85	Provides capability to send, receive, and update data between DHSR and the Replacement MMIS in support of provider maintenance functionality	N	N	N	**D.1.4.5.4.4;** D.1.4.5-26	Y

Requirement #	Requirement Description	A	B	C	D	E
	Provider Training					
40.5.1.86	Provides capability for online automated provider training and related documentation access	Y	N	N	**D.1.4.5.4.5;** D.1.4.5-26	Y
40.5.1.87	Provides capability to capture and maintain provider-written, verbal, or electronic correspondence requesting an on-site visit or training	Y	N	N	**D.1.4.5.5.2;** D.1.4.5-27	Y
40.5.1.88	Provides capability for automated workflow functionalities to process call center and provider training requests and educational monitoring activities	Y	N	N	**D.1.4.5.5.2;** D.1.4.5-27	Y
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	N	Y	N	**D.1.4.5.5.3;** D.1.4.5-30	Y
40.5.1.90	Provides capability to image, maintain, and make accessible all (current and historic) course instructional materials	Y	N	N	**D.1.4.5.5.4;** D.1.4.5-30	Y
40.5.1.91	Provides capability to image instructional materials, training evaluations, and other correspondence linked to a site visit to the provider record	N	N	N	**D.1.4.5.5.2;** D.1.4.5-28 **D.1.4.5.5.4;** D.1.4.5-30	Y
40.5.1.92	Provides capability to track and report on provider requested visits	N	N	N	**D.1.4.5.5.2;** D.1.4.5-28	Y
40.5.1.93	Provides capability for online and on-site training evaluation questionnaires for providers to complete	N	N	N	**D.1.4.5.5.2;** D.1.4.5-28	Y
40.5.1.94	Provides capability to develop a State-approved training evaluation process	N	N	N	**D.1.4.5.5.4;** D.1.4.5-30	Y
40.5.1.95	Provides capability to maintain and submit to the State provider training sessions	N	N	N	**D.1.4.5.5.4;** D.1.4.5-30	Y

Requirement #	Requirement Description	A	B	C	D	E
	participants					
40.5.1.96	Provides capability to identify providers with a claims denial rates of twenty (20) percent or higher	N	Y	N	**D.1.4.5.5.2;** D.1.4.5-27 **D.1.4.5.5.4;** D.1.4.5-30	Y
40.5.1.97	Provides capability to maintain State-approved instructional materials for viewing and retrieval	N	N	N	**D.1.4.5.5.4;** D.1.4.5-30	Y
40.5.1.98	Provides capability for initial and updated State-approved Provider Basic Training Tutorials to be available through Web access	Y	N	N	**D.1.4.5.5.3;** D.1.4.5-30	Y
	Secure, Browser-Based, Web-Enabled Capability To Record and Track All Verbal Communication between State/Fiscal Agent and Providers					
40.5.1.99	Provides capability to record, track, and report on provider and recipient communication	N	N	N	**D.1.4.5.5.5;** D.1.4.5-31	Y
40.5.1.100	Provides capability to make provider contact data accessible and retrievable	Y	N	N	**D.1.4.5.5.5;** D.1.4.5-31	Y
40.5.1.101	Provides capability to report on queries for call-related data	N	N	N	**D.1.4.5.5.5;** D.1.4.5-31	Y
40.5.1.102	Provides capability for communication tracking business area to interface with other MMIS functional areas	N	N	N	**D.1.4.5.5.5;** D.1.4.5-31	Y
40.5.1.103	Provides capability for individual access to query tools	N	N	N	**D.1.4.5.5.5;** D.1.4.5-31	Y
40.5.1.104	Provides capability to auto-populate Replacement MMIS provider data into the Web-based provider enrollment and maintenance functions	N	Y	N	**D.1.4.5.2.1;** D.1.4.5-9	Y

40.5.2 Provider Operational Requirements

Requirement #	Requirement Description	A	B	C	D	E
	General					
40.5.2.1	Fiscal Agent shall provide State-authorized access to the Provider database.	N	N	N	**D.2.1.3.1.1;** D.2.1.3-5	Y
40.5.2.2	Fiscal Agent shall receive and process provider complaints and summarize this activity in the Status Report.				**D.2.1.3.2;** D.2.1.3-19	Y
40.5.2.3	Fiscal Agent shall respond to and report on activities and outcomes of all inquiries referred by the State.				**D.2.1.3.2;** D.2.1.3-19	Y
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.	N	N	N	**D.2.1.1.4.5;** D.2.1.1-13 **D.2.1.3.4;** D.2.1.3-31	Y
40.5.2.5	Fiscal Agent shall provide the capability to link provider applications in PDF format for retrieval via a document management system.	N	N	N	**D.2.1.3.1.2.1;** D.2.1.3-10 **D.2.1.3.4;** D.2.1.3-31	Y
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.				**D.2.1.3.1.1;** D.2.1.3-4	Y
40.5.2.7	Fiscal Agent shall generate and distribute provider contract renewals to providers seventy-five (75) days before expiration.				**D.2.1.3.1.7;** D.2.1.3-11	Y
40.5.2.8**	Fiscal Agent shall accept, process, and maintain DMH attending-only provider records				**D.2.1.3.1.5;** D.2.1.3-10	Y

Requirement #	Requirement Description	A	B	C	D	E
	entered by the LME					
	Provider Enrollment, Credentialing, and Verification					
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.				**D.2.1.3.1.2.1;** D.2.1.3-8	Y
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.				**D.2.1.3.1.6;** D.2.1.3-10	Y
40.5.2.11	Fiscal Agent shall implement provider sanctions, as directed by the State.				**D.2.1.3.1.6;** D.2.1.3-10	Y
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.	N	N	N	**D.2.1.3.1.6;** D.2.1.3-10	Y
40.5.2.13	Fiscal Agent shall send enrollment information and instructions to a provider whose claims have denied for non-enrollment.	N	N	Y	**D.2.1.3.1.4;** D.2.1.3-10	Y
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.				**D.2.1.3.1.8;** D.2.1.3-11	Y
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.				**D.2.1.3.1.8;** D.2.1.3-11	Y
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.				**D.2.1.3.1.8;** D.2.1.3-11	Y

Requirement #	Requirement Description	A	B	C	D	E
40.5.2.17	Fiscal Agent shall obtain and maintain all executed EFT Agreements.	Y	N	N	**D.2.1.3.1.8;** D.2.1.3-11	Y
40.5.2.18	Fiscal Agent shall create and distribute to each independent enrolled provider or provider site a New Provider Participation Packet.				**D.2.1.3.1.2.1;** D.2.1.3-9	Y
40.5.2.19	Fiscal Agent shall respond to provider requests for participation in a NC DHHS program.				**D.2.1.3.1.2;** D.2.1.3-5	Y
40.5.2.20	Fiscal Agent shall review applications and contracts for completeness, original signature, and required participation criteria.				**D.2.1.3.1.2;** D.2.1.3-5	Y
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. **(Comment CSC232)**				**D.2.1.3.1.2;** D.2.1.3-5	Y
40.5.2.22	Fiscal Agent shall initiate communication to providers advising them of the potential for suspension of services.				**D.2.1.3.1.6;** D.2.1.3-10	Y
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.				**D.2.1.3.1.2.1;** D.2.1.3-8	Y
	Urgent Reviews					
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.				**D.2.1.3.1.10;** D.2.1.3-13	Y
40.5.2.25	Fiscal Agent shall route imaged data regarding Urgent Review through Workflow to the Quality Review/Appeals Coordinator for assessment.	Y	N	N	**D.2.1.3.1.10;** D.2.1.3-14	Y
40.5.2.26	Fiscal Agent shall send a system-generated letter to the provider advising disposition	Y	N	N	**D.2.1.3.1.10;** D.2.1.3-14	Y

Requirement #	Requirement Description	A	B	C	D	E
	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.	Y	N	N	**D.2.1.3.1.10;** D.2.1.3-14	Y
	Appeals					
40.5.2.28	Fiscal Agent shall receive, image, and link provider appeals correspondence to the provider record.				**D.2.1.3.1.11;** D.2.1.3-15	Y
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.	N	Y	N	**D.2.1.3.1.11;** D.2.1.3-15	Y
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.				**D.2.1.3.1.11;** D.2.1.3-15	Y
40.5.2.31	Fiscal Agent shall route appeals and all supporting documentation to the State Review Committee Work Queue for disposition.	N	Y	N	**D.2.1.3.1.11;** D.2.1.3-15	Y
40.5.2.32	Fiscal Agent shall update Provider data with the completed dates and disposition of appeal information.	N	Y	N	**D.2.1.3.1.11;** D.2.1.3-15	Y
	Provider Communications					
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.				**D.2.1.3.2;** D.2.1.3-17	Y
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				**D.2.1.3.2;** D.2.1.3-18	Y

Requirement #	Requirement Description	A	B	C	D	E
	(2) business days.					
40.5.2.35	Fiscal Agent shall track and report on all State-referred or provider-initiated calls and/or complaints.				**D.2.1.3.2;** D.2.1.3-19	Y
40.5.2.36	Fiscal Agent shall respond in writing to written provider inquiries within five (5) business days of the date of receipt.				**D.2.1.3.2;** D.2.1.3-21	Y
40.5.2.37	Fiscal Agent shall refer questions regarding eligibility and program benefits to the State.				**D.2.1.3.2;** D.2.1.3-20	Y
40.5.2.38	Fiscal Agent shall refer questions regarding rates and budgets to the State.				**D.2.1.3.2;** D.2.1.3-20	Y
40.5.2.39	Fiscal Agent shall respond to all other provider inquiries as referred by the State.				**D.2.1.3.2;** D.2.1.3-18 **D.2.1.3.2;** D.2.1.3-20	Y
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.	Y	N	N	**D.2.1.3.2;** D.2.1.3-21	Y
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.				**D.2.1.3.5;** D.2.1.3-32	Y
	Provider Publications					
40.5.2.42	Fiscal Agent shall prepare and post provider publications and instructions online.	Y	N	N	**D.2.1.3.4;** D.2.1.3-30	Y
40.5.2.43	Fiscal Agent shall publish approved bulletins via e-mail and Web.	Y	N	N	**D.2.1.3.4;** D.2.1.3-30	Y
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.				**D.2.1.3.4;** D.2.1.3-30	Y

Requirement #	Requirement Description	A	B	C	D	E
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.	Y	N	N	**D.2.1.3.4;** D.2.1.3-31	Y
	Provider Training					
40.5.2.46	Fiscal Agent shall present mock training sessions to the State for approval prior to conducting provider training workshops.				**D.2.1.3.4;** D.2.1.3-27	Y
40.5.2.47	Fiscal Agent shall determine topics for workshops by assessing and targeting provider types with special need.				**D.2.1.3.4;** D.2.1.3-26	Y
40.5.2.48	Fiscal Agent shall track and report on provider requested visits.	Y	N	N	**D.2.1.3.4;** D.2.1.3-28	Y
40.5.2.49	Fiscal Agent shall implement annual marketing plans for electronic commerce options.				**D.2.1.3.3;** D.2.1.3-23	Y
40.5.2.50	Fiscal Agent shall conduct provider workshops at State-approved locations.				**D.2.1.3.4;** D.2.1.3-27 **D.4.4.1;** D.4-8	Y
40.5.2.51	Fiscal Agent shall assist the State with annual meetings of billing providers.				**D.2.1.3.4;** D.2.1.3-27	Y
40.5.2.52	Fiscal Agent shall assist the State with quarterly training conferences.				**D.2.1.3.4;** D.2.1.3-27	Y
40.5.2.53	Fiscal Agent shall distribute on-site training evaluation questionnaires for providers to complete.				**D.2.1.3.4;** D.2.1.3-28	Y
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.				**D.2.1.3.4;** D.2.1.3-28 **D.4.6.8;** D.4-19	Y

Requirement #	Requirement Description	A	B	C	D	E
40.5.2.55	Fiscal Agent shall maintain and submit to the State lists of provider training session participants.				**D.2.1.3.4;** D.2.1.3-28 **D.4.6.8;** D.4-19	Y
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.				**D.2.1.3.4;** D.2.1.3-29	Y
40.5.2.57	Fiscal Agent shall ensure the accuracy and consistency of initial and ongoing updated State-approved tutorials.				**D.2.1.3.4;** D.2.1.3-29	Y
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.				**D.2.1.3.4;** D.2.1.3-29	Y
40.5.2.59	Fiscal Agent shall maintain State-approved instructional materials for viewing and retrieval.				**D.2.1.3.4;** D.2.1.3-32	Y
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.				**D.2.1.3.4;** D.2.1.3-32	Y
	Imaging Provider Communications					
40.5.2.61	Fiscal Agent shall image all provider written communications.				**D.2.1.1.4.5;** D.2.1.1-13 **D.2.1.3.4;** D.2.1.3-31	Y
	Imaging Provider On-Site Visit Materials and Evaluation					
40.5.2.62	Fiscal Agent shall perform imaging of all materials and the provider on-site evaluation				**D.2.1.1.4.5;** D.2.1.1-14	Y

Requirement #	Requirement Description	A	B	C	D	E
	applicable to a provider site visit, linking to the provider identification number for complete profile data retrieval.				**D.2.1.3.4;** D.2.1.3-31	
	Imaging Provider Training Workshop Materials and Provider Evaluation Forms					
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.				**D.2.1.1.4.5;** D.2.1.1-14 **D.2.1.3.4;** D.2.1.3-32	Y
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.				**D.2.1.3.5;** D.2.1.3-32	Y
40.5.2.65	Fiscal Agent shall provide all Customer Service Call Center reports according to State specification.	Y	N	N	**D.2.1.3.2;** D.2.1.3-21	Y
40.5.2.66	Fiscal Agent shall maintain up-to-date complete system and user documentation.				**D.2.1.3.4;** D.2.1.3-31	Y
40.5.2.67	Fiscal Agent shall develop workflow processes for customer service support activities.	Y	N	N	**D.2.1.3;** D.2.1.3-1 **D.2.1.3;** D.2.1.3-3 **D.2.1.3.2;** D.2.1.3-20	Y
	E-mail Communications					
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.				**D.2.1.3.3;** D.2.1.3-24 **D.2.1.3.4;** D.2.1.3-30	Y

Requirement #	Requirement Description	A	B	C	D	E
	Recording/Tracking Provider/Recipient Verbal Communications					
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.	N	N	N	**D.2.1.3.2;** D.2.1.3-18	Y
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.	N	N	N	**D.2.1.3.2;** D.2.1.3-18	Y
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.	Y	N	N	**D.2.1.3.5;** D.2.1.3-32	Y
40.5.2.72	Fiscal Agent shall provide appropriate staff to monitor and support the continuous availability of the recording/tracking query tool.				**D.2.1.3.2;** D.2.1.3-18	Y

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 (1) State business day of receipt.				**D.2.1.1.6;** D.2.1.1-19 **D.2.1.3.10;** D.2.1.3-51	Y
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.				**D.2.1.3.1.2.1;** D.2.1.3-7 **D.2.1.3.10;** D.2.1.3-51	Y

Requirement #	Requirement Description	A	B	C	D	E
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.				**D.2.1.3.1.2.1;** D.2.1.3-8 **D.2.1.3.10;** D.2.1.3-51	Y
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.				**D.2.1.3.1.2.1;** D.2.1.3-9 **D.2.1.3.10;** D.2.1.3-51	Y
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.				**D.2.1.3.1.2.1;** D.2.1.3-9 **D.2.1.3.10;** D.2.1.3-51	Y
40.5.3.6	Fiscal Agent shall initiate Urgent Reviews within one (1) State business day of receipt of any adverse provider information.				**D.2.1.3.1.10;** D.2.1.3-13 **D.2.1.3.10;** D.2.1.3-51	Y
40.5.3.7	Fiscal Agent shall acknowledge receipt of provider appeal requests within one (1) State business day of receipt.				**D.2.1.3.1.11;** D.2.1.3-15 **D.2.1.3.10;** D.2.1.3-51	Y
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.				**D.2.1.3.1.11;** D.2.1.3-15 **D.2.1.3.10;** D.2.1.3-51	Y
40.5.3.9	Fiscal Agent shall provide the State with an extract of the MMIS Provider tables each business night.	N	N	N	**D.2.1.3.10;** D.2.1.3-51	Y
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.	N	N	N	**D.2.1.3.10;** D.2.1.3-52	Y

Requirement #	Requirement Description	A	B	C	D	E
	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.	N	N	N	**D.2.1.3.10;** D.2.1.3-52	Y
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.	N	N	N	**D.2.1.3.10;** D.2.1.3-52	Y
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.	N	N	N	**D.2.1.3.10;** D.2.1.3-52	Y
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.	N	N	N	**D.2.1.3.10;** D.2.1.3-52	Y
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.	N	N	N	**D.2.1.3.10;** D.2.1.3-52	Y
40.5.3.16	Fiscal Agent shall provide monthly system check logs in the content, frequency, format, and media as directed by the State.	N	N	N	**D.2.1.3.10;** D.2.1.3-52	Y
40.5.3.17	Fiscal Agent shall produce State-approved initial and ongoing updates to training				**D.2.1.3.4;** D.2.1.3-29	Y

Requirement #	Requirement Description	A	B	C	D	E
	materials and secure, browser-based, Web-enabled tutorials in the content, frequency, format, and all media as directed by the State.				**D.2.1.3.10;** D.2.1.3-53	

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	N	Y	N	**D.1.4.6.1;** D.1.4.6-4	Y
40.6.1.2	Provides capability for online access to all Reference and pricing data	N	N	N	**D.1.4.6.1;** D.1.4.6-6	Y
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	N	Y	N	**D.1.4.6.1;** D.1.4.6-6	Y
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	N	Y	N	**D.1.4.6.3;** D.1.4.6-11	Y
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	N	N	N	**D.1.4.6.3;** D.1.4.6-11	Y
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	N	N	N	**D.1.4.6.3;** D.1.4.6-11	Y

Requirement #	Requirement Description	A	B	C	D	E
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: ▪ Financial payer ▪ Billing provider (i.e., single county or multi-county) ▪ Population group ▪ Procedure code ▪ Begin and end date of service ▪ Attending provider (i.e., single county or multi-county) ▪ Recipient	N	Y	N	**D.1.4.6.4;** D.1.4.6-13	Y
40.6.1.8	Provides capability to allow reformatting of automated files to develop or update fee schedules and/or rate files	N	Y	N	**D.1.4.6.1;** D.1.4.6-6	Y
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	N	Y	N	**D.1.4.6.9;** D.1.4.6-22	Y
40.6.1.10	Provides capability for parameter-driven, ad hoc activity logging reports	N	N	N	**D.1.4.6.9;** D.1.4.6-22	Y
40.6.1.11	Provides capability to ensure appropriate tracking, controls, and audit logs are associated with all file updates	N	Y	N	**D.1.4.6.9;** D.1.4.6-22	Y
40.6.1.12	Provides capability to link Reference File updates to applicable edits/audits	N	N	N	**D.1.4.6.9;** D.1.4.6-22	Y
40.6.1.13	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: ▪ Valid age ▪ Valid gender ▪ Family planning indicator ▪ Health Check indicator	N	Y	N	**D.1.4.6.3;** D.1.4.6-11	Y

Requirement #	Requirement Description	A	B	C	D	E
	▪ Prior approval requirements ▪ Reference indicator ▪ TPL, emergency, accident trauma diagnosis, and cause code/indicator ▪ Inpatient length of stay criteria ▪ Description of the diagnosis ▪ Attachment required ▪ Primary and secondary diagnosis code usage ▪ Cross-reference to procedure codes ▪ Drug by designated parameters					
40.6.1.14	Provides capability for online, updateable edit disposition tables and files that contain unlimited edit numbers with: ▪ Description of edit ▪ Description of edit for RA per RA media ▪ RA print indicator, exception print detail, or list indicator ▪ Disposition, force indicator, deny indicator, location code, prior approval override indicator, location override per claim type, per claim media, per program, per provider ▪ Cross-referencing edits/audits ▪ Information line	N	Y	N	**D.1.4.6.2;** D.1.4.6-10	Y
40.6.1.15	Provides capability to audit HCPCS codes and associated National Drug Codes (NDCs) against pharmacy NDCs to prevent duplicative services	N	N	N	**D.1.4.6.4;** D.1.4.6-14	Y
40.6.1.16	Provides capability to maintain an online, updateable claims Edit Resolution Manual that reflects correct processes for adjudicating edits and audits	N	N	N	**D.1.4.6.2;** D.1.4.6-10	Y
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	N	N	N	**D.1.4.6.2;** D.1.4.6-10	Y

Requirement #	Requirement Description	A	B	C	D	E
	or specified range					
40.6.1.18	Provides capability to generate a report of edits/audits associated with codes that will be end-dated	N	N	N	**D.1.4.6.2;** D.1.4.6-10	Y
40.6.1.19	Provides capability to categorize edits/audits	N	N	N	**D.1.4.6.2;** D.1.4.6-10	Y
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	N	Y	N	**D.1.4.6.2;** D.1.4.6-10	Y
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: ▪ Edit relationships ▪ Other procedure, revenue, diagnosis, dental codes ▪ Modifiers related ▪ Sex, age indicators (by day, month, year) ▪ State Memo effective date with a link to a separate promulgated policy file to obtain policy or related detail information ▪ Any other parameters that drive the edit	N	N	N	**D.1.4.6.2;** D.1.4.6-10	Y
40.6.1.22	Provides capability to upload State-approved HCPCS updates from CMS, including Resource-Based Relative Value Scale (RBRVS)	N	N	N	**D.1.4.6.4;** D.1.4.6-12	Y
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	N	Y	N	**D.1.4.6.4;** D.1.4.6-12	Y

Requirement #	Requirement Description	A	B	C	D	E
	following elements: ▪ Valid tooth surface codes and tooth number/quadrant designation ▪ Date-specific pricing segments by program code, provider taxonomy, and/or provider type and or specialty ▪ Five (5) date-specific pricing segments, including two (2) occurrences of pricing action ▪ Five (5) status code segments with effective beginning and end dates for each segment ▪ Indicator of covered/not-covered and effective and end dates by program code ▪ Allowed amount for each pricing segment ▪ Multiple modifiers and the percentage of the allowed price applicable to each modifier or procedure code/modifier combination ▪ State-specified restrictions on conditions to be met for a claim to be paid, including, but not limited to: o Recipient eligibility o Pricing Action Code o Category of service o Specialty o Lab certification o Recipient age/sex restrictions o Allowed diagnosis codes o Prior approval required o Medical review required o Place of service o Pre- and post-operative days o Appropriate diagnosis o Acceptable place of service o Units of service					

Requirement #	Requirement Description	A	B	C	D	E
	o Once-in-a-lifetime indicator o Attachments required o Valid provider type/specialty o NDC codes and units o Claim type o Purge criteria o Provider subspecialty o Drug Coverage (effective/term dates) o Health Check reporting indicator o Family Planning indicator o Family Planning Waiver Indicator ▪ Narrative language of procedure codes in both short and long description ▪ Indication of when or whether claims for the procedure can be archived from online history (such as once-in-a-lifetime procedures) ▪ Indication of TPL actions, such as cost avoidance, benefit recovery, or pay and chase by procedure code ▪ Indication of third party payers, non-coverage by managed care organizations by managed care organization type ▪ Other information, such as accident/trauma indicators for possible TPL, Federal cost-sharing indicators, and Medicare coverage indicator					
40.6.1.24	Provides capability to maintain Pharmacy Point-of-Sale (POS) reference files that include: ▪ NDC number ▪ Generic Code Number (GCN) or formulation ID ▪ Generic Code Number-Sequence (GCN-Sequence) or clinical formulation ID ▪ Therapeutic class-specific (TxCL) or Therapeutic class code (General	N	Y	N	**D.1.4.6.6;** D.1.4.6-16	Y

Requirement #	Requirement Description	A	B	C	D	E
	Classification Code 3 [GC3]) ▪ Ingredient list ID (HICL-S, relational and non-relational) ▪ HICL sequence number ▪ Med ID ▪ Routed DF Med ID ▪ Routed MED ID ▪ Med Name ID ▪ HIC Sequence ▪ Generic name (GNN) ▪ Ingredient List ID (HICL) ▪ Brand name ▪ Label name ▪ Manufacturer ▪ Enhanced Therapeutic Classification (ETC) system ▪ American Hospital Formulary (AHF) classification ▪ Universal Product Code (UPC) 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	N	N	N	**D.1.4.6.1;** D.1.4.6-6	Y
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 1st	N	Y	N	**D.1.4.6.5;** D.1.4.6-14	Y

Requirement #	Requirement Description	A	B	C	D	E
	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	N	N	N	**D.1.4.6.6;** D.1.4.6-15	Y
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	N	N	Y	**D.1.4.6.6;** D.1.4.6-15	Y
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	N	N	N	**D.1.4.6.6;** D.1.4.6-15	Y
40.6.1.30	Provides capability for State-specified customized updates to the drug file from a contracted or State-owned drug update service	N	N	Y	**D.1.4.6.6;** D.1.4.6-15	Y
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	Y	Y	N	**D.1.4.6.5;** D.1.4.6-14	Y
40.6.1.32	Provides capability to maintain rate files for all services and institutional rates to support pricing that conforms to program requirements	N	N	N	**D.1.4.6.4;** D.1.4.6-13	Y
40.6.1.33	Provides capability to create NC Title XIX Tables Manual and Edit Resolution Manuals	N	N	N	**D.1.4.6.2;** D.1.4.6-10	Y
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	Y	Y	N	**D.1.4.6.2;** D.1.4.6-8	Y

Requirement #	Requirement Description	A	B	C	D	E
40.6.1.35	Provides capability to electronically store State-assigned EOB and ESC message descriptions	N	N	N	**D.1.4.6.2;** D.1.4.6-9	Y
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.	N	N	N	**D.1.4.6.9;** D.1.4.6-22	Y
40.6.1.37	Provides capability to electronically store accommodation rate data	N	N	N	**D.1.4.6.4;** D.1.4.6-13	Y
40.6.1.38	Provides capability to maintain indefinitely procedure codes that have timeframe limitations	N	N	N	**D.1.4.6.1;** D.1.4.6-6	Y
40.6.1.39	Provides capability to electronically store modifier information with appropriate multiple modifier and payment calculations	N	Y	N	**D.1.4.6.4;** D.1.4.6-13	Y
40.6.1.40	Provides capability to produce electronic copies of Reference Files	N	N	N	**D.1.4.6.8;** D.1.4.6-21	Y
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	N	Y	N	**D.1.4.6.1;** D.1.4.6-6	Y
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	N	N	Y	**D.1.4.6.4;** D.1.4.6-14	Y
40.6.1.43	Provides capability to apply State-approved policy to: ▪ 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 ▪ Drug codes	N	Y	N	**D.1.4.6.1;** D.1.4.6-6	Y

Requirement #	Requirement Description	A	B	C	D	E
	▪ Edits ▪ Rate methodology and calculations ▪ Professional services fees					
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	N	N	N	**D.1.4.6.3;** D.1.4.6-11	Y
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: ▪ Narrative of procedure code ▪ Narrative of modifier, including effective end dates by either date of service, date of processing, or date of receipt ▪ Modifier and narrative applicable to the use of the procedure code/modifier combination ▪ Modifier pricing information, including effective end dates by either date of service, date of processing, or date of receipt ▪ Applicable modifier combinations ▪ Applicable procedure/modifier combinations ▪ Applicable providers for each modifier, including effective and end dates					
40.6.1.46	Provides capability to maintain Reference data with all procedure codes and pricing action codes (PAC) that indicate where pricing occurs based on: ▪ Procedure code, type of service, and/or modifier ▪ Provider type, provider specialty, taxonomy, and procedure code	N	Y	N	**D.1.4.6.4;** D.1.4.6-12	Y

Requirement #	Requirement Description	A	B	C	D	E
	▪ Type of service ▪ Place of service ▪ Provider and per diem rate ▪ Provider, DRG rate, and financial payer ▪ Provider accommodation code ▪ Provider number, percentage of charges, and financial payer ▪ Pharmacy dispensing fee ▪ Enhanced pharmacist professional services fee for performing cognitive services and State-approved interventions ▪ Revenue code ▪ Accommodation code on the Accommodation Rate File ▪ Capitation payments and management fees					
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	N	N	Y	**D.1.4.6.4;** D.1.4.6-14	Y
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	Y	Y	N	**D.1.4.6.4;** D.1.4.6-12	Y
40.6.1.49	Provides capability to search for drugs using the following search criteria: ▪ NDC number ▪ Generic code number or formulation ID ▪ Generic sequence number or clinical formulation ID ▪ Therapeutic class specific or Therapeutic class code	N	Y	N	**D.1.4.6.6;** D.1.4.6-16	Y

Requirement #	Requirement Description	A	B	C	D	E
	▪ Ingredient list ID (HICL-S, relational and non-relational) ▪ HICL sequence number ▪ Med ID ▪ Routed DF Med ID ▪ Routed Med ID ▪ Med Name ID ▪ HIC Sequence ▪ Generic name (GNN) ▪ Ingredient List ID (HICL) ▪ Brand name ▪ Label name ▪ Manufacturer ▪ Enhanced Therapeutic Classification (ETC) ▪ AHF classification ▪ UPC					
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	N	Y	N	**D.1.4.6.6;** D.1.4.6-16	Y
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	N	N	N	**D.1.4.6.6;** D.1.4.6-16	Y
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	N	Y	N	**D.1.4.6.6;** D.1.4.6-16	Y

Requirement #	Requirement Description	A	B	C	D	E
40.6.1.53	Provides capability to electronically store and maintain all State-approved pharmacy pricing methodologies	N	N	N	**D.1.4.6.1;** D.1.4.6-6	Y
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	N	N	Y	**D.1.4.6.4;** D.1.4.6-14	Y
40.6.1.55	Provides capability to create a crosswalk of HCPCS Level I and Level II codes to rebateable NDCs	N	N	Y	**D.1.4.6.4;** D.1.4.6-14	Y
40.6.1.56	Provides capability to identify Drug Efficacy Study Implementation (DESI) drugs	N	N	N	**D.1.4.6.6;** D.1.4.6-16	Y
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	N	Y	N	**D.1.4.6.4;** D.1.4.6-14	Y
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)	N	N	N	**D.1.4.6.4;** D.1.4.6-13	Y
40.6.1.59	Provides capability to electronically store laboratory maximum reimbursement rates for individual and “panel” laboratory procedures	N	N	N	**D.1.4.6.4;** D.1.4.6-13	Y
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	N	Y	N	**D.1.4.6.9;** D.1.4.6-22	Y
40.6.1.61	Provides capability to receive memos from the State online and send memos to the State online for approval	N	N	N	**D.1.4.6.9;** D.1.4.6-22	Y
40.6.1.62	Provides capability to electronically store and track State Memos with online status updates	N	N	N	**D.1.4.6.9;** D.1.4.6-22	Y

Requirement #	Requirement Description	A	B	C	D	E
40.6.1.63	Provides capability to generate an online status report of State Memos	N	N	N	**D.1.4.6.9;** D.1.4.6-22	Y
40.6.1.64	Provides capability for note entry	N	N	N	**D.1.4.6.9;** D.1.4.6-22	Y
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 **(Comment CSC88)**	N	Y	N	**D.1.4.6.9;** D.1.4.6-22	Y
40.6.1.66	Provides capability to link a State/Fiscal Agent Memo with associated procedure codes	N	Y	N	**D.1.4.6.9;** D.1.4.6-22	Y
40.6.1.67**	Provides capability to maintain budget criteria information	N	Y	N	**D.1.4.6.4;** D.1.4.6-14	Y
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	N	Y	N	**D.1.4.6.4;** D.1.4.6-14	Y
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	N	N	Y	**D.1.4.6.8;** D.1.4.6-21	Y
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	N	Y	N	**D.1.4.6.9;** D.1.4.6-22	Y
40.6.1.71	Provides capability for a user-controlled method to maintain edit criteria online	N	Y	N	**D.1.4.6.2;** D.1.4.6-7	Y
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	N	Y	N	**D.1.4.6.4;** D.1.4.6-14	Y
40.6.1.73	Provides capability for inquiry, entry, and updates to group-level pricing parameters for the determination of pharmacy reimbursement calculations	N	N	N	**D.1.4.6.6;** D.1.4.6-18	Y
40.6.1.74	Provides capability to maintain and electronically store pharmacy pricing	N	N	Y	**D.1.4.6.1;** D.1.4.6-6	Y

Requirement #	Requirement Description	A	B	C	D	E
	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	N	Y	N	**D.1.4.6.1;** D.1.4.6-6	Y
40.6.1.76	Provides capability to search for drug data using as primary search criteria: ▪ NDC ▪ Generic code number ▪ Generic sequence number ▪ Therapeutic class ▪ Drug name ▪ Any State-identified First DataBank (FDB) data element	N	Y	N	**D.1.4.6.6;** D.1.4.6-16	Y
40.6.1.77	Provides capability for inquiry, entry, and updates of existing and new drug data for a specific drug	N	Y	N	**D.1.4.6.6;** D.1.4.6-16	Y
40.6.1.78	Provides capability to search for claim exception parameter data using primary and/or secondary search criteria	Y	Y	N	**D.1.4.6.6;** D.1.4.6-16	Y
40.6.1.79	Provides capability to search by phonetic and partial description or user-defined selection criteria	N	N	Y	**D.1.4.6.6;** D.1.4.6-16	Y
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	N	N	N	**D.1.4.6.6;** D.1.4.6-15	Y
40.6.1.81	Provides capability to restrict pharmacy services according to State policy and	N	N	N	**D.1.4.6.6;** D.1.4.6-18	Y

Requirement #	Requirement Description	A	B	C	D	E
	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	N	N	N	**D.1.4.6.6;** D.1.4.6-18	Y
40.6.1.83	Provides capability to electronically store and maintain the Prescription Advantage List (PAL) tiers	N	N	N	**D.1.4.6.6;** D.1.4.6-15	Y
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	N	N	N	**D.1.4.6.6;** D.1.4.6-15	Y
40.6.1.85	Provides capability to search inquiry, entry, and updates for step care data	N	N	Y	**D.1.4.6.6;** D.1.4.6-19	Y
40.6.1.86	Provides capability for inquiry, entry, and updates to a list of preferred agents for a specific step care plan	N	N	Y	**D.1.4.6.6;** D.1.4.6-19	Y
40.6.1.87	Provides capability to ensure that all prior approval requirements and associated edits and audits are linked	N	N	N	**D.1.4.6.2;** D.1.4.6-8	Y
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	N	Y	N	**D.1.4.6.8;** D.1.4.6-21	Y
40.6.1.89	Provides capability to create Fee Schedule reports detailed in the bullets below: ▪ Adult Care Home Personal Care ▪ Ambulance ▪ Ambulatory Surgical Centers/Birthing Centers ▪ Behavioral Health (separate schedules) ▪ Certified Clinical Supervisor and Addictions Specialist	N	Y	N	**D.1.4.6.7;** D.1.4.6-21	Y

Requirement #	Requirement Description	A	B	C	D	E
	▪ Children's Developmental Service Agencies ▪ Licensed Clinical Social Worker and Licensed Professional Counselor and Licensed Marriage and Family Therapist ▪ Licensed Psychological Associate ▪ Mental Health Enhanced Services ▪ Mental Health (LME) ▪ Mental Health Non-Licensed Clinical Fee Schedule ▪ Nurse Practitioner ▪ Nurse Specialist ▪ Prospective Rates ▪ Psychologist ▪ Residential Treatment Level III and IV ▪ Community Alternatives Program (CAP) Rates (separate rates) ▪ CAP/AIDS ▪ CAP/Children ▪ CAP/DA ▪ CAP/Mentally Retarded-Development Disability (MR-DD) ▪ DRG Weight Table ▪ Dental Services ▪ Durable Medical Equipment ▪ Federally Qualified Health Center ▪ Home Health Agency Services					

Requirement #	Requirement Description	A	B	C	D	E
	▪ Home Infusion Therapy ▪ Hospice ▪ Local Education Agency Practitioners ▪ Local Health Department ▪ Multi-specialty Independent Practitioner ▪ Nursing Facility Rates ▪ Occupational Therapy ▪ Orthotics and Prosthetics ▪ Physical Therapy ▪ Physician Drug Program ▪ Respiratory Therapy ▪ Rural Health Center ▪ Speech and Audiology Services					
40.6.1.90	Provides capability 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	N	N	N	**D.1.4.6.7;** D.1.4.6-21	Y

Requirement #	Requirement Description	A	B	C	D	E
40.6.1.91	Provides capability to create rate reports for internal State use only, including: ▪ Lower Level NF Rates ▪ Outpatient Hospital Pricing, Ratio-Cost-to-Charge ▪ Nursing Facility Rates	N	N	N	**D.1.4.6.7;** D.1.4.6-21	Y
40.6.1.92	Provides capability to electronically store a daily file of county DSS mailing addresses	N	N	Y	**D.1.4.6.8;** D.1.4.6-21	Y
New Requirement 40.6.1.93	Provides capability to calculate selected physician fee schedule records based on periodic Resource-Based Relative Value Scale (RBRVS) updates	N	N	Y	**D.1.4.6.4;** D.1.4.6-12	Y

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. **(Comment CSC191)**				**D.2.1.4.1.1;** D.2.1.4-4	Y
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. **(Comment CSC191)**				**D.2.1.4.1.1;** D.2.1.4-4	Y
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**. (Comment CSC191)**				**D.2.1.4.1.1;** D.2.1.4-3 **D.2.1.4.1.1;** D.2.1.4-4	Y

Requirement #	Requirement Description	A	B	C	D	E
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. **(CSC Comment 191)**				**D.2.1.4.1.1;** D.2.1.4-4	Y
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. **(Comment CSC191)**	N	N	N	**D.2.1.4.1.1;** D.2.1.4-4	Y
40.6.2.6	Fiscal Agent shall perform research and analysis for adjudication and policy issues.				**D.2.1.4.1.1;** D.2.1.4-3	Y
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.				**D.2.1.4.1.1;** D.2.1.4-3	Y
40.6.2.8	Fiscal Agent shall update edit criteria and all applicable documentation and notify the State when updates occur. **(Comment CSC191)**				**D.2.1.4.1.1;** D.2.1.4-3 **D.2.1.4.1.1;** D.2.1.4-4	Y
40.6.2.9	Fiscal Agent shall provide PAL tiers information for provider inquiries.				**D.2.1.4.3;** D.2.1.4-14	Y
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.				**D.2.1.4.3;** D.2.1.4-13	Y

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: ▪ Online updates within two (2) State business days of receipt ▪ Mass adjustments within two (2) claims cycles ▪ Other within timeframe, as directed by the State.	N	N	N	**D.2.1.4.5;** D.2.1.4-27	Y
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.	N	N	N	**D.2.1.4.5;** D.2.1.4-27	Y
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.				**D.2.1.4.5;** D.2.1.4-27	Y
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.	N	N	N	**D.2.1.4.5;** D.2.1.4-27	Y
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.	N	N	N	**D.2.1.4.5;** D.2.1.4-27	Y

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	N	N	N	**D.1.4.7.1;** D.1.4.7-4	Y
40.7.1.2	Provides capability to integrate prior approval functionality for all applicable claims and benefit plans (services and drugs)	N	N	N	**D.1.4.7.1;** D.1.4.7-5	Y
40.7.1.3	Provides capability for secure electronic submissions of adjudicated Prior Approval data from State-contracted Prior Approval vendors	N	N	N	**D.1.4.7.2;** D.1.4.7-7	Y
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	N	N	Y	**D.1.4.7.2;** D.1.4.7-7	Y
40.7.1.5	Provides capability to receive and manage prior approval, override, and referral requests via telephone, mail, and fax	N	N	Y	**D.1.4.7.2;** D.1.4.7-7	Y
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	N	N	N	**D.1.4.7.2.2;** D.1.4.7-9	Y
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	N	N	N	**D.1.4.7.2.2;** D.1.4.7-9	Y
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	N	N	Y	**D.1.4.7.2.1;** D.1.4.7-8	Y
40.7.1.9	Provides capability to review online claims and stored electronic health information	N	N	N	**D.1.4.7.4;** D.1.4.7-24	Y

Requirement #	Requirement Description	A	B	C	D	E
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	N	N	N	**D.1.4.7.4;** D.1.4.7-24 **D.1.4.8.9;** D.1.4.8-79	Y
40.7.1.11	Provides capability for entry, inquiry, updates, and reporting for prior approvals, overrides, and referrals	N	Y	Y	**D.1.4.7.1;** D.1.4.7-4	Y
40.7.1.12**	Provides capability to manage and adjudicate prior approval requests for individuals who are not currently on the Recipient File	N	N	N	**D.1.4.7.3.4;** D.1.4.7-20	Y
40.7.1.13	Provides capability for entry and adjudication of prior approval request by LOB	Y	Y	N	**D.1.4.7.3.4;** D.1.4.7-20	Y
40.7.1.14	Provides capability for online, real-time update and adjudication of prior approval requests by State and State Prior Approval contractors	N	N	N	**D.1.4.7.3;** D.1.4.7-9	Y
40.7.1.15	Provides capability for interface with State-contracted Prior Approval vendors to accept adjudicated prior approvals	N	N	N	**D.1.4.7.2;** D.1.4.7-7	Y
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	N	N	N	**D.1.4.7.2;** D.1.4.7-7	Y
40.7.1.17	Provides capability to retain the relationship of recipient-based hospice information (recipient, diagnosis, provider, and coverage dates)	N	N	Y	**D.1.4.7.3.4;** D.1.4.7-20	Y
40.7.1.18	Provides capability for a secure online entry of overrides and referrals	N	N	Y	**D.1.4.7.2.1;** D.1.4.7-8	Y
40.7.1.19	Provides capability to enter comments (free-form text) within a prior approval, referral, or override	N	N	N	**D.1.4.7.3.1;** D.1.4.7-13	Y

Requirement #	Requirement Description	A	B	C	D	E
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	N	N	N	**D.1.4.7.2.1;** D.1.4.7-8	Y
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	N	N	N	**D.1.4.7.5.1;** D.1.4.7-25	Y
40.7.1.22	Provides capability for tracking override date and time of receipt and date decision was rendered	N	N	N	**D.1.4.7.5.1;** D.1.4.7-26	Y
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	N	N	N	**D.1.4.7.5.3;** D.1.4.7-27	Y
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	N	N	N	**D.1.4.7.5.1;** D.1.4.7-26	Y
40.7.1.25	Provides capability to enter prior approval, referral, and override services and limitations	N	Y	Y	**D.1.4.7.3.2;** D.1.4.7-15 **D.1.6.1;** D.1.6-2	Y
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	N	N	N	**D.1.4.7.5.2;** D.1.4.7-26	Y
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	N	N	N	**D.1.4.7.5.2;** D.1.4.7-27	Y

Requirement #	Requirement Description	A	B	C	D	E
40.7.1.28	Provides capability to assign system-generated unique prior approval, referral, and override numbers to approved, pended, and denied requests	N	N	N	**D.1.4.7.3;** D.1.4.7-9	Y
40.7.1.29**	Provides capability to encumber funds associated with approved prior approval/authorizations	N	N	Y	**D.1.4.7.6;** D.1.4.7-29	Y
40.7.1.30**	Provides capability to establish variable recipient co-pay percentages on a prior approval	N	N	Y	**D.1.4.7.6;** D.1.4.7-29 **D.1.6.1.1;** D.1.6-3	Y
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	N	N	N	**D.1.4.7.6;** D.1.4.7-28	Y
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	N	N	N	**D.1.4.7.6;** D.1.4.7-28	Y
40.7.1.33	Provides capability to generate letters of notification for approved, denied, reduced, or pended prior approval requests	N	N	N	**D.1.4.7.7;** D.1.4.7-29	Y
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	N	N	N	**D.1.4.7.3.3;** D.1.4.7-19	Y
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	N	N	N	**D.1.4.7.5.3;** D.1.4.7-28	Y
40.7.1.36	Provides capability to apply Prior Approval logic by LOB, benefit, and recipient	N	Y	Y	**D.1.4.7.3.4;** D.1.4.7-21	Y

Requirement #	Requirement Description	A	B	C	D	E
	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	N	N	N	**D.1.4.7.7;** D.1.4.7-31	Y
	Prior Approval Customer Service Center					
40.7.1.38	Provides capability to support inquiries regarding prior approval, referrals and overrides from physicians, pharmacists, recipients, and other health care professionals	N	N	Y	**D.1.4.7.4.1;** D.1.4.7-25	Y
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	N	N	Y	**D.1.4.7.8.2;** D.1.4.7-35	Y
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	N	N	N	**D.1.4.7.4;** D.1.4.7-24	Y
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, category of service, clerk identification, effective dates, prior approval type, diagnosis, HCPCS, or revenue code and any combinations thereof	N	N	Y	**D.1.4.7.4;** D.1.4.7-21	Y
40.7.1.42	Provides capability to search referrals by recipient ID, referring provider ID, referred provider ID, and referral number	N	N	Y	**D.1.4.7.4.1;** D.1.4.7-25	Y
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	N	N	Y	**D.1.4.7.8.2;** D.1.4.7-35	Y

Requirement #	Requirement Description	A	B	C	D	E
40.7.1.44	Provides capability to dispense a seventy-two-hour (72-hour) supply of drugs without prior approval in emergency situations	N	N	Y	**D.1.4.7.8.2;** D.1.4.7-35	Y
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)	N	N	N	**D.1.4.8.5.4.4;** D.1.4.8-48	Y
40.7.1.46	Provides capability for inquiry and update of prior approval, overrides, and referrals reason/exception codes and descriptions	N	N	N	**D.1.4.7.3.2;** D.1.4.7-18	Y
40.7.1.47	Provides capability to edit DME prior approvals online to include: ▪ Valid provider identification and eligibility, including other payers and place of residence ▪ Valid recipient age for service ▪ Duplicate approval check for previously authorized or previously adjudicated services, including the same service over the same timeframe by different providers	N	N	Y	**D.1.4.7.3.4;** D.1.4.7-20	Y
40.7.1.48	Provides capability to maintain multiple referral types	N	N	Y	**D.1.4.7.1;** D.1.4.7-5	Y
40.7.1.49	Provides capability for data validation and duplicate prior approval, referral, and override editing	N	N	Y	**D.1.4.7.3.4;** D.1.4.7-20	Y
40.71.50	Provides capability for authorized users to search for a provider number for purposes of authorizing a referral	N	N	N	**D.1.4.7.4.1;** D.1.4.7-25	Y
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	N	N	Y	**D.1.4.7.4.1;** D.1.4.7-25	Y

Requirement #	Requirement Description	A	B	C	D	E
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	N	N	Y	**D.1.4.7.2.1;** D.1.4.7-8	Y
40.7.1.53	Provides capability to allow the referring provider and the referred-to provider to inquire on referrals	N	N	Y	**D.1.4.7.4.1;** D.1.4.7-25	Y
40.7.1.54	Provides capability to produce a report that lists all open referrals not used within a specified period of time	N	N	Y	**D.1.4.7.5.3;** D.1.4.7-28	Y
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	N	N	N	**D.1.4.7.5.3;** D.1.4.7-28	Y
40.7.1.56	Provides capability for workflow imaging application, to enable automated processing and work queue functionality for prior approvals and overrides	N	N	N	**D.1.4.7.2.2;** D.1.4.7-9	Y
	Searching and Tracking of Therapeutic Leave					
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	N	N	N	**D.1.4.7.5.1;** D.1.4.7-26	Y
	Pharmacy Benefits Management					
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	N	N	N	**D.1.4.7.8;** D.1.4.7-31	Y
40.7.1.59	Provides capability to generate adjudicated prior approval appeal letters to recipients and providers when prior approval was denied or reduced	N	N	N	**D.1.4.7.7;** D.1.4.7-31	Y
40.7.1.60	Provides capability to identify and capture recipient drug information where aberrant	N	N	N	**D.1.4.7.8.2;** D.1.4.7-35	Y

Requirement #	Requirement Description	A	B	C	D	E
	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	N	N	Y	**D.1.4.7.8.1;** D.1.4.7-32	Y
40.7.1.62	Provides capability to ensure verification of recipient eligibility, provider program participation, and third party coverage during adjudication of prior approvals	N	N	N	**D.1.4.7.8.1;** D.1.4.7-32	Y
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	N	N	Y	**D.1.4.7.8.1;** D.1.4.7-32	Y
40.7.1.64	Provides for search capability of covered drugs by: • Effective, termination, or a range of dates • NDC. Generic name, brand name • HICL, HICL-Sequence, HICL code, GCN, GCN-Sequence, GNN, label name manufacturer, UPC, GC3, TxCL, AHF	N	Y	N	**D.1.4.7.8.2;** D.1.4.7-35	Y

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 as the pharmacy paper/facsimile hard copy version.				**D.2.1.4.3;** D.2.1.4-11	Y

Requirement #	Requirement Description	A	B	C	D	E
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.	N	N	N	**D.2.1.4.2.2;** D.2.1.4-7	Y
40.7.2.3	Fiscal Agent shall adjudicate prior approvals and mail system-generated disposition letters.	N	N	N	**D.2.1.4.2.2;** D.2.1.4-9	Y
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.				**D.2.1.4.2.2;** D.2.1.4-9	Y
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.				**D.2.1.4.2.3;** D.2.1.4-9	Y
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.	N	N	Y	**D.2.1.4.2.3;** D.2.1.4-10	Y
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.				**D.2.1.4.2.3;** D.2.1.4-10	Y
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.				**D.2.1.4.2.3;** D.2.1.4-10	Y
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				**D.2.1.4.2.3;** D.2.1.4-10	Y

Requirement #	Requirement Description	A	B	C	D	E
	retrospective and therapeutic days.					
40.7.2.10	Fiscal Agent shall provide the capability for authorized services to be flagged for pre-payment review.	N	N	N	**D.2.1.4.2.2;** D.2.1.4-7	Y
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.				**D.2.1.4.2.4;** D.2.1.4-10	Y
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.				**D.2.1.4.2.5;** D.2.1.4-11	Y
40.7.2.13	Fiscal Agent shall evaluate and determine prior approval adjudication for: ▪ Eye exams or refraction ▪ Visual aids ▪ Hearing aids, accessories, ear molds, FM systems, repairs ▪ Dental and orthodontics ▪ Hyperbaric oxygenation therapy ▪ Blepharoplasty/blepharoptosis eyelid repair ▪ Panniculectomy ▪ Breast surgery ▪ Clinical severe obesity surgery ▪ Lingual frenulum surgery ▪ Stereotactic pallidotomy				**D.2.1.4.2.2;** D.2.1.4-6	Y

Requirement #	Requirement Description	A	B	C	D	E
	▪ Electrical osteogenic stimulators ▪ Keloids ▪ Craniofacial/facial surgeries ▪ Out-of-state ambulance ▪ Rhinoplasty ▪ Chiropractic and podiatry ▪ Durable medical equipment ▪ Orthotics and prosthetics ▪ Pharmacy ▪ All services for DPH payment programs					
40.7.2.14	Fiscal Agent shall present prior approval, referral, and override information and provide education at provider workshops.				**D.2.1.4.2.5;** D.2.1.4-10	Y
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.				**D.2.1.4.3;** D.2.1.4-11	Y
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.				**D.2.1.4.3;** D.2.1.4-11	Y
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				**D.2.1.4.2.1;** D.2.1.4-6	Y

Requirement #	Requirement Description	A	B	C	D	E
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).				**D.2.1.4.3;** D.2.1.4-11	Y
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.				**D.2.1.4.2.1;** D.2.1.4-6	Y
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.	N	N	N	**D.2.1.4.2.2;** D.2.1.4-9	Y
40.7.2.21	Fiscal Agent shall provide training for Prior Approval Vendors and State staff.				**D.2.1.4.2.5;** D.2.1.4-10	Y
40.7.2.22	Fiscal Agent shall ensure verification of recipient eligibility, provider program participation, and third party coverage during adjudication of prior approvals.	N	N	N	**D.2.1.4.2.2;** D.2.1.4-8	Y
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.	N	N	N	**D.2.1.4.2.2;** D.2.1.4-7	Y
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				**D.2.1.4.2.1;** D.2.1.4-6	Y
	Pharmacy Benefits Management					
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.	N	N	N	**D.2.1.4.3;** D.2.1.4-12	Y

Requirement #	Requirement Description	A	B	C	D	E
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.	N	N	N	**D.2.1.4.3;** D.2.1.4-12	Y
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.	N	N	N	**D.2.1.4.3;** D.2.1.4-13	Y
40.7.2.28	Fiscal Agent shall prepare monthly Pharmacy Newsletter for State approval and distribute as directed by the State.				**D.2.1.4.3;** D.2.1.4-13	Y
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.				**D.2.1.4.3;** D.2.1.4-15	Y
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.				**D.2.1.4.3;** D.2.1.4-12	Y
40.7.2.31	Fiscal Agent shall post on the Web site the EBM updates to PAL clinical pearls.	Y	N	Y	**D.2.1.4.3;** D.2.1.4-13	Y
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.	N	N	Y	**D.2.1.4.3;** D.2.1.4-13	Y
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.				**D.2.1.4.3;** D.2.1.4-15	Y
40.7.2.34	Fiscal Agent shall develop criteria-driven recommendations for each new drug within				**D.2.1.4.3;** D.2.1.4-15	Y

Requirement #	Requirement Description	A	B	C	D	E
	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.				**D.2.1.4.3;** D.2.1.4-12	Y
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.				**D.2.1.4.3;** D.2.1.4-14	Y
40.7.2.37	Fiscal Agent shall adjudicate provider appeals.				**D.2.1.4.3;** D.2.1.4-15	Y
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.				**D.2.1.4.3;** D.2.1.4-13	Y
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. **(Comment CSC243)**	N	N	Y	**D.2.1.4.3;** D.2.1.4-15	Y
40.7.2.40	Fiscal Agent shall identify pharmacy provider training issues related to prior approvals and shall address at workshops				**D.2.1.4.3;** D.2.1.4-14	Y
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.				**D.2.1.4.3;** D.2.1.4-15	Y
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)	N	N	N	**D.2.1.4.3;** D.2.1.4-15	Y

Requirement #	Requirement Description	A	B	C	D	E
	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.				**D.2.1.4.5;** D.2.1.4-27	Y
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.				**D.2.1.4.5;** D.2.1.4-27	Y
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.	N	N	N	**D.2.1.4.5;** D.2.1.4-27	Y
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.				**D.2.1.4.5;** D.2.1.4-27	Y
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.	N	N	N	**D.2.1.4.5;** D.2.1.4-27	Y
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	N	N	N	**D.2.1.4.5;** D.2.1.4-28	Y

Requirement #	Requirement Description	A	B	C	D	E
	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.	N	N	N	D.2.1.4.5 D.2.1.4-28	Y
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.	N	N	N	**D.2.1.4.5;** D.2.1.4-28	Y
40.7.3.9	Fiscal Agent shall produce weekly Pharmacy Alerts.	N	N	N	**D.2.1.4.5;** D.2.1.4-28	Y
40.7.3.10	Fiscal Agent shall adjudicate each complete pharmacy prior approval request within one (1) State business day of receipt.				**D.2.1.4.5;** D.2.1.4-28	Y
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.				**D.2.1.4.5;** D.2.1.4-28	Y
40.7.3.12	Fiscal Agent shall adjudicate provider pharmacy prior approval request appeals within one (1) State business days of receipt.				**D.2.1.4.5;** D.2.1.4-28	Y
40.7.3.13	Fiscal Agent shall respond to a requesting provider within one (1) hour for a telephone request for an emergency override.				**D.2.1.4.5;** D.2.1.4-28	Y

40.8 Claims Processing Requirements

40.8.1 Claims Processing System Requirements

Requirement #	Requirement Description	A	B	C	D	E
	Mailroom					
40.8.1.1	Provides capability for mechanized date stamping of all mail	N	N	Y	**D.1.4.8.2.1;** D.1.4.8-9	Y
40.8.1.2	Provides capability to access system for logging receipt of packages and envelopes received from couriers	N	N	N	**D.1.4.8.2.4;** D.1.4.8-18	Y
40.8.1.3	Provides capability to access system log for entering checks received	N	Y	N	**D.1.4.8.2.4;** D.1.4.8-18	Y
40.8.1.4	Provides capability for system-generated logging of regular mail costs	N	N	N	**D.1.4.8.2.4;** D.1.4.8-18	Y
40.8.1.5	Provides capability for automated Return to Provider (RTP) letter	N	N	Y	**D.1.4.8.2.1;** D.1.4.8-10	Y
40.8.1.6	Provides capability for automated system log/accounting for mailroom	N	N	N	**D.1.4.8.2.4;** D.1.4.8-18	Y
	Claim Acquisition					
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	N	N	N	**D.1.4.8.2.1;** D.1.4.8-9	Y
40.8.1.8	Provides capability for tracking of all claims, adjustments, and financial transactions from receipt to final disposition	N	N	N	**D.1.4.8.2.1;** D.1.4.8-10	Y
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	N	N	N	**D.1.4.8.2.1;** D.1.4.8-10	Y

Requirement #	Requirement Description	A	B	C	D	E
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	N	N	N	**D.1.4.8.4;** D.1.4.8-21	Y
40.8.1.11	Provides capability to identify any activated claim batches that fail to balance to control counts	N	N	N	**D.1.4.8.4;** D.1.4.8-22	Y
40.8.1.12	Provides capability for editing to prevent duplicate entry of electronic media claims	N	N	N	**D.1.4.8.2.3;** D.1.4.8-18	Y
40.8.1.13	Provides capability to perform CLIA editing based on the provider CLIA number and the CLIA number for the service	N	N	N	**D.1.4.8.5.4.3;** D.1.4.8-47 **D.1.4.8.5.4.4;** D.1.4.8-47	Y
40.8.1.14	Provides capability to perform diagnosis editing by line item	N	N	N	**D.1.4.8.5.4.4;** D.1.4.8-47	Y
40.8.1.15	Provides capability to adjudicate a claim to the fullest extent possible in order to report all errors	N	N	N	**D.1.4.8.5;** D.1.4.8-22	Y
40.8.1.16	Provides capability to adjudicate claims for Medicare Part D dual-eligible recipients according to State business rules and policies	N	N	N	**D.1.4.8.5;** D.1.4.8-22	Y
40.8.1.17	Provides capability for key re-verification of critical fields, data entry software editing, and supervisor audit verification of keyed claims	N	N	N	**D.1.4.8.3.1;** D.1.4.8-20	Y
40.8.1.18	Provides capability to maintain extract tables that contain key elements to verify the validity of entered claim information	N	N	N	**D.1.4.8.3;** D.1.4.8-19	Y
40.8.1.19	Provides capability to perform presence and format editing on all entered claims	N	N	N	**D.1.4.8.3;** D.1.4.8-19	Y
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	N	N	N	**D.1.4.8.5;** D.1.4.8-22	Y

Requirement #	Requirement Description	A	B	C	D	E
	Files or business area/interfaces					
40.8.1.21	Provides capability to support the Medicare Correct Coding Initiative (CCI)	Y	Y	N	**D.1.4.8.5.6;** D.1.4.8-59	Y
40.8.1.22	Provides capability for front-end claim, adjustment, or crossover denials when required attachments are not present	N	N	N	**D.1.4.8.5.4.4;** D.1.4.8-48	Y
40.8.1.23	Provides capability to generate RTP letters with entry available to denote front-end claim error conditions	N	N	N	**D.1.4.8.3;** D.1.4.8-19	Y
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	N	N	N	**D.1.4.8.5.3.2;** D.1.4.8-36 D.1.4.14.2.16; D.1.4.14-37	Y
40.8.1.25	Provides capability to override service limitations for Early Periodic Screening, Diagnosis, and Treatment (EPSDT) -eligible recipients	N	N	N	**D.1.4.8.5.3.2;** D.1.4.8-36	Y
40.8.1.26	Provides capability to identify and allow online correction to claims suspended as a result of data entry errors	N	N	N	**D.1.4.8.7;** D.1.4.8-68	Y
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	N	N	N	**D.1.4.8.2.2;** D.1.4.8-17 **D.1.4.8.2.3;** D.1.4.8-18	Y
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	N	N	N	**D.1.4.8.2.3;** D.1.4.8-18	Y
40.8.1.29	Provides capability to reject electronic claims at the claim level	N	N	N	**D.1.4.8.2.3;** D.1.4.8-18	Y
40.8.1.30	Provides capability to process claims and financial transaction adjustments	N	N	N	**D.1.4.8.8;** D.1.4.8-72	Y

Requirement #	Requirement Description	A	B	C	D	E
					D.1.4.14.2.3; D.1.4.14-10	
40.8.1.31	Provides capability to perform duplicate editing of drugs billed by physicians and pharmacy	N	N	N	**D.1.4.8.5.6;** D.1.4.8-58	Y
40.8.1.32	Provides capability to use transfer of assets data on the Medicaid recipient record in claims processing	Y	Y	N	**D.1.4.8.5.5.7;** D.1.4.8-56	Y
40.8.1.33	Provides capability to populate each claim detail with appropriate header level EOB	N	N	N	**D.1.4.8.5.3.2;** D.1.4.8-37	Y
40.8.1.34	Provides capability to use Medicaid/Medicare coverage data from EIS to adjudicate claims	N	N	N	**D.1.4.8.5.4.2;** D.1.4.8-44	Y
40.8.1.35	Provides capability to update the Claims History tables with paid and denied claims from the previous audit run	N	N	N	**D.1.4.8.10;** D.1.4.8-89	Y
40.8.1.36	Provides capability for inquiry on suspended claims, accessible for online inquiry	N	N	N	**D.1.4.8.7;** D.1.4.8-68	Y
40.8.1.37	Provides capability to accept the indicator denoting whether a third party was billed for TPL claims	N	N	N	**D.1.4.8.3;** D.1.4.8-19	Y
40.8.1.38	Provides capability to use EDB and BENDEX information to detect Medicare and Medicare HMO entitlement for use in claims processing	Y	N	Y	**D.1.4.8.5.5.6;** D.1.4.8-55	Y
40.8.1.39**	Provides capability to define parameters and create a file for the negative and positive eligibility quality control sampling for DMH	N	N	N	**D.1.4.8.11;** D.1.4.8-90	Y
40.8.1.40**	Provides capability to produce reports regarding the results of the DMH negative and positive sampling	N	N	N	**D.1.4.8.11;** D.1.4.8-90	Y

Requirement #	Requirement Description	A	B	C	D	E
40.8.1.41**	Provides capability to accept an MEQC positive sample file from DMA via DIRM	N	N	N	**D.1.4.8.11;** D.1.4.8-90	Y
40.8.1.42	Provides capability to produce claim history reports using the MEQC positive sample file from DMA via DIRM	N	N	N	**D.1.4.8.11;** D.1.4.8-90	Y
40.8.1.43	Provides capability to reflect all premium payments and adjustments on the online paid Claims History files	N	N	N	**D.1.4.8.10;** D.1.4.8-89	Y
40.8.1.44	Provides capability to maintain a complete history of all claims: paid, adjusted, and denied	N	N	N	**D.1.4.8.10;** D.1.4.8-89	Y
40.8.1.45	Provides capability to accrue all appropriate EOBs messages for relevant claim adjudication for each detail line and report on RA	N	N	N	**D.1.4.8.5.7.4;** D.1.4.8-64	Y
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	N	N	N	**D.1.4.8.5.6;** D.1.4.8-57 **D.1.4.8.10;** D.1.4.8-89	Y
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	N	N	N	**D.1.4.8.5;** D.1.4.8-23	Y
40.8.1.48	Provides capability to adjust paid claims history for State-specified TPL recoveries at the detail level to include duplicate check	N	N	N	**D.1.4.8.8;** D.1.4.8-72	Y
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	N	N	N	**D.1.4.8.5.5;** D.1.4.8-50	Y
40.8.1.50	Provides capability for providers to bill ambulance services using multiple claim types	N	N	N	**D.1.4.8.5.4.4;** D.1.4.8-47	Y

Requirement #	Requirement Description	A	B	C	D	E
40.8.1.51**	Provides capability for an extract of DMH claims denied due to insufficient budget	N	Y	N	D.1.4.14.2.3; D.1.4.14-11	Y
	Pharmacy Point-of-Sale					
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	N	N	N	**D.1.4.8.9;** D.1.4.8-79	Y
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	N	N	N	**D.1.4.8.9.1;** D.1.4.8-87	Y
40.8.1.54	Provides capability to identify informational alerts for warning on claim denials	N	N	N	**D.1.4.8.9.1;** D.1.4.8-87	Y
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	N	N	N	**D.1.4.8.5.7.7;** D.1.4.8-65	Y
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	N	N	N	**D.1.4.8.5.7.1;** D.1.4.8-61	Y
40.8.1.57	Provides capability to price all pharmacy claims using lesser of logic incorporating all State-approved pricing methodologies	N	N	N	**D.1.4.8.5.5.1;** D.1.4.8-51	Y
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	N	N	N	**D.1.4.8.9;** D.1.4.8-79	Y
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	N	N	N	**D.1.4.8.5.5.1;** D.1.4.8-51	Y
40.8.1.60	Provides capability to interface with Comprehensive Neuroscience (CNS) Program-	Y	Y	N	**D.1.4.8.5.5.1;** D.1.4.8-53	Y

Requirement #	Requirement Description	A	B	C	D	E
	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	Y	Y	N	**D.1.4.8.9;** D.1.4.8-78	Y
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	N	N	N	**D.1.4.8.9;** D.1.4.8-80	Y
40.8.1.63	Provides capability to allow for online pharmacy claim reversal/adjustment within one (1) year of date of service	N	N	N	**D.1.4.8.5.7.4;** D.1.4.8-63	Y
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	N	Y	N	**D.1.4.8.5.6;** D.1.4.8-58	Y
40.8.1.65	Provides capability for an online audit trail of all POS/PRO-DUR transactions	N	N	N	**D.1.4.8.5.7.7;** D.1.4.8-66	Y
40.8.1.66	Provides capability for submissions and responses for all Replacement MMIS POS/PRO DUR via the Web Portal	N	N	Y	**D.1.4.8.9;** D.1.4.8-79	Y
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	Y	Y	N	**D.1.4.8.5.5.1;** D.1.4.8-52	Y
40.8.1.68	Provides capability for flexible State-determined dispensing fees	N	N	N	**D.1.4.8.5.5.1;** D.1.4.8-51	Y
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	N	N	N	**D.1.4.8.5.7.4;** D.1.4.8-63	Y

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	N	N	N	**D.1.4.8.9.1;** D.1.4.8-83	Y
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	N	N	N	D.1.4.8.5.7.7; D.1.4.8-66	Y
40.8.1.72	Provides capability to allow for the submitting provider to respond to alerts by overriding alerts or reversing the claim submitted	N	N	N	**D.1.4.8.9.1;** D.1.4.8-87	Y
40.8.1.73	Provides capability to edit for and deny FDA DESI-identified drugs	N	N	N	**D.1.4.8.9.1;** D.1.4.8-81	Y
40.8.1.74	Provides capability to pay or deny (but not suspend) all pharmacy claims entered through POS devices	N	N	N	**D.1.4.8.5.7.4;** D.1.4.8-63	Y
40.8.1.75	Provides capability to edit against lock-in/lock-out recipient data for pharmacy, primary care provider, and/or prescriber	Y	Y	N	**D.1.4.8.5.4.2;** D.1.4.8-45	Y
40.8.1.76	Provides capability to process claims for pharmacist's professional services and to price according to the cognitive service provided	N	N	N	**D.1.4.8.5.5.1;** D.1.4.8-51	Y
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	N	N	N	**D.1.4.8.9;** D.1.4.8-79	Y
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	N	N	N	**D.1.4.8.5.5.1;** D.1.4.8-51	Y
40.8.1.79	Provides capability to edit against all State-determined DUR alerts	N	N	N	**D.1.4.8.9.1;** D.1.4.8-87	Y

Requirement #	Requirement Description	A	B	C	D	E
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	N	N	Y	**D.1.4.8.9;** D.1.4.8-80	Y
40.8.1.81	Provides capability to apply edits for coverage of non-legend drugs within compound drugs	N	Y	N	**D.1.4.8.5.5.1;** D.1.4.8-53	Y
40.8.1.82	Provides capability to ensure use of the appropriate package size in calculating the maximum allowable unit cost for reimbursement	N	N	N	**D.1.4.8.5.5.1;** D.1.4.8-51	Y
40.8.1.83	Provides capability to edit for Part D eligibility or suspect and deny appropriately	N	N	N	**D.1.4.8.5.4.2;** D.1.4.8-44	Y
40.8.1.84	Provides capability to ensure drugs have not been previously issued within the Physician Drug Program and Pharmacy POS	N	N	N	**D.1.4.8.5.6;** D.1.4.8-58	Y
	Determination of Financial Payer and Population Group					
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	N	N	Y	**D.1.4.8.5.1;** D.1.4.8-25	Y
40.8.1.86	Provides capability to determine the most appropriate LOB and benefit plan for each claim (by line detail)	N	N	Y	**D.1.4.8.5.1;** D.1.4.8-27	Y
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	N	N	Y	**D.1.4.8.5.1;** D.1.4.8-26	Y
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	N	N	N	**D.1.4.8.5.1;** D.1.4.8-29	Y

Requirement #	Requirement Description	A	B	C	D	E
40.8.1.89	Provides capability to determine financial payer hierarchy	N	N	N	**D.1.4.8.5.1;** D.1.4.8-29	Y
40.8.1.90	Provides capability to determine population group hierarchy within a specified financial payer	N	N	Y	**D.1.4.8.5.1;** D.1.4.8-29	Y
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	N	N	N	**D.1.4.8.10;** D.1.4.8-89	Y
40.8.1.92	Provides capability to identify any claim details and track back to the original claim	N	N	N	**D.1.4.8.5.1;** D.1.4.8-27	Y
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	N	N	N	**D.1.4.8.5.1;** D.1.4.8-27	Y
40.8.1.94	Provides capability to apply appropriate Replacement MMIS edits to any claim detail that is processed independent of the original claim	N	N	N	**D.1.4.8.5.1;** D.1.4.8-27	Y
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	N	Y	N	**D.1.4.8.5.4.4;** D.1.4.8-48	Y
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	N	N	N	**D.1.4.8.4;** D.1.4.8-21	Y
40.8.1.97	Provides capability to perform claims processing based on recipient's enrollment and eligibility information	N	N	N	**D.1.4.8.5.4.2;** D.1.4.8-44	Y
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	N	N	N	**D.1.4.8.5.3.2;** D.1.4.8-33	Y

Requirement #	Requirement Description	A	B	C	D	E
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	N	N	N	**D.1.4.8.5.3.2;** D.1.4.8-34	Y
40.8.1.100	Provides capability for online claims correction and resolution of suspended claims	N	N	N	**D.1.4.8.7;** D.1.4.8-68	Y
40.8.1.101	Provides capability to receive paper/electronic claims for Medicare and Medicare HMO cost sharing	N	N	N	**D.1.4.8.2;** D.1.4.8-7	Y
40.8.1.102	Provides capability for the identification of potential TPL (including Medicare) and suspend, deny, or pay and report the claim	N	N	N	**D.1.4.8.5.5.6;** D.1.4.8-55	Y
40.8.1.103	Provides capability to distinguish between a Medicare denial versus private insurance denials	N	N	N	**D.1.4.8.5.5.6;** D.1.4.8-55	Y
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	N	N	N	**D.1.4.8.5.5.6;** D.1.4.8-55	Y
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	N	N	N	**D.1.4.8.5.7.2;** D.1.4.8-62	Y
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	N	N	N	**D.1.4.8.5.1;** D.1.4.8-29	Y
40.8.1.107	Provides capability for editing to ensure that all required attachments are present	N	N	N	**D.1.4.8.7;** D.1.4.8-68	Y
40.8.1.108	Provides capability to edit for cost-sharing requirements on applicable claims	N	N	N	**D.1.4.8.5.5.7;** D.1.4.8-56	Y
40.8.1.109	Provides capability to edit any suspended claims requiring provider or recipient prepayment review	N	N	N	**D.1.4.8.7;** D.1.4.8-68	Y

Requirement #	Requirement Description	A	B	C	D	E
40.8.1.110	Provides capability to process all claims against the edit criteria	N	N	N	**D.1.4.8.5.4;** D.1.4.8-43	Y
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	N	Y	N	**D.1.4.8.5.5.6;** D.1.4.8-55	Y
40.8.1.112	Provides capability to edit for recipient eligibility on date(s) of service	N	N	N	**D.1.4.8.5.4.2;** D.1.4.8-44	Y
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	N	Y	N	**D.1.4.8.5.4.2;** D.1.4.8-43	Y
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	N	N	N	**D.1.4.8.5.4.2;** D.1.4.8-44	Y
40.8.1.115	Provides capability to edit for recipient living arrangement within the dates of service	N	N	N	**D.1.4.8.5.4.2;** D.1.4.8-44	Y
40.8.1.116	Provides capability to edit for Provider program eligibility to perform procedure rendered on date of service	N	N	N	**D.1.4.8.5.4.3;** D.1.4.8-46	Y
40.8.1.117	Provides capability to edit for provider participation as a member of the billing group	N	N	N	**D.1.4.8.5.4.3;** D.1.4.8-46	Y
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	N	N	N	**D.1.4.8.5.4.2;** D.1.4.8-44	Y
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	N	N	N	**D.1.4.8.5.7.1;** D.1.4.8-60	Y
40.8.1.121	Provides capability to edit for step therapy criteria and protocol for selected drugs	N	N	N	**D.1.4.8.9.1;** D.1.4.8-85	Y

Requirement #	Requirement Description	A	B	C	D	E
40.8.1.122	Provides capability to override the thirty-four-day (34-day) supply limit edit for drugs	N	N	N	**D.1.4.8.9.1;** D.1.4.8-87	Y
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	N	N	N	**D.1.4.8.5.7.1;** D.1.4.8-60	Y
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	N	N	N	**D.1.4.8.5.7.1;** D.1.4.8-60	Y
40.8.1.125	Provides capability for automated cross-checks and relationship edits on all claims	N	N	N	**D.1.4.8.5.6;** D.1.4.8-57	Y
40.8.1.126	Provides capability for automated audit processing against history, suspended, and same cycle claims	Y	Y	N	**D.1.4.8.5.6;** D.1.4.8-57	Y
40.8.1.127	Provides capability to apply Medical Procedure Audit Policy (MPAP) to determine audits on a specific claim detail	N	N	N	**D.1.4.8.5.6;** D.1.4.8-59	Y
40.8.1.128	Provides capability to ensure that auditing supports claim denials, automatic recoupments or cutbacks, suspended for review, or specific pricing	Y	Y	N	**D.1.4.8.5.6;** D.1.4.8-59	Y
40.8.1.129	Provides capability for automatic system recoupment and denial of hospital claim when prior approval for surgery was not granted	N	N	N	**D.1.4.8.5.7.1;** D.1.4.8-60	Y
40.8.1.130	Provides capability to apply clinical and pricing business rules in claims processing	N	N	N	**D.1.4.8.5.5;** D.1.4.8-49	Y
40.8.1.131	Provides capability to identify paid and denied claims in Claims History	N	N	N	**D.1.4.8.10;** D.1.4.8-89	Y
40.8.1.132	Provides capability for editing an unlimited number of claim lines	N	N	N	**D.1.4.8.5.3;** D.1.4.8-31	Y
40.8.1.133	Provides capability to process multiple units of service for a span of dates of service	N	N	N	**D.1.4.8.5.4.4;** D.1.4.8-47	Y

Requirement #	Requirement Description	A	B	C	D	E
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	N	N	N	**D.1.4.8.5.6;** D.1.4.8-58	Y
40.8.1.135	Provides capability to identify potential and/or exact duplicate claims in the MMIS and POS within and across financial payers	N	N	N	**D.1.4.8.5.6;** D.1.4.8-58	Y
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	N	N	N	**D.1.4.8.5.6;** D.1.4.8-58	Y
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	Y	Y	N	**D.1.4.8.5;** D.1.4.8-23	Y
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	N	N	N	**D.1.4.8.5;** D.1.4.8-23	Y
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	N	N	N	**D.1.4.8.7;** D.1.4.8-69	Y
40.8.1.141	Provides capability for the acceptance of overrides of claim edits and audits	N	N	N	**D.1.4.8.7;** D.1.4.8-70	Y
40.8.1.142	Provides capability to turn off and on edits/audits for program types as specified by State Memo	N	N	N	**D.1.4.8.5.3.2;** D.1.4.8-36	Y
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	N	N	N	**D.1.4.8.5.3.2;** D.1.4.8-36	Y
40.8.1.144	Provides capability to maintain a record of service codes required for audit processing	N	N	N	**D.1.4.8.5.6;** D.1.4.8-57	Y

Requirement #	Requirement Description	A	B	C	D	E
	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: ▪ Suspend for special handling ▪ Deny and print an explanatory message on the provider RA ▪ Suspend to a specific location unit ▪ Pay and report to a specific location/unit ▪ Pay	N	N	N	**D.1.4.8.5.3.2;** D.1.4.8-34	Y
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	Y	Y	N	**D.1.4.8.5.3.2;** D.1.4.8-36 **D.1.4.8.5.3.3;** D.1.4.8-40 **D.1.4.8.5.3.3;** D.1.4.8-38-42	Y
40.8.1.147	Provides capability to perform edits against claims for limits on dollars, units, and percentages	Y	Y	N	**D.1.4.8.5.3.3;** D.1.4.8-40	Y
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	N	Y	N	**D.1.4.8.5.7.1;** D.1.4.8-61	Y
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	N	N	N	**D.1.4.8.9.1;** D.1.4.8-83 **D.1.6.1;** D.1.6-2	Y

Requirement #	Requirement Description	A	B	C	D	E
40.8.1.150	Provides capability to allow for exceptions to pharmacy lock-ins	N	N	N	**D.1.4.8.5.4.2;** D.1.4.8-45	Y
40.8.1.151	Provides capability to edit claims with billed amounts that vary by a specified degree above or below allowable amounts	N	N	N	**D.1.4.8.5.5;** D.1.4.8-49	Y
40.8.1.152	Provides capability to validate provider IDs for billing, attending, referring, and prescribing providers	N	N	N	**D.1.4.8.5.4.3;** D.1.4.8-46	Y
40.8.1.153	Provides capability to edit for valid CLIA certification for laboratory procedures	N	N	N	**D.1.4.8.5.4.3;** D.1.4.8-47 **D.1.4.8.5.4.4;** D.1.4.8-47	Y
40.8.1.154	Provides capability to edit claim for tooth numbers for procedures requiring tooth number, surface, or quadrant	N	N	N	**D.1.4.8.5.3.3;** D.1.4.8-42	Y
40.8.1.155	Provides capability to edit for procedure to procedure on same date of service	N	N	N	**D.1.4.8.5.3.3;** D.1.4.8-42	Y
40.8.1.156	Provides capability to edit for service limitations	N	N	N	**D.1.4.8.5.3;** D.1.4.8-32 **D.1.4.8.5.3.3;** D.1.4.8-42 **D.1.6.1;** D.1.6-2	Y
40.8.1.157	Provides capability to edit for the identification of the quadrant based on tooth number for editing	N	N	N	**D.1.4.8.5.3.3;** D.1.4.8-42	Y
40.8.1.158	Provides capability to track service limitations online	N	N	N	**D.1.4.8.5.3.3;** D.1.4.8-42	Y
40.8.1.159	Provides capability to edit and suspend with procedure codes set to manually price	N	N	N	**D.1.4.8.5.5.5;** D.1.4.8-54	Y

Requirement #	Requirement Description	A	B	C	D	E
	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	N	N	N	**D.1.4.8.5.1;** D.1.4.8-25	Y
40.8.1.161	Provides capability to edit for timely filing	N	N	N	**D.1.4.8.5.4;** D.1.4.8-43	Y
40.8.1.162	Provides capability to cut back units on claims, retaining the original units billed and units paid	Y	Y	N	**D.1.4.8.5.7.1;** D.1.4.8-60	Y
40.8.1.163	Provides capability to process Medicare cost-sharing charges using the full claim input information and system edit capability	N	N	N	**D.1.4.8.5.5.4;** D.1.4.8-54	Y
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	N	N	N	**D.1.4.8.5.5;** D.1.4.8-50 **D.1.4.8.5.6;** D.1.4.8-57 **D.1.4.8.5.6;** D.1.4.8-58	Y
40.8.1.165	Provides capability to edit for disproportionate share hospitals	Y	Y	N	**D.1.4.8.5.6;** D.1.4.8-59	Y
40.8.1.166	Provides capability for all edits as listed by the State	N	N	N	**D.1.4.8.5.3;** D.1.4.8-31	Y
40.8.1.167	Provides capability for encounter-specific editing and auditing	N	N	N	**D.1.4.8.5.5.2;** D.1.4.8-53	Y
40.8.1.168	Provides capability to edit billed charges for high and low variances	N	N	N	**D.1.4.8.5.5;** D.1.4.8-49	Y

Requirement #	Requirement Description	A	B	C	D	E
	Suspended Claims					
40.8.1.169	Provides capability to suspend claims for review, as required by the State	N	N	N	**D.1.4.8.7;** D.1.4.8-67	Y
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	N	N	N	**D.1.4.8.7;** D.1.4.8-67	Y
40.8.1.171	Provides capability to process Medicare cost-sharing charges	N	N	N	**D.1.4.8.5.5.4;** D.1.4.8-54	Y
40.8.1.172	Provides capability to electronically store and report comparable codes used to price unlisted procedure codes	Y	Y	N	**D.1.4.8.5.5.5;** D.1.4.8-54	Y
40.8.1.173	Provides capability to subject all pharmacy claims to the automated POS PRO-DUR consistently	N	N	N	**D.1.4.8.9;** D.1.4.8-78 **D.1.4.8.9.1;** D.1.4.8-81	Y
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	N	N	N	**D.1.4.8.5.7.4;** D.1.4.8-63	Y
	General Claims Resolution					
40.8.1.175	Provides capability for online claims resolution, edit override capabilities for all claim types, and online adjudication	N	N	N	**D.1.4.8.7;** D.1.4.8-67	Y
40.8.1.176	Provides capability to ensure that all corrected claims are completely re-edited	N	N	N	**D.1.4.8.7;** D.1.4.8-70	Y
40.8.1.177	Provides capability for claims correction process that allows inquiry and update by	N	N	N	**D.1.4.8.7;** D.1.4.8-67	Y

Requirement #	Requirement Description	A	B	C	D	E
	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	N	N	N	**D.1.4.8.7;** D.1.4.8-67	Y
40.8.1.179	Provides capability to forward suspended claims to multiple locations	N	N	N	**D.1.4.8.7.2;** D.1.4.8-71	Y
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	N	N	Y	**D.1.4.8.7;** D.1.4.8-68	Y
40.8.1.182	Provides capability to maintain error codes and messages that clearly identify the reason(s) for the suspension	N	N	N	**D.1.4.8.7;** D.1.4.8-67	Y
40.8.1.183	Provides capability for the methodology to process the adjustment offset in the same payment cycle as the adjusting claim	N	N	N	**D.1.4.8.8.1;** D.1.4.8-73	Y
40.8.1.184	Provides capability to adjust Claims History only	N	N	N	**D.1.4.8.8;** D.1.4.8-72	Y
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	N	N	N	**D.1.4.8.8;** D.1.4.8-73	Y
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	N	N	N	**D.1.4.8.8;** D.1.4.8-73	Y
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	N	Y	N	**D.1.4.8.8;** D.1.4.8-72	Y

Requirement #	Requirement Description	A	B	C	D	E
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	N	N	N	**D.1.4.8.8;** D.1.4.8-73	Y
Requirement Deleted 40.8.1.189	~~Provides capability to generate exception sheets online~~					
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	N	N	N	**D.1.4.8.7;** D.1.4.8-69	Y
40.8.1.191	Provides capability to identify and access the status of any related limitations for which the recipient has had services	N	N	N	**D.1.4.8.7;** D.1.4.8-70	Y
40.8.1.192	Provides capability to enter multiple error codes for a claim to appear on the RA	N	N	N	**D.1.4.8.7;** D.1.4.8-70	Y
40.8.1.193	Provides capability to assign a unique status to corrected claims	N	Y	N	**D.1.4.8.7;** D.1.4.8-70	Y
40.8.1.194	Provides capability of entering multiple error codes for a claim to appear on the RA	N	N	N	**D.1.4.8.7;** D.1.4.8-70	Y
40.8.1.195	Provides capability to maintain all claims on the suspense file until corrected, automatically recycled, or automatically denied	N	N	N	**D.1.4.8.7.5;** D.1.4.8-71	Y
40.8.1.196	Provides capability to adjudicate special batches of claims	N	N	N	**D.1.4.8.3.1;** D.1.4.8-19	Y
40.8.1.197	Provides capability to force release of claims	N	N	N	**D.1.4.8.7.5;** D.1.4.8-71	Y
40.8.1.198	Provides capability to adjudicate and track non-covered service claims for EPSDT recipients	N	N	N	**D.1.4.8.5.1;** D.1.4.8-25	Y

Requirement #	Requirement Description	A	B	C	D	E
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	N	N	N	**D.1.4.12.4.3;** D.1.4.12-10 **D.1.4.14.2.16;** D.1.4.14-38	Y
	Retrospective Drug Utilization Review					
40.8.1.200	Provides capability to generate a file of paid drug claims to the Retrospective DUR Vendor	N	N	N	**D.1.4.8.9.3;** D.1.4.8-89	Y
40.8.1.201	Provides capability to generate a file of physician, clinic, hospital, and pharmacy Provider data to the Retrospective DUR Vendor	N	N	N	**D.1.4.8.9.3;** D.1.4.8-89	Y
40.8.1.202	Provides capability to generate a file of the recipient data to the Retrospective DUR Vendor	N	N	N	**D.1.4.8.9.3;** D.1.4.8-89	Y
40.8.1.203	Provides capability to produce the CMS Annual Drug Utilization Review Report	N	N	N	**D.1.4.8.9.3;** D.1.4.8-89	Y
	Adjustment Processing					
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: ▪ Recipient identifier ▪ Provider identifier ▪ Pharmacy number ▪ Internal control number (ICN) ▪ Prescription number ▪ Therapeutic class	N	Y	N	**D.1.4.8.5.7.6;** D.1.4.8-64	Y

Requirement #	Requirement Description	A	B	C	D	E
	▪ Drug codes ▪ GCN ▪ GCN-Sequence ▪ NDC					
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	N	N	N	**D.1.4.14.2.10;** D.1.4.14-29	Y
40.8.1.206	Provides capability to link an original claim with all adjustment transactions	N	N	N	**D.1.4.8.8.1.1;** D.1.4.8-74	Y
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	N	N	N	**D.1.4.8.8.2;** D.1.4.8-76	Y
40.8.1.208	Provides capability to correct the tooth surface on dental claims and process as an adjustment	N	N	N	**D.1.4.8.8;** D.1.4.8-73	Y
40.8.1.209	Provides capability to process unit dose credits	Y	Y	N	**D.1.4.8.5.7.4;** D.1.4.8-63	Y
40.8.1.210	Provides capability to input transactions to Drug Rebate and TPL of all collected dollars **(Comment CSC178)**	Y	Y	N	**D.1.4.11.6;** D.1.4.11-15 **D.1.4.12.5.2;** D.1.4.12-15 **D.1.4.14.2.11;** D.1.4.14-29	Y
40.8.1.211	Provides capability to capture pharmacy/drug rebates on professional and institutional claims	N	N	N	D.1.4.14.2.16 D.1.4.14-38	Y
40.8.1.212	Provides capability to capture and electronically store the clerk ID of the individual who	N	Y	N	**D.1.4.8.7;** D.1.4.8-69	Y

Requirement #	Requirement Description	A	B	C	D	E
	initially entered the adjustment and the clerk ID who worked the suspended adjustment					
	General Payment Processing					
40.8.1.213	Provides capability to process all claims and adjustments in accordance with Replacement MMIS policy and procedure	N	N	N	**D.1.4.8.5;** D.1.4.8-22	Y
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	N	N	N	**D.1.4.8.5;** D.1.4.8-23	Y
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	N	N	N	**D.1.4.14.2.2;** D.1.4.14-9 **D.1.4.14.2.3;** D.1.4.14-12 **D.1.4.14.2.11;** D.1.4.14-29	Y
40.8.1.216	Provides capability to generate Health Insurance Premium Payments (HIPP)	N	N	Y	**D.1.4.14.2.12;** D.1.4.14-30	Y
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	N	Y	N	**D.1.4.8.5.7.1;** D.1.4.8-60	Y
	Financial and Related Processing					
40.8.1.218	Provides capability to maintain complete audit trails of adjustment processing activities	N	N	N	**D.1.4.8.8.1.1;** D.1.4.8-74	Y
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	N	N	N	**D.1.4.8.5;** D.1.4.8-23	Y

Requirement #	Requirement Description	A	B	C	D	E
	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	N	N	N	**D.1.4.14.2.3;** D.1.4.14-11	Y
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	N	N	N	**D.1.4.14.2.3;** D.1.4.14-15	Y
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	N	N	N	**D.1.4.14.2.3;** D.1.4.14-11	Y
40.8.1.225	Provides capability to produce a monthly file of all adjudicated claims and other financial transactions by LOB	N	N	N	**D.1.4.14.2.4;** D.1.4.14-18	Y
40.8.1.226	Provides capability to track the status of all financial transactions by payer source	N	N	N	**D.1.4.14.2.16;** D.1.4.14-37	Y
40.8.1.227	Provides capability to run separate payment cycles by each LOB	N	N	N	**D.1.4.14.2.3;** D.1.4.14-11	Y
40.8.1.228	Provides capability to override the system date used for the payment cycle through a system parameter	N	N	N	**D.1.4.14.2.3;** D.1.4.14-11	Y
40.8.1.229	Provide the capability to use the same system date for all outputs of a claims payment cycle	N	N	N	**D.1.4.14.2.3;** D.1.4.14-11	Y

Requirement #	Requirement Description	A	B	C	D	E
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)	N	N	N	**D.1.4.14.2.12;** D.1.4.14-31	Y
40.8.1.232**	Provides capability to generate beneficiary Recipient Explanation of Benefits (REOBs) by LOB	N	N	N	**D.1.4.14.2.12;** D.1.4.14-31	Y
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	N	N	N	**D.1.4.14.2.4;** D.1.4.14-18	Y
40.8.1.235	Provides capability for EFT by LOB	N	N	N	**D.1.4.14.2.3;** D.1.4.14-12	Y
40.8.1.236	Provides capability to update historical files with information from RAs/835s and checks	N	N	N	**D.1.4.14.2.3;** D.1.4.14-15	Y
40.8.1.237	Provides capability to ensure RAs contain State-approved EOB messages by LOB	N	N	N	**D.1.4.14.2.4;** D.1.4.14-20 **D.1.4.14.2.12;** D.1.4.14-31	Y
40.8.1.238	Provides capability for producing statistically valid sampling reports for use in provider audits by LOB	N	N	N	**D.1.4.14.2.16;** D.1.4.14-36	Y
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	N	N	N	**D.1.4.14.2.3;** D.1.4.14-18	Y

Requirement #	Requirement Description	A	B	C	D	E
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	N	N	N	**D.1.4.14.2.15;** D.1.4.14-35	Y
40.8.1.242	Provides capability to modify payment cycle schedule	N	N	N	**D.1.4.14.2.3;** D.1.4.14-11	Y
40.8.1.243	Provides capabilities to provide independent and separate banking	N	N	N	**D.1.4.14.2.3;** D.1.4.14-12	Y
40.8.1.244	Provides capability to combine claims from MMIS and POS for payment processing	N	N	N	**D.1.4.14.2.16;** D.1.4.14-37	Y
40.8.1.245	Provides capability to withhold adjudicated claims from the payment cycle by payer source	N	N	N	**D.1.4.14.2.16;** D.1.4.14-37	Y
40.8.1.246	Provides capability to retrieve budget and available balance data from North Carolina Accounting System (NCAS)	N	N	N	**D.1.4.14.2.14;** D.1.4.14-34	Y
40.8.1.247**	Provides capability to accept and process budget data from a DMH file	N	N	N	**D.1.4.14.2.3;** D.1.4.14-11	Y
40.8.1.248	Provides capability to use approved budget data for expenditure allotment and control	N	N	N	**D.1.4.14.2.3;** D.1.4.14-11	Y
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	N	N	N	**D.1.4.14.2.2;** D.1.4.14-9	Y
40.8.1.250**	Provides capability to deny claims for services for lack of available funds	N	Y	N	**D.1.4.14.2.2;** D.1.4.14-9	Y
40.8.1.251	Provides capability to hold payment of a claim for a specified period of time	N	N	N	**D.1.4.14.2.11;** D.1.4.14-30	Y
40.8.1.252	Provides capability to exclude “to be paid” claims for payment processing when the provider is in hold status	N	N	N	**D.1.4.14.2.3;** D.1.4.14-11	Y

Requirement #	Requirement Description	A	B	C	D	E
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	N	N	N	**D.1.4.14.2.3;** D.1.4.14-11	Y
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	N	N	N	**D.1.4.8.8;** D.1.4.8-72	Y
40.8.1.255	Provides capability to create a financial transaction to correct overpayments, link to original transaction, and apply to offset future payments	N	N	N	**D.1.4.14.2.11;** D.1.4.14-29	Y
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	N	N	N	**D.1.4.14.2.11;** D.1.4.14-29	Y
40.8.1.257	Provides capability to use the Thursday following the processing date as the last payment cycle of the month	N	N	N	D.1.4.14.2.3; D.1.4.14-11	Y
40.8.1.258	Provides capability to process adjustment claims and credit the appropriate budgets before processing any new day claims	N	N	N	**D.1.4.14.2.11;** D.1.4.14-29	Y
40.8.1.259	Provides capability to apply Patient Monthly Liability (PML) to specific types of claims and post liability amounts used	Y	Y	N	**D.1.4.8.5.5.7;** D.1.4.8-56 D.1.4.14.2.16; D.1.4.14-37	Y
40.8.1.260	Provides capability to apply recipient deductible balance to specified types of claims	Y	Y	N	**D.1.4.8.5.5.7;** D.1.4.8-56 **D.1.4.14.2.16;** D.1.4.14-37	Y
40.8.1.261	Provides the capability for positive pay processing	N	N	N	**D.1.4.14.2.3;** D.1.4.14-17	Y

Requirement #	Requirement Description	A	B	C	D	E
40.8.1.262	Provides the capability for provider payment data	N	N	N	**D.1.4.14.2.3;** D.1.4.14-15	Y
40.8.1.263	Provides capability to apply withholds to capitation payments	N	N	N	**D.1.4.14.2.16;** D.1.4.14-37	Y
40.8.1.264	Provides capability to release withholds to capitation payments	N	N	N	**D.1.4.14.2.16;** D.1.4.14-37	Y
40.8.1.265	Provides capability to apply provider sanctions by rate or percentage	N	N	N	**D.1.4.14.2.11;** D.1.4.14-29	Y
40.8.1.266	Provides capability to apply provider incentives to management fee claims	N	N	N	**D.1.4.14.2.16;** D.1.4.14-38	Y
40.8.1.267	Provides all payments, adjustments, and other financial transactions to enrolled providers for approved services	N	N	N	**D.1.4.14.2.2;** D.1.4.14-7 **D.1.4.14.2.3;** D.1.4.14-10	Y
40.8.1.268	Provides the capability to associate all drug rebates to the claim detail	N	N	N	**D.1.4.14.2.16;** D.1.4.14-38	Y
	Financial Management and Accounting Business Area					Y
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	N	N	N	**D.1.4.14.2.10;** D.1.4.14-29	Y
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	N	N	N	**D.1.4.14.2.10;** D.1.4.14-28	Y
40.8.1.272	Provides capability to create ~~r~~eceivables generated from other MMIS functions	N	N	N	**D.1.4.14.2.10;** D.1.4.14-28	Y
40.8.1.273	Provides capability to create provider, recipient, reference, and account receivable/payout data	N	N	N	**D.1.4.14.2.3;** D.1.4.14-10	Y

Requirement #	Requirement Description	A	B	C	D	E
40.8.1.274	Provides capability to make retroactive changes to deductibles	N	N	N	**D.1.4.14.2.16;** D.1.4.14-38	Y
40.8.1.275	Provides capability to create transactions for corrections to receivables entered into the Replacement MMIS	N	N	N	**D.1.4.14.2.10;** D.1.4.14-29	Y
40.8.1.276	Provides capability to create transactions for manual checks	N	N	N	**D.1.4.14.2.3;** D.1.4.14-13	Y
40.8.1.277	Provides capability to create transactions for paper checks	N	N	N	**D.1.4.14.2.3;** D.1.4.14-12	Y
40.8.1.278	Provides capability to validate new and updated EFT provider information	N	N	N	**D.1.4.14.2.3;** D.1.4.14-14	Y
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	N	N	N	**D.1.4.14.2.3;** D.1.4.14-16	Y
40.8.1.280	Provides capability to create transactions of check voucher status from the State Controller's Office	N	N	N	**D.1.4.14.2.7;** D.1.4.14-26	Y
40.8.1.281	Provides capability for notes tracking to accommodate tracking of calls	N	N	N	**D.1.4.14.2.16;** D.1.4.14-36	Y
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	N	N	Y	**D.1.4.14.1;** D.1.4.14-5	Y
40.8.1.283	Provides capability for Financial Management and Accounting functions with system update capability	N	N	N	**D.1.4.14.2.16;** D.1.4.14-37	Y
40.8.1.284	Provides capability to maintain a consolidated accounting function, by program, type, and provider	N	N	N	**D.1.4.14.2.16;** D.1.4.14-37	Y
40.8.1.285	Provides capability to process capitation payments	N	N	N	**D.1.4.8.6;** D.1.4.8-67 **D.1.4.14.2.16;**	Y

Requirement #	Requirement Description	A	B	C	D	E
					D.1.4.14-37	
40.8.1.286	Provides capability to withhold a percentage of capitation payments	N	N	N	**D.1.4.8.6;** D.1.4.8-67 **D.1.4.14.2.16;** D.1.4.14-37	Y
40.8.1.287	Provides capability to process Managed Care management fees	N	N	Y	**D.1.4.8.6;** D.1.4.8-67	Y
40.8.1.288	Provides capability to process management fees for Health Check	N	N	Y	**D.1.4.8.6;** D.1.4.8-67	Y
40.8.1.289	Provides capability to process capitation and/or management fee adjustments	N	N	Y	**D.1.4.8.6;** D.1.4.8-67	Y
40.8.1.290	Provides capability to process management fees for APs/LMEs	N	N	Y	**D.1.4.8.6;** D.1.4.8-67	Y
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	N	N	N	**D.1.4.8.5.5.2;** D.1.4.8-53 **D.1.4.14.2.16;** D.1.4.14-38	Y
40.8.1.292	Provides capability to produce an output extract of encounters (an Encounter RA)	N	N	Y	**D.1.4.14.2.16;** D.1.4.14-38	Y
40.8.1.293	Provides capability to produce an output extract of enhanced Pharmacist Professional fee (on a Pharmacy RA)	N	N	Y	D.1.4.14.2.16; D.1.4.14-38	Y
40.8.1.294	Provides capability for system-generated log and tracking of receipt date of request for changes	N	N	N	D.1.4.14.2.16; D.1.4.14-37	Y
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	N	N	N	**D.1.4.8.5;** D.1.4.8-22 **D.1.4.14.2.3;** D.1.4.14-10	Y

Requirement #	Requirement Description	A	B	C	D	E
40.8.1.296	Provides capability to carry the provider's selection of receiving checks or EFT form of payment	N	N	N	**D.1.4.14.2.3;** D.1.4.14-14	Y
40.8.1.297	Provides capability to carry the provider's selection of receiving hard copy, electronic RAs, or both	N	N	N	**D.1.4.14.2.4;** D.1.4.14-18	Y
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: ▪ 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 ▪ An itemization of suspended claims, including dates of receipt and suspense and dollar amount billed by LOB ▪ 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 ▪ Reason for recoupment or adjustment by LOB ▪ 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 ▪ Tooth number and surface ▪ Explanatory messages relating to the claim payment cutback, denial, or suspension ▪ 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	N	Y	N	**D.1.4.14.2.4;** D.1.4.14-18	Y

Requirement #	Requirement Description	A	B	C	D	E
	▪ Listing of all relevant error messages per claim header and claim detail that would cause a claim to be denied by LOB					
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	N	Y	N	**D.1.4.14.2.4;** D.1.4.14-20	Y
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	Y	N	N	**D.1.4.14.2.4;** D.1.4.14-19	Y
40.8.1.302	Provides capability to update provider payment data	N	N	N	**D.1.4.14.2.3;** D.1.4.14-15	Y
40.8.1.303	Provides capability to maintain a process of fiscal pends	N	N	N	**D.1.4.14.2.2** D.1.4.14-9	Y
40.8.1.304	Provides capability to not accumulate claims in a “to be paid” status that have been excluded from payment	N	N	N	**D.1.4.14.2.3;** D.1.4.14-11	Y
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	N	N	Y	**D.1.4.14.2.4;** D.1.4.14-19	Y
40.8.1.306	Provides capability to maintain all data items received on all incoming claims, including the tooth number and tooth surface(s)	N	N	N	**D.1.4.8.3;** D.1.4.8-19 **D.1.4.8.10;** D.1.4.8-89	Y
40.8.1.307	Provides capability to update Claims History and online financial files with the date of payment and amount paid	N	N	N	**D.1.4.14.2.3;** D.1.4.14-15	Y
40.8.1.308	Provides capability for summary-level provider accounts receivable and payable data	N	N	N	**D.1.4.14.2.10;** D.1.4.14-29	Y

Requirement #	Requirement Description	A	B	C	D	E
	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	N	N	N	**D.1.4.14.2.10;** D.1.4.14-29	Y
40.8.1.310	Provides capability to automatically establish new accounts receivables	N	N	N	**D.1.4.14.2.10;** D.1.4.14-28	Y
40.8.1.311	Provides identification of providers with credit balances and no claim activity, by program, during a State-specified number of months	N	N	N	**D.1.4.14.2.6;** D.1.4.14-23	Y
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	N	N	N	**D.1.4.14.2.3;** D.1.4.14-10	Y
40.8.1.314	Provides capability to process transactions for manually written checks generating a Claims History record	N	N	N	**D.1.4.14.2.3;** D.1.4.14-13	Y
40.8.1.315	Provides capability to process EFT provider information, updating provider records to reflect their status with EFT	N	N	N	**D.1.4.14.2.3;** D.1.4.14-14	Y
40.8.1.316	Provides capability to accept requests to override EFT payment to a provider	N	N	N	**D.1.4.14.2.3;** D.1.4.14-12	Y
40.8.1.317	Provides capability to process check voucher information from the State Controller's Office	N	N	N	**D.1.4.14.2.7;** D.1.4.14-26	Y
40.8.1.318	Provides capability to update Claims History with RA number and RA issued date from the State Controller's Register file	N	N	N	**D.1.4.14.2.4;** D.1.4.14-18	Y
40.8.1.319	Provides capability to ensure that the weekly budget reporting is consistent with the	N	N	N	D.1.4.14.2.3 D.1.4.14-18	Y

Requirement #	Requirement Description	A	B	C	D	E
	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	N	N	N	**D.1.4.14.2.11;** D.1.4.14-29	Y
40.8.1.322	Provides capability to use a hierarchy table when a provider has multiple recoupment accounts	N	N	N	**D.1.4.14.2.11;** D.1.4.14-29	Y
40.8.1.323	Provides capability to identify and recoup payments from the provider made for services after a recipient's date of death	N	N	N	**D.1.4.14.2.11;** D.1.4.14-29	Y
40.8.1.324	Provides capability to apply claims payments recoupments to more than one (1) account receivable at a time	N	N	N	**D.1.4.14.2.11;** D.1.4.14-29	Y
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	N	N	N	**D.1.4.14.2.11;** D.1.4.14-29	Y
40.8.1.326	Provides capability to validate provider tax identification numbers and associated tax names	N	N	N	D.1.4.14.2.13 D.1.4.14-33	Y
40.8.1.327	Provides capability to process any change transactions received for corrections to checks by LOB	N	N	N	**D.1.4.14.2.16** D.1.4.14-35	Y
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	N	N	N	**D.1.4.14.2.15;** D.1.4.14-35	Y
40.8.1.329	Provides capability to generate weekly, monthly, quarterly, and annual financial reports after checkwrites	N	N	N	**D.1.4.14.2.15;** D.1.4.14-35	Y

Requirement #	Requirement Description	A	B	C	D	E
40.8.1.330	Provides capability for Advance Provider payments by LOB	N	N	N	**D.1.4.14.2.3;** D.1.4.14-12	Y
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	N	N	N	**D.1.4.14.2.16;** D.1.4.14-36	Y
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	N	N	Y	**D.1.4.14.2.16;** D.1.4.14-36	Y
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	N	N	N	**D.1.4.14.2.3;** D.1.4.14-11	Y
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	N	N	N	D.1.4.14.2.2; D.1.4.14-9 D.1.4.14.2.3; D.1.4.14-18	Y
40.8.1.335	Provides capability to identify and calculate pricing amounts according to the fee schedules, per diems, rates, and business rules	N	N	N	**D.1.4.8.5.5;** D.1.4.8-49	Y
40.8.1.336	Provides capability to apply pricing and reimbursement methodologies to appropriately price claims according to NC DHHS pricing standards	N	N	N	**D.1.4.8.5.5;** D.1.4.8-49	Y
40.8.1.337	Provides capability to price using any combination of procedure code, population group, billing provider, attending provider, and client	Y	Y	N	**D.1.4.8.5.5.3;** D.1.4.8-54	Y
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	N	N	N	**D.1.4.8.5.5;** D.1.4.8-48	Y
40.8.1.339	Provides capability to apply percentages for dual-eligible recipients	N	N	N	**D.1.4.8.5.5.4;** D.1.4.8-54	Y

Requirement #	Requirement Description	A	B	C	D	E
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	Y	Y	N	**D.1.4.8.5.5;** D.1.4.8-49	Y
40.8.1.341	Provides capability to determine calculations for the PAL tiers	Y	Y	N	**D.1.4.8.5.5.1;** D.1.4.8-53	Y
40.8.1.342	Provides capability to process and reimburse pharmacy-enhanced professional service fees as defined by State policy and business rules	N	N	N	**D.1.4.8.5.5.1;** D.1.4.8-51	Y
40.8.1.343	Provides capability to price pharmacy claims using lesser of logic incorporating all State-approved pricing methodologies	N	N	N	**D.1.4.8.5.5.1;** D.1.4.8-51	Y
40.8.1.344	Provides capability to price using State-specific services from the Prior Approval File	N	N	N	**D.1.4.8.5.5.5;** D.1.4.8-54	Y
40.8.1.345	Provides capability to apply recipient liability and co-pay rules, including varying co-pay amounts	N	N	N	**D.1.4.8.5.5.7;** D.1.4.8-56	Y
40.8.1.346	Provides capability to identify and calculate payment amounts for Health Check procedures when higher rate applies	Y	Y	N	**D.1.4.8.5.5.3;** D.1.4.8-54	Y
40.8.1.347	Provides capability to deduct either the provider reported or recipient database deductible amount	N	N	N	**D.1.4.8.5.5.7;** D.1.4.8-56	Y
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	N	N	N	**D.1.4.8.5.5.7;** D.1.4.8-56	Y
40.8.1.349	Provides capability to allow the deductible amount to be assigned to specific providers for recipients classed as medically needy	Y	Y	N	**D.1.4.8.5.5.7;** D.1.4.8-56	Y
40.8.1.350	Provides capability to invoke State-approved “Medicare Suspect” procedures	N	N	N	**D.1.4.8.5.5.6;** D.1.4.8-55	Y

Requirement #	Requirement Description	A	B	C	D	E
40.8.1.351	Provides capability to deduct or otherwise apply TPL amounts when pricing claims	N	N	N	**D.1.4.8.5.5.6;** D.1.4.8-55	Y
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	Y	Y	N	**D.1.4.8.5.5.3;** D.1.4.8-54	Y
40.8.1.353	Provides capability to price units for procedures based on the cutback units	N	Y	N	**D.1.4.8.5.7.1;** D.1.4.8-60	Y
40.8.1.354	Provides capability to price encounter claims at equivalent fee for service payment less deductions, such as TPL or co-payments	N	Y	N	**D.1.4.8.5.5.2;** D.1.4.8-53	Y
40.8.1.355	Provides capability to maintain multiple date-specific prices for each applicable provider, procedure code, revenue code, and DRG	N	N	N	**D.1.4.8.5.5;** D.1.4.8-50	Y
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	N	Y	N	**D.1.4.8.5.5.3;** D.1.4.8-54	Y
40.8.1.357	Provides capability to ensure that NC DHHS programs are payers of last resort with respect to private insurance	N	N	N	**D.1.4.8.5.5.6;** D.1.4.8-55	Y
40.8.1.358	Provides capability to ensure that claims with known TPL are reduced by the liability in accordance with NC DHHS standards	N	N	N	**D.1.4.8.5.5.6;** D.1.4.8-55	Y
40.8.1.359	Provides capability to support application of State-specific services for claims processing	N	N	N	**D.1.4.8.5.5.5;** D.1.4.8-54	Y
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	N	N	N	**D.1.4.8.5.4.2;** D.1.4.8-44	Y
40.8.1.361	Provides capability to automate the calculation for Ambulatory Surgical Centers	N	N	N	**D.1.4.8.5.5;** D.1.4.8-51	Y
40.8.1.362	Provides capability to apply Graduate Medical Education (GME), both direct and	N	N	N	**D.1.4.8.5.5;** D.1.4.8-51	Y

Requirement #	Requirement Description	A	B	C	D	E
	indirect, to inpatient claims					
40.8.1.363	Provides capability to price NDC codes	N	N	N	**D.1.4.8.5.5.1;** D.1.4.8-51	Y
40.8.1.364	Provides capability to price or deny claims with Medicare participation, including Medicare HMOs Part C, according to program pricing rules	N	N	N	**D.1.4.8.5.5.4;** D.1.4.8-54	Y
40.8.1.365	Provides capability to calculate a DRG per diem for undocumented alien's claims	N	N	N	**D.1.4.8.5.5;** D.1.4.8-49	Y
40.8.1.366	Provides capability to apply a percentage of an existing fee schedule rate for a different provider specialty	Y	Y	N	**D.1.4.8.5.5;** D.1.4.8-50	Y
40.8.1.367	Provides capability to apply variable recipient co-pay percentages to a claim from a prior approval	N	Y	N	**D.1.4.8.5.5.7;** D.1.4.8-57	Y
40.8.1.368	Provides capability to prorate monthly rate for days billed according to State business rules	Y	Y	N	**D.1.4.8.5.5;** D.1.4.8-51	Y
40.8.1.369	Provides capability to calculate provider reimbursement according to business rules	N	N	N	**D.1.4.8.5.5;** D.1.4.8-49	Y
40.8.1.370	Provides capability to price pharmacy claims up to a maximum level allowed by current NCPDP and FDB	N	N	N	**D.1.4.8.5.5.1;** D.1.4.8-51	Y
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	N	N	N	**D.1.4.8.5.5.5;** D.1.4.8-54 **D.1.4.8.5.5.8;** D.1.4.8-57	Y
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 *2007 PERM Data Submission Instructions–Jan 2007[1].pdf* for current PERM	N	N	Y	**D.1.4.8.11;** D.1.4.8-91	Y

Requirement #	Requirement Description	A	B	C	D	E
	data submission requirements.					
40.8.1.373	Provides capability to process HIPP payments	N	Y	N	**D.1.4.14.2.12;** D.1.4.14-30	Y
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	N	N	Y	**D.1.4.14.2.12;** D.1.4.14-30	Y
40.8.1.375	Provides capability to collect recipient premium payments	N	N	N	**D.1.4.14.2.12;** D.1.4.14-30	Y
40.8.1.376	Provides capability to produce refunds of recipient premiums	N	N	N	**D.1.4.14.2.12;** D.1.4.14-30	Y
40.8.1.377	Provides capability to process financial accounting records for premium payments and refunds	N	N	Y	**D.1.4.14.2.12;** D.1.4.14-30	Y
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	N	N	Y	**D.1.4.14.2.12;** D.1.4.14-30 **D.1.4.14.2.12;** D.1.4.14.-31	Y
40.8.1.379	Provides capability to apply cost-sharing, e.g., recipient co-insurance, deductibles, co-payments	N	N	Y	**D.1.4.8.5.5.7;** D.1.4.8-56	Y
40.8.1.380	Provides capability to ensure cost-sharing does not exceed threshold for the family group	Y	Y	N	**D.1.4.8.5.5.7;** D.1.4.8-56	Y
40.8.1.381	Provides capability to produce and send recipient letters/notices and Explanations of Benefits (EOB) in the recipient's preferred language	N	Y	N	**D.1.4.14.2.12;** D.1.4.14-31	Y

40.8.2 Claims Processing Operational Requirements

Requirement #	Requirement Description	A	B	C	D	E
	General Responsibilities					
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: ▪ Pickup and delivery of mail ▪ Sorting and screening of documents ▪ Scanning and batching of documents ▪ Batch control ▪ Data entry ▪ Pharmacy Point-of-Sale ▪ Payer determination processing ▪ Edit processing ▪ Suspense resolution ▪ Medical review ▪ Claims pricing ▪ Adjudication processing ▪ Adjustment processing ▪ Payment processing ▪ Financial processing ▪ Encounter processing				**D.2.1.1.2;** D.2.1.1-4	Y

Requirement #	Requirement Description	A	B	C	D	E
40.8.2.2	Fiscal Agent shall maintain and update the current State-approved Medical Procedure Audit Policy (MPAP).				**D.2.1.4.1.1;** D.2.1.4-4	Y
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. **(Comment CSC19) (Comment CSC116)**	N	N	N	**E.4.6.2;** E.4-18	Y
	Mailroom					
40.8.2.4	Fiscal Agent shall prepare and process all incoming and outgoing mail.				**D.2.1.1.3.2;** D.2.1.1-7	Y
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.				**D.2.1.1.3.1;** D.2.1.1-6	Y
40.8.2.7	Fiscal Agent shall ensure no mail, claims, tapes, diskettes, cash, or checks are misplaced after receipt by the Fiscal Agent.				**D.2.1.1.3.2;** D.2.1.1-6	Y
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.				**D.2.1.1.4.2;** D.2.1.1-10	Y
40.8.2.9	Fiscal Agent shall maintain system logging for packages/envelopes mailed via USPS or any other mailing service. **(Comment CSC245)**				**D.2.1.1.3.4;** D.2.1.1-7 **D.2.1.1.3.5;** D.2.1.1-8	Y
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				**D.2.1.1.3.5;** D.2.1.1-7	Y

Requirement #	Requirement Description	A	B	C	D	E
	packages for First Class Mail delivery.					
40.8.2.11	Fiscal Agent shall print and mail/deliver electronically Replacement MMIS State-approved forms.				**D.2.1.1.3.5;** D.2.1.1-8	Y
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	N	N	N	**D.2.1.1.3.6;** D.2.1.1-8	Y
40.8.2.13	Fiscal Agent shall prepare RAs for mailing and/or transmitting, EFTs for transmitting, and checks for release and mailing.	N	N	N	**D.2.1.1.3.7;** D.2.1.1-9	Y
	Claims Acquisition					
40.8.2.14	Fiscal Agent shall scan hard copy claims and accompanying documentation.				**D.2.1.1.4.2;** D.2.1.1-11	Y
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.				**D.2.1.1.4.2;** D.2.1.1-11	Y
	Adjustments					
40.8.2.16	Fiscal Agent shall sort, log, and batch adjustment requests and supporting documentation.				**D.2.1.1.4.3;** D.2.1.1-12	Y
40.8.2.17	Fiscal Agent shall assign adjustment internal control numbers that can associate back with the original claim or previous adjustment.	N	N	N	**D.2.1.1.4.3;** D.2.1.1-12	Y
40.8.2.18	Fiscal Agent shall return adjustment requests with RTP letter to provider, indicating missing or other required information needs.				**D.2.1.1.4.3;** D.2.1.1-12	Y
40.8.2.19	Fiscal Agent shall scan adjustments and supporting documentation.				**D.2.1.1.4.3;** D.2.1.1-12	Y

Requirement #	Requirement Description	A	B	C	D	E
40.8.2.20	Fiscal Agent shall verify the quality and readability of scanned adjustment documents.				**D.2.1.1.4.3;** D.2.1.1-12	Y
40.8.2.21	Fiscal Agent shall reconcile all adjustments (hard copy) entered into the system to batch processing cycle input and output figures.				**D.2.1.1.4.3;** D.2.1.1-12	Y
	Claims Entry					
40.8.2.22	Fiscal Agent shall perform data entry of all hard copy claims.				**D.2.1.1.4.4;** D.2.1.1-12	Y
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).				**D.2.1.1.4.5;** D.2.1.1-14	Y
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				**D.2.1.1.5.3;** D.2.1.1-17	Y
	Specific to Adjustments					
40.8.2.25	Fiscal Agent shall perform data entry of adjustments.				**D.2.1.2.1.12;** D.2.1.2-9	Y
	Specific to Electronic Claims Submission/Electronic Data Interchange					
40.8.2.26	Fiscal Agent shall distribute provider claim submission software.	N	N	Y	**D.2.1.3.6;** D.2.1.3-36	Y
40.8.2.27	Fiscal Agent shall develop and implement procedures to ensure the integrity of claims submitted by providers via ECS/EDI.				**D.2.1.3.6;** D.2.1.3-38	Y
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”				**D.2.1.3.6;** D.2.1.3-38	Y

Requirement #	Requirement Description	A	B	C	D	E
	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.				**D.2.1.3.6;** D.2.1.3-38	Y
40.8.2.30	Fiscal Agent shall accept tape-to-tape billing from defined sources.	N	N	Y	**D.2.1.3.6;** D.2.1.3-35	Y
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.	N	N	Y	**D.2.1.3.6;** D.2.1.3-39	Y
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.				**D.2.1.3.6;** D.2.1.3-41	Y
40.8.2.33	Fiscal Agent shall perform provider ECS/EDI acceptance testing.				**D.2.1.3.6;** D.2.1.3-40	Y
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.				**D.2.1.3.6;** D.2.1.3-40	Y
40.8.2.35	Fiscal Agent shall log tapes and diskettes upon receipt and assigns batch number.				**D.2.1.3.6;** D.2.1.3-41	Y
40.8.2.36	Fiscal Agent shall perform acceptance testing of VANs for Pharmacy POS claim submission.				**D.2.1.3.6;** D.2.1.3-41	Y
40.8.2.37	Fiscal Agent shall obtain and maintain signed Pharmacy POS Trading Partner Agreements prior to accepting any "production" POS claim data.				**D.2.1.3.6;** D.2.1.3-41	Y
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.				**D.2.1.1.5;** D.2.1.1-14	Y

Requirement #	Requirement Description	A	B	C	D	E
	Drug Utilization Review					
40.8.2.39	Fiscal Agent shall produce information to support the State in completing the CMS Annual Drug Utilization Review Report.	N	N	N	**D.2.1.4.3;** D.2.1.4-12	Y
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.				**D.2.1.4.3;** D.2.1.4-11	Y
	Retrospective Drug Utilization Review					
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.				**D.2.1.4.3;** D.2.1.4-12	Y
	Manual Review					
40.8.2.42	Fiscal Agent shall conduct manual reviews of claims for specific services.				**D.2.1.4.1.2;** D.2.1.4-5	
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.				**D.2.1.4.1.2;** D.2.1.4-5	Y
40.8.2.44	Fiscal Agent shall refer claims requiring policy decisions to the State.				**D.2.1.4.1.2;** D.2.1.4-5	Y
40.8.2.45	Fiscal Agent shall perform manual review when claim for EPSDT eligible recipient is denied for "non-covered" services.				**D.2.1.4.1.2;** D.2.1.4-5	Y
	Adjustments					
40.8.2.46	Fiscal Agent shall return adjustment requests not acceptable due to individual invalid information.				**D.2.1.2.1.12;** D.2.1.2-9	Y

Requirement #	Requirement Description	A	B	C	D	E
40.8.2.47	Fiscal Agent shall review adjustment requests.				**D.2.1.2.1.12;** D.2.1.2-9	Y
40.8.2.48	Fiscal Agent shall process claim-specific retroactive rate adjustments as specified by the State.	N	N	N	**D.2.1.2.1.12;** D.2.1.2-10	Y
	State-Authorized Claim Overrides					
40.8.2.49	Fiscal Agent shall refer denied claims to the State for review when special circumstances require override designation.				**D.2.1.2.1.12;** D.2.1.2-10	Y
40.8.2.50	Fiscal Agent shall provide a method to process payments for any specific claim and maintain an audit trail.	N	N	N	**D.2.1.2.1.12;** D.2.1.2-10	Y
	General Claims Resolution					
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.	N	N	N	**D.2.1.2.1.14;** D.2.1.2-12	Y
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.	N	N	N	**D.2.1.2.4.1;** D.2.1.2-14	Y
40.8.2.53	Fiscal Agent shall use claims consultants to serve as technical supervisors to staff performing claims processing. These individuals shall: ▪ Research and analyze problem areas at the request of the State ▪ Provide consultation on complex cases and advise when to refer to the Fiscal Agent's medical consultant and/or the State ▪ Review, analyze, and recommend suggestions affecting State operations.				**D.2.1.1.2;** D.2.1.1-5	Y

Requirement #	Requirement Description	A	B	C	D	E
40.8.2.54	Fiscal Agent shall obtain approval from NC DHHS for the amount to be applied for payment.				**D.2.1.2.1.14;** D.2.1.2-12	Y
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.	N	N	N	**D.2.1.2.1.8;** D.2.1.2-6	Y
40.8.2.56	Fiscal Agent shall manually price claims as designated by State policy.				**D.2.1.4.1.2;** D.2.1.4-5	Y

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.				**D.2.1.1.6;** D.2.1.1-19	Y
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).				**D.2.1.1.6;** D.2.1.1-19	Y
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.				**D.2.1.3.6;** D.2.1.3-39 **D.2.1.3.10;** D.2.1.3-53	Y
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.	N	N	N	**D.2.1.3.10;** D.2.1.3-53	Y
40.8.3.5	Fiscal Agent shall assign an ICN to every claim, attachment, and adjustment within				**D.2.1.1.6;** D.2.1.1-19	Y

Requirement #	Requirement Description	A	B	C	D	E
	twenty-four (24) hours of receipt.					
40.8.3.6	Fiscal Agent shall maintain data entry-field accuracy rates above ninety-eight (98) percent.				**D.2.1.1.6;** D.2.1.1-19	Y
40.8.3.7	Fiscal Agent shall scan every claim and attachment within one (1) State business day.				**D.2.1.1.6;** D.2.1.1-19	Y
40.8.3.8	Fiscal Agent shall return hard copy claims missing State-specified required data within two (2) State business days of receipt.				**D.2.1.1.6;** D.2.1.1-19	Y
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.	N	Y	N	**D.2.1.2.5;** D.2.1.2-21	Y
40.8.3.10	Fiscal Agent shall adjudicate: ▪ Ninety (90) percent of all clean claims for payment or denial within thirty (30) calendar days of receipt ▪ Ninety-nine (99) percent of all clean claims for payment or denial within ninety (90) calendar days of receipt ▪ All non-clean claims within thirty (30) calendar days of the date of correction of the condition that caused the claim to be unclean.					
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.	N	N	N	**D.2.1.1.6;** D.2.1.1-20	Y
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.				**D.2.1.2.5;** D.2.1.2-21	Y
40.8.3.13	Fiscal Agent shall notify the State immediately upon discovery of any erroneous				**D.2.1.2.5;** D.2.1.2-21	Y

Requirement #	Requirement Description	A	B	C	D	E
	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.	N	N	N	**D.2.1.2.5;** D.2.1.2-21	Y
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.	N	N	N	**D.2.1.4.5;** D.2.1.4-28	Y
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.	N	N	N	**D.2.1.2.5;** D.2.1.2-21	Y
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.	N	N	N	**D.2.1.1.6;** D.2.1.1-20	Y
40.8.3.19	Fiscal Agent shall successfully complete each checkwrite by the date on the State-approved Checkwrite Schedule.				**D.2.1.2.1.3;** D.2.1.2-4	Y

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	N	N	N	**D.1.4.9.5;** D.1.4.9-13	Y
40.9.1.2	Provides capability for online access to all recipient, provider, claims, and reference data related to Managed Care	N	N	N	**D.1.4.9.2;** D.1.4.9-5	Y
40.9.1.3	Provides capability to support multiple Managed Care programs, including those currently in existence: ▪ Primary Care Case Management (PCCM) ▪ Pre-Paid Inpatient Mental Health Plan (PIHP)	N	Y	N	**D.1.4.9.1;** D.1.4.9-4	Y
40.9.1.4	Provides capability to maintain Managed Care capitation rates for specific groups of recipients	N	Y	N	**D.1.4.9.1;** D.1.4.9-5	Y
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	N	N	N	**D.1.4.9.1;** D.1.4.9-4	Y
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	N	N	N	**D.1.4.9.1;** D.1.4.9-4	Y
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	N	N	Y	**D.1.4.9.1;** D.1.4.9-4	Y

Requirement #	Requirement Description	A	B	C	D	E
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.	N	N	Y	**D.1.4.9.3;** D.1.4.9-12	Y
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	N	N	Y	**D.1.4.9.5;** D.1.4.9-13	Y
40.9.1.10	Provides capability to calculate member months per Managed Care program by age groups and/or by aid categories	N	N	Y	**D.1.4.9.1;** D.1.4.9-5	Y
40.9.1.11	Provides capability to maintain an online audit trail of all updates to Managed Care data	Y	N	N	**D.1.4.9.6;** D.1.4.9-14	Y
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	Y	N	N	**D.1.4.9.5;** D.1.4.9-13	Y
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	N	N	N	**D.1.4.9.2;** D.1.4.9-6	Y
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	Y	Y	N	**D.1.4.9.6;** D.1.4.9-14	Y
40.9.1.15	Provides capability to support encounter processing data and costing for the following functions for generation of reports:	N	N	N	**D.1.4.9.1;** D.1.4.9-5	Y

Requirement #	Requirement Description	A	B	C	D	E
	▪ State History File ▪ Finalized Claim Activity File ▪ Storage of encounter fee for service equivalent cost					
40.9.1.16	Provides capability to produce monthly Managed Care enrollment reports	N	N	N	**D.1.4.9.5;** D.1.4.9-13	Y
40.9.1.17	Provides capability to produce a file to DIRM/EIS on a weekly basis to report auto-assignment results	N	N	N	**D.1.4.9.3;** D.1.4.9-12	Y
40.9.1.18	Provides capability to produce county-specific Managed Care Provider Directory and transmit electronically to DIRM nightly	N	N	N	**D.1.4.9.4;** D.1.4.9-12	Y
40.9.1.19	Provides capability to produce a county-specific Provider Availability Report and transmit electronically to DIRM nightly	N	N	N	**D.1.4.9.5;** D.1.4.9-13	Y
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	N	N	N	**D.1.4.9.4;** D.1.4.9-12	Y
40.9.1.21	Provides capability to generate management fees monthly	N	N	Y	**D.1.4.9.1;** D.1.4.9-5	Y
40.9.1.22	Provides capability to generate capitation payments monthly and retroactively for one (1) year	N	N	Y	**D.1.4.9.1;** D.1.4.9-5	Y
40.9.1.23	Provides capability to generate prorated capitation payments for a partial month of eligibility	N	N	Y	**D.1.4.9.1;** D.1.4.9-5	Y
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	N	Y	N	**D.1.4.9.2;** D.1.4.9-6	Y

Requirement #	Requirement Description	A	B	C	D	E
	combinations thereof					
40.9.1.25	Provides capability to generate a monthly Federal report of auto-assigned Medicaid recipients	N	N	N	**D.1.4.9.5;** D.1.4.9-13	Y
40.9.1.26	Provides capability to produce PAL scorecard for Managed Care providers	N	Y	Y	**D.1.4.9.5;** D.1.4.9-13	Y
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	N	N	Y	**D.1.4.9.1;** D.1.4.9-3	Y
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	N	N	Y	**D.1.4.9.5;** D.1.4.9-13	Y
40.9.1.29	Provides capability to produce a monthly report of all adjusted management fees	N	N	N	**D.1.4.9.5;** D.1.4.9-13	Y
40.9.1.30	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) 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.	N	N	N	**D.1.4.9.5;** D.1.4.9-13	Y
40.9.1.31	Provides capability to calculate utilization outlier data for the purpose of provider education, utilization management, and quality improvement This data shall be produced in conjunction with the Utilization Review Report.	N	N	Y	**D.1.4.9.5;** D.1.4.9-13	Y
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,	N	N	N	**D.1.4.9.5;** D.1.4.9-13	Y

Requirement #	Requirement Description	A	B	C	D	E
	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	N	N	Y	**D.1.4.9.5;** D.1.4.9-13	Y
40.9.1.34	Provides capability to generate a report of mailed letters	N	N	N	**D.1.4.9.5;** D.1.4.9-13	Y

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.				**D.2.1.3.9;** D.2.1.3-49	Y
40.9.2.2	Fiscal Agent shall monitor encounter processing to ensure no payments are generated as a result of encounter processing.				**D.2.1.3.9;** D.2.1.3-49	Y
40.9.2.3	Fiscal Agent shall compile, update, and distribute the Data Submission Manual for encounter data processing.				**D.2.1.3.9;** D.2.1.3-50	Y
40.9.2.4	Fiscal Agent shall serve as first point of contact for questions regarding encounter-related issues.				**D.2.1.3.9;** D.2.1.3-50	Y
40.9.2.5	Fiscal Agent shall conduct training seminars with providers and State staff regarding the encounter claim submission process.				**D.4.2.1;** D.4-6	Y
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				**D.2.1.3.9;** D.2.1.3-50	Y

Requirement #	Requirement Description	A	B	C	D	E
	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.				**D.2.1.3.2;** D.2.1.3-18	Y
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.				**D.2.1.3.2;** D.2.1.3-18	Y

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.	N	N	N	**D.2.1.3.10;** D.2.1.3-54	Y
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.	N	N	N	**D.2.1.3.10;** D.2.1.3-54	Y
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.	N	N	N	**D.2.1.3.10;** D.2.1.3-54	Y
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.	N	N	N	**D.2.1.3.10;** D.2.1.3-54	Y
40.9.3.5	Fiscal Agent shall respond to a requesting provider within one (1) hour for a telephone				**D.2.1.3.10;** D.2.1.3-54	Y

Requirement #	Requirement Description	A	B	C	D	E
	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.				**D.2.1.3.10;** D.2.1.3-54	Y
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.				**D.2.1.3.10;** D.2.1.3-54	Y
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.				**D.2.1.3.10;** D.2.1.3-54	Y
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.	N	N	N	**D.2.1.3.10;** D.2.1.3-54	Y
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.	N	N	N	**D.2.1.3.10;** D.2.1.3-55	Y
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.				**D.2.1.3.10;** D.2.1.3-55	Y

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	N	N	N	**D.1.4.10.3;** D.1.4.10-10	Y
40.10.1.2	Provides capability for online inquiry to all Health Check data with access by recipient ID and provider number	N	N	N	**D.1.4.10.2;** D.1.4.10-5	Y
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	N	Y	N	**D.1.4.10.2;** D.1.4.10-6	Y
40.10.1.4	Provides capability to identify paid and denied screening claims	N	N	N	**D.1.4.10.3;** D.1.4.10-10	Y
40.10.1.5	Provides capability to identify abnormal conditions by screening date and whether the condition was treated or referred for treatment	Y	Y	N	**D.1.4.10.3;** D.1.4.10-10	Y
40.10.1.6	Provides capability to update recipient Health Check data with screening results and dates and referral information	N	Y	N	**D.1.4.10.2;** D.1.4.10-7	Y
40.10.1.7	Provides capability for online, updateable letter templates for Health Check monthly notifications, standardized letters, and inserts	N	N	Y	**D.1.4.10.4;** D.1.4.10-10	Y
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	N	Y	N	**D.1.4.10.4;** D.1.4.10-11	Y
40.10.1.9	Provides capability to maintain all notices sent, identifying case and recipient and date the notice was sent	N	N	Y	**D.1.4.10.4;** D.1.4.10-11	Y

Requirement #	Requirement Description	A	B	C	D	E
40.10.1.10	Provides capability to maintain an online audit trail of all updates to Health Check data	N	Y	N	**D.1.4.10.7;** D.1.4.10-12	Y
40.10.1.11	Provides capability for Web-based Health Check functionality that allows for the creation, update, and management of: ▪ Health Check Information Notifications ▪ Monthly Accounting of Activities Report (MAAR) Information ▪ County Options Change Request (COCR) Information ▪ Full-Time Equivalency (FTE) Information ▪ Health Check Recipient Data	N	Y	Y	**D.1.4.10.5;** D.1.4.10-11 **D.1.8.2;** D.1.8-8	Y
40.10.1.12	Provides capability for the following Web-based functionality: ▪ Search recipient data ▪ Enter comments ▪ Update notification suppression ▪ Send standardized notifications	N	Y	N	**D.1.4.10.2;** D.1.4.10-8	Y
40.10.1.13	Provides capability to calculate and system-generate Health Check Coordinator management fees	N	N	Y	**D.1.4.10.5;** D.1.4.10-11 **D.1.8.2;** D.1.8-8	Y
40.10.1.14	Provides capability to generate a monthly FTE report based on information received on the MAAR and COCR	N	N	N	**D.1.4.10.6;** D.1.4.10-12 **D.1.8.2;** D.1.8-8	Y
40.10.1.15	Provides capability to capture and electronically store all Health Check county staff information	N	Y	N	**D.1.4.10.5;** D.1.4.10-11 **D.1.8.2;** D.1.8-8	Y

Requirement #	Requirement Description	A	B	C	D	E
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	N	Y	N	**D.1.4.10.2;** D.1.4.10-4	Y
40.10.1.17	Provides capability to produce the Health Check Activity Report	N	N	N	**D.1.4.10.6;** D.1.4.10-12	Y
40.10.1.18	Provides capability to convert HCC comments from legacy FoxPro Data Shell application into the Replacement MMIS	N	N	N	**D.1.4.10.5;** D.1.4.10-11	Y
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.	N	N	N	**D.1.4.10.6;** D.1.4.10-12	Y
40.10.1.20	Provides capability to produce monthly MAAR Summary reports	N	N	N	**D.1.4.10.6;** D.1.4.10-12 **D.1.8.2;** D.1.8-8	Y
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	N	N	N	**D.1.4.10.6;** D.1.4.10-12	Y

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).				**D.2.1.3.8;** D.2.1.3-45	Y
40.10.2.2	Fiscal Agent shall provide telephone and on-site technical support and training for Health Check Coordinators.				**D.2.1.3.8;** D.2.1.3-45	Y
40.10.2.3	Fiscal Agent shall participate in Health Check Coordinator Training Sessions in Raleigh, NC.				**D.2.1.3.8;** D.2.1.3-46	Y
40.10.2.4	Fiscal Agent shall update Health Check Billing Guide.				**D.2.1.3.8;** D.2.1.3-46	Y
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.				**D.2.1.3.8;** D.2.1.3-46	Y
40.10.2.6	Fiscal Agent shall conduct annual regional Health Check workshops for participating providers in six (6) separate sites throughout the State.				**D.2.1.3.8;** D.2.1.3-47	Y
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.				**D.2.1.3.8;** D.2.1.3-47	Y
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.				**D.2.1.3.8;** D.2.1.3-48	Y
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.				**D.2.1.3.8;** D.2.1.3-47	Y

Requirement #	Requirement Description	A	B	C	D	E
40.10.2.10	Fiscal Agent shall submit the monthly FTE Report to the State for approval.				**D.2.1.3.8;** D.2.1.3-47	Y
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.				**D.2.1.3.8;** D.2.1.3-45	Y
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.				**D.2.1.3.8;** D.2.1.3-45 **D.2.1.3.8;** D.2.1.3-47	Y
40.10.2.13	Fiscal Agent shall coordinate rewrite of the Health Check Billing Guide.				**D.2.1.3.8;** D.2.1.3-46	Y

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) days of a change in policy/procedures and shall notify HCCS within two (2) days after posting.				**D.2.1.3.10;** D.2.1.3-53	Y
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.	N	N	N	**D.2.1.3.10;** D.2.1.3-53	Y
40.10.3.3	Fiscal Agent shall produce a monthly FTE Report by the second Friday from the end of each month.	N	N	N	**D.2.1.3.10;** D.2.1.3-53	Y
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.				**D.2.1.3.10;** D.2.1.3-53	Y

Requirement #	Requirement Description	A	B	C	D	E
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.				**D.2.1.3.10;** D.2.1.3-53	Y
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.				**D.2.1.3.10;** D.2.1.3-53	Y
40.10.3.7	Fiscal Agent shall update addresses in the Health Check County Option File within twenty-four (24) hours of receipt.	N	N	N	**D.2.1.3.10;** D.2.1.3-54	Y
40.10.3.8	Fiscal Agent shall coordinate with the State for the annual revisions to the Health Check Billing Guide.				**D.2.1.3.10;** D.2.1.3-54	Y

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	N	N	N	**D.1.4.11.2;** D.1.4.11-9	Y
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	N	N	N	**D.1.4.11.5;** D.1.4.11-14	Y
40.11.1.3	Provides capability to ensure that claims for inpatient hospital stays for pregnant	N	N	N	**D.1.4.11.5;** D.1.4.11-14	Y

Requirement #	Requirement Description	A	B	C	D	E
	women are cost avoided					
40.11.1.4	Provides capability for updating of insurance carrier information	N	N	N	**D.1.4.11.2;** D.1.4.11-7	Y
40.11.1.5	Provides capability to retrieve/search third party resource information by the following: ▪ 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 ▪ Insurance carrier ▪ Policy number (by any part of number), Medicare Health Insurance Claim (HIC) number (by any part of number), or railroad number ▪ Group name and number ▪ Source code indicating source of suspect TPL information ▪ Name, SSN, and/or ID number of policy holder (by any part of number) ▪ Prescription number, whole number, or any part of number ▪ Therapeutic code ▪ Therapeutic class ▪ User ID of individual entering or updating TPL record	N	N	N	**D.1.4.11.2;** D.1.4.11-9	Y
40.11.1.6	Provides capability to electronically store multiple, date-specific TPL resources for each recipient	N	N	N	**D.1.4.11.3;** D.1.4.11-12	Y
Requirement Deleted 40.11.1.7	~~Provides capability to electronically store multiple, date-specific TPL resources for each Medicare recipient~~					

Requirement #	Requirement Description	A	B	C	D	E
40.11.1.8	Provides capability to electronically store all third party resource information by recipient	N	N	N	**D.1.4.11.3;** D.1.4.11-12	Y
40.11.1.9	Provides capability to electronically store third party carrier information	N	N	N	**D.1.4.11.3;** D.1.4.11-12	Y
40.11.1.10	Provides capability to identify all cost-avoided payments due to established TPL	N	N	N	**D.1.4.11.5;** D.1.4.11-14	Y
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	N	N	Y	**D.1.4.11.5;** D.1.4.11-14	Y
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	N	N	Y	**D.1.4.11.6;** D.1.4.11-16	Y
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.	N	N	Y	**D.1.4.11.6;** D.1.4.11-16	Y
40.11.1.14	Provides capability to track and post recoveries to individual claim histories	N	N	Y	**D.1.4.11.6;** D.1.4.11-17	Y
40.11.1.15	Provides capability for archival and retrieval of closed TPL recovery cases	N	N	Y	**D.1.4.11.6;** D.1.4.11-17	Y
40.11.1.16	Provides capability to identify accident/trauma claims and automatically generate questionnaire/reports	N	N	Y	**D.1.4.11.6;** D.1.4.11-16	Y
40.11.1.17	Provides capability to approve or cancel trauma questionnaires	N	N	Y	**D.1.4.11.6;** D.1.4.11-19	Y
40.11.1.18	Provides capability to retrieve paid claims from history to assist in TPL recovery	N	N	N	**D.1.4.11.6;** D.1.4.11-17	Y
40.11.1.19	Provides capability to maintain an online audit trail of all updates to TPL data	N	N	N	**D.1.4.11.2;** D.1.4.11-6 **D.1.4.11.9**	Y

Requirement #	Requirement Description	A	B	C	D	E
					D.1.4.11-21	
40.11.1.20	Provides capability to generate carrier update transactions to the State	N	N	N	**D.1.4.11.7;** D.1.4.11-21	Y
40.11.1.21	Provides capability to provide online inquiry, add, and update to TPL data	N	N	N	**D.1.4.11.2;** D.1.4.11-6	Y
40.11.1.22	Provides capability to enter or update recovery cases from recoveries received	N	N	Y	**D.1.4.11.6;** D.1.4.11-19	Y
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	N	N	N	**D.1.4.11.3;** D.1.4.11-12	Y
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	N	N	N	**D.1.4.11.3;** D.1.4.11-12 **D.1.4.11.6;** D.1.4.11-16	Y
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	N	N	N	**D.1.4.11.6;** D.1.4.11-17	Y
40.11.1.26	Provides capability to produce and bill drug invoices for insurance carriers	N	N	Y	**D.1.4.11.6;** D.1.4.11-17	Y
40.11.1.27	Provides capability to produce accident inquiry letters for identified recipients	N	N	Y	**D.1.4.11.6;** D.1.4.11-16	Y
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	N	Y	N	**D.1.4.11.3;** D.1.4.11-12	Y
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	N	N	Y	**D.1.4.11.6;** D.1.4.11-15	Y
40.11.1.30	Provides capability to flag and maintain Estate Recovery claims for a lifetime	N	N	Y	**D.1.4.11.6;** D.1.4.11-16	Y

Requirement #	Requirement Description	A	B	C	D	E
40.11.1.31	Provides capability to produce claims/invoices in order to bill for Estate Recovery	N	N	Y	**D.1.4.11.6;** D.1.4.11-17	Y
40.11.1.32	Provides capability to track and report on invoices	N	N	Y	**D.1.4.11.6;** D.1.4.11-17	Y
40.11.1.33**	Provides capability to route specific DME claims to Medicaid after Children's Special Health Services (CSHS) has paid	N	N	Y	**D.1.4.11.5;** D.1.4.11-15	Y
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	N	N	Y	**D.1.4.11.6;** D.1.4.11-19	Y
40.11.1.35	Provides capability to view the invoices for prescription drugs generated by Fiscal Agent, by carrier, or by recipient	N	N	Y	**D.1.4.11.6;** D.1.4.11-19	Y
40.11.1.36	Provides capability for online updating, payment, and reporting for the HIPP Program	N	Y	N	**D.1.4.11.4;** D.1.4.11-14	Y
40.11.1.37	Provides capability to systematically build recovery cases, allowing users to inquire, add, and update recovery case records	N	N	Y	**D.1.4.11.6;** D.1.4.11-17	Y
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	N	N	Y	**D.1.4.11.6;** D.1.4.11-19	Y
40.11.1.39	Provides capability to include attorney name, attention line, address, and telephone number in a recovery case record	N	N	Y	**D.1.4.11.6;** D.1.4.11-15	Y
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	N	N	Y	**D.1.4.11.6;** D.1.4.11-19	Y
40.11.1.41	Provides capability to add or delete claims that are included in any recovery case	N	N	Y	**D.1.4.11.6;** D.1.4.11-19	Y

Requirement #	Requirement Description	A	B	C	D	E
40.11.1.42	Provides capability to add and update the TPL threshold amount online	N	N	Y	**D.1.4.11.6;** D.1.4.11-19	Y
40.11.1.43	Provides capability to enter free-form text in a recovery case	N	N	Y	**D.1.4.11.6;** D.1.4.11-19	Y
40.11.1.44	Provides capability to maintain all open recovery cases online until closed by authorized user	N	N	Y	**D.1.4.11.6;** D.1.4.11-19	Y
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	N	N	Y	**D.1.4.11.6;** D.1.4.11-19	Y
40.11.1.46	Provides capability to flag a recipient for which a TPL recovery case has been created	N	N	Y	**D.1.4.11.6;** D.1.4.11-19	Y
40.11.1.47	Provides capability to generate unique Case Identification Numbers	N	N	Y	**D.1.4.11.6;** D.1.4.11-17	Y
40.11.1.48	Provides capability to close a case without full recovery	N	N	Y	**D.1.4.11.6;** D.1.4.11-19	Y
40.11.1.49	Provides capability to reproduce a claim and send either by fax, mail or electronically	N	N	N	**D.1.4.11.6;** D.1.4.11-19	Y
40.11.1.50	Provides the capability to flag claims for recipients who have reached a defined threshold	N	Y	N	**D.1.4.11.6;** D.1.4.11-19	Y
40.11.1.51	Provides capability for online access and update to TPL data by State-designated staff	N	N	N	**D.1.4.11.2;** D.1.4.11-6 **D.1.4.11.2;** D.1.4.11-7	Y
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	Y	Y	N	**D.1.4.11.7;** D.1.4.11-21	Y
40.11.1.53	Provides capability for daily (next business day) transmission logs showing successful	N	N	N	**D.1.4.11.7;** D.1.4.11-21	Y

Requirement #	Requirement Description	A	B	C	D	E
	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	N	N	N	**D.1.4.11.5;** D.1.4.11-15	Y
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	N	N	N	**D.1.4.11.5;** D.1.4.11-15	Y
40.11.1.56	Provides capability to associate and track Non-Custodial Parent (NCP) policy holder information to covered individuals	N	N	N	**D.1.4.11.3;** D.1.4.11-12	Y
40.11.1.57	Provides capability to pend updates to TPL resource data received from Child Support for Medicaid recipients	N	Y	N	**D.1.4.11.3;** D.1.4.11-13	Y
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	N	Y	N	**D.1.4.11.3;** D.1.4.11-13	Y
40.11.1.59	Provides capability to produce a report of TPL segments that have been updated more than once in thirty (30) days	N	N	N	**D.1.4.11.8;** D.1.4.11-21	Y
40.11.1.60	Provides capability to produce a Health Choice Recipient Activity Report in addition to the reports listed in the Design documentation	N	N	N	**D.1.4.11.8;** D.1.4.11-21	Y
40.11.1.61	Provides capability to provide TPL edit/error report(s) for ACTS for State staff access	N	N	N	**D.1.4.11.8;** D.1.4.11-21	Y
40.11.1.62	Provides capability to extract and process TPL data transmitted by ACTS from the DIRM electronic File Cabinet	N	N	N	**D.1.4.11.7;** D.1.4.11-21	Y
40.11.1.63	Provides capability to produce a daily extract of TPL carrier and recipient resource	N	N	N	**D.1.4.11.7;** D.1.4.11-21	Y

Requirement #	Requirement Description	A	B	C	D	E
	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	N	N	N	**D.1.4.11.7;** D.1.4.11-21	Y
40.11.1.65	Provides capability for batch access to TPL data using API and SOA concepts between EIS, ACTS, and the Replacement MMIS	N	N	N	**D.1.4.11.7;** D.1.4.11-21	Y
New Requirement 40.11.1.66	Provides capability to produce system-generated letters to providers, recipients, and county offices	Y	Y	N	**D.1.4.11.8;** D.1.4.11-21	Y

40.11.2 TPL Operational Requirements

Requirement #	Requirement Description	A	B	C	D	E
New Requirement 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.				**D.2.1.2.4.1;** D.2.1.2-14	Y
New Requirement 40.11.2.2	Fiscal Agent shall process and track recoveries and collections	N	N	N	**D.2.1.2.4.2;** D.2.1.2-14	Y
New Requirement 40.11.2.3	Fiscal Agent shall track and post recoveries to individual claim histories.	N	N	N	**D.2.1.2.4.2;** D.2.1.2-14	Y
New Requirement 40.11.2.4	Fiscal Agent shall enter or update recovery cases from recoveries received	N	N	N	**D.2.1.2.4.2;** D.2.1.2-14	Y

Requirement #	Requirement Description	A	B	C	D	E
New Requirement 40.11.2.5	Fiscal Agent shall generate carrier update transactions to the State	N	N	N	**D.2.1.2.4.3;** D.2.1.2-15	Y
New Requirement 40.11.2.6	Fiscal Agent shall extract and process TPL data transmitted by ACTS from the DIRM electronic File Cabinet	N	N	N	**D.2.1.2.4.3;** D.2.1.2-15	Y
New Requirement 40.11.2.7	Fiscal Agent shall produce a daily extract of TPL carrier and recipient resource data for ACTS, CSDW, and EIS	N	N	N	**D.2.1.2.4.3;** D.2.1.2-15	Y
New Requirement 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	N	N	N	**D.2.1.2.4.3;** D.2.1.2-15	Y

40.11.3 TPL Operational Performance Standards

Requirement #	Requirement Description	A	B	C	D	E
Requirement Deleted 40.11.3.1	~~Fiscal Agent shall produce system-generated letters to providers, recipients, and county offices.~~					
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.	N	N	N	**D.2.1.2.5;** D.2.1.2-15	Y
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.	N	N	N	**D.2.1.2.5;** D.2.1.2-15	Y

Requirement #	Requirement Description	A	B	C	D	E
40.11.3.4	Fiscal Agent shall produce and bill drug invoices for insurance carriers within five (5) State business days of TPL entry.	N	N	N	**D.2.1.2.5;** D.2.1.2-16	Y
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.				**D.2.1.2.5;** D.2.1.2-16	Y
40.11.3.6	Fiscal Agent shall generate an Estate Recovery invoice within 2 business days after a recipient meets the defined criteria.	N	N	Y	**D.2.1.2.5;** D.2.1.2-16	Y
40.11.3.7	Fiscal Agent shall provide TPL edit/error report(s) for ACTS for State staff access each State business day.	N	N	N	**D.2.1.2.5;** D.2.1.2-16	Y
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.	N	N	N	**D.2.1.2.5;** D.2.1.2-16	Y
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.	N	N	N	**D.2.1.2.5;** D.2.1.2-16	Y
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	N	N	N	**D.2.1.2.5;** D.2.1.2-16	Y
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.	N	N	N	**D.2.1.2.5;** D.2.1.2-16	Y

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: ▪ Manufacturer ID numbers and labeler codes ▪ Indication of collection media ▪ Indication of invoicing media ▪ Contact name, mailing and e-mail address, phone and fax numbers ▪ Manufacturer (labeler) enrollment, termination and reinstatement dates ▪ Manufacturer Unit Rebate Amount (URA) ▪ Manufacturer units of measure	N	N	N	**D.1.4.12.4.1;** D.1.4.12-8	Y
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	N	N	N	**D.1.4.12.2.1;** D.1.4.12-4 **D.1.4.12.4.2;** D.1.4.12-9	Y
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	N	N	N	**D.1.4.12.2.4;** D.1.4.12-5	Y
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	N	N	N	**D.1.4.12.4.5;** D.1.4.12-11	Y
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					

Requirement #	Requirement Description	A	B	C	D	E
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	N	N	N	**D.1.4.12.4.6;** D.1.4.12-13	Y
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	N	N	N	**D.1.4.12.4.3;** D.1.4.12-10	Y
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	N	N	N	**D.1.4.12.4.6;** D.1.4.12-13	Y
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	N	N	N	**D.1.4.12.5.2;** D.1.4.12-15	Y
40.12.1.10	Provides capability to generate invoice cover letters, collection letters, and follow-up collection letters	N	N	N	**D.1.4.12.4.7;** D.1.4.12-13	Y
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	N	N	N	**D.1.4.12.4.7;** D.1.4.12-13	Y
40.12.1.12	Provides capability to maintain and retrieve history of letters sent to manufacturers	N	N	Y	**D.1.4.12.4.7;** D.1.4.12-13	Y
40.12.1.13	Provides capability to update payment details and adjustments to the Replacement MMIS accounting system	N	N	N	**D.1.4.12.3.1;** D.1.4.12-6	Y
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	N	N	N	**D.1.4.12.7;** D.1.4.12-18	Y
40.12.1.15	Provides capability for system identification and exclusion of claims for drugs not eligible for drug rebate program	N	N	N	**D.1.4.12.2.3;** D.1.4.12-4	Y

Requirement #	Requirement Description	A	B	C	D	E
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)	N	N	N	**D.1.4.12.2.2;** D.1.4.12-4	Y
40.12.1.17	Provides capability for online access by the State to quarterly manufacturer drug rebate invoice detail and balances	N	N	N	**D.1.4.12.3.1;** D.1.4.12-6	Y
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	N	Y	N	**D.1.4.12.7;** D.1.4.12-17	Y
40.12.1.19	Provides capability for online posting of accounts receivables labeler, NDC for each quarter, rebates receivable, and interest receivable	N	N	N	**D.1.4.12.5.2;** D.1.4.12-16	Y
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	N	N	N	**D.1.4.12.2.4;** D.1.4.12-5	Y
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	N	N	Y	**D.1.4.12.7;** D.1.4.12-17	Y
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	N	N	N	**D.1.4.12.3.1;** D.1.4.12-6	Y
40.12.1.23	Provides capability to adjust accounts receivable balances for: ▪ Rebates only at labeler/quarter level ▪ Interest only at labeler/quarter level ▪ Rebates and units at NDC level, which would also update labeler/quarter balances ▪ Adjustments and State approved write-offs	N	Y	N	**D.1.4.12.3.2;** D.1.4.12-7	Y

Requirement #	Requirement Description	A	B	C	D	E
	▪ Interest only at the drug detail level					
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	N	N	Y	**D.1.4.12.6;** D.1.4.12-17	Y
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	N	N	N	**D.1.4.12.6;** D.1.4.12-17	Y
40.12.1.26	Provides capability for generation of manufacturer mailing labels on request	N	N	N	**D.1.4.12.4.6;** D.1.4.12-13	Y
40.12.1.27	Provides capability for an online audit trail of all activities and updates to drug rebate data	N	N	N	**D.1.4.12.7;** D.1.4.12-17	Y
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	N	N	N	**D.1.4.12.5.1;** D.1.4.12-14	Y
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	N	N	N	**D.1.4.12.8;** D.1.4.12-18	Y
40.12.1.30	Provides capability for adjustment and State-approved write-off records	N	N	N	**D.1.4.12.3.2;** D.1.4.12-7	Y
40.12.1.31	Provides capability for system interest calculation on outstanding Drug Rebate balances and applies results to DRS Accounts Receivable File	N	N	N	**D.1.4.12.4.9;** D.1.4.12-14	Y
40.12.1.32	Provides capability to perform end-of-month balancing process	N	N	N	**D.1.4.12.8;** D.1.4.12-18	Y

Requirement #	Requirement Description	A	B	C	D	E
40.12.1.33	Provides capability to load all pharmacy claims to the Drug Rebate business area weekly, regardless of where they are paid	N	N	N	**D.1.4.12.4.3;** D.1.4.12-9	Y
40.12.1.34	Provides capability to maintain the Drug Rebate Labeler Data, facilitating automatic updating with information from CMS and the State	N	Y	N	**D.1.4.12.4.1;** D.1.4.12-7	Y
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	N	N	Y	**D.1.4.12.7;** D.1.4.12-17	Y
40.12.1.36	Provides capability for audits that ensure consistency of data from detail level to summary level	N	N	N	**D.1.4.12.4.3;** D.1.4.12-10	Y
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	N	N	Y	**D.1.4.12.4.8;** D.1.4.12-13	Y
40.12.1.38	Provides capability to freeze invoices so they can no longer be recalculated	N	N	Y	**D.1.4.12.4.6;** D.1.4.12-12	Y
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	N	N	N	**D.1.4.12.8;** D.1.4.12-18	Y
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	N	N	N	**D.1.4.12.8;** D.1.4.12-18	Y
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	N	N	N	**D.1.4.12.8;** D.1.4.12-19	Y
40.12.1.42	Provides capability to produce Rebate Summary Report to display payments received,	N	N	N	**D.1.4.12.8;** D.1.4.12-19	Y

Requirement #	Requirement Description	A	B	C	D	E
	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	N	N	N	**D.1.4.12.8;** D.1.4.12-19	Y
40.12.1.44	Provides capability to produce the NDC Detail Report to give summary data by quarter for selected NDCs	N	N	N	**D.1.4.12.8;** D.1.4.12-19	Y
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	N	N	N	**D.1.4.12.8;** D.1.4.12-19	Y
40.12.1.46	Provides capability to produce the Manufacturer Summary Report to display information by quarter, including amounts invoiced, paid, and disputed	N	N	N	**D.1.4.12.8;** D.1.4.12-19	Y
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	N	N	N	**D.1.4.12.8;** D.1.4.12-19	Y
40.12.1.48	Provides capability to produce the Unallocated Balance Report to display unallocated balances selected according to user-supplied criteria	N	N	N	**D.1.4.12.8;** D.1.4.12-19	Y
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	N	N	N	**D.1.4.12.8;** D.1.4.12-19	Y
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	N	N	N	**D.1.4.12.8;** D.1.4.12-19	Y
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	N	N	N	**D.1.4.12.8;** D.1.4.12-19	Y

Requirement #	Requirement Description	A	B	C	D	E
40.12.1.52	Provides capability to produce Excluded Provider Listing, displaying the claims paid for providers not subject to rebate	N	N	N	**D.1.4.12.8;** D.1.4.12-19	Y
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	N	N	N	**D.1.4.12.8;** D.1.4.12-19	Y
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	N	N	N	**D.1.4.12.8;** D.1.4.12-20	Y
40.12.1.55	Provides capability to produce a Balance Due Report listing the top ten (10) credit balances at run time	N	N	N	**D.1.4.12.8;** D.1.4.12-20	Y
40.12.1.56	Provides capability to produce a Balance Due Report listing the top twenty (20) debit balances at run time	N	N	N	**D.1.4.12.8;** D.1.4.12-20	Y
40.12.1.57	Provides capability to produce a Check/Deposit Comparison Report for reconciliation with deposit slips	N	N	N	**D.1.4.12.8;** D.1.4.12-20	Y
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	N	N	N	**D.1.4.12.8;** D.1.4.12-20	Y
40.12.1.59	Provides capability to produce a Disputes Activity Report to display disputes by Unassigned, Assigned, and Resolved dispute types	N	N	N	**D.1.4.12.8;** D.1.4.12-20	Y
40.12.1.60	Provides capability to produce an Interest Activity Report to display all interest overrides	N	N	N	**D.1.4.12.8;** D.1.4.12-20	Y
40.12.1.61	Provides capability to produce an Interest Detail Report to display all interest for a labeler and quarter	N	N	N	**D.1.4.12.8;** D.1.4.12-20	Y

Requirement #	Requirement Description	A	B	C	D	E
40.12.1.62	Provides capability to produce a report of invoiced amounts greater than the sum of claim reimbursement amounts	N	N	N	**D.1.4.12.8;** D.1.4.12-20	Y
40.12.1.63	Provides capability to produce an Invoice not Paid Report, showing all invoices for which no payment has been received	N	N	N	**D.1.4.12.8;** D.1.4.12-20	Y
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 **(Comment CSC244)**	N	N	Y	**D.1.4.12.8;** D.1.4.12-20	Y
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	N	N	N	**D.1.4.12.8;** D.1.4.12-20	Y
40.12.1.66	Provides capability to produce a report of payments received for drugs with CMS URA of zero	N	N	N	**D.1.4.12.8;** D.1.4.12-20	Y
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.	N	N	N	**D.1.4.12.8;** D.1.4.12-20	Y
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	N	N	N	**D.1.4.12.8;** D.1.4.12-21	Y
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	N	N	N	**D.1.4.12.8;** D.1.4.12-21	Y
40.12.1.70	Provides capability to access current and historical URA amounts for all rebateable drugs	N	N	N	**D.1.4.12.4.2;** D.1.4.12-8	Y

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.	N	N	N	**D.2.1.4.4.6;** D.2.1.4-19 **D.2.1.4.4.16.5;** D.2.1.4-25	Y
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.	N	N	N	**D.2.1.4.4.6;** D.2.1.4-19 **D.2.1.4.4.6;** D.2.1.4-20	Y
40.12.2.3	Fiscal Agent shall receive and process rebate checks from labelers.	N	N	N	**D.2.1.4.4.16.3;** D.2.1.4-25 **D.2.1.4.4.16.4;** D.2.1.4-25	Y
40.12.2.4	Fiscal Agent shall deposit labeler checks.				**D.2.1.4.4.16.4;** D.2.1.4-25	Y
40.12.2.5	Fiscal Agent shall allow for adjustment and write-off records.	N	N	N	**D.2.1.2.1.12;** D.2.1.2-9 **D.2.1.4.4.16.9;** D.2.1.4-26	Y
40.12.2.6	Fiscal Agent shall perform interest calculation on outstanding Drug Rebate balances and apply results to Drug Rebate accounts receivable file.	N	N	N	**D.2.1.4.4.16.6;** D.2.1.4-25	Y
40.12.2.7	Fiscal Agent shall perform end-of-month balancing process.	N	N	N	**D.2.1.4.4.10;** D.2.1.4-21	Y
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	N	N	N	**D.2.1.4.4.16.1;** D.2.1.4-24	Y

Requirement #	Requirement Description	A	B	C	D	E
	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.	N	N	N	**D.2.1.4.4.16.5;** D.2.1.4-25	Y
40.12.2.10	Fiscal Agent shall receive, log, and process labeler disputes.				**D.2.1.4.4.16.7;** D.2.1.4-26	Y
40.12.2.11	Fiscal Agent shall maintain data for each quarter that a labeler disputes a particular NDC.	N	N	N	**D.2.1.4.4.6;** D.2.1.4-20	Y
40.12.2.12	Fiscal Agent shall research and resolve discrepancies, including calling providers about questionable claims.				**D.2.1.4.4.16.5;** D.2.1.4-25	Y
40.12.2.13	Fiscal Agent shall initiate any necessary adjustments to change units of NDC.	N	N	N	**D.2.1.4.4.16.5;** D.2.1.4-25	Y
40.12.2.14	Fiscal Agent shall produce a Recapitulation Report.	N	N	N	**D.2.1.4.4.16.8;** D.2.1.4-26	Y
40.12.2.15	Fiscal Agent shall send Recapitulation Report to NC DHHS Auditor(s) for review and approval.	N	N	N	**D.2.1.4.4.16.8;** D.2.1.4-26	Y
40.12.2.16	Fiscal Agent shall send Recapitulation Report to labeler with copy of current summary balance once report is approved.	N	N	N	**D.2.1.4.4.16.8;** D.2.1.4-26	Y
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.	N	N	N	**D.2.1.4.4.16.1;** D.2.1.4-24	Y
40.12.2.18	Fiscal Agent shall update DRS Labeler Data with information from CMS and the State.	N	N	N	**D.2.1.4.4.16.1;** D.2.1.4-24	Y
40.12.2.19	Fiscal Agent shall ensure automated electronic transfer process to deliver invoice data and detail history to CMS and the State.	N	N	N	**D.2.1.4.4.15.1;** D.2.1.4-23	Y
40.12.2.20	Fiscal Agent shall attend CMS-sponsored Drug Rebate Labeler Dispute meetings as				**D.2.1.4.4.15.3;**	Y

Requirement #	Requirement Description	A	B	C	D	E
	required by the State and based on relevance of agenda.				D.2.1.4-24	

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.	N	N	N	**D.2.1.4.5;** D.2.1.4-29	Y
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.	N	N	N	**D.2.1.4.5;** D.2.1.4-29	Y
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.	N	N	N	**D.2.1.4.5;** D.2.1.4-29	Y
40.12.3.4	Fiscal Agent shall update the Drug Rebate accounts receivable within two (2) State business days of receipt.	N	N	N	**D.2.1.4.5;** D.2.1.4-29	Y
40.12.3.5	Fiscal Agent shall deposit all labeler checks within one (1) State business day of receipt.				**D.2.1.4.5;** D.2.1.4-29	Y
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.	N	N	N	**D.2.1.4.5;** D.2.1.4-29	Y

Requirement #	Requirement Description	A	B	C	D	E
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.	N	N	N	**D.2.1.4.5;** D.2.1.4-29	Y
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.	N	N	N	**D.2.1.4.5;** D.2.1.4-29	Y
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.	Y	N	N	**D.2.1.4.5;** D.2.1.4-29	Y
40.12.3.10	Fiscal Agent shall process all labeler disputes within ten (10) State business days from the date of receipt.				**D.2.1.4.5;** D.2.1.4-29	Y
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.	N	N	N	**D.2.1.4.5;** D.2.1.4-30	Y
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.	N	N	N	**D.2.1.4.5;** D.2.1.4-30	Y
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.	N	N	N	**D.2.1.4.5;** D.2.1.4-30	Y
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.	N	N	N	**D.2.1.4.5;** D.2.1.4-30	Y

Requirement #	Requirement Description	A	B	C	D	E
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.	N	N	N	**D.2.1.4.5;** D.2.1.4-30	Y
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.	N	N	N	**D.2.1.4.5;** D.2.1.4-30	Y
40.12.3.17	Fiscal Agent shall attend CMS-sponsored Drug Rebate Labeler Dispute meetings, as directed by the State.				**D.2.1.4.5;** D.2.1.4-30	Y
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.	N	N	N	**D.2.1.4.5;** D.2.1.4-30	Y

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	N	N	N	**D.1.4.13.1.1;** D.1.4.13-3	Y
40.13.1.2	Provides capability for compiling subtotals, totals, averages, variances, and percents of items and dollars on all reports, as appropriate	N	N	N	**D.1.4.13.1.3;** D.1.4.13-5	Y

Requirement #	Requirement Description	A	B	C	D	E
40.13.1.3	Provides capability to generate user-identified reports on a State-specified schedule	N	N	N	**D.1.4.13.1.3;** D.1.4.13-6	Y
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	N	N	N	**D.1.4.13.2;** D.1.4.13-7	Y
40.13.1.5	Provides capability to identify, separately or in combination as requested by the State, the various types of recoupments and collections	N	N	N	**D.1.4.13.2;** D.1.4.13-7	Y
Requirement Deleted 40.13.1.6	~~Provides capability to meet all enhanced requirements for the Replacement MMIS~~					
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	N	N	N	**D.1.4.13.1.2;** D.1.4.13-5	Y
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	N	N	N	**D.1.4.13.1.3;** D.1.4.13-6	Y
40.13.1.9	Provides capability for a statistically valid trend methodology approved by the State for generating MARS reports	N	N	Y	**D.1.4.13.1.1;** D.1.4.13-4	Y
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: ▪ Participating and non-participating eligible recipient counts and trends by program and category of eligibility	N	Y	N	**D.1.4.13.1.1;** D.1.4.13-4	Y

Requirement #	Requirement Description	A	B	C	D	E
	▪ Utilization patterns by program, recipient medical coverage groups, provider type, and summary and detailed category of service ▪ Charges, expenditures, and trends by program and summary and detailed category of service ▪ Lag factors between date of service and date of payment to determine billing and cash flow trends ▪ Any combination of the above					
40.13.1.11	Provides capability to describe codes and values to be included on reports	N	N	N	**D.1.4.13.1.3;** D.1.4.13-5	Y
40.13.1.12	Provides capability for users to specify selection, summarization, and un-duplication criteria when requesting claim detail reports from Claims History	N	N	N	**D.1.4.13.7;** D.1.4.13-9	Y
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	N	N	N	**D.1.4.13.1.4;** D.1.4.13-6	Y
40.13.1.14	Provides capability to generate all MARS reports that will be sent to CMS in the format specified by Federal requirements	N	N	N	**D.1.4.13.6;** D.1.4.13-9	Y
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	N	N	N	**D.1.4.13.1.1;** D.1.4.13-4	Y
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	N	N	N	**D.1.4.13.1.2;** D.1.4.13-5	Y
40.13.1.17	Provides capability for consistent transaction processing cutoff points to ensure the consistency and comparability of all reports	N	N	N	**D.1.4.13.1.3;** D.1.4.13-6	Y

Requirement #	Requirement Description	A	B	C	D	E
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)	N	N	N	**D.1.4.13.1.2;** D.1.4.13-5	Y
40.13.1.19	Provides capability for an audit trail for balanced reporting	N	N	N	**D.1.4.13.1.2;** D.1.4.13-5	Y
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	N	N	N	**D.1.4.13.1.1;** D.1.4.13-4	Y
40.13.1.21	Provides capability for the MARS database to include the following types of data: ▪ Adjudicated claims data ▪ Adjustment/void data ▪ Financial transactions for the reporting period ▪ Reference data for the reporting period ▪ Provider data for the reporting period ▪ Recipient data (including LTC, EPSDT, cost of care, co-pays, benefits used, and insurance information) for the reporting period ▪ Budget data from the NCAS ▪ Financial data, for the reporting period ▪ Other, such as Medco and Health Check, inputs not available from or through the Replacement MMIS claims financial function	N	Y	N	**D.1.4.13.1.1;** D.1.4.13-4	Y
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	N	N	N	**D.1.4.13.1.1;** D.1.4.13-4	Y

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	N	N	N	**D.1.4.13.1.3;** D.1.4.13-6	Y
40.13.1.24	Provides capability to create all required MMA file and MMA State Response File reports	N	N	N	**D.1.4.13.6;** D.1.4.13-9	Y
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	N	N	N	**D.1.4.13.1.3;** D.1.4.13-5	Y

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.				**D.1.4.13.1.2;** D.1.4.13-5	Y
40.13.2.2	Fiscal Agent shall respond to State requests for information concerning the reports.				**D.1.4.13.1.3;** D.1.4.13-5	Y

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	N	Y	N	**D.1.4.14.2.16** D.1.4.14-36	Y
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	N	N	N	**D.1.4.14.2.7;** D.1.4.14-25	Y
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)	N	N	N	**D.1.4.14.2.16** D.1.4.14-35	Y
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	N	N	N	**D.1.4.14.2.5;** D.1.4.14-21 **D.1.4.14.2.11;** D.1.4.14-29	Y
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	N	N	N	**D.1.4.14.2.3;** D.1.4.14-16	Y
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	N	N	N	**D.1.4.14.1;** D.1.4.14-5 **D.1.4.14.2.11;** D.1.4.14-29	Y
40.14.1.8	Provides capability to automatically compute financial participation (State, Federal,	N	N	N	**D.1.4.14.2.15;**	Y

Requirement #	Requirement Description	A	B	C	D	E
	county, and other)				D.1.4.14-34	
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	N	N	N	**D.1.4.14.2.15;** D.1.4.14-34	Y
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	N	N	N	**D.1.4.14.2.11;** D.1.4.14-29	Y
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	N	Y	N	**D.1.4.14.2.1;** D.1.4.14-6	Y
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	N	N	N	**D.1.4.14.2.7;** D.1.4.14-25	Y
40.14.1.13	Provides capability to produce NCAS interface file weekly to support checkwrite activity	N	N	N	**D.1.4.14.2.14;** D.1.4.14-34	Y
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	N	N	N	**D.1.4.14.2.16** D.1.4.14-36	Y
40.14.1.16	Provides capability to identify and update payment data with each payment cycle	N	N	N	**D.1.4.14.2.10;** D.1.4.14-29	Y
40.14.1.17	Provides capability to interface with NCAS for accounts receivable and accounts	N	N	N	**D.1.4.14.2.14;**	Y

Requirement #	Requirement Description	A	B	C	D	E
	payable functions				D.1.4.14-34	
40.14.1.18**	Provides capability for a Client Data Warehouse extract of DMH data	N	N	N	**D.1.4.14.2.14;** D.1.4.14-34	Y
	MMIS Accounts Payable Processes					
40.14.1.19	Provides capability for accounts payable functionality for all programs	N	N	N	**D.1.4.14.2.6;** D.1.4.14-22	Y
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	N	Y	N	**D.1.4.14.2.6;** D.1.4.14-23	Y
40.14.1.21	Provides capability to process transactions for checks from outside systems, generating a Claims History record	Y	Y	N	**D.1.4.14.2.6;** D.1.4.14-22	Y
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: ▪ Provider number ▪ Issue date ▪ Check voucher number ▪ Amount ▪ Disposition ▪ Disposition date	N	N	N	**D.1.4.14.2.6;** D.1.4.14-23	Y
40.14.1.23	Provides capability for online inquiry access and update ability on selected individual fields	N	N	N	**D.1.4.14.2.6;** D.1.4.14-23	Y

Requirement #	Requirement Description	A	B	C	D	E
40.14.1.24	Provides capability to generate a stop payment or cancel transaction	N	N	N	**D.1.4.14.2.6;** D.1.4.14-23	Y
40.14.1.25	Provides capability to process the check voucher returned file for failed EFTs	N	N	N	**D.1.4.14.2.3;** D.1.4.14-15	Y
40.14.1.26	Provides capability to update funding sources and criteria lists based on financial participation rate information received from the State	N	Y	N	**D.1.4.14.2.6;** D.1.4.14-23	Y
40.14.1.27	Provides capability to ensure that weekly budget reporting is consistent with the costs allocated during the checkwrite	N	N	N	**D.1.4.14.2.3;** D.1.4.14-11	Y
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	N	N	N	**D.1.4.14.2.6;** D.1.4.14-22	Y
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	N	Y	N	**D.1.4.14.2.11;** D.1.4.14-30	Y
Requirement Deleted 40.14.1.30	~~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~~					
40.14.1.31	Provides capability to set up an accounts payable for non-provider-specific payments, issue payment, and adjust the financial reporting	N	N	Y	**D.1.4.14.2.6;** D.1.4.14-22	Y

Requirement #	Requirement Description	A	B	C	D	E
	MMIS Accounts Receivable Process					
40.14.1.32	Provides capability to ensure accurate collection and management of account receivables	N	N	N	**D.1.4.14.2.10;** D.1.4.14-28	Y
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	N	Y	N	**D.1.4.14.2.10;** D.1.4.14-29	Y
40.14.1.34	Provides capability to maintain an accounts receivable detail and summary section for each account	N	N	N	**D.1.4.14.2.10;** D.1.4.14-29	Y
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)	N	N	N	**D.1.4.14.2.7** D.1.4.14-23 **D.1.4.14.2.7;** D.1.4.14-24	Y
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	N	N	N	**D.1.4.14.2.7;** D.1.4.14-25	Y
40.14.1.37	Provides capability to produce collection letters within the financial processing function of the checkwrite cycle	N	N	N	**D.1.4.14.2.7;** D.1.4.14-25	Y
40.14.1.38	Provides capability to establish systematic payment plans or recoupments for provider receivable balances, as directed by the State	N	N	N	**D.1.4.14.2.11** D.1.4.14-29	Y
40.14.1.39	Provides capability to "write off" outstanding account receivables when approved by the State	N	N	N	**D.1.4.14.2.7** D.1.4.14-25	Y

Requirement #	Requirement Description	A	B	C	D	E
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	N	N	N	**D.1.4.14.2.11;** D.1.4.14-29	Y
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	N	N	N	**D.1.4.14.2.5;** D.1.4.14-21	Y
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	N	N	Y	**D.1.4.14.2.9;** D.1.4.14-26	Y
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	N	N	N	**D.1.4.14.2.11;** D.1.4.14-29	Y
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: ▪ Claims paid in error ▪ Cost settlements receivables ▪ Program integrity receivables ▪ Provider advances tax withholding ▪ Tax levies	N	N	N	**D.1.4.14.2.7;** D.1.4.14-24 **D.1.4.14.2.11;** D.1.4.14-29	Y
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:	N	N	N	**D.1.4.14.2.11;** D.1.4.14-29	Y

Requirement #	Requirement Description	A	B	C	D	E
	▪ Percent ▪ Dollar amount ▪ Total amount					
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	N	N	N	**D.1.4.14.2.11;** D.1.4.14-29	Y
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	N	N	N	**D.1.4.14.2.11;** D.1.4.14-30	Y
40.14.1.48	Provides capability to apply claims payments recoupments to more than one (1) account receivable at a time	N	N	N	**D.1.4.14.2.11;** D.1.4.14-29	Y
40.14.1.49	Provides capability to allow the portion of payments made against each account receivable to be controlled by State staff	N	N	N	**D.1.4.14.2.7;** D.1.4.14-23	Y
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	N	N	N	**D.1.4.14.2.7;** D.1.4.14-25	Y
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	N	N	N	**D.1.4.14.2.11;** D.1.4.14-29	Y
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	N	N	N	**D.1.4.14.2.5;** D.1.4.14-21	Y
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,	N	N	Y	**D.1.4.14.2.12;** D.1.4.14-30	Y

Requirement #	Requirement Description	A	B	C	D	E
	cancellation notices, receipts, and refunds					
40.14.1.54	Provides capability to collect recipient premium payments	N	N	Y	**D.1.4.14.2.12**; D.1.4.14-30	Y
40.14.1.55	Provides capability to produce refunds of recipient premiums	N	N	Y	**D.1.4.14.2.12;** D.1.4.14-30	Y
40.14.1.56	Provides capability to process financial accounting records for premium payments and refunds	N	N	Y	**D.1.4.14.2.12;** D.1.4.14-30	Y
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	N	N	N	**D.1.4.14.2.12;** D.1.4.14-31	Y
40.14.1.58	Provides capability to apply cost-sharing, e.g., recipient co-insurance, deductibles, co-payments	N	N	N	**D.1.4.14.2.12;** D.1.4.14-31	Y
40.14.1.59	Provides capability to ensure cost-sharing does not exceed threshold for the family group	N	N	N	**D.1.4.14.2.12;** D.1.4.14-31	Y
40.14.1.60	Provides capability to produce and send recipient letters/notices and Explanations of Benefits (EOB) in the recipient's preferred language	N	N	N	**D.1.4.14.2.12;** D.1.4.14-31	Y
	Financial Accounting and Reporting Processes					
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	N	N	N	**D.1.4.14.2.16** D.1.4.14-36	Y
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	N	N	N	**D.1.4.14.2.1;** D.1.4.14-6	Y

Requirement #	Requirement Description	A	B	C	D	E
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	N	N	N	**D.1.4.14.2.16** D.1.4.14-35	Y
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	N	N	N	**D.1.4.14.2.10;** D.1.4.14-29	Y
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 30th to reflect activity between the last June checkwrite and June 30th	N	N	N	**D.1.4.14.2.1;** D.1.4.14-7 **D.1.4.14.2.15;** D.1.4.14-34	Y
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 30th; provides capability to generate these reports in accordance with State-approved format, media, distribution, and frequency	N	N	N	**D.1.4.14.2.1;** D.1.4.14-7	Y
40.14.1.67	Provides capability to summarize financial data to meet reporting requirements on a State and Federal fiscal-year basis	N	N	N	**D.1.4.14.2.1;** D.1.4.14-7	Y
40.14.1.68	Provides capability to ensure all reporting cross-checks and balances to other reports using the same data	N	N	N	**D.1.4.14.2.15;** D.1.4.14-34	Y
40.14.1.69	Provides capability to produce reporting on providers required by the Federal False Claims Act	N	N	N	**D.2.1.3.1.9.3;** D.2.1.3-12	Y
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	N	N	N	**D.1.4.14.2.16** D.1.4.14-39	Y
40.14.1.71	Provides capability to ensure that all financial reports can be tied into the basic financial activity recorded in Provider History	N	N	N	**D.1.4.14.2.16** D.1.4.14-35	Y

Requirement #	Requirement Description	A	B	C	D	E
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	N	N	N	**D.1.4.14.2.15;** D.1.4.14-34	Y
40.14.1.73	Provides capability to balance details posted to each receivable transaction and update Claims History and Provider paid claims summary information	N	N	N	**D.1.4.14.2.10;** D.1.4.14-29	Y
40.14.1.74	Provides capability to incorporate data from State-approved automated systems to satisfy accounting and record keeping objectives	N	N	Y	**D.1.4.14.2.16;** D.1.4.14-35	Y
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	N	Y	N	**D.1.4.14.2.13;** D.1.4.14-33	Y
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	N	N	N	**D.1.4.14.2.13;** D.1.4.14-33	Y
40.14.1.77	Provides capability to provide the State with confirmation and validation for each completed date of withholding or penalty	N	N	N	**D.1.4.14.2.13;** D.1.4.14-33	Y
40.14.1.78	Provides capability to implement backup withholding from all providers who do not respond to the notices within the required timeframes	N	N	N	**D.1.4.14.2.13;** D.1.4.14-33	Y
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	N	N	N	**D.1.4.14.2.13;** D.1.4.14-33	Y
40.14.1.80	Provides capability to report year-to-date provider 1099 earnings	N	N	N	**D.1.4.14.2.13;** D.1.4.14-31	Y

Requirement #	Requirement Description	A	B	C	D	E
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	N	N	N	**D.1.4.14.2.13;** D.1.4.14-31	Y
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	N	Y	N	**D.1.4.14.2.13;** D.1.4.14-31	Y
40.14.1.83	Provides capability to issue corrected 1099s to providers prior to March 31st each year; provides capability to ensure that corrections are incorporated into the IRS file to report earnings for the prior year	N	N	N	**D.1.4.14.2.13;** D.1.4.14-31	Y
	Cash Control and Bank Accounts					
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 *DHHS Cash Management Plan* in the Procurement Library.	N	N	N	D.1.4.14.1 D.1.4.14-3	Y
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	N	N	N	**D.1.4.14.2.5;** D.1.4.14-21	Y
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	N	N	N	**D.1.4.14.2.5;** D.1.4.14-22	Y
40.14.1.87	Provides capability to process and post transactions for all program cash receipts received in Fiscal Agent/bank managed lock-boxes	N	N	N	**D.1.4.14.2.5;** D.1.4.14-21	Y
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	N	N	Y	**D.1.4.14.2.5;** D.1.4.14-22	Y

Requirement #	Requirement Description	A	B	C	D	E
	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 (**Comment CSC89**)	N	N	N	**D.1.4.14.2.5;** D.1.4.14-22	Y
40.14.1.90	Provides capability for an audit trail of corrections to posted transactions	N	N	N	**D.1.4.14.2.5;** D.1.4.14-22	Y
	Budget Checking Prior To Payment of Claims					
40.14.1.91	Provides capability to link the detail financial transaction to the claim detail level activity	N	N	Y	**D.1.4.14.2.2;** D.1.4.14-9	Y
40.14.1.92**	Provides capability to produce balancing reports available online at detail and summary levels on budget availability	N	N	N	**D.1.4.14.2.3;** D.1.4.14-11	Y
40.14.1.93	Provides capability to produce exception reports on un-reconciled balances or undefined chart of accounts shall be available online	N	N	N	**D.1.4.14.2.3;** D.1.4.14-18	Y
	Accounting Processes					
40.14.1.94	Provides capability for integration of all Medicaid Accounting System (MAS) legacy system functionality, processes, data, reports and interfaces Refer to *Approved MAS Requirements & Business Rules—Updated 12-06-06* and attachments in the Procurement Library.	N	Y	N	D.1.4.14.2.16 D.1.4.14-37	Y
	General Account Receivable/Accounts Payable Requirements					
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	N	N	N	**D.1.4.14.2.8;** D.1.4.14-26	Y

Requirement #	Requirement Description	A	B	C	D	E
	from third parties Refer to *Approved AR-AP Requirements & Business Rules—Updated 12-19-06* in the Procurement Library.					

40.14.2 Financial Management and Accounting Operational Requirements

Requirement #	Requirement Description	A	B	C	D	E
	General Financial Management and Accounting					
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.	N	N	N	**D.2.1.2.1.4;** D.2.1.2-4 **D.2.1.2.1.12;** D.2.1.2-10	Y
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.				**D.2.1.2.1.8;** D.2.1.2-7	Y
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.	N	N	N	**D.2.1.2.1.10;** D.2.1.2-8	Y
40.14.2.4**	Fiscal Agent shall provide nightly interface to NCAS to validate availability of funds for claim-specific reimbursement.	N	N	N	**D.2.1.2.1.8;** D.2.1.2-6	Y
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.	N	N	N	**D.2.1.2.1.13;** D.2.1.2-11	Y

Requirement #	Requirement Description	A	B	C	D	E
	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.)	N	N	N	**D.2.1.2.1.4;** D.2.1.2-5 **D.2.1.2.1.13;** D.2.1.2-11	Y
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.	N	N	N	**D.2.1.2.1.3;** D.2.1.2-4	Y
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.	N	N	N	**D.2.1.2.1.10;** D.2.1.2-7	Y
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.	N	N	N	**D.2.1.2.1.3;** D.2.1.2-3	Y
40.14.2.10	Fiscal Agent shall accept and process all check voucher reconciliation.	N	N	N	**D.2.1.2.1.14;** D.2.1.2-11	Y
40.14.2.11	Fiscal Agent shall execute Positive Pay processing.	N	N	N	**D.2.1.2.1.6;** D.2.1.2-6 **D.2.1.2.1.7;** D.2.1.2-6	Y
40.14.2.12	Fiscal Agent shall ensure weekly budget reporting is consistent with the costs allocated during the checkwrite.	N	N	N	**D.2.1.2.1.10;** D.2.1.2-8	Y
40.14.2.13	Fiscal Agent shall submit a draft annual checkwrite schedule by the last State business day in September each year.				**D.2.1.2.1.3;** D.2.1.2-4	Y

Requirement #	Requirement Description	A	B	C	D	E
40.14.2.14	Fiscal Agent shall perform checkwrites per the State-approved checkwrite schedules.	N	N	N	**D.2.1.2.1.3;** D.2.1.2-4 **D.2.1.2.1.4;** D.2.1.2-4	Y
40.14.2.15	Fiscal Agent shall notify the State of the total checkwrite expenditure on the first day following the cycle.				**D.2.1.2.1.3;** D.2.1.2-3	Y
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.				**D.2.1.2.1.3;** D.2.1.2-3 **D.2.1.2.1.3;** D.2.1.2-4	Y
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.				**D.2.1.2.1.3;** D.2.1.2-4	Y
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.				**D.2.1.2.1.3;** D.2.1.2-3	Y
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.				**D.2.1.2.1.10;** D.2.1.2-7	Y
40.14.2.20	Fiscal Agent shall process check voucher information from the State Controller's Office, updating payment information.	N	N	N	**D.2.1.2.1.14;** D.2.1.2-11	Y
40.14.2.21	Fiscal Agent shall ensure that the weekly budget reporting is consistent with the costs allocated during the checkwrite.	N	N	N	**D.2.1.2.1.10;** D.2.1.2-8	Y
40.14.2.22	Fiscal Agent shall produce third party letters within the financial processing function of the checkwrite cycle.	N	N	Y	**D.2.1.2.1.10;** D.2.1.2-8	Y

Requirement #	Requirement Description	A	B	C	D	E
					D.2.1.2.1.14; D.2.1.2-11	
Requirement Deleted 40.14.2.23	~~Fiscal Agent shall produce reports and State claims 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.	N	N	N	**D.2.1.2.1.14;** D.2.1.2-12	Y
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.	N	N	N	**D.2.1.2.2;** D.2.1.2-12	Y
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.	N	N	N	**D.2.1.2.2;** D.2.1.2-12	Y
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.				**D.2.1.2.1.1;** D.2.1.2-2 **D.2.1.2.2;** D.2.1.2-12	Y
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.				**D.2.1.2.1;** D.2.1.2-2 **H.1;** H-2	Y
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				**D.2.1.2.1;** D.2.1.2-2	Y

Requirement #	Requirement Description	A	B	C	D	E
	the NC DHHS Controller.					
	MMIS Program Account Payable					
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.	N	N	N	**D.2.1.2.1.14;** D.2.1.2-12	Y
40.14.2.31	Fiscal Agent shall determine daily cash requirements and draw program cash from a special State disbursing account as needed.				**D.2.1.2.1.5;** D.2.1.2-5	Y
40.14.2.32	Fiscal Agent shall collect recipient premium payments.	N	N	Y	**D.2.1.2.1.11;** D.2.1.2-8	Y
40.14.2.33	Fiscal Agent shall produce refunds of recipient premiums.	N	N	Y	**D.2.1.2.1.14;** D.2.1.2-12	Y
	Replacement MMIS Accounts Receivable Process					
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.	N	N	N	**D.2.1.2.1.13;** D.2.1.2-11	Y
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.	N	N	Y	**D.2.1.2.1.13;** D.2.1.2-11	Y
40.14.2.36	Fiscal Agent shall monitor compliance with written procedures to meet State and Federal guidelines for collecting outstanding provider accounts receivable.				**D.2.1.2.1.13;** D.2.1.2-11	Y
40.14.2.37	Fiscal Agent shall “write off” outstanding accounts receivable, when directed by the	N	N	N	**D.2.1.2.1.13;** D.2.1.2-11	Y

Requirement #	Requirement Description	A	B	C	D	E
	State.					
40.14.2.38	Fiscal Agent shall ensure accurate collection and management of accounts receivables.				**D.2.1.2.1.13;** D.2.1.2-11	Y
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.)	N	N	N	**D.2.1.2.1.4;** D.2.1.2-5	Y
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.	N	N	N	**D.2.1.2.1.13;** D.2.1.2-11	Y
	Financial Accounting and Reporting Process					
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 30th to reflect activity between the last June checkwrite and June 30th.	N	N	N	**D.2.1.2.1.3;** D.2.1.2-4	Y
40.14.2.42**	Fiscal Agent shall make details of the general ledger, including all entries and balances, available to authorized State staff.				**D.2.1.2.1.2;** D.2.1.2-3 **D.2.1.2.1.3;** D.2.1.2-4	Y
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 30th and provide these reports in accordance with State-approved format, media, distribution, and frequency.	N	N	N	**D.2.1.2.1.2;** D.2.1.2-3	Y
40.14.2.44	Fiscal Agent shall change financial participation rates in the Replacement MMIS to correspond with the Federal fiscal year.	N	Y	N	**D.2.1.2.1.14;** D.2.1.2-12	Y

Requirement #	Requirement Description	A	B	C	D	E
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.	N	N	N	**D.2.1.2.1.10;** D.2.1.2-7	Y
40.14.2.46**	Fiscal Agent shall refer questions regarding rates and budgets to the State.				**D.2.1.2.1.14;** D.2.1.2-12	Y
40.14.2.47	Fiscal Agent shall ensure adherence to NC DHHS Cash Management Plan and Procedures.				**D.2.1.2.1.1;** D.2.1.2-2	Y
40.14.2.48	Fiscal Agent shall incorporate State-approved automated and manual systems to satisfy accounting and record-keeping objectives.				**D.2.1.2.2;** D.2.1.2-12	Y
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.				**D.2.1.2.1.3;** D.2.1.2-4	Y
40.14.2.50**	Fiscal Agent shall produce an extract of DMH claims data for the Client Data Warehouse (CDW) with each checkwrite.	N	N	N	**D.2.1.2.1.8;** D.2.1.2-7	Y
	IRS Reporting and Compliance					
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 15th 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.	N	N	Y	**D.2.1.2.1.9;** D.2.1.2-7	Y
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.	Y	N	N	**D.2.1.2.1.9;** D.2.1.2-7	Y
40.14.2.53	Fiscal Agent shall record receipt date of each withholding and penalty request and completion date of withholding or penalty.	N	N	N	**D.2.1.2.1.9;** D.2.1.2-7	Y

Requirement #	Requirement Description	A	B	C	D	E
40.14.2.54	Fiscal Agent shall provide the State with confirmation and validation for each completed date of withholding or penalty.				**D.2.1.2.1.9;** D.2.1.2-7	Y
40.14.2.55	Fiscal Agent shall comply with all IRS regulations.				**D.2.1.2.1.1;** D.2.1.2-2	Y
40.14.2.56	Fiscal Agent shall issue corrected 1099s to providers prior to March 31st each year and shall ensure that corrections are incorporated into the IRS file to report earnings for the prior year.	N	N	N	**D.2.1.2.1.9;** D.2.1.2-7	Y
40.14.2.57	Fiscal Agent shall ensure accuracy of tax identification numbers and tax names reported.				**D.2.1.2.1.9;** D.2.1.2-7	Y
	Cash Control and Bank Accounts					
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.				**D.2.1.2.1.11;** D.2.1.2-9	Y
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.)	N	N	N	**D.2.1.2.1.11;** D.2.1.2-9	Y
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.				**D.2.1.2.1.11;** D.2.1.2-9	Y
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				**D.2.1.2.1.11;** D.2.1.2-8	Y

Requirement #	Requirement Description	A	B	C	D	E
	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.				**D.2.1.2.1.5;** D.2.1.2-5	Y
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.				**D.2.1.2.1.5;** D.2.1.2-5	Y
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."				**D.2.1.2;** D.2.1.2-1 **D.2.1.2.1.5;** D.2.1.2-5	Y
40.14.2.65	Fiscal Agent shall accept responsibility for and bear the cost of any overdraft penalties on Fiscal Agent-controlled checking accounts.				**D.2.1.2.1.5;** D.2.1.2-5	Y
40.14.2.66	Fiscal Agent shall monitor security of checks during matching, stuffing, and mailing process.				**D.2.1.2.1.10;** D.2.1.2-8	Y
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.	N	N	N	**D.2.1.2.1.8;** D.2.1.2-6	Y
	MMIS Program Cash Receiving					
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.	N	N	N	**D.2.1.2.1.11;** D.2.1.2-8	Y

Requirement #	Requirement Description	A	B	C	D	E
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 received.				**D.2.1.2.1.11;** D.2.1.2-8	Y
	Production and Distribution of Management and Financial Reports					
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.	N	N	N	**D.2.1.2.1.2;** D.2.1.2-3	Y
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.	N	N	N	**D.2.1.2.1.3;** D.2.1.2-4	Y

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.				**D.2.1.2.5;** D.2.1.2-16	Y
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.	N	N	N	**D.2.1.2.5;** D.2.1.2-17	Y
40.14.3.3	Fiscal Agent shall provide deposit of returned monies the same State business day of receipt.				**D.2.1.2.5;** D.2.1.2-17	Y

Requirement #	Requirement Description	A	B	C	D	E
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.	N	N	N	**D.2.1.2.5;** D.2.1.2-17	Y
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.	N	N	N	**D.2.1.2.5;** D.2.1.2-17	Y
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.				**D.2.1.2.5;** D.2.1.2-17	Y
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.				**D.2.1.2.5;** D.2.1.2-17	Y
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.				**D.2.1.2.5;** D.2.1.2-17	Y
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.				**D.2.1.2.5;** D.2.1.2-17	Y
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.	N	N	N	**D.2.1.2.5;** D.2.1.2-17	Y
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.	N	N	N	**D.2.1.2.5;** D.2.1.2-17	Y
40.14.3.12	Fiscal Agent shall ensure that weekly budget reporting is accurate and consistent	N	N	N	**D.2.1.2.5;** D.2.1.2-17	Y

Requirement #	Requirement Description	A	B	C	D	E
	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.	N	N	N	**D.2.1.2.5;** D.2.1.2-17	Y
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.	N	N	N	**D.2.1.2.5;** D.2.1.2-17	Y
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).	N	N	N	**D.2.1.2.5;** D.2.1.2-18	Y
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.				**D.2.1.2.5;** D.2.1.2-18	Y
40.14.3.17	Fiscal Agent shall produce and mail out 1099/W9 earnings reports no later than January 31st each year and report to the IRS no later than March 1st.	N	N	N	**D.2.1.2.5;** D.2.1.2-18	Y
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.	N	N	N	**D.2.1.2.5;** D.2.1.2-18	Y
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.	N	N	N	**D.2.1.2.5;** D.2.1.2-18	Y
40.14.3.20	Fiscal Agent shall summarize each provider's NC DHHS for the previous calendar year no later than January 15th of the succeeding year, providing the summary to the Internal Revenue Service and NC DOR by sending a file using FTP media. Fiscal	N	N	N	**D.2.1.2.5;** D.2.1.2-18	Y

Requirement #	Requirement Description	A	B	C	D	E
	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.	N	N	N	**D.2.1.2.5;** D.2.1.2-18	Y
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.	N	N	N	**D.2.1.2.5;** D.2.1.2-18	Y
40.14.3.23	Fiscal Agent shall comply with all IRS regulations ninety-nine and nine tenths (99.9) percent of the time.				**D.2.1.2.5;** D.2.1.2-18	Y
40.14.3.24	Fiscal Agent shall issue corrected 1099s to providers prior to March 31st 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.	N	N	N	**D.2.1.2.5;** D.2.1.2-18	Y
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.	N	N	N	**D.2.1.2.5;** D.2.1.2-18	Y
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.				**D.2.1.2.5;** D.2.1.2-19	Y
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.				**D.2.1.2.5;** D.2.1.2-19	Y

Requirement #	Requirement Description	A	B	C	D	E
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.	N	N	N	**D.2.1.2.5;** D.2.1.2-19	Y
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.	N	N	N	**D.2.1.2.5;** D.2.1.2-19	Y
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.	N	Y	N	**D.2.1.2.5;** D.2.1.2-19	Y
40.14.3.31**	Fiscal Agent shall apply special "timely filing" edits at the end of the State fiscal year: ▪ AP/LMEs shall file all services rendered prior to May 1st no later than the cutoff for the last payment cycle in June. ▪ 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.	N	N	N	**D.2.1.2.5;** D.2.1.2-19	Y
Requirement Deleted 40.14.3.32	~~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.~~					
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 30th	N	N	N	**D.2.1.2.5;** D.2.1.2-19	Y
40.14.3.34	Fiscal Agent shall assure that Checkwrite Financial Summary and FPR Reports are	N	N	N	**D.2.1.2.5;** D.2.1.2-19	Y

Requirement #	Requirement Description	A	B	C	D	E
	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.	N	N	N	**D.2.1.2.5;** D.2.1.2-19	Y
40.14.3.36	Fiscal Agent shall produce and maintain accounts receivable reports.	N	N	N	**D.2.1.2.5;** D.2.1.2-20	Y
40.14.3.37	Fiscal Agent shall produce and maintain MMIS Medicaid Accounting System Reporting.	N	N	N	**D.2.1.2.2;** D.2.1.2-12 **D.2.1.2.5;** D.2.1.2-20	Y
40.14.3.38	Fiscal Agent shall produce and maintain Maximum Allowable Cost (MAC) Transactions and Reporting.	N	N	Y	**D.2.1.2.5;** D.2.1.2-20	Y
40.14.3.39	Fiscal Agent shall produce and maintain Medicaid Adjustments Register Reporting.	N	N	Y	**D.2.1.2.5;** D.2.1.2-20	Y
40.14.3.40	Fiscal Agent shall produce and maintain listing of paid claims for Indians on reservations.	N	N	Y	**D.2.1.2.5;** D.2.1.2-20	Y
40.14.3.41	Fiscal Agent shall produce and maintain the listing of buy-in premiums paid for Indians on reservations.	N	N	Y	**D.2.1.2.5;** D.2.1.2-21	Y
40.14.3.42	Fiscal Agent shall produce and maintain the listing and file containing Indian financial adjustment transactions.	N	N	Y	**D.2.1.2.5;** D.2.1.2-20	Y
40.14.3.43	Fiscal Agent shall produce and maintain the Medicaid Cost Calculation Reporting.	N	N	N	**D.2.1.2.5;** D.2.1.2-20	Y
40.14.3.44	Fiscal Agent shall produce and maintain NCAS Program Cost Interface.	N	N	N	**D.2.1.2.5;** D.2.1.2-20	Y
40.14.3.45	Fiscal Agent shall produce and maintain the Monthly County Bank Draft File.	N	N	Y	**D.2.1.2.5;** D.2.1.2-20	Y

Requirement #	Requirement Description	A	B	C	D	E
40.14.3.46	Fiscal Agent shall produce and maintain MMIS Summary of Paid Claims.	N	N	N	**D.2.1.2.5;** D.2.1.2-20	Y
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.	N	N	Y	**D.2.1.2.5;** D.2.1.2-20	Y
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.	N	N	Y	**D.2.1.2.5;** D.2.1.2-20	Y
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.				**D.2.1.2.5;** D.2.1.2-20	Y
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.	N	N	N	**D.2.1.2.5;** D.2.1.2-20	Y
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.	N	N	N	**D.2.1.2.5;** D.2.1.2-20	Y
40.14.3.52	The Fiscal Agent shall produce an extract of DMH claims data for CDW with each checkwrite.	N	Y	N	**D.2.1.2.5;** D.2.1.2-20	Y
40.14.3.53	Fiscal Agent shall successfully complete each checkwrite by the date on the State-approved Checkwrite Schedule. **(Comment CSC126)**	N	N	N	**D.2.1.2.5; D.2.1.2-21**	y

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Appendix 50, Attachment C, Exhibit 1: Delta State Requirements Matrix Updates, May 1, 2008

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
	Security					
40.1.1.18	Provides capability for initial batch loading of user identification/demographic records and profiles	N	N	N	**D.1.4.1.5;** D.1.4.1-11 **H.1.2;** H-7	Y

Requirement #	Requirement Description	A	B	C	D	E
	Rules Engine					
40.1.1.107	**Goal:** Provides capability to register, classify, inquire, manage, and automate date-specific business rules in a graphical, user-friendly rules engine	N	N	N	**D.1.4.1.14;** D.1.4.1-23 **D.1.4.1.14;** D.1.4.1-24	Y
40.1.1.108	**Goal:** Provides capability to modify rules, allowing the application to be adaptable with the dynamic rules	N	N	N	**D.1.4.1.14;** D.1.4.1-24 **D.1.4.1.14;** D.1.4.1-25	Y
40.1.1.109	**Goal:** Provides capability for generating media events or application events as a result of the execution of a business rule	N	N	N	**D.1.4.1.14;** D.1.4.1-25 **D.1.4.1.14;** D.1.4.1-29	Y
40.1.1.110	**Goal:** 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	N	N	N	**D.1.4.1.14;** D.1.4.1-25	Y
40.1.1.111	**Goal:** Provides capability for a debugging process that automatically analyzes and identifies logical errors (i.e., conflict, redundancy, and incompleteness) across business rules	N	N	N	**D.1.4.1.14;** D.1.4.1-27	Y
40.1.1.113	**Goal:** Provides capability for a built-in rule review and approval process that will identify any conflicts in business rules as they are being developed	N	N	N	**D.1.4.1.14;** D.1.4.1-24	Y
40.1.1.114	**Goal:** Provides capability to track and report rules usage	N	N	N	**D.1.4.1.14;** D.1.4.1-29	Y
40.1.1.116	**Goal:** Provides capability for integration with a workflow management process	N	N	N	**D.1.4.1.14;** D.1.4.1-24	Y

Requirement #	Requirement Description	A	B	C	D	E
40.1.1.118	**Goal:** Provides capability to reuse business rules across processes	N	N	N	**D.1.4.1.14;** D.1.4.1-26	Y
40.1.1.119	**Goal:** Provides capability to change business rules independent of process	N	N	N	**D.1.4.1.14;** D.1.4.1-25 **D.1.4.1.14;** D.1.4.1-27	Y
40.1.1.120	**Goal:** Provides capability to apply Procedure Code Pricing (PR) File Cleanup business rules against current Procedure Code Pricing (PR) File	N	Y	N	**D.1.4.1.14;** D.1.4.1-30	Y
40.1.1.174 **(New)**	Provides capability to mass adjust the end date on Prior Approvals by benefit plan	N	N	Y	**D.1.4.1.21;** D.1.4.1-47	Y

40.1.2 General Operational Requirements

Requirement #	Requirement Description	A	B	C	D	E
	Security					
40.1.2.109 **(New)**	Fiscal Agent shall receive and process batch loads of user identification/demographic records and profiles prior to implementation and throughout the life of the contract	N	N	N	**D.1.4.1.21;** D.1.4.1-47 **D.2.1.5.1.5;** D.2.1.5-6 **D.2.1.5.1.5;** D.2.1.5-7	Y

40.2 Recipient Requirements

40.2.1 Recipient System Requirements

Requirement #	Requirement Description	A	B	C	D	E
40.2.1.23**	Provides capability for online updates to the CNDS for maintenance of cross-reference and demographic information	N	N	Y	**D.1.4.2.3;** D.1.4.2-8	Y
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	N	N	Y	**D.1.4.2.4;** D.1.4.2-12	Y
40.2.1.40	Provides capability for notification to all appropriate business areas when a recipient is retroactively enrolled/disenrolled into/from a benefit plan; then the appropriate business rules must be applied, including automatic re-adjudication of claims	N	N	Y	**D.1.4.2.4;** D.1.4.2-11	Y

40.5 Provider Requirements

40.5.1 Provider System Requirements

Requirement #	Requirement Description	A	B	C	D	E
	Provider Maintenance					
40.5.1.78	Provides capability to place the provider on review for withholds or initiate incentives, at the LOB(s) level, with an associated pre-payment/post-payment status, by provider tax ID and/or by a single provider number within a tax ID.	N	N	Y	**D.1.4.5.4.1;** D.1.4.5-24	Y

40.6 Reference Requirements

40.6.1 Reference System Requirements

Requirement #	Requirement Description	A	B	C	D	E
40.6.1.45	Provides capability to maintain Reference Modifier information with effective and end dates including a sub-database/matrix by benefit plan that supports State/Fiscal Agent staff authorized access that includes, but is not limited to displaying: • narrative of Medicaid covered modifier noting by either date of service, date of processing or date of receipt, • applicable provider type/specialties (by effective/end dates), • type of modifier, pricing indicator, pricing percent, type of service crosswalk, applicable edit and audit numbers, • remarks specific to use of modifier and memo(s) or CSR number(s), • all modifier/modifier combinations with search capability, • all modifier/procedure code combinations with search capability, • all procedure code/modifier combinations with search capability, and • all standard modifiers with narrative and type (processing, pricing, crossover or informational), with effective and end date, memo or CSR number and search capability	N	Y	N	**D.1.4.6.4;** D.1.4.6-13	Y

40.7 Prior Approval Requirements

40.7.1 Prior Approval System Requirements

Requirement #	Requirement Description	A	B	C	D	E
40.7.1.65 **(New)**	Provides capability by a single LOB and benefit plan to limit the maximum cumulative dollars for a specific billing provider, or a specific billing and referring provider, or a specific billing and attending provider for services to be paid within a specific date range	N	N	Y	**D.1.4.8.5.3.3;** D.1.4.8- 42	Y
40.7.1.66 **(New)**	Provides capability by a single LOB and benefit plan to limit the maximum cumulative dollars paid for services for a specific recipient, or a specific recipient and billing provider, or a specific recipient and referring provider within a specific date range	N	N	Y	**D.1.4.8.5.3.3;** D.1.4.8-42	Y
40.7.1.67 **(New)**	Provides capability to indicate a status on a PA record (i.e., deny, track, or re-enter) which would indicate how the claim detail will process when the limitation on the PA is exceeded	N	Y	N	**D.1.4.7.3.4;** D.1.4.7-21	Y

40.8 Claims Processing Requirements

40.8.1 Claims Processing System Requirements

Requirement #	Requirement Description	A	B	C	D	E
	Determination of Financial Payer and Population Group					
40.8.1.119	Provides capability to edit for prior approval, referrals, and overrides whether or not	N	N	Y	**D.1.4.8.5.4.4;** D.1.4.8-48	Y

Requirement #	Requirement Description	A	B	C	D	E
	the prior approval, referral, or override information is entered on the claim					
40.8.1.138	Provides capability to edit an unlimited number of edits per claim and display and report a system-configurable number of failed edits per detail line	N	Y	N	**D.1.4.8.5.3.2;** D.1.4.8-33	Y
	General Claims Resolution					
Requirement Deleted 40.8.1.180	~~Provides capability to accept mass adjustments to suspended claims~~					
	Financial and Related Processing					
40.8.1.222	Provides capability to produce system-generated check registers and RAs and update control totals by single LOB and across multiple LOBs	N	Y	N	**D.1.4.14.2.3** D.1.4.14-13	Y
40.8.1.223	Provides capability to print provider voucher statements and checks by single LOB as well as across multiple LOBs as defined by the State	N	Y	N	**D.1.4.14.2.3** D.1.4.14-13	Y
40.8.1.230	Provides capability to create in each instance a single check or EFT per payment cycle for each provider across multiple LOBs	N	Y	N	**D.1.4.14.2.3** D.1.4.14-13	Y
Requirement Deleted 40.8.1.233	~~Provides capability to produce and distribute paper RAs formatted separately for individual provider types~~					
40.8.1.240	Provides capability to produce EFT register and ANSI 835 by single LOB as well as across multiple LOBs	N	Y	N	**D.1.4.14.2.3** D.1.4.14-13	Y

Requirement #	Requirement Description	A	B	C	D	E
	Financial Management and Accounting Business Area					
40.8.1.270	Provides capability for claims that have paid, denied, and (when requested by provider) suspended to be documented on the RA by single LOB or across multiple LOBs	N	N	N	**D.1.4.14.2.4** D.1.4.14-18	Y
40.8.1.298	Provides capability to post paid claims against Provider Earnings file	N	N	N	**D.1.4.14.2.3** D.1.4.14-15	Y
40.8.1.312	Provides capability for the issuance of a single provider check and/or EFT for all claims in the current checkwrite cycle across multiple LOBs	N	N	N	**D.1.4.14.2.3** D.1.4.14-13	Y
40.8.1.320	Provides capability to produce financial reports based on the checkwrite by single LOB and/or across multiple LOBs	N	N	N	**D.1.4.14.2.4** D.1.4.14-18	Y
40.8.1.382 **(New)**	Provides capability to process and track "$ 0 paid claims," as mandated by the Legislature, when specific LMEs receive funds outside the system	N	Y	N	**D.1.4.14.2.3** D.1.4.14-11 **D.1.4.14.2.3** D.1.4.14-12 **D.1.4.8.5.5.2** D.1.4.8-53	Y
	Financial and Related Processing					
40.8.1.383 **(New)**	Provides capability to store and display all of the eligible benefit plans associated with the claim detail, and indicate which benefit plan was used and which ones were considered	N	Y	N	**D.1.4.8.5.1** D.1.4.8-29 **D.1.4.14.2.3;** D.1.4.14-15	Y

40.8.2 Claims Processing Operational Requirements

Requirement #	Requirement Description	A	B	C	D	E
40.8.2.5	Fiscal Agent shall pick up and deliver mail to each Division's designated site as defined by the State: once in the morning, once in the afternoon of each State business day, and at the request of the State				**D.2.1.1.3.3;** D.2.1.1-7	Y

40.8.3 Claims Processing Operational Performance Standards

Requirement #	Requirement Description	A	B	C	D	E
40.8.3.10	Fiscal Agent shall adjudicate: 1. Ninety (90) percent of all clean claims for payment or denial within thirty (30) calendar days of receipt 2. Ninety-nine (99) percent of all clean claims for payment or denial within ninety (90) calendar days of receipt for DMA and DMH, and (forty-five [45] calendar days for DPH and ORHCC claims) 3. All non-clean claims within thirty (30) calendar days of the date of correction of the condition that caused the claim to be unclean	N	N	N	**D.2.1.1.6;** D.2.1.1-19	Y
40.8.3.16	Fiscal Agent shall adjudicate for payment all claims with date of service in previous State fiscal year by the State-designated checkwrite of the current State fiscal year	N	N	N	**D.2.1.1.6;** D.2.1.1-20	Y

40.12 Drug Rebate Requirements

40.12.1 Drug Rebate System Requirements

Requirement #	Requirement Description	A	B	C	D	E
40.12.1.5	Provides capability to determine the amount of rebates due by NDC, using paid claim data and eligible data from both the pharmacy program and NDCs from the physician drug program procedure codes	N	Y	N	**D.1.4.12.4.4;** D.1.4.12-10	Y

40.14 Financial Management and Accounting Requirements

40.14.1 Financial Management and Accounting System Requirements

Requirement #	Requirement Description	A	B	C	D	E
40.14.1.2	Provides capability to create [at LOB(s) level] withholds, advance payments, and recovery of advance payments by provider tax ID and/or by a single provider number within a tax ID	N	N	N	**D.1.4.14.2.7;** D.1.4.14-23 **D.1.4.14.2.11;** D.1.4.14-29	Y
40.14.1.14**	Provides capability to apply special "timely filing" edits at the end of the State fiscal year	N	N	N	**D.1.4.14.2.16;** D.1.4.14-38	Y

Statement of Objectives (SOO) Requirements Matrix

Section #	Page	Mandatory/ Non-Mandatory	Statement	Vendor will meet the requirement or objective (Y/N)	Proposal Page Reference(s)
10.1-1	1	M	…Vendor, who shall also operate the system and perform other Medicaid-related functions as the State's Fiscal Agent.	Y	C.1-2 D.2.1-1
10.1-2	2	M	The Replacement MMIS will expand claims payment functionality to include the DPH, ORHCC, DMA, and DMH.	Y	C.1-2 D.1.1-2 D.1.2-1 D.1.2-7 D.1.4.1-4 D.1.4.8-3 D.1.4.8-24 D.1.7-3
10.2-1	2	M	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.	Y	C.1-2 C.1-3 C.1-13 D.1.1-2 D.1.2-1 D.1.2-7 D.1.4.1-4 D.1.4.6-4 D.1.4.8-3 D.1.7-1 D.1.7-6 D.1.16-4

Section #	Page	Mandatory/ Non-Mandatory	Statement	Vendor will meet the requirement or objective (Y/N)	Proposal Page Reference(s)
10.2-2	2	M	...the Vendor shall provide a single Replacement MMIS solution to coordinate recipient benefit processing among DMA, DPH, DMH, and the Migrant Health Program.	Y	C.1-1 C.1-3 D.1.1-2 D.1.4.1-4 D.1.7-4 D.1.16-4 D.1.16-6
10.2-3	2	M	...ensure the proper assignment of the financially-responsible payer, benefit plan, and pricing methodology for each service tendered in a claim.	Y	D.1.4.1-4 D.1.4.6-5 D.1.4.8-27 D.1.7-6
10.2-4	2	M	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.	Y	D.1.4.1-4 D.1.4.6-6 D.1.7-2
10.2-5	2	M	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.	Y	D.1.4.1-4 D.1.4.8-27
10.2-6	2	M	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.	Y	D.1.4.1-4 D.1.4.6-4 D.1.4.6-5

Section #	Page	Mandatory/ Non-Mandatory	Statement	Vendor will meet the requirement or objective (Y/N)	Proposal Page Reference(s)
10.2-7	2	M	The selected Vendor shall use a hierarchy of payment criteria to determine the correct payer when multiple payers are involved.	Y	D.1.4.1-4 D.1.4.8-28
10.3.1-1	3	M	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.	Y	C.1-2 C.1-3 C.1-13 D.1.4.1-4 D.1.4.8-1 D.1.16-3
10.3.1-2	3	M	The successful Offeror shall present a solution to support health coverage programs for DMA, DPH, DMH, and ORHCC that is flexible in technological design.	Y	C.1-6 C.1-13 D.1.1-2 D.1.2-1 D.1.2-7 D.1.4.1-4 D.1.7-3 D.1.4.2-2
10.3.1-3	3	M	The solution(s) shall provide timely and accurate access to shared information while maintaining multi-payer measurements of recipient healthcare outcomes and services.	Y	C.1-13 D.1.1-2
10.3.1-4	3	M	...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.	Y	C.1-13 D.1.1-2 D.1.10-5 D.2.1-3

Section #	Page	Mandatory/ Non-Mandatory	Statement	Vendor will meet the requirement or objective (Y/N)	Proposal Page Reference(s)
10.3.2-1	3	M	...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.	Y	C.1-7 D.1.1-5
10.3.3-1	3	M	...the Replacement MMIS shall interact with DHSR processes and exchange data, beginning with early implementation services (as defined in subsection 10.6).	Y	D.1.1-3 D.1.4.2-19; D.2.1.3-7 D.2.1.5-12
10.3.3-2	4	M	...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.	Y	C.1-7 D.1.1-3 D.2.1.5-12
10.4-1	4	M	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.	Y	E.5-13
10.4-2	5	M	Offerors shall propose appropriate implementation dates based on their specific strategies.	Y	E.3-8 E.3-9

Section #	Page	Mandatory/ Non-Mandatory	Statement	Vendor will meet the requirement or objective (Y/N)	Proposal Page Reference(s)
10.4-3	5	M	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.	Y	F.1-2
10.5-1	5	M	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.	Y	Cost Proposal
10.5-2	5	M	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.	Y	Cost Proposal
10.5-3	5	M	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.	Y	Cost Proposal
10.5-4	5	M	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.	Y	D.1.16-3 Cost Proposal

Section #	Page	Mandatory/ Non-Mandatory	Statement	Vendor will meet the requirement or objective (Y/N)	Proposal Page Reference(s)
10.5-5	5	M	Offerors shall define key deliverables and appropriate payments associated with those activities for DDI.	Y	Cost Proposal
10.5-6	8	M	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)	Y	Cost Proposal
10.5-7	5	M	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.	Y	Cost Proposal
10.5-8	5	M	Milestone or delivery approval dates shall reflect a reasonable duration for the State to review and approve any necessary items required for payment.	Y	Cost Proposal
10.5-9	6	M	Offerors shall not include the licensing, maintenance, or support costs of such software products [that the State intends to acquire through Enterprise License Agreements] in its Cost Proposal.	Y	Cost Proposal

Section #	Page	Mandatory/ Non-Mandatory	Statement	Vendor will meet the requirement or objective (Y/N)	Proposal Page Reference(s)
10.7-1	6	M	The Replacement MMIS requires additional services and technological enhancements that are not currently offered by the Legacy MMIS+ and/or legacy processes.	Y	C.1-1 D.1.2-1 D.1.2-7 D.1.4.5-3 D.1.5-3 D.1.8-1 D.1.10-4 D.1.16-3
10.7-2	6	M	Offerors considering early implementation shall detail the options, benefits, costs, risks and impact on the Replacement MMIS.	Y	D.1.4.5-3 D.1.8-7
10.7-3	7	M	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.	Y	D.1.4.5-3 D.1.8-2
10.7-4	7	M	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 provider system when it is ready for implementation.	Y	D.1.8-2
10.7-5	7	M	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.	Y	D.1.8-2

Section #	Page	Mandatory/ Non-Mandatory	Statement	Vendor will meet the requirement or objective (Y/N)	Proposal Page Reference(s)
10.8-1	7	M	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 methods they use to ensure the quality of these data.	Y	C.1-8 D.1.16-3 D.1.16-7 D.1.16-9 E.5-5
10.8-2	7	M	The Vendor shall provide the State on-line access to current versions of all of this information. [as listed in the row directly above]	Y	C.1-8 D.1.10-5
10.8-3	7	M	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.	Y	C.1-8 C.1-14 D.1.16-3 D.1.16-7 D.1.16-9 E.2-2
10.8-4	7	M	The Offerors shall create and maintain 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.	Y	C.1-14 E.3-1 D.1.16-7 D.1.16-10
10.8-5	7	M	The Offerors shall create and maintain financial reporting via an Earned Value Management System (EVMS).	Y	C.1-8 E.1-22
10.8-6	8	M	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.	Y	E.1-25 E.1, App. A-1

Section #	Page	Mandatory/ Non-Mandatory	Statement	Vendor will meet the requirement or objective (Y/N)	Proposal Page Reference(s)
10.8-7	8	M	The Offerors shall create and maintain a risk and issue management system in which the State is integrated as a partner.	Y	D.1.16-17 E.7-3
10.8-8	8	M	This process [risk and issue management system] shall include elements of risk and issue identification, evaluation, mitigation, and reporting, and shall be responsive across the spectrum of risks and issues.	Y	D.1.16-17 E.7-3 E.7-9 E.7-11 E.7-12 E.7-13
10.8-9	8	M	The formats of documents created during DDI are at the discretion of the Vendors; samples shall be provided as part of the Technical Proposals.	Y	E.1-23
10.8-10	8	M	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.	Y	E.1-23 E.7-13 J.4-2
10.8-11	8	M	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.	Y	C.1-7 C.1-15 E.1-5
10.8-12	8	M	Vendors shall maintain a collaborative online tool to facilitate information sharing.	Y	C.1-7 E.1-5
10.8-13	8	M	The formats of posted data shall be coordinated with and approved by the State to ensure compatibility with applications used by the State.	Y	E.1-23

Section #	Page	Mandatory/ Non-Mandatory	Statement	Vendor will meet the requirement or objective (Y/N)	Proposal Page Reference(s)
10.8-14	8	M	The Offerors shall propose a plan for Program Management Reviews to include their planned content and frequency.	Y	C.1-10 E.1-30
10.8-15	8	M	...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.	Y	E.1-31
10.8-16	8	M	The Vendor shall support the State in providing other reasonable data needed for budgeting and reporting.	Y	E.1-23
10.8-17	8	M	The State requires the successful Offeror to ensure timely and appropriate communications among all stakeholders during DDI, including the provider community.	Y	D.1.16-8 E.6-12
10.8-18	8	M	...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.	Y	D.1.16-8 E.6-3 E.6-14
10.8-19	8	M	...the MMIS Replacement Vendor shall serve as the the System Integrator.	Y	C.1-7
10.8-20	8	M	...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.	Y	C.1-7 D.1.1-3

Section #	Page	Mandatory/ Non-Mandatory	Statement	Vendor will meet the requirement or objective (Y/N)	Proposal Page Reference(s)
10.8-21	9	M	The Vendor shall manage the Change Control Board process.	Y	E.9-1 E.9-16
10.8-22	9	M	Offerors shall propose a process that efficiently and effectively manages technical, programmatic, and operational changes within the overall program.	Y	C.1-14 D.1.16-9 D.1.16-10
10.9-1	9	M	The Vendor shall maintain engineering processes that support requirements analysis, design, construction, testing, data conversion and data migration, and implementation of the system.	Y	D.1.14-18 D.1.16-9
10.9-2	9	M	The Vendor shall also establish practices suitable for life-cycle support of the system including change management.	Y	D.1.14-18 D.1.16-3
10.9-3	9	NM	The Vendor's systems engineering processes should include active management of those technical elements influencing Total Cost of Ownership (TCO), and seek to minimize them while still meeting the State's requirements.	Y	D.1.12-2 D.1.12-5 D.1.14-3
10.9-4	9	M	Offerors shall describe the State's role in their systems engineering processes.	Y	D.1.14.1-3

Section #	Page	Mandatory/ Non-Mandatory	Statement	Vendor will meet the requirement or objective (Y/N)	Proposal Page Reference(s)
10.9-5	9	M	To reduce risk on the project, the State requires a staged-delivery process.	Y	C.1-14 D.1.1-3 D.1.2-6 D.1.2-7 D.1.5-1 D.1.14-5 D.1.5-1 D.1.5-2 D.1.16-7
10.9-6	9	M	Offerors shall describe their strategies for this [Staged-Delivery] process to include the number of stages and their contents as well as the key risks to be mitigated.	Y	C.1-14 D.1.1-3 E.8-10
10.9-7	9	M	...the Vendor shall provide remote access to the software from the latest completed stage to the State.	Y	C.1-12 C.1-14 D.1.1-3
10.9-8	9	M	During requirements analysis, the Vendor shall provide remote access to the baseline system to facilitate the users' understanding of it.	Y	D.1.9.2
10.9-9	9	M	Offerors shall propose systems that align with [the principles and practices of the State Technical Architecture (STA) as much as is technically and fiscally reasonable.	Y	D.1.2-5 D.1.10-2

Section #	Page	Mandatory/ Non-Mandatory	Statement	Vendor will meet the requirement or objective (Y/N)	Proposal Page Reference(s)
10.9-10	9	M	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.	Y	C.1-13 D.1.1-4 D.1.2-1 D.1.2-5 D.1.2-7 D.1.4.1-3 D.1.5-1 D.1.10-4
10.9-11	10	NM	Offerors are encouraged to consider MITA principles, standards, and architecture configuration in their technical approach to the North Carolina Replacement MMIS.	Y	D.1.1-4 D.1.2-5 D.1.7-1 D.1.10-1 D.1.16-7 D.1.16-9
10.9-12	10	M	Offerors shall propose solutions that externalize the management of these [business] rules as much as practical, such as using a business rules engine.	Y	D.1.1-6 D.1.2-5 D.1.4.6-4 D.1.4.6-7 D.1.4.6-9 D.1.4.6-10 D.1.4.6-11 D.1.4.6-12 D.1.4.6-22 D.1.5-3
10.9-13	10	M	Offerors shall propose methods to allow the analysis of changes to these [business] rules without changing the production system, and shall describe how changes will be tested thoroughly prior to their implementation in the production system.	Y	D.1.4.1-30 E.4-19

Section #	Page	Mandatory/ Non-Mandatory	Statement	Vendor will meet the requirement or objective (Y/N)	Proposal Page Reference(s)
10.9-14	10	NM	Offerors should propose systems and operations that are as compliant with the Statewide Information Technology Security Manual and Federal requirements as is practical.	Y	D.1.1-4 D.1.4.1-10 D.1.2-5 H-2 H-3 H-11 H-17
10.9-15	10	M	…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.).	Y	D.1.4.1-2 D.1.4.1-10 D.1.4.1-11 D.1.4.1-13 D.1.4.1-37 D.1.5-3
10.9-16	10	M	Offerors shall describe their strategies for successfully completing data conversion and data migration to support development, testing, certification, and long-term operations.	Y	D.1.15-4 D.1.15-10 D.1.15-13 D.1.15-15 D.1.16-17
10.9-17	10	M	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.	Y	D.1.14-29 D.1.14-45 E.4-1 E.4-17
10.9-18	10	M	...testing within a realistic operating environment-to include load testing and security testing-is required	Y	D.1.14-27 D.1.4.1-30 E.4-7

Section #	Page	Mandatory/ Non-Mandatory	Statement	Vendor will meet the requirement or objective (Y/N)	Proposal Page Reference(s)
10.9-19	10	NM	The testing and quality assurance programs should emphasize the removal of defects at the earliest practical stage as well as continual improvement.	Y	C.1-10 D.1.14-44 D.1.16-5 E.4-19 E.5-12 E.5-24
10.9-20	11	M	Offerors should assume that this [User Acceptance Testing (UAT)] 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).	Y	D.1.16-7 D.1.16-15 E.4-16
10.9-21	11	M	...the Vendor shall be required to perform planning and evaluation on detailed activities normally performed by the Fiscal Agent.	Y	E.4-16
10.9-22	11	M	The Vendor will be asked to make at least one change to the system during this test to evaluate the change management process and its impact on operations	Y	E.4-16
10.9-23	11	M	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.	Y	E.4-6 E.5-12
10.9-24	11	M	The Vendor shall support this [early] testing with equipment, data, facilities, and streamlined training during early development as well as the Operations Phase.	Y	D.1.2-7 D.1.5-1 D.1.5-2 E.4-6

Section #	Page	Mandatory/ Non-Mandatory	Statement	Vendor will meet the requirement or objective (Y/N)	Proposal Page Reference(s)
10.9-25	11	M	The Vendor shall provide Internet access at the Vendor's facility for use by State personnel.	Y	D.1.9-3 D.2.2-2
10.10-1	11	M	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.	Y	D.1.13-2 D.1.16-21
10.10-2	11	M	…[this warranty] shall include at minimum the provisions set forth in Section 30.21(b) and 30.21(g) of this RFP.	Y	D.1.13-2
10.10-3	11	M	The Vendor shall retain an organizational structure capable of maintaining and updating the system software during the Operations Phase.	Y	D.1.16-3 E.5-25
10.10-4	11	M	Offerors shall plan for 100,080 hours per year for software CSRs and indicate the cost of those hours in their Cost Proposals.	Y	E.5-25
10.10-5	11	M	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.	Y	D.1.4.5-27 D.1.16-5 D.1.16-18 D.4-1 E.5-5 E.5-20
10.10-6	11	M	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.	Y	D.1.4.5-27 D.1.16-5 D.1.16-18 D.4-1

Section #	Page	Mandatory/ Non-Mandatory	Statement	Vendor will meet the requirement or objective (Y/N)	Proposal Page Reference(s)
10.10-7	11	M	This training capability must be available in time to support testing and remain current and available throughout the Operations Phase.	Y	D.1.16-5 D.1.16-18 D.4-4
10.10-8	12	NM	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.	Y	D.1.4.5-28 D.4-8 D.4-13
10.10-9	12	M	This [training] solution shall include online access to materials and training news.	Y	D.1.4.5-26; D.1.4.5-27; D.1.4.5-30 D.4-18
10.10-10	12	M	...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.	Y	D.1.4.5-28 D.4-7 D.4-18
10.10-11	12	M	The Vendor shall establish a local facility for its staff to be used during DDI and Operations within (15) miles of the NC DHHS headquarters.	Y	D.1.9-1 D.2.2-1
10.10-12	12	M	This [local] facility shall house the Vendor's key personnel and requirements analysis staff.	Y	D.1.9-1 D.2.2-2
10.10-13	12	M	The Vendor shall provide [the space for hosting of large meetings].	Y	D.1.9-2 D.2.2-5 K-2

Section #	Page	Mandatory/ Non-Mandatory	Statement	Vendor will meet the requirement or objective (Y/N)	Proposal Page Reference(s)
10.10-14	12	M	The vendor shall hire sufficient numbers of qualified personnel to support the Operations Phase.	Y	D.1.16-3 E.5-7 E.5-11 E.5-18 E.5-19 E.5-20 F.1-2
10.10-15	12	M	The Vendor shall be responsible for all costs associated with operating and maintaining its Fiscal Agent operations.	Y	F.1-2
10.10-16	12	M	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.	Y	G-1
10.10-17	12	M	These [Contract] deliverables shall be included in a Contract Data Requirements List (CDRL).	Y	G-1
10.10-18	12	M	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 in the CDRL.	Y	G-1 G-2
10.10-19	12	M	...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.	Y	G-1
10.11-1	12	M	...the State must secure sufficient rights to all custom and customized software to allow it to support the system internally or via another vendor.	Y	D.1.11-2

Section #	Page	Mandatory/ Non-Mandatory	Statement	Vendor will meet the requirement or objective (Y/N)	Proposal Page Reference(s)
10.11-2	12	M	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.	Y	D.1.11-2
10.11-3	12	M	Commercial licenses shall be provided for products and services for which the Vendor does not have greater rights.	Y	D.1.11-2
10.12.1-1	12	M	The Vendor shall be responsible for the Fiscal Agent delivery and support of all operational services in the most efficient and effective manner.	Y	D.2.1-1 J.1-20
10.12.1-2	13	M	Offerors shall describe their approach to operations management and how it will succeed.	Y	F.1-2 J.1-20
10.12.1-3	13	M	The Vendor shall acquire and maintain the required staff needed to perform Fiscal Agent duties.	Y	E.5-20 F.1-2 J.1-20
10.12.1-4	13	M	...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.	Y	D.4-14
10.12.1-5	13	M	Offerors shall describe their planned organization, along with the key roles and responsibilities.	Y	D.1.16-13 E.5-25
10.12.1-6	13	M	Offerors shall propose a plan for operations management reviews, including their frequency and general content.	Y	F.1-16

Section #	Page	Mandatory/ Non-Mandatory	Statement	Vendor will meet the requirement or objective (Y/N)	Proposal Page Reference(s)
10.12.1-7	13	M	Offerors shall develop metrics to these performance standards specified by the State or accepted by the State from the Offeror's Proposal].	Y	D.1.16-3 F.1-13
10.12.1-8	13	M	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.	Y	F.1-15 F.1-16
10.12.1-9	13	M	The Vendor shall give the State on-line access to current versions of these performance metrics and the metrics developed by the Vendor as well as its internal performance measurements.	Y	D.2.1-3 E.1-23 F.1-15
10.12.1-10	13	M	The Vendor shall also provide the State with significant visibility into ongoing operations.	Y	C.1-12 D.1.16-5 D.2.1-3
10.12.1-11	13	M	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.	Y	E.7-20
10.12.1-12	13	M	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.	Y	E.7-21 F.4-1 H-2 H-5

Section #	Page	Mandatory/ Non-Mandatory	Statement	Vendor will meet the requirement or objective (Y/N)	Proposal Page Reference(s)
10.12.1-13	13	M	Issue management during the Operations Phase must 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.	Y	E.7-21
10.12.1-14	13	M	The Vendor shall continue the change management process initiated during DDI into Fiscal Agent operations.	Y	E.9-1
10.12.1-15	13	M	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.	Y	D.4-15 E.9-12
10.12.1-16	14	M	The Vendor shall continue to manage the Change Control Board [during operations] with the State retaining the position of chairperson.	Y	E.9-16
10.12.1-17	14	M	The Vendor shall serve in the role of system integrator during Fiscal Agent operations.	Y	C.1-7
10.12.1-18	14	M	The Vendor shall also continue to support coordination efforts of organizations and business processes [during operations].	Y	D.2.1-3
10.12.1-19	14	M	The Vendor shall be responsible for initiating and coordinating all workflow processes, including those having responsibilities assigned to the State and external organizations	Y	D.2.1.2-9 D.2.1. 4-27

Section #	Page	Mandatory/ Non-Mandatory	Statement	Vendor will meet the requirement or objective (Y/N)	Proposal Page Reference(s)
10.12.1-20	14	M	Consistent with the technical requirements, the State requires automated online management and reporting of those workflows [as stated in the line directly above] where practical and appropriate.	Y	D.2.1-2
10.12.1-21	14	M	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	Y	D.1.4.6-6
10.12.1-22	14	M	Scheduling shall include system job flow activities, distribution activities, and other periodic activities such as training and audits.	Y	F.1-2
10.12.1-23	14	M	The Vendor shall ensure that product inventories and State-specific forms inventories needed to perform Fiscal Agent operational requirements are maintained at consistent levels.	Y	D.2.1.1-8
10.12.1-24	14	M	The Vendor shall staff, operate, and monitor mail room activity at the Fiscal Agent operational site.	Y	D.2.1.1-7 E.5-22
10.12.1-25	14	M	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.	Y	D.2.1.1-6
10.12.1-26	14	M	The Vendor shall provide and maintain a secure operations environment as defined by the DHHS Security Policies and Standards. Vendor operations and systems shall be subject to an internal audit any time deemed necessary by the State.	Y	D.1.1-4 H-15 H-18

Section #	Page	Mandatory/ Non-Mandatory	Statement	Vendor will meet the requirement or objective (Y/N)	Proposal Page Reference(s)
10.12.1-27	14	M	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 Funding Participation (FFP) splits.	Y	D.1.4.14-39 F.1-2
10.12.1-28	14	M	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.	Y	F.1-17
10.12.1-29	14	M	The [SAS 70] 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.	Y	F.1-17
10.12.2-1	15	M	...the new and legacy operating entities must work jointly to ensure that these [turnover and implementation] activities are as transparent to users as feasible.	Y	I-1 I-8
10.12.2-2	15	M	...it [the MMIS system] shall have no down time that affects the users' ability to conduct their day-to-day business during [deployment/rollout and turnover]...	Y	I-1 I-2
10.12.2-3	15	M	Both deployment/rollout and turnover approaches shall be part of the proposals submitted by each Offeror followed by completed plans during the DDI Phase.	Y	I-1 I-2 I-3 I-8

Section #	Page	Mandatory/ Non-Mandatory	Statement	Vendor will meet the requirement or objective (Y/N)	Proposal Page Reference(s)
10.12.2-4	15	M	Offerors shall describe the activities that will be performed [during deployment/rollout and turnover] to ensure that required system and operational documentation will be created, maintained, and available to support a knowledge transfer of the information.	Y	I-1 I-3 I-4 I-8
10.12.2-5	15	M	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.	Y	I-7 I-8 I-9
10.12.2-6	15	M	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.	Y	I-7 I-11
10.12.2-7	15	M	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 the IMS for the DDI effort.	Y	E.2-2 E.3-1 I-4 I-7 I-8

Section #	Page	Mandatory/ Non-Mandatory	Statement	Vendor will meet the requirement or objective (Y/N)	Proposal Page Reference(s)
10.12.2-8	15	M	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.	Y	D.1.13-3 I-12
10.12.2-9	15	M	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.	Y	E.6-2 E.6-8 F.6-1 I-5
10.12.3-1	15	M	the Vendor shall perform managed care and other benefit plan enrollment processing and consolidate the data into a common recipient database.	Y	D.1.4.9-5
10.12.3-2	15	M	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.	Y	D.2.1.1-6
10.12.3-3	15	M	The Vendor shall manage processes and activities related to the MMA, SCHIP, and EPSDT Program.	Y	D.1.4.10-2 D.2.1.3-44

Section #	Page	Mandatory/ Non-Mandatory	Statement	Vendor will meet the requirement or objective (Y/N)	Proposal Page Reference(s)
10.12.3-4	15	M	the Vendor shall manage the determination billing and collection of premium payments and cost-sharing amounts.	Y	D.1.4.11-13
10.12.3-5	15	M	...the system must capture the FFP [Federal Financial Participation] rate for each recipient based on program eligibility and category of service.	Y	D.1.4.14-18
10.12.3-6	16	M	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.	Y	D.1.4.3-4 D.1.4.3-7
10.12.3-7	16	M	It [Recipient business area] must also include an Automated Voice Response System (AVRS) for use by providers and recipients to verify recipient eligibility and enrollment information.	Y	D.1.4.4-10
10.12.3-8	16	M	...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.	Y	D.1.4.4-8
10.12.4-1	16	M	The Vendor shall provide an enrollment process that is streamlined and easy to understand and complete	Y	D.1.4.5-3 D.2.1.3-4
10.12.4-2	16	M	The Vendor shall conduct provider enrollment and maintenance activities for NC DHHS health care and atypical providers.	Y	D.1.4.5-11 D.2.1.3-11

Section #	Page	Mandatory/ Non-Mandatory	Statement	Vendor will meet the requirement or objective (Y/N)	Proposal Page Reference(s)
10.12.4-3	16	M	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.	Y	D.2.1.3-14
10.12.4-4	16	M	Enrollment processes must employ a consolidated provider agreement that is flexible and scalable enough for use by all provider types including atypical providers.	Y	D.2.1.3-4
10.12.4-5	16	M	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.	Y	D.1.4.5-9 D.1.4.5-10 D.2.1.3-12
10.12.4-6	16	M	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.	Y	D.1.4.5-21; D.2.1.3-7
10.12.4-7	16	M	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.	Y	D.1.4.5-3; D.1.4.5-20
10.12.4-8	16	M	Provider maintenance processes must include validation that health care providers continue to meet and maintain NC DHHS participation standards.	Y	D.1.4.5-22; D.2.1.3-7

Section #	Page	Mandatory/ Non-Mandatory	Statement	Vendor will meet the requirement or objective (Y/N)	Proposal Page Reference(s)
10.12.4-9	16	M	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.	Y	D.1.4.5-22; D.2.1.3-11; D.2.1.3-14
10.12.4-10	16	NM	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.	Y	D.1.4.1-17 D.1.4.5-6; D.1.4.5-8; D.1.4.5-10; D.1.4.5-21; D.1.4.5-23; D.1.4.5-26; D.1.4.5-31; D.2.1.3-6; D.2.1.3-12
10.12.4-11	16	M	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.	Y	D.1.4.5-27; D.1.4.5-31; D.2.1.3-23 D.2.1.4-10
10.12.4-12	16	M	Vendor representatives shall conduct multiple training workshops; participate in an annual Medicaid Fair; participate in the semi-annual DMH LME FARO meetings; and initiate and conduct individual on-site provider training as appropriate and/or requested by the provider or the State.	Y	D.1.4.5-28 D.2.1.3-24 D.4-6 D.4-14 D.4-15

Section #	Page	Mandatory/ Non-Mandatory	Statement	Vendor will meet the requirement or objective (Y/N)	Proposal Page Reference(s)
10.12.4-13	17	M	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.	Y	D.1.4.5-11 D.1.4.5-15
10.12.4-14	17	M	The system must also support the ability to accept provider enrollment records for attending providers from LMEs for participation within the DMH program.	Y	D.1.4.5-17
10.12.4-15	17	M	...the system must include conversion of the intelligence embedded in the legacy provider identification numbers and in provider type and specialty categories.	Y	D.1.4.5-18
10.12.5-1	17	M	The Vendor shall implement claims processing procedures that facilitate processing efficiencies through claims control, data verification, and flexible, business rules management.	Y	D.1.1-6 D.1.4.8-7 D.2.1.1-12
10.12.5-2	17	M	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.	Y	D.1.4.8-6 D.2.1.4-7
10.12.5-3	17	M	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.	Y	D.1.4.8-23
10.12.5-4	17	M	The system shall adjudicate claims by determining service line item benefit plan eligibility, service rules, and limitations.	Y	D.1.4.1-4 D.1.4.8-27

Section #	Page	Mandatory/ Non-Mandatory	Statement	Vendor will meet the requirement or objective (Y/N)	Proposal Page Reference(s)
10.12.5-5	17	M	The system shall edit claims using the enrolled provider, benefit plan, recipient history, and correct coding rules.	Y	D.1.4.8-22
10.12.5-6	17	M	The system shall determine claims pricing, funding source, financial encumbrance, and reporting.	Y	D.1.4.8-48 D.1.4.8-51 D.1.7-5
10.12.5-7	17	M	The system shall process and differentiate the non-claim related transactions that are system generated to capture management fees associated with various types of services.	Y	D.1.4.8-66
10.12.5-8	17	M	All claims, including point-of-sale claims shall be processed in concert with MMIS claims to avoid duplicate payments for the same services.	Y	D.1.4.8-22 D.1.4.8-80
10.12.5-9	17	M	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.	Y	D.1.4.7-1
10.12.5-10	17	M	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.	Y	D.1.4.7-6 D.1.4.7-8 D.1.4.7-31
10.12.5-11	18	M	The Vendor shall also receive and process managed care referrals, override requests, and crossover claims.	Y	D.1.4.7-5

Section #	Page	Mandatory/ Non-Mandatory	Statement	Vendor will meet the requirement or objective (Y/N)	Proposal Page Reference(s)
10.12.5-12	18	M	For non-Fiscal Agent directed prior approval requests, the Vendor shall receive and manage adjudicated prior approval information from external interfaces.	Y	D.1.4.7-7
10.12.5-13	18	M	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.	Y	D.2.1.4-5
10.12.5-14	18	M	The Vendor shall ensure that the 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.	Y	D.1.4.11-1 D.2.1.2-13
10.12.5-15	18	M	The Vendor shall support these [EPSDT] requirements in the system as well as in Fiscal Agent operations.	Y	D.1.4.10-1 D.2.1.3-44
10.12.6-1	18	M	The Vendor shall provide an enterprise-wide financial management and accounting solution that will allocate all financial transactions by Federal, State, and county shares.	Y	D.1.4.14-1
10.12.6-2	18	M	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.	Y	D.2.1.2-6 D.2.1.2-9 D.2.1.2-19

Section #	Page	Mandatory/ Non-Mandatory	Statement	Vendor will meet the requirement or objective (Y/N)	Proposal Page Reference(s)
10.12.6-3	18	M	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 program data and interfaces.	Y	D.1.4.14-37 D.2.1.2-20
10.12.6-4	18	M	[The system] 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.	Y	D.2.1.2-8; D.2.1.2-11
10.12.6-5	18	M	The system shall interface with the North Carolina Accounting System (NCAS) to update financial transactions and determine fund balances.	Y	D.1.4.14-6 D.2.1.2-6 D.2.1.2-19
10.12.6-6	18	M	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.	Y	D.1.4.12-2 D.2.1.4-24 D.2.1.4-25 D.2.1.4-26
10.12.6-7	18	M	If a manufacturer invoice requires adjustment, the system must ensure that the appropriate claim adjustments are also made.	Y	D.1.4.12-6

Section #	Page	Mandatory/ Non-Mandatory	Statement	Vendor will meet the requirement or objective (Y/N)	Proposal Page Reference(s)
10.12.6-8	18	M	Regardless of the source, 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.	Y	D.1.4.14-35
10.12.7-1	19	M	The Vendor shall maintain the Replacement MMIS Reference File, respond to file maintenance requests from NC DHHS, and perform quality control reviews.	Y	D.2.1.4-4 D.1.4.6-1
10.12.7-2	19	M	The system should be configurable to adapt to changes in NC DHHS policies and services and must allow for centralized control over data modifications.	Y	D.2.1.4-4 D.1.4.6-1 D.1.4.6-6 D.1.4.6-7 D.1.4.6-9 D.1.4.6-10 D.1.4.6-11 D.1.4.6-12 D.1.4.6-13 D.1.4.6-14
10.12.8-1	19	M	...the Vendor shall support Medicaid Eligibility Quality Control (MEQC) requirements.	Y	D.1.4.8-90

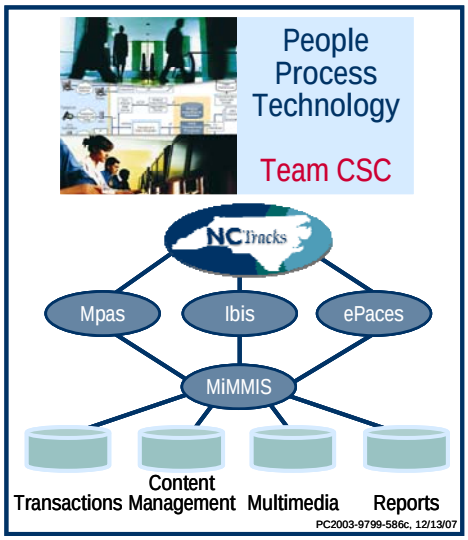
Section #	Page	Mandatory/ Non-Mandatory	Statement	Vendor will meet the requirement or objective (Y/N)	Proposal Page Reference(s)
10.12.8-2	19	M	The MEQC activity is based on random-sampling techniques. The Vendor's solution shall support the processing required to accumulate, select, and report the data in the sample.	Y	D.1.4.8-90
10.12.9-1	19	M	The Vendor shall produce all Medicaid Management and Administrative Reports required for CMS certification and, quarterly produce the Federal Medicaid Statistical Information System (MSIS) extract files, as required by CMS, using only Medicaid data.	Y	D.1.4.13-9
10.12.9-2	19	M	...both the State and the counties participate in the Medicaid cost; therefore, the State seeks a solution that incorporates this breakdown in MARS reporting.	Y	D.1.4.13-9

D.1.18 ADJUSTED FUNCTION POINT COUNT

The combination of our Gap Analysis (see Integrated Master Schedule), IMS planning and data in the State Requirements Matrix all demonstrate that the Team CMS baseline system meets or exceeds the vast majority of Replacement MMIS requirements.

D.1.18.1 CSC and Function Points

CSC has been a corporate worldwide member of the International Function Point Users Group (IFPUG) for over 10 years. Currently we have employees serving as a member of the board of directors of IFPUG, chairman of the communications and marketing committee and a member of the management reporting committee. CSC has 10 certified function point specialists working on various accounts worldwide. Function points are used to manage application portfolios, estimate projects and track productivity service levels.



D.1.18.2 Background

This section contains Appendix 50, Attachment C, Exhibit 2. We used this table to estimate a count of function points organized by Business/ Functional Areas listed in the table.

The model to estimate function points was developed by analyzing the requirements from the RFP as outlined below. An unadjusted function point count was derived using the average complexity values for function point transactions as defined by the IFPUG Counting Practices Manual, version 4.2.

The model separated these unadjusted function points into the three types requested in the RFP:

- Baseline Adjusted FP (Configuration required via manual table updates). The proposed system fully satisfies the RFP requirement with no coding changes.
- Enhancement Adjusted FP (Software modification required). The proposed system partially satisfies the RFP requirement and some coding changes are necessary. Typically the modification involves adding additional data to a report or input screen.
- New Capabilities Adjusted FP (New functionality via software modification). The proposed system does not address the RFP requirement and new code will be developed.

A Value Adjustment Factor (VAF) was obtained from a Subject Matter Expert (SME) for the system who answered the fourteen General Systems Characteristics questions as defined by the IFPUG Counting Practices Manual, version 4.2. This value (1.20)

was used to multiply the unadjusted function points to get an estimated adjusted value.

D.1.18.3 Requirements Analysis

The function point analysis was performed after a through in-depth review of each RFP requirement. The first review of the requirements was intended to identify significant impacts to the baseline MMIS. The review was conducted by Operational staff as well as System and IT personnel all with extensive knowledge of Medicaid and the baseline system. This first review was used to earmark gaps within the baseline that would need to be filled with third-party applications and staffing solutions. While it was determined that the baseline system and team capabilities could satisfy the vast majority of requirements, the first review identified the need for such items as provider credentialing services, single sign-on and expanded workflow capability. After identifying the gaps we selected specific companies for Team CSC that could augment the capability of our baseline system. These vendors and teammates validated data in our initial analysis. All of this information was captured and used as input into the appropriate entries in the State Requirements Matrix.

For those requirements where third-party support was not needed, key technical and operational eMedNY staff assigned each requirement into one of three groupings:

1) Requirement was understood as stated (No additional research was required to understand the meaning and scope). Baseline MMIS experts were then able to directly determine the work, if any, that would be required to modify the baseline system to fully satisfy the requirement. Documentation was captured to support the estimate as well define the approach.
2) Clarification needed (Basic framework understood, more follow up was necessary to fully understand the scope). For the requirements where clarification was needed, eMedNY experts utilized the information provided in the Detailed System Design (DSD) to flush out the scope of the requirement and to understand the impact to the baseline MMIS. Through the use of the RFP and DSD, baseline experts defined an approach to satisfying the requirement as well as estimate the level of work needed if any.
3) Functionality all new (Full extent of requirement not known). For these requirements, eMedNY experts once again utilized the DSD to understand the direction North Carolina was taking previously. Furthermore, detailed discussion were conducted with Biz-Logic staff with detailed knowledge of North Carolina Medicaid and Multi-Payor direction, to reach consensus on the requirement scope. This provided the estimation team, sufficient knowledge to properly define a solution and assess the effort. As a result of this activity, the baseline SMEs developed an initial approach and a level of effort required to satisfy each requirement. This analysis resulted in a set of data files that contained the requirement and whether it was met, partially met or a new requirement.

D.1.18.4 Input Data Files

The following spreadsheets were used as input data to the function point estimate model. They are from three different sources in the NC MMIS RFP; Section 40 [40.2

through 40.14], Appendix 40, Attachment G [Reports] and Appendix 40, Attachment H [Interfaces].

Numbered Requirements:

- All AVR Requirements v 1.4
- All Claims Requirements v 1.3
- All Drug Rebate Requirements v 1.0
- All EVS Requirements v 1.0
- All Financial Requirements v 1.0
- All Health Check Requirements v 1.0
- All Managed Care Requirements v 1.4
- All MARS Requirements v 1.0
- All PA Requirements v 1.0
- All Provider Requirements v 1.0
- All Recipient Requirements v 1.0
- All Reference Requirements v 1.0
- All Third Party Liability Requirements v 1.2

The breakdown of records was:

AVRS	49
Claims	365
Drug Rebate	111
EVS	14
Financial	317
Health Check	38
Managed Care	50
MARS	38
Prior Approval	110
Provider	188
Recipient	106
Reference	102
TPL	100

Report Requirements:

- Report Requirements Worksheet v 1

There were 1,978 report records.

Interface Requirements:

- Interface Requirements Worksheet v 1.2

There were 157 interface records.

Out of Scope

- NC MMS Requirements (Potential Pega Solution) v4

This file contained requirement numbers that already existed in other requirement files and was not used.

D.1.18.5 Process

An individual tab was created for each Business/ Functional Area with the following synonyms:

Recipient	Client
EVS	Electronic Commerce
AVRS	
Provider	Provider
Reference	Reference
Prior Approval	Prior Authorization
Claims	Claims Processing
Managed Care	
Health Check	EPSDT
TPL	Third Party Liability
Drug Rebate	Drug Rebate
MARS	MAR
Financial	Financial

The tab template calculates function points (FPs) based on average complexity for each transaction type: External Input (Add, Change, Delete) [EI = 4 FPs], External Inquiry [EQ = 4 FPs] and External Output [EO = 5 FPs].

If an EI (Change or Delete) occurs, an EQ is also counted.

All EI (Delete) transactions are Low Complexity [3 FPs].

The FPs were assigned one of three types, Baseline, Enhancement and New Capability based on the following words in the Data Files:

FP Type	Requirement Match
Baseline	Meets
Enhancement	Partial

FP Type	Requirement Match
New Capability	New

All the reports were counted as EOs

The interfaces were counted as indicated:

Input	EI (A, C, D) and EQ
Output	EO

For **Requirements** files, only System Requirements were counted. Operational and Operational Performance Requirements were ignored since they don't have any function points associated with them. Each requirement was further analyzed and categorized in one of the following:

- EI: External Input (A, C, D) and External Query
- EO: External Output
- EQ: External inquiry
- NA: Not Applicable – no function points assigned

The **Interface** Requirements file was sorted by eMed Subsystem and records were parsed to individual tabs.

The **Reports** Requirements file was sorted by eMed Subsystem and records were parsed to individual tabs.

APPENDIX 50, ATTACHMENT C, EXHIBIT 2 (Comment CSC9)

Business/Functional Area	Baseline Adjusted FP	Enhancement Adjusted FP	New Capabilities Adjusted FP	Notes
Recipient	338	153	475	
EVS	35	11	6	
AVRS	90	0	58	
Provider	922	0	394	
Reference	768	453	192	
Prior Approval	404	138	160	
Claims	2,687	316	308	
Managed Care	14	6	209	
Health Check	491	102	84	
TPL	1,128	31	484	
Drug Rebate	719	56	112	
MARS	273	47	12	
Financial	2,609	194	292	
Multi-Payer Requirements	30	66	40	
Data Transfer and Conversion	0	0	0	No requirements in RFP found that have FPs for this Functional Area.
Interfaces	1,914	0	0	
Architecture	5	0	0	
System Software Controls	0	0	0	No requirements in RFP found that have FPs for this Functional Area.
User Interface and Navigation	0	0	0	No requirements in RFP found that have FPs for this Functional Area.
Document Management and Correspondence Tracking	41	0	54	
Audit Trail	28	72	36	
Online Help	0	0	0	No requirements in RFP found that have FPs for this Functional Area.
Search and Query	0	0	0	No requirements in RFP found that have FPs for this Functional Area.
Correspondence and Letters	0	0	0	No requirements in RFP found that have FPs for this Functional Area.
Reports	0	0	0	No requirements in RFP found that have FPs for this Functional Area.
Workflow Management	47	18	42	
Rules Engine	0	0	0	No requirements in RFP found that have FPs for this Functional Area.
Integrated Test Facility	0	0	0	No requirements in RFP found that have FPs for this Functional Area.
Training	72	0	41	
Call Center Services	0	0	18	
System Availability	0	0	0	No requirements in RFP found that have FPs for this Functional Area.
Customer Service Request Tracking System	0	0	0	No requirements in RFP found that have FPs for this Functional Area.
Web Portal	32	17	115	
Fiscal Agent Data Center and Offices	0	0	0	No requirements in RFP found that have FPs for this Functional Area.
Regulatory Compliance	0	0	0	No requirements in RFP found that have FPs for this Functional Area.

Business/Functional Area	Baseline Adjusted FP	Enhancement Adjusted FP	New Capabilities Adjusted FP	Notes
Data Protection Assurance	0	0	0	No requirements in RFP found that have FPs for this Functional Area.
Enterprise Security Approach	0	0	0	No requirements in RFP found that have FPs for this Functional Area.
Facility Access	0	0	0	No requirements in RFP found that have FPs for this Functional Area.
Application Systems Change Control	0	0	0	No requirements in RFP found that have FPs for this Functional Area.
Logging and Reporting	18	0	0	
Service Continuity Controls	0	0	0	No requirements in RFP found that have FPs for this Functional Area.
Data Backup and Recovery	0	0	0	No requirements in RFP found that have FPs for this Functional Area.

Business/Functional Area	Baseline Adjusted FP	Enhancement Adjusted FP	New Capabilities Adjusted FP	Notes
Records Retention	0	0	0	No requirements in RFP found that have FPs for this Functional Area.
LAN/WAN Management Operational Requirements	42	0	0	
System/Software Maintenance	0	0	0	No requirements in RFP found that have FPs for this Functional Area.
System Modifications	0	0	0	No requirements in RFP found that have FPs for this Functional Area.
Other (specify)	0	0	0	No requirements in RFP found that have FPs for this Functional Area.

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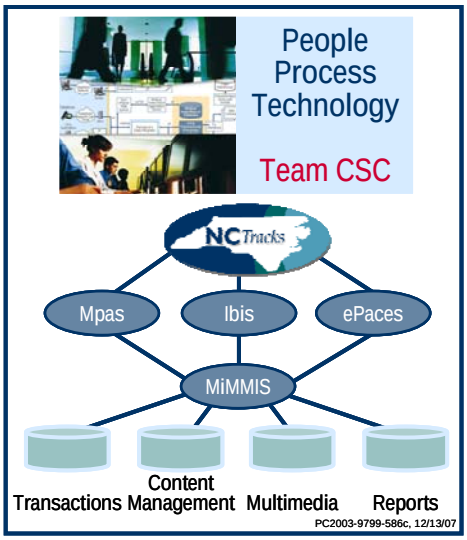
Appendix 50, Attachment C, Exhibit 2

Pages D.2.1-1 through D.2.1-6 contain confidential information.

D.2.1.1 Claims Management

Team CSC brings a proven claims processing system and in-depth experience in claims operations garnered from over 20 years of processing Medicaid claims for the State of New York. We stand ready to adapt our cost saving procedures, innovative business processes, and processing enhancements to position North Carolina as a leader in healthcare transaction processing for all NC DHHS programs.



The primary goal of a Medicaid Management Information System (MMIS) is to process, adjudicate and report claims accurately and timely. The North Carolina Replacement MMIS must be flexible enough to efficiently process claims for the Division of Medical Assistance (DMA), Division of Mental Health/Developmental Disabilities and Substance Abuse Services (DMH), the Division of Public Health (DPH), and the Migrant Health Program in the Office of Rural Health and Community Care (ORHCC).

To achieve this objective, Team CSC is proposing a powerful, highly functional, table-driven, multi-payer solution to healthcare claims processing. The proposed Replacement MMIS provides a configurable architecture with embedded audits and edits that support the full range of claims processing operations: receipt, entry, adjudication, pricing, payment, tracking, and reporting.

High Volume Transaction Processing

The Replacement MMIS is based on a high volume, CMS-certified system that processes a monthly average 30 million Medicaid claims for New York State, resulting in claims payments in excess of 40 billion dollars.

The Team CSC solution is an evolution of the already successful MMIS that currently processes claims for the State of New York. From July 2006 to June 2007, the system processed more than 450 million claims for recipients, representing over $35 billion in payments to Medicaid providers without missing or delaying a checkwrite. The majority of these claim transactions were processed in real time, on average, within two seconds; today the system processes in real time, 24 hours a day, 7 days a week.

For the State of North Carolina, Team CSC has expanded the claims processing capabilities by adding innovative, automated workflow technology that is integrated with new Web capabilities to facilitate NC DHHS, providers, recipients and Team CSC's access to data. (Details of these system capabilities are described in section D.1.4.1 General System Requirements). **Team CSC will customize the system to enhance interoperability through increased automation of business processes. This collaborative and transparent approach to claims processing results in the sharing of information across subsystems and programs, which significantly improves the State's capabilities and stakeholder involvement in the NC DHHS healthcare programs.**

From the operations perspective, the Replacement MMIS represents the next generation in transaction processing. The use of graphic user interface (GUI) pages allows for ease of navigation among subsystems, and visually displays health care data to Claims Management and NC DHHS staff in an easy-to-understand manner. The system emphasizes

drag and drop and point-and-click capability, automated security rules, and integrated applications to facilitate user acceptance and learning. Constructed with edits, business rules, and system logic the system enables NC DHHS to quickly establish numerous reimbursement methodologies, define benefit plans, set preauthorization requirements, and implement new State policies and criteria. **Authorized users can view and, in most cases, edit claims status, history, and recipient data online, in real time, resulting in increased processing efficiencies and a lower cost per claim.**

NC DHHS also benefits from enhanced processing features that have been added to Team CSC's baseline system. These value–added modifications include the following:

- **Criteria-Based Pend Resolution.** Users have the capability of entering claim-related criteria online to allow systematic adjudication and tracking of claims submitted by suspected fraudulent providers.
- **Claim Audit Review. Over** 50 different criteria can be entered into the MMIS online by authorized users. Any claim matching the criteria automatically suspends for State audit. For example, the system can be configured to pend any claim set to pay over $100,000; these claims are immediately queued for the State's audit staff to review.
- **POS Terminal Support.** The Replacement MMIS is built to support the use of card readers for eligibility verification, should NC DHHS decide to use plastic ID cards. This expedites processing for both recipients and the pharmacies.
- **Service Utilization**. Authorized users can create and maintain client-based service utilization parameters to enforce State policy that limits the number of services provided to a client in a predetermined time frame. Examples include North Carolina's 8 prescription per month limitation or 24 office visits per year. Authorized users, such as NC DHHS and Team CSC also have available the Medicaid Override Application System (MOAS) to support client-based overrides to service limits.

Service Utilization Tracking:

With the Replacement MMIS, Authorized users, including Providers can view whether or not a recipient has exceeded their number of visits in a year, the number of prescriptions in a month, and any other limitations NC DHHS so chooses to track.

- **Post and Clear**. To help reduce fraud and overpayments, the Replacement MMIS supports a process in which providers requesting ordered services (such as laboratory or radiology) must 'post' the request within the system. When the 'posted' laboratory performs the work, the laboratory then 'clears' the posted transaction. This process eliminates multiple laboratory services being billed; only the 'cleared' provider receives payment. This automated process reduces the time spent manually auditing and investigating suspect claims.
- **Case Management.** The Case Management feature allows authorized users to add and update information for clients that are involved in the case management process for eligible waiver programs. The Case Management feature provides the functionality necessary to add and maintain client information specific to case management and assign Case Managers to eligible clients. The Case Management feature also provides the functionality necessary to add and maintain Case Management Plan and budget tracking data, generate reminders, and generate corresponding reports.

One significant innovation proposed by Team CSC is the Integrated Business Information System (Ibis). Ibis is the automated workflow system that is integrated with the claims processing functions to assist NC DHHS and Team CSC staff in the

Page D.2.1.1-3 contains confidential information.

Claims management personnel undergo an extensive training program in State and Team CSC policies and procedures. Staff assigned to the Pend Resolution area receives additional training in all State programs to prepare them to handle claims submitted by the various State agencies. All personnel are instructed in the need for confidentiality and security when dealing with personal health care information and the role they play in meeting all performance standards required by the contract. Proposal section E.5.2.2, Organization Chart and Descriptions-Operations, details the operational staffing that Team CSC employs to meet and exceed the State's expectations for a well-managed claims processing operation.

In addition, Claims Management is responsible for supporting a wide array of stakeholders including State agencies, county and local agencies, providers, recipients, and vendors, as well as Team CSC staff. The Claims operations unit serves as a nexus for stakeholders and the Replacement MMIS. This unit relies heavily on Ibis and the Web Portal to perform all key functions, such as claims resolution, operations monitoring and reporting, metrics development, performance standards attainment, and training. We also are proposing the creation of an Operational Excellence Committee, composed of representatives of all MMIS-involved State agencies, to serve as a vehicle for identifying process improvements and for enhancing communications among all affected parties.

In the following sections, we expand on the specific functions that the Claims Management unit performs for the NC Replacement MMIS Operations Phase, addressing the RFP requirements assigned to each of the claims management units and presenting our approach for meeting all required performance standards. **(Comment CSC248)**

D.2.1.1.2 Claims Management Operations Overview

The proposed Team CSC Replacement MMIS solution offers agile processing power, dedicated and highly trained staff, and tested operational procedures that contribute to the successful performance of all general responsibilities required by the NC DHHS contract. **Exhibit D.2.1.1.2-1** details the allocation of these responsibilities:

Mail Room	Claims Preparation and Imaging	Claims Resolution
• Pickup and delivery of mail • Sorting and screening of documents • Courier services for USPS and State units • Processing Return to Provider mail	• Document control • Batch control • Document imaging • Data entry • Claims optical character recognition	• Edit overrides • Suspense resolution • Claims pricing for exceptions • Encounter processing (Comment CSC248)

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Exhibit D.2.1.1.2-1. Claims Management Operations Responsibilities. *Clear responsibilities for successful claims and document processing.*

For more details on the Claims Processing Subsystem, refer to Section D.1.4.8 of our proposal. **(40.8.2.1)**

(40.8.2.1)

To meet these responsibilities, our Claims Management Operations staff follows proven procedures and written policies for performing the general claims responsibilities. All claims operations functions, from the delivery of mail to payment processing, are systematically monitored for quality control. Additionally, our Quality Assurance team evaluates all work effort of this unit, ensuring performance standards are achieved and to identify areas of process improvement.

To further develop and refine operations efficiencies, Team CSC designates talented individuals who are experienced in claims systems, processing, and operations as claim

consultant business analysts. These business analysts, who are part of the Claims Management operations team, provide additional support to the Claims Operations staff; they function as claims consultants to help identify areas of process improvement and implement best practices in the claims processing area, and they serve as end user testers for any system enhancements. Among the duties these individuals perform are:

- Research and analyze problem areas at the request of the State
- Provide technical supervision to staff on claims processing
- Review processing procedures and policies to ensure compliance with State requirements
- Provide consultation on complex cases and advise when to refer to the Fiscal Agent's medical consultant and/or the State.
- Reviewing, analyze, and recommend changes that affect State operations
- Evaluate the impact of CSRs on the Claims Management Operations unit. **(40.8.2.53)**

(40.8.2.53)

The Claim Management component of Team CSC builds on operational experience gained from effectively processing Medicaid claims for New York State for over 20 years. We are proud of our record in meeting over 220 Service Level Agreements (SLAs) since December 2006. Team CSC plans to transfer the claims management successes to the North Carolina contract while simultaneously implementing operations process improvement.

Service Level Agreements (SLAs)

Team CSC has shown its operations experience and commitment to process improvement by meeting over 220 SLAs for the New York contract since December 2006.

To continue to provide exemplary service, the three processing units within Claims Management are structured to make optimum use of the proposed Replacement MMIS. **Exhibit D.2.1.1.2-2, Claims Management Work Flow**, shows the relationship of each unit to the system functionality and identifies the major steps that occur for incoming claims and adjustments for entry and processing by the new system.

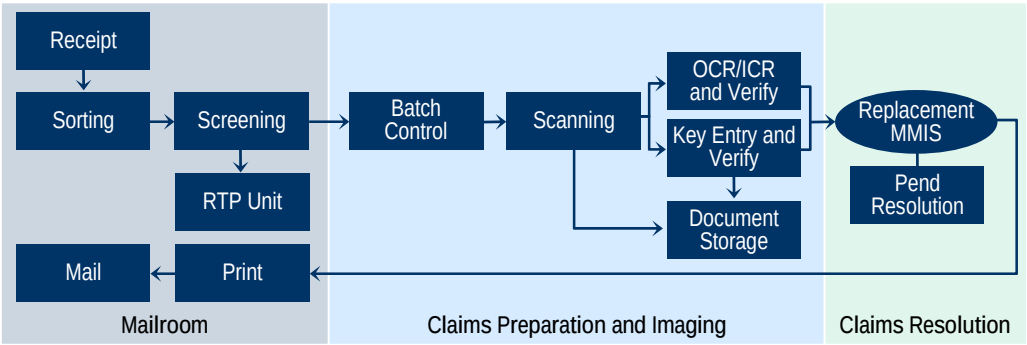

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Exhibit D.2.1.1.2-2. Claims Management Workflow. *All incoming forms, claims, and adjustments undergo the same initial processes for entry and processing by the NC Replacement MMIS.*

D.2.1.1.3 Mailroom Services

The Team CSC Mailroom encompasses those processes that initiate claims processing operations. Among the activities performed by this area are courier services, the receipt of mail, including paper claims and adjustments, the preparation and printing of checks and remittance advices, and the batching and initial screening of documents. This unit also prepares all outbound mail and controls the mail until it enters the delivery system. All

Team CSC staff follows written procedures and policies that are closely monitored by the unit supervisors. **(Comment CSC248)**

D.2.1.1.3.1 Mailroom

The Mailroom in Team CSC's Operations facility in NC is the focal point for preparing and processing all incoming mail. Mailroom staff receives mail from the Postal Service, private delivery services, inter-office collections, and courier pick-ups. The mailroom clerks log the total USPS mailbags and trays received each business day as a general control. This log is also helpful to identify the occurrence of unexpected highs or lows in volume of received mail. The in-bound mail may contain claims, claim attachments, prior approval requests, claim adjustments, x-rays, returned eyeglasses, State Memoranda, and any variety of State-approved forms from providers. Team CSC will utilize a series of US Post Office boxes for provider mail, instructing providers which P.O. Box is to be used for specific claims functions. As a partial example, one P.O. Box would be used for CMS 1500 claims, one for UB-04 claims, and yet another for Dental Claims. Use of these P.O. Box types pre-sorts the provider mail without use of fiscal agent personnel.

Some claims may come via courier package from the State divisions when special instructions regarding edit overrides or pricing are involved. We also expect to receive claims and other supporting documentation for some DPH recipients based on a current or recent submission of a DPH financial eligibility application. All such applications and supporting documents are imaged to support eligibility determinations, claims processing, workflow processing, and Division updates to recipient records.**(Comment CSC24) (SOO 10.12.3-2)**

(10.12.3-2)

Outbound mail is handled by one of two Mailrooms. First, high volume mail, such as remittances, forms, and checks, are processed in our large volume mail center located in New York. Use of this existing facility permits NC DHHS to enjoy the lower operations cost of our high-speed printing and insertion equipment, lowering Total Cost of Ownership. Mail generated by fiscal agent staff housed in our NC Operations facility is processed by the mailroom located within that NC facility. Examples of this low volume mail would be items returned to providers (x-rays, incomplete claims, and special correspondence).

Hand-delivered mail is controlled at the main entrance of the NC facility. The receptionist or security personnel on duty accept the mail/packages and note the time, date, addressee, item, delivery company, and tracking number in an electronic mail log. The mail is then removed by the Mailroom staff for delivery to the appropriate management personnel or functional unit. Once received items arrive in the mailroom, the Mailroom supervisor reviews the electronic log to indicate receipt of the mail and ensure accuracy. **(40.8.2.6)**

(40.8.2.6)

D.2.1.1.3.2 Incoming Mail Verification & Sorting

All incoming mail is opened by Mailroom clerks, who then sort the mail by form type using appropriately marked containers. Sorting of mail by type of document and by presence or absence of attachments before invoking scanning processes ensures images enter the appropriate workflow. In the event cash or checks are received, they are immediately handed to the Mailroom supervisor for entry on a special log and preparation for delivery to the bank lock box service. Any mail received not belonging to Team CSC or NC DHHS is placed in the Returns container and delivered to the US Postal Service at the end of the day. **(40.8.2.7) (SOO 10.12.1-25)**

(40.8.2.7, 10.12.1-25)

All mail identified for NC DHHS is delivered by the CSC courier to the appropriate DHHS division during the scheduled daily trips. Incoming mail for Team CSC staff addressed to specific individuals or marked “Personal and Confidential” is sorted by department and individual and distributed within the hour.

During the sorting process, our mailroom clerks quickly screen the documents to ensure that they can be imaged. They verify that no red ink or white-out was used to complete the forms; remove all obstructions, such as staples and paper clips; ensure that no significant rips or tears are present; and, orient all documents in the bins in the same direction. Claims that cannot enter the imaging system are worked as Return to Provider (RTP) items, whereby a cover page is prepared indicating the reason for the return to the submitter, along with a request for the required information or method of completion. **(40.8.2.4) (SOO 10.12.1-24)**

(40.8.2.4, 10.12.1-24)

D.2.1.1.3.3 Courier Service

Team CSC provides a courier service between the Team CSC facility and each NC DHHS Division’s designated offices. The courier drives this circuit twice each State business day, beginning the first run at 10:30 AM and driving the last run at 3 PM. Additional courier runs are made when requested by the State. **(40.8.2.5)**

(40.8.2.5)

D.2.1.1.3.4 Mail Delivery Services

Mail delivered to the Team CSC facility by the courier undergoes the routine checks and date-stamping procedures prior to internal distribution. Distribution clerks are also responsible for logging each package of mail designated to be picked up and delivered by the courier. The electronic log form identifies each package with a tracking number, the ‘ship to’ and ‘ship from’ locations, and a description of the item. As each package is delivered, the courier signs the log for the particular package and obtains a signature from the individual accepting the package at its destination.

The Mailroom also receives deliveries from FEDEX (Federal Express), UPS (United Parcel Service), Airborne/DHL, and USPS (United States Postal Service). When received, these deliveries are recorded on electronic log sheets, which note the time of the delivery and the number of packages received. For each package, the tracking number is recorded as well as the name of the department, company, and person to whom it is addressed. Express mail is delivered to recipients through normal mail distribution at the Team CSC facility and by courier to the State. **(40.8.2.9)**

(40.8.2.9)

D.2.1.1.3.5 Printing Forms and Labels

All printing is done in either the NC or NY CSC facilities, including Return to Provider (RTP) Letters, Recipient Explanation of Medicaid Benefits (REOMBs), notice of service approval or prior approval denial decisions, appeal rights letters, Third Party Liability (TPL) letters, drug recovery invoices, Estate letters, and Certificate of Creditable Coverage (COCC) letters. These computer-generated documents require First Class postage and are mailed daily. Team CSC uses sophisticated Bell & Howell hardware and Pitney Bowes software applications to fold, insert, and affix postage. An inserter meter automatically tracks postage costs. **(40.8.2.10)**

(40.8.2.10)

Recipient mail that is printed and returned to the mailroom is tracked and documented for retrieval in **NC***Tracks*, allowing for report generation and reproduction, as needed. Any recipient mail returned to Team CSC as non-deliverable will be shredded. **(40.1.1.12 – 13)**

(40.1.1.12 – 13)

Team CSC also prints and mails Replacement MMIS State-approved forms, when requested. An appropriate inventory of these forms is consistently kept on hand. As part of the business process improvement, Team CSC encourages the use of the Web Portal for downloading forms. Providers can also use the Web Portal to complete and submit forms, eliminating the associated mailing costs. **(40.8.2.11) (SOO 10.12.1-23)**

(40.8.2.11, 10.12.1-23)

For sending small packages and non-standard mailings, Mailroom staff relies on an application that weighs the items, calculates the correct postage, and generates a mailing label. This information is recorded in a postage log, which lists the item, addressee, date, and postage cost. For receiving packages, Team CSC uses an application that allows the use of hand-held barcode readers to quickly identify the sender, the person who signed receipt of the package, and receipt date and time.

CSC maintains detailed logs of all outbound envelopes and packages shipped via the US Postal Service or any other mailing service. These logs contain, by date of mailing, a description of the type of outbound mail, the exact count and total postage expense or shipping fees incurred. Our mailing software presorts mail for postage discounts whenever possible. **(40.8.2.9)(Comment CSC245)**

(40.8.2.9)

D.2.1.1.3.6 Postage Costs

On a daily basis, the Mailroom supervisor logs all postage costs associated with the Mailroom activities, including metered mail, packages, letters, and other correspondence. The postage log lists the types of articles mailed, the date, and recorded costs. This information is given to the Financial Division where a reconciliation report is prepared for the State. (40.8.2.12)

(40.8.2.12)

D.2.1.1.3.7 Printing Checks and Remittance Advices (RAs)

Another responsibility of the Distribution staff is the printing and mailing of checks and Remittance Advices. Checks are issued to providers following the processing of the Replacement MMIS weekly payment cycle. Each step of the check printing process is thoroughly documented and stringently monitored to ensure that the provider receives the proper check and corresponding RA.

During the printing process, checks used for the weekly payment cycle are transferred from a secured check storage area by the Program Accounting staff and put into a secured vault until printing is required. An authorized Systems Administration staff member will sign a Check Processing Summary Transmittal form, which will verify that all checks were received and accounted for. Once the printing process is complete, a review by Systems Administration, Program Accounting, and Quality Assurance staff will be performed. The Check Processing Summary Transmittal form will be documented and approved by each department. The printed checks will be secured within the storage area until the cycle is released, and unused checks will be secured until the following cycle.

Team CSC employs strict internal controls over the receipt, printing and storage of the blank check stock. Program Accounting and Quality Assurance will be responsible for the establishment of physical security and internal control procedures designed to protect the blank check stock. These procedures will include control over incoming check shipments, restricted access to the supply of blank check stock and validation of printed financial data.

Team CSC's procedures for safeguarding blank check stock will be consistent with generally accepted internal control practices and will include the following:

- Each shipment of check stock will be inspected upon receipt by Program Accounting and Quality Assurance staff.
- Sealed boxes of blank check stock will be logged, inventoried, and placed in a locked vault.
- Access to the vault will be controlled by a combination lock and electronic alarm system.
- Usage of the check stock during the printing process will be accounted for by Systems Administration personnel and reviewed by Quality Assurance and Program Accounting staff.
- Checks will be printed in a secure area within the Data Center complex.
- Printed checks will be physically secured in the vault at all times.
- Physical inventories will be conducted periodically by Quality Assurance staff and reconciled with perpetual inventory records.
- Each week, printed checks will be subjected to extensive reviews by Team CSC's Quality Assurance department.

After printing, the staff matches the printed checks to the printed remittance statements. Checks and remittances are matched and then inserted into envelopes. Post-insertion, our Quality Assurance team performs random sampling and verifies proper insertion of documents by provider. The validated envelopes are metered and taken by courier to the US Post Office for mailing. **(40.8.2.13)**

(40.8.2.13)

D.2.1.1.4 Claims Preparation and Imaging

The Claims Preparation and Imaging team is responsible for controlling all documents received from the fiscal agent mailroom, batching documents for scanning and stamping of date of receipt, working any Optical Character Recognition (OCR) edits, and finally, performing data entry for documents that cannot be effectively put through an OCR process.

D.2.1.1.4.1 Claims Preparation and Batch Control

Claims Preparation Clerks group similar paper claims in batches of 100. Team CSC utilizes an automated batch reservation application to reserve the appropriate number of batches for the type of form being batched. This application prints one batch header page for each batch number reserved. More than one set of batch numbers can be requested through the reservation screen. The system also tracks the batch numbers and claims types, as shown in **Exhibit D.2.1.1.3.8-1,** Batch Tracking Screen.

The automated batching system generates the batch header sheets that contain the Julian date and batch number. The sheets also list the form type, attachment indicator, and processing priority and are placed on the batches by the Preparation clerks and forwarded to the Imaging Unit.

Pages D.2.1.1-10 through D.2.1.1-11 contain confidential information.

Capture, and the Ibis workflow resulting in a decrease in incomplete claims entering the Replacement MMIS and thus improved operational efficiencies and quality control. (SOO 10.12.5-1)

(10.12.5-1)

D.2.1.1.4.3 Adjustments Control

Adjustments can be submitted on the same media as the original claims (i.e., CMS 1500, UB 04, 837I, 837P, 837D, etc). There is no need to have a separate adjustment form or media. When received in the Mailroom, adjustments follow the same process as all paper claims. **Mailroom staff receives, sorts and verifies claims adjustments, then passes to the Claims Preparation team for batching. After batched by form type, these adjustments receive their batch covers, are scanned and assigned a DCN, then become stored images.**

During claims processing, the Replacement MMIS applies a Transaction Control Number (TCN), a 17-digit number that contains the 5-digit Julian date, the 10-digit sequence number, the 1-digit media code, and the 1-digit adjustment code. Clerks can track the original claim by the DCN that must be included on the adjustment and authorize the void, credit, or payment of the claim. **(40.8.2.16, 40.8.2.17, 40.8.2.19)**

(40.8.2.16, 40.8.2.17, 40.8.2.19)

The Data Capture application, Verify, is also used to monitor the quality and readability of scanned adjustment documents; this is the same process used for all imaged data. An example of the Verify page is shown in Exhibit D.2.1.1.4-1, Verify Data Capture. **(40.8.2.20)**

(40.8.2.20)

Those adjustments that require additional information are rejected by the system, controlled by the workflow management system, and queued for the RTP Unit. These individuals can view the rejected adjustment and initiate the RTP notification via mail or secure inbox that advises the provider to resubmit with the required information. **(40.8.2.18)**

(40.8.2.18)

Another advantage of the Trans*form*™ imaging and data capture applications is the Quality Assurance function. This program verifies the integrity of the files being uploaded for transmission over communication lines to the mainframe. It also provides a count of batches by Julian date and product type. This count can be reconciled against the cover sheet, accompanying the batched adjustments sent for imaging. **By relying on automated processes and proven applications such as** Trans*form*™ and Verify**, Team CSC provides a highly accurate, efficient approach to handling and controlling incoming paper claims and documents. (40.8.2.21)**

(40.8.2.21)

D.2.1.1.4.4 Data Entry

As previously stated, all paper documents are scanned into images and controlled in the front-end processing. Team CSC proposes using OCR capabilities to eliminate the need for data entry of most hard copy claims. For those claims and adjustments that require direct data entry (e.g., special pharmacy claims), Data Entry operators within the Claims Department key data directly into the Replacement MMIS using the stored images of the original paper claims. Performing data entry from images permits us to use any available trained operator to enter the claims information, rather than limiting us to using only those operators working in the same facility as the paper claims. **Exhibit D.2.1.1.4.2-1,** Key from Image, depicts the scanned document that appears to the Data Entry operators who are assigned to this task. **(40.8.2.22)**

(40.8.2.22)

Page D.2.1.1-13 contains confidential information.

scanned and linked to the appropriate provider. The provider identification number is used on all materials for electronic document linking for future reference. A complete description of the provider materials, communication, and training can be found in proposal section, Client Relations, D.2.1.3**. (40.5.2.62, 40.5.2.63)**

(40.5.2.62, 40.5.2.63)

Following the successful creation of claims images, Team CSC stores the original paper claims for sixty days, as required by RFP Appendix 40, Attachment A**.** During the DDI phase we will review the State's retention requirements for other imaged paper documents.

During the DDI Phase, Team CSC works with State staff to review all front-end processing procedures. **Our goal is to work in partnership with the State to improve the current methods and develop new processes to expedite claims operations.** We will analyze the efficacy of creating new automatic and manual procedures that will address the concerns of the State, including the automatic rejection of claims that do not have the required sterilization forms or suspending claims that have a Medicare voucher attached for a Medicaid claim. **(40.8.2.23)**

(40.8.2.23)

D.2.1.1.5 Claims Resolution

The Replacement MMIS, with its built-in audits, edits, business rules and system logic, is designed to adjudicate claims quickly, accurately, and with minimal intervention. Those claims that pend for additional review, such as suspected duplicates, benefits limitations, and program policies, are handled by the Claims Resolution Unit. This staff, knowledgeable in the MMIS Replacement System applications and State programs and policies, performs the bulk of suspense corrections.

For the North Carolina contract, the Team CSC Claims Resolution Unit receives extensive training in DMA, DMH, DPH, and ORHCC programs that are processed by the Replacement MMIS. Their responsibilities include the processing of adjustments and the overriding of edits, according to State-defined criteria.

The Claims Resolution Unit relies on the queuing feature of the MMIS that directs suspended claims to the appropriate specialists for resolution. As the pended claims are corrected online, they are re-adjudicated immediately. Pharmacy claims received electronically are either denied or paid. Paper pharmacy claims are imaged and, if pended, queued for resolution. There is no need to perform pharmacy worksheet resolutions to resolve pending front-end edits and submit to data entry for processing. **(40.8.2.38)**

(40.8.2.38)

Because of the system's flexible architecture, pended claims can be resolved virtually 24 hours a day, 7 days a week, if necessary, to reduce backlogs of suspended claims. **Providers can also correct their own suspended claims through the state-of-the-art Web Portal, providing more self-service features for providers and improving provider satisfaction**. Claims that require manual review, including pharmacy claims, are queued for the Medical Policy Unit for resolution. Proposal section D.2.1.4.1.2, Claims Medical Review, details the process for performing high-level manual reviews.

The claims resolution function allows Claims staff to correct suspended claims by location queue or by specific claim TCN. The authorized user makes the required corrections, and the Replacement MMIS System re-adjudicates the claim online. **This capability results in increased operational efficiencies and enhanced provider satisfaction because payments are not delayed.**

D.2.1.1.5.1 Adjustment Processing

The Replacement MMIS efficiently processes voids and adjustments of previously adjudicated claims. There are two types of reversal or adjustment: for payment and for history-only. For-pay processing effects the provider's payment; history-only adjustment is an internal mechanism to reallocate money from one funding source to another and does not effect the provider's payment. The system's adjustment capabilities support the efficient correction of claim data due to processing errors, administrative sanctions, fraud cases, and other situations. Providers can quickly correct submission errors using the claims entry method they prefer.

In void processing, the system creates an exact reversal of the original paid claim. The voided claim bypasses the normal claims processing data validation and pricing steps so that the user can reverse the outcome of the original claim submitted. In adjustment processing, the system creates two transactions: a reversal of the original claim and an adjustment claim. The adjustment claim fully adjudicates like a new claim.

Adjustment requests submitted by providers are automatically processed by the Replacement MMIS, and all adjustment requests can be reviewed online. Claims Resolution staff also processes claim-specific retroactive rate adjustments as specified by the State, according to State policies.

In addition, there is no limit to the number of times a claim can be adjusted. The Claims Subsystem maintains a complete and accurate audit trail of each adjustment or void, including the reason for the adjustment or void, the disposition of the claim, and the user who initiated the action. State and Team CSC users can view the complete history of a voided or adjusted claim in chronological order, including all associated transactions.

D.2.1.1.5.2 Mass Adjustments

The Replacement MMIS easily accommodates mass adjustments. Systematic adjustment/reversal requests may be triggered by events such as the addition of a recipient, updated rates, or the addition of other insurance coverage resource identification. System-generated mass adjustments allow the system to reprocess large subsets of claims automatically with little manual intervention.

When mass adjustment requests are processed, the Claim Management staff selects the appropriate claims by entering in the selection criteria. Requesters can view an impact report to determine the dollar impact of the mass adjustment. Once the mass adjustment is queued, the claims are then completely reprocessed through the Replacement MMIS, including the application of all relevant edits and audits. The claims are re-priced according to the current Reference Subsystem database information. A special edit is posted to each claim so that the claims are held in the claims database until the results of the mass adjustment are analyzed to ensure that the desired results are achieved.

The Online Mass Adjustment Main Page, shown in **Exhibit D.2.1.1.5.2-1 i**s used by the authorized staff to initiate or update a mass adjustment request. Adjustment criteria can be added, changed, or deleted. DMA, DPH, DMH and ORHCC or Team CSC users can view the details of an existing adjustment request or update the details, including Claim Header Transaction Type Code, Claim Batch Payment Type Code, Claim Adjustment Selection Status Code, and adjustment criteria for a specific adjustment request.

Pages D.2.1.1-16 through D.2.1.1-18 contain confidential information.

location is a factor in selection. The single location code that is assigned to the document is determined by the edit with the highest severity level. If two edits with the same severity are set, then the location code number hierarchy will be the determining factor as to which location the document is routed. Location codes can be overridden by Pend Resolution staff.

D.2.1.1.6 Claims Operations Performance Standards

Team CSC is confident that the proposed claims management policies and procedures meet all North Carolina claims performance standards. The following chart lists the required operational performance standards and the corresponding actions Team CSC will perform to meet these standards.

	Performance Standards	Team CSC Meets this Standard by:
40.5.3.1	Fiscal Agent shall log and image all hard copy provider applications received within one (1) State business day of receipt.	• Establishing claims distribution and acquisition procedures to collect, control, and image all provider enrollment applications • Assigning a DCN to each imaged document for control and dating • Preparing batch sheets and header pages for balancing and monitoring • Monitoring the date received and imaged to meet State standards
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.	• Establishing claims distribution and acquisition procedures to collect, control, and image all mail • Monitoring mail logs • Assigning a DCN to each imaged document for control
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).	• Fulfilling dated, system-generated requests & delivering packages to USPS. • Recording the request and mailing date in the Automated Workflow • Monitoring mailing logs and printing procedures • Working with the Provider Services to educate providers on availability of Web Portal to request and print forms.
40.8.3.5	Fiscal Agent shall assign an ICN to every claim, attachment, and adjustment within twenty-four (24) hours of receipt	• Establishing distribution and acquisition procedures to collect, control, and image all documents • Assigning a DCN (ICN) to each imaged claim, attachment, and adjustment for control and dating • Monitoring the date received and imaged to meet State standards. • Preparing batch sheets and header pages for balancing and monitoring • Reviewing management, inventory control, and balancing reports
40.8.3.6	Fiscal Agent shall maintain data entry-field accuracy rates above ninety eight (98) percent.	• Reviewing OCR/ICR system reports to identify problem areas • Establishing metrics for data entry processing • Sampling and reviewing data entry fields to verify accuracy • Providing remedial or additional training for specific those not performing
40.8.3.7	Fiscal Agent shall scan every claim and attachment within one (1) State business day.	• Establishing distribution and acquisition procedures to collect, control, and image all claims and attachments • Investigating potential problems and proactively initiating changes • Conducting thorough and effective maintenance during scheduled downtime to ensure optimal system performance and availability
40.8.3.8	Fiscal Agent shall return hard copy claims missing State-specified required data within two (2) State business days of receipt	• Imagining all claims and systematically identifying missing information • Designating a RTP Unit to generate letters to providers • Developing metrics and quality assurance procedures • Monitoring the turnaround time for compliance with State standards
40.8.3.10	Fiscal Agent shall adjudicate Ninety (90) percent of all clean claims for payment or denial within thirty (30) calendar days of receipt; Ninety-nine (99) percent of all clean claims for payment or denial within ninety (90) calendar days of receipt for DMA and DMH, and (forty-five [45] calendar days for DPH and ORHCC claims; All non-clean claims within thirty (30) calendar days of the date of	• Placing claims that require additional information into specific work queues for resolution by experienced personnel • Monitoring Inventory, Aging Claims, and Suspended Claims reports • Monitoring work queue inventories and making dynamic adjustments to ensure that all processing standards are met • Proactively resolving issues that affect the claims processing • Providing new and remedial claims resolution training for State and Team CSC staff • Performing quality assurance assessments to denote areas for improvement in submission and processing

	Performance Standards	Team CSC Meets this Standard by:
	correction of the condition that caused the claim to be unclean.	
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.	• Implementing proven claims processing processes and procedures • Identifying system and operations problem areas and implementing corrective action • Setting performance metrics to gauge performance • Performing sampling and internal audits to verify correct claims disposition • Reviewing claim error and processing reports • Using the Automated Workflow to monitor and track information requests • Conducting all appropriate training for State and Team CSC staff
40.8.3.16	Fiscal Agent shall adjudicate for payment all claims with date of service in previous State fiscal year by the State-designated checkwrite of the current State fiscal year	• Implementing proven claims processing processes and procedures • Identifying system and operations problem areas and implementing corrective action • Setting performance metrics to gauge performance • Performing sampling and internal audits to verify correct and timely claims disposition • Reviewing claim error and processing reports • Auditing financial reports • Conducting all appropriate training for State and Team CSC staff
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.	• Establishing metrics in each processing area to gauge overall effectiveness of claims operations • Developing and implementing new process improvement systems and procedures • Conducting new, ongoing, & remedial training for State & Team CSC staff • Consistent monitoring and tracking of operations through the review of management and performance reporting • Reviewing financial procedures and reports for compliance with Federal and State regulations • Designating experience staff to investigate provider late payment complaints • Maintaining constant communications with NC DHHS and the providers

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Exhibit D.2.1.1.6-1. Claims Management Performance Standards. *Team CSC employs comprehensive monitoring, communication, and quality assurance approaches to protect performance and meet standards.*

D.2.1.1.7 Claims Management Conclusion

Team CSC understands that all areas of claim management must be synchronized to operate as efficiently as possible. The flexible, high-powered Replacement MMIS, along with the advanced NC Tracks and Web technologies, guarantee the flow of information providing NC DHHS a highly functional claims management operation. Team CSC is committed to meeting the claims operations performance standards that serve as instant gauge of our work. **We are confident that our proven processes and procedures, quality assurance techniques, knowledgeable personnel, and strong commitment to service can only reduce the overall cost of ownership to all stakeholders who are part of the North Carolina Replacement System endeavor.**

Pages D.2.1.2-1 through D.2.1.2-2 contain confidential information.

report generation, ensuring the timely exchange of processing results and other key information.

In order to ensure the timeliest availability of system-generated reports, Team CSC's approach will include the use of an online reporting application. This robust application will provide immediate access to all scheduled reports produced by the financial system, posting them to a repository shortly after completion of the job streams that lead to their generation. Reports and interface files, including the NCAS interface, can be transferred to other media, such as hardcopy, CD, or electronic files easily, using reports stored in the online repository. **(40.14.2.70)** An important phase of our reporting activity will be to summarize checkwrite activity in the Checkwrite Financial Summary, Financial Participation Report, and general expenditure reports on a year-to-date basis. Within ten (10) days of the State's fiscal year end on June 30th, Team CSC will provide these reports in accordance with State-approved format, media, distribution, and frequency. **(40.14.2.42, 40.14.2.43)**

(40.14.2.70)

(40.14.2.42, (40.14.2.43

D.2.1.2.1.3 Regular Communications with State Officials

Team CSC will establish a communications approach that will provide State personnel with critical information in a timely manner, using techniques that have been successfully implemented on similar projects:

- Scheduled Status Meetings.
- Availability and responsiveness of Team CSC staff. Team CSC's assigned Transaction Accounting staff will be continuously available to meet with NC DHHS personnel, or to discuss topics over the telephone on a moment's notice. We understand that there is a need to process last-minute garnishments or other adjustments to provider disbursements, or process requests to cancel an EFT payment to a provider. Team CSC will accommodate these urgent transactions, responding immediately to help NC DHHS reach its operational and financial objectives. **(40.14.2.9)**

(40.14.2.9)

- Informal and formal communications. Team CSC's communications approach will include immediate notification through informal verbal or email messages, followed by a more formal component, normally in the form of an official transmittal (paper or electronic instruction via Ibis workflow) documenting the event. Several examples are worthy of note:
  - Timing of cycle completion. As each payment cycle is completed, Transaction Accounting staff will verbally notify NC DHHS staff that the disbursements are ready, and that Team CSC is awaiting final authorization procedures to be exercised by NC DHHS. This verbal communication is to be followed by a formal exchange of documents, one to be issued by Team CSC on the first day following cycle completion, summarizing relevant statistics such as the number of cycle transactions, and the total checkwrite expenditure. A second document is to be generated by NC DHHS, formally authorizing release of payments on the specified release date. **(40.14.2.15)**

(40.14.2.15)

  - State Memos. Any State Memos canceling or delaying checkwrites or release of system-generated checks or EFTs will be discussed fully at the time of issuance to be certain that Team CSC understands the precise actions to take. At a later time, Team CSC will generate a formal document describing the actions taken in response to the State Memo. **(40.14.2.16, 40.14.2.18)**

(40.14.2.16, 40.14.2.18)

- Following any delays in check mailings and EFTs, Team CSC will also inform the State by close of business about notification from the State Controller's Office that funds are in place. Again, these notifications will have an immediate, verbal component, followed by a formal memorandum to document the notification. **(40.14.2.16, 40.14.2.17, 40.14.2.49)**

(40.14.2.16, 40.14.2.17, 40.14.2.49)

- Cut-off procedures. This process will begin each year when Team CSC meets with State officials to discuss the checkwrite schedule and other cut-off procedures informally. Based on these discussions, Team CSC will submit a formal checkwrite schedule at least 60 days prior to the beginning of the upcoming calendar year. **(40.14.2.13)** After this schedule has been approved, Team CSC understands and will fulfill the requirement to successfully complete each checkwrite by the date on the State-approved Checkwrite Schedule. (**40.14.2.7, 40.8.3.19)** The checkwrite schedule will define the processing cycles to be included in 1099 reporting for the calendar year. This checkwrite schedule will also be included in provider bulletins to be released to the provider community. **(40.14.2.13, 40.14.2.14, 40.14.2.71)** Cut off procedures will be established to produce receivable, payable and program expenditure balances to correspond to the checkwrite over the State's fiscal year, and adjust these balances on June 30th to reflect activity between the last June checkwrite and June 30th. Details relating to these balances and related entries will be made available to all authorized State staff **(40.14.2.41 40.14.2.42)**

(40.14.2.13)

(40.14.2.7, 40.8.3.19)

(40.14.2.13, 40.14.2.14, 40.14.2.71)

(40.14.2.41, 40.14.2.42)

D.2.1.2.1.4 Leveraging the Many features of the Replacement MMIS System

A leading advantage of the Replacement MMIS system is the high degree of automation it provides. This streamlined approach allows Team CSC to perform required functions with lower headcounts. An excellent example of how the high level of automation enhances financial operations is presented in the description of Adjustment processing discussed later in this proposal.

In addition to the high degree of automation, the robust Replacement MMIS systems and applications offer additional advantages that will support efficient and accurate financial processing and disbursements to providers. Some of the more important features are highlighted as follows:

- Claim payments are generated only on the basis of approved entries to recipient and provider master files, as well as official procedure, formulary and rate files
- Replacement MMIS systems are able to accommodate various benefit programs, and will prepare financial reports, including funding requirements, separately for each program component. Accounts Receivable balances will likewise be segregated by program, supported by detail claim level transactions which total to the amount due by program for each provider with outstanding balances, allowing Team CSC to deduct amounts from provider payments as needed. **(40.14.2.1)**

(40.14.2.1)

- Systems provide flexibility in the frequency of disbursement cycles. The RFP requirement is to process as many cycles as the State would like, and Replacement MMIS systems will provide this flexibility. Cycles can be weekly, or can be processed according to a shorter time frame at the State's direction. **(40.14.2.14)**

(40.14.2.14)

- It should also be noted that the Replacement MMIS will have the ability to calculate and record funding sources at the claim level for each of the various NC DHHS program components to be processed using Replacement MMIS applications. As a result, funding

will be calculated and recorded in conformity with program requirements for all current benefit programs to be processed using Replacement MMIS systems. **(40.14.2.6, 40.14.2.39)**

(40.14.2.6, 40.14.2.39)

D.2.1.2.1.5 Enhanced Banking Services

Prior to contract startup, Team CSC will contract with a State-approved banking institution to provide all required banking functionality for the Replacement MMIS project. This institution will be selected by Team CSC based on its ability to provide a comprehensive range of banking services to include the following:

- Lockbox services to facilitate receipts from providers and Buy-In payments from recipients
- Processing for the main disbursement accounts
- Processing for additional special accounts, such as a funds received account, a Buy-In account, and a manual advance account
- Full Support for EFT transactions. **(40.14.2.62)**

(40.14.2.62)

One essential requirement for Team CSC's selected Bank will be the ability to use automatic funding procedures for ongoing NC DHHS disbursements. This approach offers significant control and administrative benefits to the State. Automated account funding also provides the State with the opportunity to eliminate any interest opportunity cost, because there are never any idle NC DHHS funds. A description of the process for automated funding will more fully illustrate the advantages of this approach. **(40.14.2.63)**

(40.14.2.63)

The fundamental processing objective of automatic account funding is to draw down cycle-approved funds only on the basis of transactions that have actually been presented to the bank for payment (presentments). From a procedural standpoint, the main disbursement bank accesses funds maintained in a separate State account to cover the amount of presentments for the current business day. Of course, EFT transfers would need to be available immediately, since funds are transferred to payees' accounts without delay.

The advantages of this approach are significant, and include the following:

- The draw-down functions described in RFP section 40.14.2.31 occur in an automated fashion, streamlining the funding process. Team CSC stands prepared to communicate draw-down information to NC DHHS in whatever format is requested based on presentations posted by the bank each day. **(40.14.2.31)**
- The incremental draw-down of funds provides NC DHHS to with the opportunity to fully participate in overnight repurchase agreements or other short term investments designed to maximize interest earnings.
- Although Team CSC accepts full responsibility for overdrafts as required by the RFP, our selected approach virtually eliminates the possibility of such errors**. (40.14.2.31, 40.14.2.63, 40.14.2.64, 40.14.2.65)**

(40.14.2.31)

(40.14.2.31, 40.14.2.63, 40.14.2.64, 40.14.2.65)

D.2.1.2.1.6 Account Controls and Reconciliation Procedures

Account Controls and Reconciliation Procedures begin each payment cycle with a secure transfer from Team CSC to the bank of an EFT file with scheduled payments to be transferred to the bank accounts of providers on EFT. Additionally, an authorized check file is transferred to the bank containing an entry for every paper check printed during the

disbursement cycle. This file includes a number of relevant data elements including check number, check date, provider name, and approved payment amount.

The authorized check file is loaded to the disbursement bank's internal system and is accessed during the check clearing process every night. As checks presented during the day are processed, each check is compared to the corresponding entry on the authorized check file. If presented items do not match, the funds are not disbursed, and follow-up action is initiated by the bank and Team CSC. This control, Positive Pay, is very effective, and has virtually eliminated the possibility of counterfeit presentations. **(40.14.2.11)**

(40.14.2.11)

D.2.1.2.1.7 Support for Positive Pay

The Replacement MMIS' Positive Pay processing also informs the disbursement bank of check voids and replacements. As checks become stale dated according to DHHS policies and/or the Uniform Commercial Code, or as checks have been voided due to unclaimed funds transferred to the NC Treasurer's Escheat Fund, the Positive Pay process again updates the bank. A similar Positive Pay system is used by the NC Treasurer (NCDST) for the detection of counterfeit State warrants.

During the transition period, Team CSC will work closely with DHHS Controller's Office to develop file layouts, transfer procedures and reconciliations to ensure that Positive Pay is well coordinated. **(40.14.2.11) (SOO 10.12.6-2)**

(40.14.2.11, 10.12.6-2)

D.2.1.2.1.8 File Transfers and Updates

In order to facilitate required sharing of data, Team CSC will establish detailed procedures for file transfers and updates with our selected disbursement bank, as well as NCAS and the Data warehouse.

As noted previously, Team CSC will transfer an approved EFT file and an authorized check file to the disbursing bank after each processing cycle. The transfer of these files will occur only after the cycle payout has been reviewed and approved by NC DHHS. Files transferred from Team CSC's selected banking institution to our data center include a cleared/uncleared check file and an Automated Clearing House (ACH) Return file, which includes any EFT transactions that failed. These files will be uploaded to the Replacement MMIS financial subsystem to update the status of checks issued, and in the case of failed EFT transactions, change the payee's status so that a paper check is generated for all future cycles, until the source of the EFT error can be researched and corrected. The transfer schedule for these files will be arranged with the disbursing bank to ensure its availability at Team CSC such that bank reconciliations can be completed within 10 business days of month-end, as required by the RFP. **(40.14.2.67)**

(40.14.2.67)

Team CSC will also provide a nightly interface to NCAS to validate availability of funds for claim specific reimbursement. **(40.14.2.4)**. This step is critically important, and will be completed as soon as the processing cycle is finished, allowing NC DHHS to determine whether adequate funds are available. Team CSC will work closely with the State to establish procedures for checking the remaining balance as each payment amount is calculated to verify that the budgeted amount is not exceeded. **(40.8.2.55)** Team CSC will also work closely with NC DHHS to develop appropriate procedures to be followed in cases where inadequate funds are available. **(SOO 10.12.6-5)**

(40.14.2.4)

(40.8.2.55)

(10.12.6-5)

Another important file transfer is periodic generation of an extract of DMH claims data, as well as other designated financial data to be used as updates to the Data warehouse. (40.14.2.50) **(40.14.2.50)**

In order to exercise good control over file transfers and updates, Team CSC will provide the State with confirmation and validation for each completed file maintenance request related to Financial Management and Accounting, including receipt date of file maintenance request file maintenance initiation date, file maintenance completion date, and supervisor validation date. (40.14.2.2) **(40.14.2.2)**

D.2.1.2.1.9 1099 Processing

We know that an important task within Transaction Accounting will be to summarize each provider's NC DHHS earnings by LOB for the previous calendar year no later than January 15th of the succeeding year. The proposed Replacement MMIS includes modules that do this summarization automatically, allowing Team CSC to provide 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. The Replacement MMIS also provides this annual summarization on each provider's Remittance Advice (RA) throughout the calendar year, not just the final RA for the year, as well as on the official IRS form 1099. (40.14.2.51) **(40.14.2.51)**

1099 processing begins with procedures to ensure the accuracy of tax identification numbers for each provider. The Replacement MMIS applications allow for the issuance of 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. In addition, Team CSC will record receipt date of each withholding and penalty request and completion date of withholding or penalty, and provide the State with confirmation and validation for each completed date of withholding or penalty. (40.14.2.57, 40.14.2.54, 40.14.2.52, 40.14.2.53) **(40.14.2.57, 40.14.2.54, 40.14.2.52, 40.14.2.53)**

In certain instances, there is a need to generate replacement 1099 forms. Team CSC's Transaction Accounting unit will be responsive to provider requests for reissued 1099 forms, and will issue corrected 1099s to providers prior to March 31st each year. Team CSC will also ensure that all corrections are incorporated into the IRS file to accurately report earnings for the prior year. (40.14.2.56) **(40.14.2.56)**

D.2.1.2.1.10 Internal Balancing and Reconciliation procedures

These procedures will be designed to 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. Reconciliation procedures also provide cross-checks and balances to ensure other reporting is using the same data and is categorized to facilitate informed program administration and support the State's receipt of maximum funding. (40.14.2.19, 40.14.2.8 , 40.14.2.45) **(40.14.2.19, 40.14.2.8, 40.14.2.45)**

Some of the more important procedures are described below:

Reconciliation of Total Payments to Approved Claims and Related Cycle Funding

At the conclusion of each processing cycle, Transaction Accounting staff will reconcile the total value of funds to be disbursed to the total value of claims approved by the automated system. This reconciliation clearly demonstrates that 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. This analysis also helps ensure that weekly budget reporting is consistent with costs allocated during the checkwrite. At month end, individual cycles will be summarized into a more comprehensive reconciliation, which will be formally transmitted to NC DHHS. **(40.14.2.3, 40.14.2.12, 40.14.2.21, 40.14.2.22) (SOO 10.12.6-4)**

(40.14.2.3, 40.14.2.12, 40.14.2.21, 40.14.2.22, 10.12.6-4)

Reconciliation of Disbursement Check Usage to Cycle Payments

A key to this control flow is the use of both preprinted and system-applied check numbers, which provide a good mechanism for ensuring proper handling of check disbursements. This control begins when a specified number of checks are transferred from Team CSC's secure vault to the computer room floor where printing will occur in a secure and controlled environment. At the conclusion of cycle processing, Transaction Accounting staff will prepare several reconciliations: **(40.14.2.66)**

(40.14.2.66)

- The total number of checks transferred from the vault will be reconciled to the sum of good checks printed, unused checks at the end of the print job, and checks that were damaged during printing.
- The number of checks printed will be reconciled to the number of check transactions generated during the cycle by the Replacement MMIS, as recorded on the cycle check register.
- The number of checks verified in these first two reconciliations will then be compared and agreed to postal manifests showing the number of checks actually mailed.

D.2.1.2.1.11 Careful Control of Returned Funds

An important functional activity within Transaction Accounting will be proper handling of cash receipts.

There are a number of sources of cash receipts, including the following:

- Drug Rebate payments
- Provider returns of overpayments, including erroneous billings
- Recipient premium payments
- TPL amounts
- Funds returned from a provider due to investigations/audits perform by the Program Integrity Unit of DMA

Team CSC's approach for processing incoming funds will be highly structured and well controlled, ensuring that all funds are promptly deposited to appropriate bank accounts and allocated to the appropriate accounts within the Replacement MMIS. **(40.14.2.32, 40.14.2.61, 40.14.2.68)**

(40.14.2.32, 40.14.2.61, 40.14.2.68)

Our approach will embrace open and timely communication to State personnel including daily reporting of deposit totals to the NC DHHS Controller by 1:30 P.M. for all program cash receipts. Receipt totals to be reported each day will include TPL, Drug Rebates, FADS, audit recoveries, cost settlements, refunds, and any other program receipts in accounts receivable. The amounts reported will be easily traceable to complete, accurate and detailed accounting records for all program funds received. **(40.14.2.69)**

(40.14.2.69)

Receipt of incoming payments will be greatly enhanced by the use of separate lockboxes for each type of receipt. The Lockbox vendor provides digital images of receipt documentation to Team CSC through a secure data transmission. These images

are used by Transaction Accounting staff for researching remittances that arrived without adequate documentation, allowing for the proper accounting treatment to be applied. Because of the efficiency of scanned images, they offer the additional advantage of easy retention and retrieval, allowing images of check and documentation to be easily maintained throughout the contract term. Of course, access to check images will be limited to those who have the appropriate access authorization. **(40.14.2.58, 40.14.2.59, 40.14.2.60)**

(40.14.2.58, 40.14.2.59, 40.14.2.60)

Use of automated scanning procedures will facilitate the preparation of cash receipts logs, which will be prepared for each State business day. These logs will denote the date, time, and individual processing the check, and will be provided to NC DHHS for review on a daily basis. These logs will flow into the Ibis workflow tool and trigger dispositions of receipts. (SOO 10.12.1-19)

(10.12.1-19)

Use of discrete lockboxes also allows the logs to be structured so that the type of receipt is automatically captured on the associated log. As an example, there would be a separate log for buy-in premiums received, including buy-ins for Indians on reservations**. (40.14.2.58)**

(40.14.2.58)

D.2.1.2.1.12 Dispositioning & Adjustments

After cash receipts have been logged and deposited, Team CSC's Transaction Accounting unit will proceed with dispositioning the cash payment. This process involves identifying the reason for the cash receipt and making appropriate decisions as to how the receipt should be handled and recorded. For example, funds received from providers relating to claim overpayments must be fully researched to accurately identify the claim which was overpaid, and the steps necessary to correct the error. Because the adjustment takes place at the detail claim line level, the Replacement MMIS automatically recalculates the amount of funding at the detail LOB level, effectively generating a credit back to the federal, state, local government, or other funding source based on actual system-maintained funding allocation tables. **(SOO 10.12.6-2)**

(10.12.6-2)

An important component of Team CSC's operational approach for the Replacement MMIS project is accurate processing of claim adjustments and corrections of previously paid claims to be consistent with the correct payment balance. **(40.12.2.5)** Where possible, adjustments will be initiated by the Ibis workflow. Adjustments can arise from a number of sources, as follows:

(40.12.2.5)

1) Provider-Submitted Adjustments

Team CSC will offer providers the capability to initiate provider-identified adjustments using procedures that are similar to those used for original claim transactions. Such adjustment claims will be reviewed as part of Team CSC's front-end processing, and adjustment requests found to be not acceptable due to individual invalid information will be returned to the submitter. **(40.8.2.25, 40.8.2.46, 40.8.2.47)**

(40.8.2.25, 40.8.2.46, 40.8.2.47)

It should be noted that all adjustments can take the form of either a claim adjustment, which changes one or more input parameters of the transaction, or a void transaction, which negates a previously paid claim in its entirety. These transactions are subjected to the same automated editing as original claims, ensuring validity and accuracy.

2) Mass Adjustments

The second category of adjustment is a "special input" of multiple claims, which is done by Team CSC at the direction of NC DHHS officials to correct a large number of claims which

experienced similar data problems or other kind of processing error. Mass adjustments might also be used to adjust claims for retroactive fee schedule changes. Special inputs are relatively rare, and are transacted with the use of electronic batch files intended to adjust or void a known universe of claims.

3) State-authorized Claim Overrides Adjustments

In some cases, Team CSC will refer denied claims to the State for review when special circumstances require override designation. In these cases, the claims will be logged when they are presented to the State, and held in a pend status until the override request is adjudicated by the State. After the override is adjudicated, Team CSC will release the suspended claims into the next processing cycle as a mass adjustment, where claims will either pay or deny, based on the associated state override decision. This processing is automated, and provides the ability to maintain an audit trail recording the fact that an override was applied on the claim record, and adding the claim to the formal adjudicated claims database to provide a complete audit trail**. (40.8.2.49, 40.8.2.50)**

(40.8.2.49 40.8.2.50)

4) Retroactive Adjustments

Another main category of adjustments are changes in approved institutional provider rates which give rise to positive or negative retroactive adjustment The new rates have associated time segments, and the system is designed to apply the new rate to the universe of claims paid to the provider during the associated time segment. In financial processing, the system takes the difference between the claims paid at the new rate and the claims paid at the old rate, and adds this amount to the provider's normal cycle payment as either a positive adjustment or an increase in negative balance (accounts receivable) as appropriate. **(40.8.2.48)**

(40.8.2.48)

In cases where the net effect of adjustments results in a negative financial impact, the replacement MMIS will update that associated accounts receivable balance and proceed to the next stage of processing, which entails automated recovery of negative balances. The system calculates the amount to be offset against current cycle claim payments by applying a standard *percentage* against the provider's cycle payment, establishing the amount to be collected during each payment cycle. The default value of this percentage is normally set to 15%, but the system has the ability to override the default with any collection percentage that the State may want, up to a full 100% collection amount.

The system also has the capability to establish a minimum payment amount for each provider, subject to the discretion of NC DHHS. **(40.14.2.1)**

(40.14.2.1)

After the offsets discussed above have been completed, the results of processing are again posted against the accounts receivable detail, relieving balances for cash offsets, and allowing the unrecovered balance to be carried over to the next cycle, where the process begins again.

D.2.1.2.1.13 Accounts Receivable Processing

In performing our Fiscal agent responsibilities, a key priority will be accurate collections and management of accounts receivable**. Team CSC will 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. We will establish related procedures to ensure report accuracy and the completion of a final audit for each checkwrite.** Team CSC will also 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. **(40.14.2.35 40.14.2.36, 40.14.2.38) (SOO 10.12.6-4)**

(40.14.2.35, 40.14.2.36, 40.14.2.38, 10.12.6-4)

An important operational task is the ability to generate letters to providers and recipients informing them of balances due to NC DHHS programs, offering a detailed description of the balance, and convenient instructions for remitting payment. Team CSC will provide this capability, along with a structured approach for generating these documents. **(40.14.2.40)**

(40.14.2.40)

In cases where amounts due have not been received or offset after two collection letters have been sent, Team CSC will attempt to contact the provider by telephone to verbally convey the need to repay accounts receivable balances.

An important aspect of Team CSC's Accounts receivable processing will be the ability to associate all balances and transactions with the appropriate line of business or benefit program. Accounts receivable balances arising from provider overpayments are normally tied to the related claim line that was overpaid. This fact allows the Replacement MMIS applications to establish the accounts receivable, and to allocate its balance to each of the related funding sources--and time periods--associated with the original claim. Furthermore, when the balance is actually collected from the provider, it will automatically adjust the funding for each of the sources above, reflecting the reduction in funding generated by the cash collection for the time period during which the claim was originally paid. **(40.14.2.6)**

(40.14.2.6)

Team CSC will monitor the status of each accounts receivable and report weekly and monthly to NC DHHS in aggregate and/or individual accounts, both on paper and online. As noted earlier, all of Team CSC's system reports will be available on line, in a user-friendly format at the conclusion of cycle processing. Team CSC believes that this approach will be well-received by NC DHHS personnel, but we stand prepared to generate whatever hardcopy reports that the State may require. **(40.14.2.5, 40.14.2.34, 40.14.2.40)**

(40.14.2.5, 40.14.2.34, 40.14.2.40)

Accounts receivable balances which have remained in an unpaid status will be posted to a potential write-off listing that will be communicated to NC DHHS regularly. This listing represents balances that may be subject to write-off. Team CSC will work with NC DHHS to identify accounts to be written-off, and will make entries to the Replacement MMIS consistent with State approvals. **(40.14.2.37)**

(40.14.2.37)

D.2.1.2.1.14 Comprehensive Transaction Accounting Services

In presenting the unique advantages of Team CSC's approach, we have highlighted topics where the Team CSC solution enhances Financial Management. Team CSC would like to underscore the fact that our solution is also very comprehensive, and provides all of the functionality that the RFP requires. As a result, Team CSC's operational approach will provide the most efficient processing for a number of important RFP requirements:

- Team CSC will accept and process all check voucher reconciliations from the State Controller's office, updating payment information **(40.14.2.10, 40.14.2.20)**

(40.14.2.10, 40.14.2.20)

- Although the requirement to generate third party letters presented in RFP section **40.14.2.22** appears to have been deleted by section 73 of Addendum 7, Team CSC's Replacement MMIS applications include letter generation capabilities that can be used by NC DHHS to support TPL and other processing activities. Team CSC will work with the State to develop such a capability at the State's option.

(40.14.2.22)

- Team CSC will 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. **(40.14.2.24)** (40.14.2.24)
- Team CSC will record provider claims payable less any overpayment recoupments and required withholding and produce program cash disbursements in accordance with procedures and a schedule approved by the State for each checkwrite cycle, including State-authorized payments. **(40.14.2.30)** (40.14.2.30)
- Team CSC will produce refunds of recipient premiums. **(40.14.2.33)** (40.14.2.33)
- Team CSC will change financial participation rates in the Replacement MMIS to correspond with the Federal fiscal year. **(40.14.2.44)** (40.14.2.44)
- Team CSC will refer questions regarding rates and budgets to the State. **(40.14.2.46)** (40.14.2.46)
- Team CSC will add functionality to management fee payments to allow for enhanced/reduced fees for individual providers and provide interactive updates when entering the revisions into the system. **(40.8.2.51)** (40.8.2.51)
- Team CSC will obtain approval from NC DHHS for the amount to be applied for payment. **(40.8.2.54)** (40.8.2.54)

D.2.1.2.2.Team CSC's Approach for North Carolina's Financial Accounting Function

The second major component to Financial Management is the Financial Accounting unit. This unit is assigned a portfolio of traditional accounting responsibilities designed to properly record MMIS financial transactions, by DHHS division and after completion of financial cycles. Accrual-based entries are made to subsidiary ledgers in accordance with Generally Accepted Accounting Principles, permitting prompt and accurate reporting to the DHHS Controller. **(40.14.2.25, 40.14.2.26, 40.14.2.27)** (40.14.2.25 40.14.2.26 40.14.2.27)

Team CSC intends to use State-approved automated and manual systems to record transactions associated with the Replacement MMIS project. Team CSC understands the requirement set forth in RFP section 40.14.2.48 calling for the Fiscal Agent to incorporate State-approved automated and manual systems to satisfy accounting and record-keeping objectives. We are confident that the existing systems will meet the State's expectations, and will work closely with NC DHHS at the inception of the project to demonstrate the capabilities of these systems and facilitate State approval of their use. **(40.14.2.48)** (40.14.2.48)

The Financial Accounting unit is also responsible to oversee the processing and reporting functions of the Medicaid Accounting System. **(40.14.3.37)** (40.14.3.37)

Financial Management Risks	
Potential Risk	**Mitigation Strategy**
Erroneous payments can be made to providers	Payments to providers can be made only on the basis of claims approved through the automated system, or State-approved non-claim transactions. The extensive edits of the Replacement MMIS help ensure that accuracy and legitimacy of funds disbursed.
Cash receipts are not fully accounted for	Team CSC will establish strong internal controls and reconciliation procedures to ensure that all transactions are properly recorded and cash promptly deposited to bank accounts.

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Exhibit D.2.1.2.2-1. Risk Mitigation Approach. *Our MMIS strategy focuses on prompt, accurate payment with minimal risk.*

Performance Communication	
Method	Trigger
Dashboard	Daily cash receipts Accounts receivable balances by aging category
Scorecard	Evaluation of performance standard attainment
Alert	Failure to achieve any timeliness standard as the due date passes

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Exhibit D.2.1.2.2-2. Financial Management Performance Communication. *All of our activities will be open to the State and fully transparent.*

D.2.1.2.3 Buy-In processing

Automated Buy-in Processes Reduce Administrative Overhead
In the Team CSC New York Medicaid operation, less than one percent of the Buy-in transactions processed daily require manual intervention.

The Buy-in Unit within the Finance Department uses the extensive Recipient Subsystem capabilities to perform Buy-in functions for North Carolina recipients. The Replacement MMIS creates extracts to and reconciles responses from CMS, provides online windows for updates, creates reports, and generates warrant calculation files. The system has effective, accurate, and powerful functionality to identify Medicare eligible recipients for Buy-in, maximizing the State's ability to defer benefit payment to Medicare and preserve State Medicaid funds.

The Replacement MMIS features extensive edits and capabilities to process most Buy-in transactions without the need for manual intervention. In New York, the number of Buy-in transactions that suspend for manual intervention is less than one percent of total transactions processed daily. The Buy-in Coordinator follows documented procedures to perform the following functions:

- Review and verify automated batch processes, resolving any issues with the IT staff
- Review the Buy-in Activity Report for accuracy and timeliness
- Correct suspended Buy-in transactions using online Replacement MMIS windows, or collaborate with the State to resolve these transactions
- Ensure that the Buy-in enrollment request file is generated and sent to CMS by the 25th of each month
- Review failed transactions stored in the Buy-in Reconciliation Table and work with designated State contacts to resolve problems
- Monitor production of warrant calculation files
- (40.2.2.5) Respond to State questions regarding Buy-in processing **(40.2.2.5)**

D.2.1.2.4 Third Party Liability (TPL) Processing

Team CSC understands the importance of establishing payment responsibility of third party insurance carriers for those State of NC recipients with multiple coverages. We will offer processing designed to ensure that the NC DHHS Programs are truly the "Payers of Last Resort", effectively serving to reduce the overall costs to the State wherever appropriate. (10.12.5-14) **(SOO 10.12.5-14)**

Team CSC's approach will include close cooperation with other organizations who participate in TPL activities, such as the State's TPR unit, Program Integrity, as well as the State's selected TPL recovery contractor. Our approach for operations will be fully responsive to the operational requirements of the RFP. The sections below address each TPL operational requirement.

D.2.1.2.4.1 Claim Identification and Recovery Action

Team CSC will identify claims and support recovery actions when Medicare or other third party coverage is identified or verified after claims have been paid. The identification process can emanate from a number of different sources, including provider-initiated adjustments, claims audits performed by Team CSC, reviews conducted by the State's TPR unit, Program Integrity, as well as matching analyses done by NC DHHS's TPL recovery contractor. **(40.11.2.1)** (40.11.2.1)

Once each week, Team CSC will complete a report of identified claims with the potential for TPL, including Medicare, and will make this report available to authorized State users. After identification, claims will be adjusted, as appropriate, leading to commensurate reduction in the provider's payment, or establishment of an accounts receivable balance which will be subject to normal collection processing steps **(40.8.2.52)** (40.8.2.52)

D.2.1.2.4.2 Tracking Recoveries

Team CSC's Transaction Processing unit will process and track recoveries and collections for all identified TPL recovery cases. These cases would include claims for which the provider returned cash after the claim had been erroneously paid without deducting Medicare or other coverage, as well as cases referred to the State by the TPL recovery contractor. Claims which require an adjustment due to the availability of third party coverage will be processed as described below, and if appropriate, the amount of the adjustment will be recovered against current provider payments or established as an accounts receivable. **(40.11.2.2)** (40.11.2.2)

Team CSC will establish an effective procedure to track and post recoveries to individual claim histories. As TPL recovery cases are identified, Team CSC will process adjustment claims to recalculate the amount of the claim, reflecting the residual amount that should be paid after financial participation of the third party, consistent with NC DHHS policy. In other cases, Team CSC will process a void transaction to negate the amount of the original erroneous payment in anticipation of a provider rebilling with appropriate consideration given to the proper third party coverage. In either case, the amount of the original claim on claims history will be adjusted, either to the correct payment amount after third party coverage, or to zero. **(40.11.2.3)** (40.11.2.3)

As recovery of TPL balances takes place, Team CSC will enter or update recovery cases to reflect recoveries received. In some cases, these updates will take the form of reduction in accounts receivable based on cash remittances forwarded by providers in the form of provider checks mailed to Team CSC, or actual return of MMIS checks for erroneous TPL claims. In other cases, the recovery case will be updated based on negative balances calculated by the Claims Processing subsystem after TPL claims have been voided or adjusted. Regardless of source, the recovery case will be automatically updated during current cycle processing, and the amount of any related receivable will be changed to reflect the amount of the update. **(40.11.2.4)** (40.11.2.4)

D.2.1.2.4.3 Carrier Update Transactions

An important component of Team CSC's TPL processing approach will be regular generation of carrier update transactions to the State. This process will be automated, and transactions are generated from a number of different sources. One of these sources is input of file data relating to provider-submitted TPL updates captured on form DMA-2057. These

Pages D.2.1.2-15 through D.2.1.2-21 contain confidential information.

Pages D.2.1.3-1 through D.2.1.3-10 contain confidential information.

provider to determine if there remains interest in remaining enrolled or if the provider needs assistance. This call and letter are documented in **NC***Tracks*. **(40.5.2.7) (Comment CSC237) (SOO 10.12.4-9)**

(40.5.2.7, 10.12.4-9)

Recredentialing Procedures follow the same steps as outlined for Credentialing. The difference is that Team CSC initiates the recredentialing of the provider by sending a secure alert to the provider enrollment contact on record. The provider also receives a list of supporting documentation requirements via email to return.

The provider is given the opportunity to submit the recredentialing application through the web. If no contact is made or there is no email address on file for the provider, Team CSC prints existing enrollment information and mails it to the provider for verification. Upon receipt of information that identifies a provider who may no longer meet State participation criteria, Team CSC refers the information with supporting documentation to the State Review Committee.

D.2.1.3.1.8 Provider Record Storage, Control and Retention

Team CSC provides the following recommendations for the Division's approval for control, balance, audit, as well as the retention, retrieval and confidentiality of provider files relating to this contract:

- All applications and related supporting documentation, written provider correspondence, EFT and Trading Partner Agreements, electronic and paper agency requests/responses, urgent review correspondence, and appeal documentation and related correspondence hard-copies/facsimiles are imaged and retained on-site for the duration of the Contract. Hard copies/facsimiles are stored in the Team CSC archiving warehouse and retained as defined by the State from the date of receipt or as otherwise determined by the State prior to start of Contract operations**. (40.5.2.16, 40.5.2.17)**

(40.5.2.16, 40.5.2.17)

- Billing Agent information and their specific provider associations shall also be imaged and retrievable by State and Team CSC personnel. This information is also maintained on the Provider Database as a non-participating provider entity for online access to key agent information. **(40.5.2.15)**

(40.5.2.15)

- Records and supporting documentation under audit or involved in litigation are kept for 1 year or as otherwise determined by the State.
- Authorized Federal and State representatives have access to and the right to examine the provider files during the 10-year storage period and a period of time thereafter as determined prior to the start of Contract operations. **(40.5.2.14)**

(40.5.2.14)

D.2.1.3.1.9 Provider Database Maintenance

Team CSC also performs routine file maintenance to the provider information as changes are received that do not meet the State criteria to require re-enrollment or credentialing. For example, a provider may use the **NC***Tracks* web portal to request a change in remittance address. Our staff follows State-approved protocols to validate the remittance address before updating the provider tables. We are also able to process atypical provider enrollments as they occur. **(SOO 10.12.4-2)**

(10.12.4-2)

D.2.1.3.1.9.1 Online Updates

Team CSC provides authorized personnel with the capability to perform online real time updates to add/change/delete all provider data elements This real time update capability allows Provider Enrollment staff to effect all State-approved actions such as rate changes, provider suspension or termination, and critical processing information including address changes in a timely manner. Providers may also utilize the web portal to enter some updates directly into **NC***Tracks*. During the DDI phase CSC will work with the State to define which data updates are effective immediately versus those requiring fiscal agent verification. Provider update requests via paper are processed though the previously described document imaging process, then entered into Ibis workflow. **(Comment CSC95) (SOO 10.12.4-5, 10.12.4-10)**

(10.12.4-5, 10.12.4-10)

D.2.1.3.1.9.2 Online Edits

Online edits are used to ensure the integrity of the data and to verify accuracy of the provider database. We edit against other data in the current transaction as well as on the Provider Master Database as described in D.1.4.5, Provider Subsystem. Audit trail reports relay all changes made to the Provider Database and transaction logs provide a record of updates by individual users.

D.2.1.3.1.9.3 Provider Database Update Issues

In addition to updates received from the provider community, the Provider Enrollment Unit receives State initiated Memoranda via Ibis. Such updates include changes in rates, add specialty codes, name changes, addresses, cancel codes, lien/levy data, placing providers on review, and re-opening the provider's master file. Team CSC updates the Provider Database with State-submitted or approved transactions, including approved provider applications. **All entered data is one hundred percent QC verified.**

Team CSC is aware of the special activities relating to the Deficit Reduction Act of 2005, whereby our Replacement MMIS will identify any Medicaid provider receiving annual payments of at least five million dollars. Letters are issued to the providers meeting this threshold, instructing them to return a formal attestation that they are in compliance with section 1396(a)(68) of the Social Security Act, as a condition of remaining enrolled in the North Carolina Medicaid Program. Identified providers who do not return the required attestation timely will have their active enrollment status suspended for follow-up action by the Client Services team. During the Replacement Phase, CSC looks forward to discussions with the State on various methods for using electronic communications and electronically signed documents to reduce the reporting burden on the providers and the State. **(40.14.1.69, Comment CSC89)**

(40.14.1.69)

D.2.1.3.1.9.4 Data Maintenance Policy and Procedures

Team CSC collaborates with the State personnel providing a walkthrough of existing state policies and procedures for updating and maintaining the Provider Database. Together, we gather sufficient information enabling us to incorporate

Pages D.2.1.3-13 through D.2.1.3-19 contain confidential information.

- **Knowledgebase Usage**
  - **Refresher.** Refresher training is critical to reinforce knowledge and promote continuous education. Through quality reviews, call monitoring and performance assessments the need for additional training is identified. If needed, training materials are created and an instructor assigned to conduct the Call Center refresher class.
  - **Policy/Program Changes.** Policies and programs are evolving constantly bringing about the need to educate/update the Call Center Staff. The impact to the call center is assessed by the Business Analysts and training staff. Depending on the complexity of the policy/program change, training may require classroom instruction, one-on-one review, or a simple e-mail communication. Notifications regarding changes to policy or programs will be disseminated via **NC***Tracks* logon screens.
  - **Cross Training.** Customer Service Representatives will be cross trained in additional areas to allow overflow support in the event of high call volume or staff shortages in another skill set.
- **Tools and Techniques**

Exhibit D.2.1.3.2-3 lists training activities to be used for customer service representatives:

Tools and Techniques	
Double-jacking	There are three phases of interaction involved with double-jacking for the New Hire: • Listening on another headset with a seasoned Customer Service Representative • Listening on another headset while using business applications as the seasoned Customer Service Representative works the call or working the call while the seasoned uses the business applications. • Working the call while the seasoned representative listens on another headset and provides assistance as necessary.
Scenario-based cases	Trainees are given a scenario and coached in maneuvering through the various business applications to familiarize themselves with screen content and understanding the various call types.
Real-time Monitoring of Calls	Random calls are monitored by the trainer and new representatives. The representative takes the information presented in the call and uses the business applications and other available tools to follow along on the call.
Knowledgebase	Call Center web enabled knowledgebase application provides a highly searchable repository of policies, procedures, and reference material to support the Call Center staff in assisting callers. Hands-on training is provided showing the new representative how information is organized in the knowledge base and how to most effectively use its search capabilities

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Exhibit D.2.1.3.2-3. Tools and Techniques Used for Customer Service Representatives

The Call Center learning environment strives to resolve as many calls as possible during the initial call. However, there are calls that are outside of the call center scope of responsibility that require escalation or referral using various policy and procedures. Calls related to program eligibility, rates, and State budget considerations will be referred to the State-designated representative or business function based on workflow processes supported via voice and/or electronic transactions that serve as a single integrated workflow solution. Calls in response to specific credentialing questions will be forwarded to the certified credentialing specialist for resolution and follow-up. **(40.5.2.37, 40.5.2.38, 40.5.2.39, 40.5.2.67)**

(40.5.2.37, 40.5.2.38, 40.5.2.39, 40.5.2.67)

As with voice related requests, Team CSC's Call Center solution will include multi-channel support for other methods of communication, such as, chat, email,

fax, and written correspondence. All written requests will be imaged and available in **NC***Tracks* for assignment, tracking, and monitoring that will result in a work request. Call Center staff will have the capability to produce State-approved system-generated letters and templates for timely response back to the requester to meet the State-approved time frame of five days. These letters are also maintained in electronic folders and available for authorized State and Team CSC personnel to access as needed. **(40.5.2.36)**

(40.5.2.36)

The Call Center **NC***Tracks* will have extensive reporting capabilities to provide trending and historical information for analysis of call patterns, quality issues, frequent callers, and inquiry status (open, pended, and closed). Complaint related calls will provide the status of the issue and a detail log of the call history and resolution data. Reports can be generated on demand and/or scheduled daily, weekly and monthly in batch according to State specifications. Reports will be available via the web providing easy access and drill down capabilities to view real time or historical information by State staff and key stakeholders. See section "D.1.4.1 General System Requirements" of the proposal for more information on Dashboards. **(40.5.2.40, 40.5.2.65)**

(40.5.2.40, 40.5.2.65)

D.2.1.3.3 Provider Relations

Team CSC recognizes that the Provider Relations function must consistently demonstrate the flexibility to adapt to a variety of divergent forces that are inherent to the administration of DHHS medical assistance programs. Team CSC's proposed Replacement MMIS serves as a roadmap to improve business processes, expand the universe of program data available to the provider and recipient communities, improve provider participation and satisfaction levels, and reduce operational costs.

Our accessibility and ease of use approach offers a reliable and flexible means of gathering and maintaining provider information required to support North Carolina's Provider Relations business processes. Our self-service Web portal, **NC***Tracks*, offers providers a convenient method to:

- Obtain current program policy and procedural information
- Submit enrollment and check the status of applications processing at any time throughout the enrollment process
- Communicate urgent information
- Download key program forms such as enrollment forms for program participation, electronic claims submission software agreement, electronic fund receipt, electronic remittance advice, business trading partner agreements, specialty program forms for sterilization, hysterectomy, and change requests
- View provider tutorials for claim submission, remittance advice and inquiry access.

Team CSC's Provider Relations staff understands the interdependent provider relationships within the multi-agency medical assistance programs that will receive added benefits with a provider enterprise-wide capability. Across the 100 counties

are diverse recipient demographics that depend on these programs for life supporting services. We believe it is incumbent on Team CSC as the fiscal agent to provide avenues of communication among these agencies through our Training Programs to ensure that all providers are aware of services that they can refer their recipient-patients. **We propose to use the Provider Web Portal to link external State and local provider supporting services, where possible, with informative recipient-patient information.** This additional information gives the opportunity for healthcare to extend to a larger demographic of eligible recipients. Some of these organizations are included in **Exhibit D.2.1.3.3-1**.

Provider Web Portal	
• Association for Home And Hospice Care of NC • Chain Pharmacy Committee of the NC Retail Merchants Association • Long Term Care Pharmacy Alliance • Mental Health Association in North Carolina • North Carolina Academy of Family Physicians (NCAFP) • North Carolina Assisted Living Association (NCALA) • North Carolina Association for Medical Equipment Services • North Carolina Association, Long Term Care Facilities • North Carolina Association of Community Pharmacists • North Carolina Association of Local Health Directors • North Carolina Association of Pharmacists • NC Finance and Reimbursement Organization	• North Carolina Community Care Networks (NCCCN) • North Carolina Community Health Center Association (NCCHCA) • North Carolina Council of Community Mental Health Programs • North Carolina Dental Society • North Carolina Health Care Facilities Association (NCHCFA) • North Carolina Hospital Association (NCHA) • North Carolina Medical Group Manager's Association • North Carolina Medical Society • North Carolina Opticians Association • North Carolina Pediatric Society • North Carolina Physician Advisory Group (NCPAG) • Old North State Medical Society.

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Exhibit D.2.1.3.3-1. Provider Web Portal. *We propose to use the Provider Web Portal to link external State and local provider supporting services, where possible, with informative recipient-patient information.*

Today's approach to quality healthcare extends beyond the provider's immediate environment. There are many opportunities within Provider Relations workshops and onsite training to become more familiar with specific recipient issues that enable proactive approaches to preventive care requirements. **With State approval, we propose to expand our efforts to include social agencies at state, county and local levels, introducing the availability of the enterprise-wide provider function as a source of information to assist their clients that may be eligible for services provided under the Division of Medical Assistance, Division of Mental Health, Developmental Disability and Substance Abuse Services, Division of Public Health, and the Office of Rural Health and Community Care, including the Migrant Worker Program. In reverse, these social agencies which may be governmental, charitable, non-profit church-related, advocacy, school-related, United Way, Salvation Army, may also provide their information for provider referral.**

Our emphasis on identifying potential health related needs such as those listed in **Exhibit D.2.1.3.3-2** and sharing them with the State demonstrates our awareness of the issues the North

Potential Health Related Needs	
• Chronic disease Sickle Cell Anemia Muscular Dystrophy Lupus Cancer AIDS	• Substance abuse Unintentional or violent injury Perinatal health Family and adolescent issues such as drugs and teen pregnancy

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Exhibit D.2.1.3.3-2. Potential Health Related Needs

Carolina DHHS programs confront each day and our desire to build a positive relationship with all the associated entities.

Team CSC's comprehensive approach to provider relations includes Provider Publications, Web Based Provider training, On-site Visits, Provider Workshops, Provider Email, and Annual Medicaid Fairs. Team CSC feels strongly that the Provider Website should be the first and primary source for all mass provider communications. All State-approved training materials will be available to providers online**.** In addition, Team CSC acknowledges that frequent face-to-face education via workshops and on site visit is of high value and assures the provider community of Team CSC's and the State's desire to assist. An example of our outreach, communication and training for providers will be our emphasis on the business rules for prior approval, and how a provider may efficiently use ePaces to submit and view status of prior approvals. **(40.1.2.77) (SOO 10.12.4-11)**

(40.1.2.77, 10.12.4-11)

In October of each year, Team CSC will present an education training plan to the State. This plan includes a recommended listing of the 70 upcoming Team CSC instructor-based workshops in geographical areas across the state, recommended publications for update and/or creation, recommended provider types targeted for visits, and recommended breakout sessions for the Medicaid Fair. This plan is based on reviews of claims denial reports, correspondence tracking data, provider requests and state requests. It addresses policy, procedures, regulatory guidelines, business rules, and claims processes. **(40.1.2.86, 40.1.2.85)**

(40.1.2.86, 40.1.2.85)

Included in this training plan is:

- A project plan with time lines
- Recommended action items
- Tracking of deliverables, goals, impacts
- Successes and failures of the previous year.

In addition to educational training plans, Team CSC implements and provides the State a separate annual marketing plan for electronic commerce options. Team CSC understands the benefits of electronic data interchange (EDI) to both the State and the provider community. As such, we feel strongly that the annual marketing plan for EDI should provide as much forethought as the educational training plan. **(40.5.2.49)**

(40.5.2.49)

In addition, Team CSC generates claims submission reports identifying those providers who are high volume paper claim submitters. Through meetings with the provider community and analysis of the claims data, we determine their reasoning for filing paper claims and take the appropriate actions to move them to electronic business practices. If software filing is cumbersome, we will work with the State to take corrective action. If State policies force paper submission, we will identify such policies to the State and make recommendations. These steps will help lower the total cost of ownership as more and more providers interact electronically.

In accordance with RFP requirements in both our Educational Provider Training Plan and our Electronic Commerce Plan are submitted annually for State approval, at least ninety (90) days prior to the beginning of the contract year. We update the plan as necessary throughout the year with State approval. Once approved by the State, the Provider Relations team uses both plans as its charter for the upcoming year. **(40.1.2.78)**

(40.1.2.78)

Team CSC's ongoing Provider Relations charter is to ensure providers receive accurate and timely communications. Team CSC maintains the capability to support email address listserv functionality. Email and other provider addresses can be updated during initial enrollment, recredentialing, and data maintenance as submitted by the provider community and other interested parties. Appropriate listservs are initiated for mass communication via selected media and appropriate State-approved protocols. Team CSC provides listservs for all providers as well as provider type and specialty specific listservs. **(40.5.2.68)**

(40.5.2.68)

D.2.1.3.4 Provider Training and Documentation

Under the leadership of the Provider Services Manager, Team CSC develops and maintains a comprehensive provider education program that supports the continued participation of providers in DMA, DPH, DMH and ORHCC health care programs. The Provider Services Manager leads an operational environment that supports interactive communication with providers, related associations, agencies, and other interested entities. Careful staff selection, advanced communication technology, and knowledgeable management staff support the State's Provider Education Program requirements.

Our Provider Training Specialists develop the plan, procedures, agendas and materials for provider training for State approval. Provider training can be conducted in the following venues **(SOO 10.12.4-12):**

(10.12.4-12)

- At any of the North Carolina County Department of Social Services
- At the Local Management Entities (LMEs) offices
- At the Department of Public Health
- On-site at Team CSC facilities
- On-site at the Provider location (requested by provider or by the State)
- At provider-related associations
- North Carolina Community Colleges
- At conferences, such as the Finance and Reimbursement Officers (FARO) semi-annual conference **(40.1.2.87)**

(40.1.2.87)

- Annual Medicaid Fair
- Via the web
- At other organizations and locations, as approved by the State and CSC.

Our Provider Representatives conduct provider training and continue to develop positive provider relationships by effective communications, timely follow-up and pro-active efforts to assist providers with Program billing issues. Provider Training staff continue to keep providers knowledgeable about the North Carolina DMA, DMH, DPH, and ORHCC programs and abreast of changes in the system under

the direction of the State. Consistent with the Team CSC Provider Services goals and objectives, the Provider Relations Supervisor and his/her staff develop the Provider Training plan with components that 1) Educate providers on North Carolina recommended quality care guidelines, 2) Respond to the needs of providers, 3) Support correct provider billing and 4) Educate providers on the correct processes and procedures to resolve inquiries, fair hearing requests, and recipient questions.

Team CSC will support training requirements for LMEs, local health departments, Developmental Evaluation Centers/Children's Developmental Services Agencies, DPH, and other State approved local entities. **(40.2.2.6)**

(40.2.2.6)

This training approach has supported a tradition of cultivating strong relationships with the providers. As these relationships develop, trust and confidence by the provider community increases. Providers know when they contact the Provider Training Representatives they receive the assistance they need as quickly as answers to inquiries can be obtained.

Development of the Training Plan

Team CSC develops our training plan with emphasis on two major training criteria — program and billing related information and electronic commerce.

Program and billing related training incorporates:

- Training objectives
- Structure, roles, and responsibilities
- Training development process
- Training delivery process/methods and materials including:
  - Description of online, real-time training on electronic communications and claims and other document submission
  - Examples of training agendas and test transactions used to train providers
  - Training schedule for all provider types across the State
  - Training schedule or examples of online training materials available online or in hard-copy to out-of State providers in neighboring States
  - Providing MMIS and HIPAA-experienced training staff throughout the contract period
  - Locations for training, and plans for providing desktop training at those locations
  - Plans for remedial and ongoing training during operations
    - Content
    - Evaluation
    - Community linkages
    - Electronic Commerce.

Training Development Process
Team CSC develops training materials based on the results of in-depth analyses using previous training program evaluations, telephone logs, state input, provider association input, provider correspondence, encounter data and claim processing detail, and other reporting depicting any billing errors that the providers experience.

We use a multi-phased approach to the development of provider training to ensure that we present accurate and professional training with current program information. When determining workshop content, Team CSC analyzes the following:

- Claim submission data for identification of high volume claim denials and common submission errors
- Provider association membership feedback
- Recently implemented DMA, DPH, DMH and ORHCC policies and programs
- Call center monthly complaint report
- Provider On-Site monthly summary report
- Provider correspondence
- Input for the Program Integrity from audit findings
- Input from DMA, DPH, DMH and ORHCC

At the completion of the development of our proposed training material, we provide the State a copy of the proposed training outline for its review and comment. The necessary steps to an effective and professional training session are presented below:

Provider Notification in Advance Through Alerts (Paper, Web Site, and Email)
Team CSC develops a training schedule with the State's approval that enables providers to plan ahead. We are cognizant of important State holidays, currently scheduled workshops, workshop locations, and activities to maximize participation. Prior to distribution, all provider notifications are sent to the State for approval. We ask the State to include these notifications as part of the State's regular provider publication mechanisms. Team CSC announces workshops through mailings, faxes, emails, association notifications, web content, and other venues as requested by the State.

Provider Pre-Training Questionnaire
On a quarterly basis, Team CSC emails the community pre-training questionnaires to support the educational focus as needed by the provider community. We encourage providers to identify their specific problems and address them in the subsequent training sessions. Where issues are specific to a provider, we recommend their attendance at a training session and provide an on-site visit, if requested. **(40.5.2.47)**

(40.5.2.47)

Training Registration/Confirmation

Once the need for a workshop has been determined, Team CSC submits a listing of potential workshop locations for State approval. After State approval, we ensure adequate space has been planned for provider training. Providers are asked to register for the training sessions which are held at State-approved locations. Registration can be received online, by telephone, or written correspondence. Directions to each location are provided to the provider upon our written confirmation notification. Team CSC plans for extra seating for walk-ins. In addition, those providers who indicate problems in understanding program policies and procedures are contacted directly by our provider staff to invite their participation if they have not returned a registration card. **(40.5.2.50)**

(40.5.2.50)

Assignment and Preparation of Appropriate Staff Trainers

Our Provider Representatives are selected as trainers on the basis of their skills, program knowledge and the training style to be used. With the State, we establish the training content and begin drafting the materials. Once scripting, the training package, and other handouts have been prepared/identified, Team CSC submits a complete package to the State for review and approval.

Mock Training Sessions with State Opportunity for Input and Approvals

Team CSC conducts "mock" training sessions in-house to ensure that our provider training staff is prepared for the tasks ahead. The State is invited to attend the "mock" training sessions and participate in the evaluation process, which includes public speaking skills, knowledge of materials and other program information, and appearance. Provider Training Specialists are not allowed to proceed until they have met high standards for these services. **(40.5.2.46)**

(40.5.2.46)

Develop and Obtain State Approval of Training Packages for each Provider Type

Under the direction of the Provider Services Manager, the Provider Representatives prepare provider training packages for each provider category and as appropriate, specific providers who may be experiencing a particular type of error. To develop training packages, our Provider Representatives:

- Review the telephone records as to the types of inquiries for billing support
- Review Claims reporting depicting provider denials referencing the billing error
- Profile specific providers who have a high rate of incidence of billing denials
- Address State-identified problems communicated to Team CSC.

Conduct Provider Training Sessions

Team CSC conducts training sessions for all North Carolina providers and includes State personnel, when specified. In addition, Team CSC augments State staff quarterly training conferences and annual meetings with billing providers. **(40.5.2.51, 40.5.2.52)**

(40.5.2.51, 40.5.2.52)

Team CSC provides an online sign-in form for both on-site (multiple staff members) and group training sessions by provider type. The sign-in form includes the date of the meeting, specific training category, person(s) attending, job title,

Pages D.2.1.3-28 through D.2.1.3-30 contain confidential information.

comments can be added and displaced for other reviewers. Notifications can be sent to alert reviewers that there are documents requiring their attention. **NC***Tracks* will collect each occurrence of when and who has accessed the document, checked out the document and store changes. If group review meetings are desired, **NC***Tracks* will allow multiple personnel to view the document and see changes made in real time. Once the finalized version is ready for approval the document can be routed to an individual or sequential list of authorizing personnel who will enter their approval based on their role. Until such time that all approvals are electronically entered, the document is not released for publication. **(40.5.2.45)**

(40.5.2.45)

Team CSC posts all communication on the website. When directed by the State, CSC prints and delivers the provider publications and letters to targeted providers, the State, external departments or agencies, and other designated interested parties as well as our in-house staff, for review prior to provider mailings. We commit to performing a review as the first step in any mailing plan to ensure that our respective internal organizations are well aware of the information that has been distributed to the provider community before provider inquiries are received.

System and User Documentation

In addition to provider publications, Team CSC understands the importance of current system and user documentation and pledges that all changes will be incorporated into the master system and user documentation manual by Team CSC's Documentation staff. The entire staff keeps abreast of changes in the DMA, DMH, DPH, and ORHCC programs. The publication analyst works with system personnel to identify required documentation changes associated with system and policy changes. Changes are routed for State review and approval using the workflow management system, Ibis. Once approved, CSC publishes the revisions and posts the updated documents to the website. These documents can then be used to assist in training and orientation and keeps both CSC and State staff up to date on the current state of the program. **(40.5.2.66)**

(40.5.2.66)

Imaging of Provider Documentation

Team CSC images all provider documents, contracts, agreements, enrollment application attachments, training and publication material and forms, on-site visit documentation, training evaluations as well as all written communications and Team CSC/State responses. Each of these documents is linked by transaction/provider numbers for viewing and retrieval by State and Team CSC staff. The documentation is maintained in **NC***Tracks* and accessible to authorized State and Team CSC personnel. **(40.5.2.61, 40.5.2.4, 40.5.2.5)**

(40.5.2.61, 40.5.2.4, 40.5.2.5)

Team CSC images all on-site visit related written materials including written correspondence requesting a visit, on-site summary report, claim data and other reports that are used to assess the type of support or response to a specific inquiry, training materials, on-site visit provider evaluation, any follow-up correspondence. The provider's NPI is used on all materials for electronic document linking for future reference. **(40.5.2.62)**

(40.5.2.62)

Team CSC shall organize by training schedule date and provider training category (e.g., hospital, physician, ancillary or long term care), training agendas, State-

approved training materials, question and answer summaries, provider evaluation forms and provider evaluation summaries that are imaged and maintained in **NC***Tracks*, for immediate access by authorized State and Team CSC personnel. The materials are maintained, at a minimum of 99.9% accuracy. This information may be summoned into an individual's work queue, commented and forwarded to another work queue if necessary. All accesses and comments are noted within the system. If confidentiality is an issue, higher access levels may be assigned to obtain specific data. **(40.5.2.59, 40.5.2.60, 40.5.2.63)**

(40.5.2.59, 40.5.2.60, 40.5.2.63)

D.2.1.3.5 State and Fiscal Agent Training

Team CSC understands the importance of a well trained staff in the ever changing state health care environment. To help ensure that State, local agencies, and CSC staff are current on DHHS program policies, claims processing, and the Replacement MMIS applications, CSC proposes State and Fiscal Agent training within the Client Services Department. **(40.1.2.82)**

(40.1.2.82)

The State and Fiscal Agent Training team meets with the State in October of each year and determines the training schedule for the following year. During this meeting, Team CSC presents a draft training plan that includes recommended topics for specialized training in each month. Examples of training topics include:

- A Day in the Life of a Claim
- How to use and navigate the Call Center system (both instructor led and web based) **(40.5.2.64, 40.5.2.71)**
- Basic Medicaid as well as all DHHS healthcare programs
- Health Check
- Claims Payment Methodologies
- Prior Approval
- Hospital Services
- Professional Services
- Others topics as approved by the State and CSC

(40.5.2.64, 40.5.2.71)

In addition, CSC provides a course on Fiscal Agent Replacement MMIS procedures to State and CSC staff for new employees or those employees who would benefit from a refresher course as needed throughout the year. **(40.5.2.41)**

(40.5.2.41)

Once the training plan is approved, the course topics, dates, times, syllabus, instruction method, and locations are posted on the website. State, local agencies, and CSC staff can search on all available courses as well as register for courses via the **NC***Tracks* or by mail.

Registration for Training Courses

In order to register for training classes, State, local agencies, and CSC staff search the **NC***Tracks* or go directly to the training calendar and click the enroll button. Once an enrollment form must be completed, a confirmation notice is sent back to the registree, the maximum seat count for the class is decremented and the State and Fiscal Agent training unit receives notification. Periodically, email alerts are

sent to registrees reminding them of the upcoming class. If a registree needs to cancel a class, a link is provided to do so.

Instructor and Web based Training
Training may be instructor-led or web-based dependent upon the most effective training method for the topic. If a trainee enrolls in an instructor-led course, the training occurs on site in the Team CSC training room. This training room is equipped with desktop computers with access to the Replacement MMIS for instruction. Team CSC provides trainers for each of the instructor-led courses. Upon completion of the course, the Team CSC trainer updates the tracking system to indicate the trainees' successful completion of the course.

Web Based instructions are computer based trainings (CBTs) focused on particular topics and available in the online Training Center of Excellence. Team CSC creates the CBT and once approved by the State, posts it in the training center. Trainees enroll in the CBTs via **NC***Tracks*. Once the CBT is completed, the trainee electronically signs a statement attesting to his or her completion of the course. The trainee then receives a notification of course completion and the trainee's online training file is updated.

On Line course testing is available in the Training Center should DHHS chose to test proficiency in specific courses.

Training Summary
State, local agencies, and CSC staff can view all training courses taken via the On Line Training Center of Excellence. Role based user access allows authorized users a view of training summary's for their staff and/or the entire agency. CSC provides monthly reports on fiscal agent staff training and proficiencies.

Alerts and Notifications
Multiple Alert and Notification features are available to the user community. Examples of notifications include:

- Online notifications sent to managers making them aware of a trainee's completion of the course and his/her score (pass or fail) or the trainee's failure to take the course in a designated time period.
- Alerts on helpful hints for the Replacement MMIS
- Recommended readings regarding the subject matter.

D.2.1.3.6 Electronic Claims Submission (ECS)/Electronic Data Interchange (EDI)

The ECS/EDI component of the Replacement MMIS is a multi-faceted, proven approach to electronic claims submission, one that has yielded verifiable results in increasing provider submission rates and provider satisfaction. Team CSC supplements these system features with a variety of communication techniques and a Call Center. The North Carolina provider community will experience improved operations and DHHS will see a reduction in the total cost of ownership through expanded use of electronic processing.

Team CSC actively promotes Electronic Data Interchange (EDI) services to all providers, especially those who submit a high volume of hardcopy claims. **The State benefits from increased ECS and EDI submission with streamlined operations and reduced operating costs; North Carolina providers realize reduced manual handling of claims and an accelerated return of submission information.**

Three-Prong Administrative Program to Support EDI
Providing full functional, easy to use MMIS features that are available to providers 24 hours a day, 7 days a week
Implementing a proactive campaign of marketing the benefits of EDI that included the following activities: Monthly Medicaid Updates articles accenting the benefits of EDI Direct mailings to providers Website articles tailored to EDI use E-mails to targeted provider groups One-to-one contact with providers (Call Center, provider training seminars, provider association meetings) Direct contact with the regional outreach staff
Staffing an EDI Call Center with a team of technical, claims, and HIPAA specialists to provide immediate support to the participating provider community.

Our approach to encouraging North Carolina providers to use electronic claim filing is based on the successful methodology used on the CSC New York Medicaid contract. In March 2005, all EDI activity was moved to HIPAA standard formats; all prior proprietary formats and submission methods (e.g., magnetic tape and diskette inputs) were replaced by electronic methods of transmissions over dial-up and high-speed Internet. When coupled with an aggressive 3 prong informational campaign, we were able to show significant results in EDI/ESC processing. In fiscal year 2006 alone, some 421 million New York Medicaid claims, **over 97 percent, were processed through EDI.**

Team CSC plans to implement these EDI measures to increase the current 92 percent North Carolina provider participation rate for electronic processing under the new Replacement MMIS contract. To facilitate electronic access to the Replacement MMIS, Team CSC implements an Electronic Gateway (EG) for North Carolina providers to use for claims submission. The gateway accepts all claim types using the following transmission protocols: FTP, tape, cartridge, diskette, CD, and asynchronous transmission (PC-to-PC). All electronically submitted claims undergo pre-processing routines to validate that they meet HIPAA formats and industry standards.

Before electronic claims can be entered into the Replacement MMIS, they are edited and validated according to industry-accepted standards. For example, all pharmacy claims are edited against the National Council for Prescription Drug Programs (NCPDP) Version 5.1 standards; the Accredited Standards Committee (ASC) X12 standards are used to edit and process all other claims.

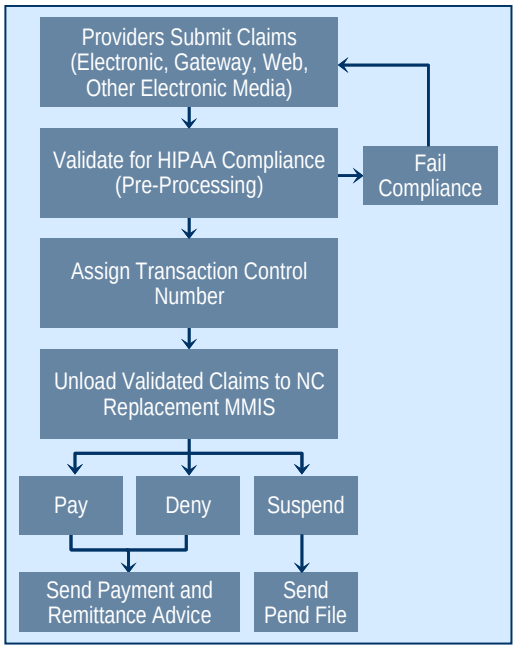

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Exhibit D.2.1.3.6-1. EDI/ECS Process Flow. *Process Flow* provides *an overview of the electronic processing for the Replacement MMIS.*

Once deemed acceptable, the claims are assigned a Transaction Control Number and uploaded to the Replacement MMIS. Claims are then paid, denied, or suspended for further investigation**. Exhibit D.2.1.3.6-1,** EDI/ECS Process Flow shows the steps claims undergo for electronic processing.

The baseline MMIS receives and processes physician claims (837 Professional, X12 format) in real-time mode. **Exhibit D.2.1.3.6-2, EDI** Communication Channels, depicts the various methods for electronic transmissions that are available with the new system. In addition to the EDI submissions, Team CSC accepts diskettes and tape-to-tape billing from defined and secure sources**.** We will work with providers to assist them with more efficient modes of electronic processing under the Replacement MMIS**. (40.8.2.30) (Comment CSC29)**

(40.8.2.30)

Inbound Transaction	Dialup Batch Electronic Gateway	Dialup Batch FTP	Real Time Direct Connection	Web-based Batch eXchange	Web-based ePACES
270 Interactive			✓		✓
270 Batch	✓	✓		✓	
278 Interactive			✓		✓
278 Batch	✓	✓		✓	
NCPDP 1.1	✓	✓		✓	
NCPDP 5.1			✓	✓	

Inbound Transaction	Dialup Batch Electronic Gateway	Dialup Batch FTP	Real Time Direct Connection	Web-based Batch eXchange	Web-based ePACES
834 Enrollment		✓		✓	
837 Dental Batch	✓	✓		✓	✓
837 Institutional Batch	✓	✓		✓	✓
837 Professional Batch	✓	✓		✓	✓
837 Professional Interactive			✓		✓
276 Claim Status	✓	✓		✓	✓

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Exhibit D.2.1.3.6-2. EDI Communication Channels informs providers at a glance on the proper mode of electronic transmissions.

Provider Software

To facilitate electronic claims processing, Team CSC offers submitters several options for transmitting their claims. Foremost of these is ePACES, the online electronic Provider-Assisted Claim Entry System. This application allows providers to request and receive HIPAA-compliant claim, prior approval, eligibility, claim inquiry, and service authorization information. Because the system is Web-based, it is not necessary to distribute application software for provider installation. The most current version of the ePACES is delivered to the client PC each time the provider accesses it over the Internet. **(40.8.2.26)**

(40.8.2.26)

To invoke ePACES, providers need only a PC, browser, and connection to the Internet. Providers must log into **NC***Tracks* using a secure and verified NPI number and password and select ePACES. They must also agree to confidentiality regulations regarding the privacy and security for a recipient's protected health information (PHI). For a detailed description of ePACES, please see proposal section D.1.4.8, Claims Processing.

ePACES Success Story

More than 35,000 New York providers rely on ePACES as their electronic claims submission venue. CSC has helped NY increase electronic claims submission to 97%.

The ePACES application was designed for the convenience of all providers and billing agents, large groups, and individual practices. **Exhibit D.2.1.3.6-3**, ePACES Entry Page, shows the initial page that is displayed to users and lists the information available through this application. The ePACES program has been instrumental in attaining the 97 percent provider participation rate for electronic processing for the New York Medicaid program. We plan to explain and emphasize the advantages of ePACES to the North Carolina providers in all provider training and informational materials.

Page D.2.1.3-37 contains confidential information.

Data Integrity

The integrity of the EDI-transmitted data is closely monitored; **all transmission methods implemented for the Replacement MMIS provide maximum security**. Files transmitted to the Replacement MMIS are required to be encrypted prior to transmission, and the system acknowledges all received transmissions by responding with a confirm-receipt file. This exchange occurs at the transmission level, before the front-end process is invoked. Standard response files are returned to the submitter by the system as part of the front-end process. These standard response transactions are the X12 997 (Functional Acknowledgment) and the NCPCP Response and NCPDP transmissions. **(40.8.2.27)**

(40.8.2.27)

Complying with the X12 and NCPDP standards provides additional integrity measures. For example, the X12 standard contains several mandatory control features. At the header and trailer levels of the transmission, the sender must report control numbers that are verified by the Replacement MMIS. Additional control numbers exist at two other levels; the Functional Group and the Transaction levels, which the Replacement MMIS also verifies. Within these control areas, counts of individual segments (or records) are kept. The verification and presence of all control numbers and record counts ensure data integrity of the EDI transmissions.

ECS/EDI Agreements

Team CSC enforces set procedures for providers who elect to bill electronically. Each provider must submit to CSC a signed ECS/EDI agreement, which becomes part of the provider's record. Providers must first apply for an Electronic Transmitter Identification Number (ETIN) by completing a Provider Electronic Transmitter Identification Number Application and a Certification Statement for Provider Utilizing Electronic Billing. The Certification Statement must be signed and a separate statement is required for each provider to be enrolled under the ETIN. The ETIN and Certification Statement are available for download from the Web Portal. **(40.8.2.28)**

(40.8.2.28)

After processing the required forms, providers are sent their User Identifiers and initial passwords, which must be changed with first time system access. As an additional security precaution, passwords expire every eight weeks. Users receive alerts one week prior to the expiration date advising them of the need to reset their passwords.

All signed and notarized Certification Statements for Provider Utilizing Electronic Billing and the Provider Electronic Transmitter Identification Number Applications, along with a Security Packet B, are controlled by the Provider Services Unit. They ensure that the applications and agreements are imaged and linked to the provider information contained within the Provider Subsystem. **(40.8.2.29)**

(40.8.2.29)

(40.8.2.31, 40.8.3.3)

ECS/EDI Help Desk

Providers have access to several avenues for information and assistance for their electronic submissions. The North Carolina Electronic Gateway is available 24 hours a day, 7 days a week, and the Team CSC Call Center is available Monday through Friday between 7AM and 10 PM, and 8:30 AM to 5:30 PM on Saturday, Sunday, and holidays. The EDI Help Desk, which provides additional EDI support, is available during State business hours, from 8 AM to 5 PM (EST). **(40.8.2.31, 40.8.3.3)**

The Call Center is the first line of contact with providers. Representatives are trained to assist providers with all billing questions and issues. Issues beyond the Call Center's expertise or those queries that cannot be handled in a timely manner are escalated to appropriate areas; electronic billing and transmission questions are referred to the EDI Unit.

The Team CSC dedicated EDI Unit assists providers in claims submission. Electronic submissions are received 24/7, and are loaded into the claims system daily for adjudication. The EDI Unit tracks these claims through the system. Specialists in this unit are responsible for working with both individual providers and all EDI business partners to ensure all submissions are properly received, processed, and acknowledged back to the original submitter. The EDI Unit is composed of two (2) teams:

- **Tier II: EDI Help Desk**: These technical experts assist providers with complicated claims (including encounters) and all other submissions, handle sign on and password resets, provide Point-of-Service (POS) device support, train Call Center personnel on EDI, perform EDI raw data troubleshooting, and process Remittance Advice recreation request from providers.
- **Tier III: Electronic Transaction Support**: Staffed by business and HIPAA subject matter experts, this team helps Trading Partners with complicated billing questions and issues, develops and maintains Companion Guides and frequently asked question documents for Trading Partners, trains Trading Partners on the use of the Replacement MMIS, attends onsite meetings and conducts conference calls with individual providers, provider associations, and standards setting organizations working on the evolution of HIPAA and EDI requirements and guidelines, works with the developers on compliance issues, monitors industry blogs and Internet sites, and serves as the liaison for State personnel and developers on industry activities and developments.

Acceptance Testing (Trading Partner, Provider, Pharmacy VANs)

Before Trading Partners, providers, pharmacies, and Value Added Networks (VANs) can submit claims and requests electronically, they must successfully complete an acceptance test. The Replacement MMIS Provider Testing Environment is designed to test for HIPAA structure and code-set (limited) validation. Team CSC provides the necessary file specifications and testing assistance to VANs on how to access EVS.

The test environment also provides sample response information based upon transaction or file submission. If a user submits a batch file containing HIPAA

X12N 837 Institutional (x096) Health Care Claim, the provider testing environment processes and returns a 997 Functional Acknowledgement or 997 Error Response, and a sample 820 Claim Remittance Advice for capitated providers or an 835 Claim Remittance Advice (x091) for non-capitated providers. **(40.8.2.33, 40.3.2.2, 40.3.3.2)**

(40.8.2.33, 40.3.2.2, 40.3.3.2)

To participate in the Replacement MMIS Provider Testing Environment, providers must have the applicable components of the following:

- An active NPI registered in the NC State Medicaid program
- An active NC State Electronic Transmitter Identification Number (ETIN)
- An active access method:
  - A **NC***Tracks* User ID and password — for testing through Exchange
  - An FTP User ID — for testing through dial-up FTP
  - A BBS User ID — for testing through the Electronic Gateway
  - A broadband network connection (limited availability) — for testing CPU-CPU (generally mainframe or mid-range)

Acceptance testing also requires that the provider profile be set in accordance with the method of transmission. If a provider elects to submit a batch file to the Replacement MMIS Provider Testing Environment, the provider profile must include this information. Similarly, if the provider wishes to submit real-time transactions using dial-up PC or a directly connected CPU-CPU link, the provider profile must also be set up accordingly. Provider profile settings are determined during initial provider enrollment, the establishment of an ETIN, the completion and subsequent submission of the appropriate Replacement MMIS Provider Security Packet, or enrollment in ePACES. This information is added to the production security file when the provider is approved for the ECS/EDI participation. **(40.8.2.34)**

(40.8.2.34)

A successful batch file test occurs when the submitter receives a 997 Functional Acknowledgement with a status of ‘Accepted’ for each functional group submitted, accompanied by a ‘canned 820 or 835’ file. A 997 Functional Acknowledgement indicates that the submission passes HIPAA X12N structural integrity and code-set (limited) validation. The 820 or 835 file represents a sample remittance advice the trading partner will receive once migrated to production. This canned remittance advice can be modified by the Trading Partners to conduct limited testing of their applications, simulating data received from the MMIS. A successful real-time transaction test using the Replacement MMIS Provider Testing Environment occurs when the submitter receives a sample response and does not receive a GS99 reject response. Adjudication of the batch or transactions is only provided by submission to the Production Environment.

Team CSC will obtain State approval and demonstrate acceptable test results to the State prior to implementing each VAN. After a Trading Partner, provider, pharmacy, or VAN has successfully completed the acceptance test, the EDI Unit forwards the request via **NC***Tracks* that includes the provider information, security identification number, date, and test results to the State for the official sign off and

(40.8.2.32, 40.3.2.1) approval. When received, this information is imaged and maintained in the Provider Subsystem and linked to the provider profile. **(40.8.2.32, 40.3.2.1)**

Acceptance testing is also required for VANs or pharmacy switches that submit Pharmacy POS claims. All clearinghouses and/or switch vendors must complete signed and notarized Pharmacy POS Trading Partner Agreements prior to accepting any production POS claims data. Team CSC will provide the necessary instructions to the State and VANs in how to use the EVS. The VANS are then responsible for training the providers who contract with them. **(40.8.2.36, 40.8.2.37, 40.3.2.3)**

(40.8.2.36, 40.8.2.37, 40.3.2.3)

Logging of Tapes and Diskettes

Claims Distribution is responsible for the logging and preparation of tapes and diskettes for electronic media processing. Preparation Clerks verify that each submission is accompanied by a completed and signed transmittal. Media with a properly prepared transmittal is sorted by media type and assigned a sequential slot number, which is an internal control number used for tracking and accountability. A pressure-sensitive label displaying this number is affixed to each item (disc sleeve or tape ring) and to its associated transmittal. On a daily basis, a summary of the beginning and ending batch number is prepared on the EMC Slot Number Log. All slotted media are staged for pickup at periodic intervals throughout the day. **(40.8.2.35)**

(40.8.2.35)

The CSC Production Control schedules preprocessor jobs periodically, throughout the day, to process all batch claims received. All diskettes or tapes are returned to the submitting providers, and Team CSC retains electronic backups of submitted batch claims for the duration of the contract.

Although Team CSC has the procedures and processes to accommodate tapes and diskettes for electronic processing, we will encourage providers who rely on these legacy transmission methods to use the new electronic gateway and Web features of the Replacement MMIS.

D.2.1.3.7 Recipient Services/EVS

Team CSC provides a Recipient Services team to ensure recipients receive their certificates of credible coverage and that the Recipient Subsystem is performing as required in the RFP. Team CSC understands that when a recipient is no longer eligible for DHHS programs, the recipient must be provided a certificate of credible coverage (COCC) that indicates the dates they were covered in the DHHS medical assistance program. This COCC is generated within one month of termination from the program, and the mail date is logged in **NC***Tracks*. Team CSC provides a monthly report with the number of recipients/clients terminated from each health plan and the number of COCCs mailed within one (1) month of the termination, as well. **(40.2.3.4)**

(40.2.3.4)

Recipients and their employers often have questions regarding their COCC or need a duplicate copy of their COCC. Team CSC provides staff to answers these recipient and employer calls and questions via phone and writing. These communications are documented in **NC***Tracks*. **(40.2.2.7)**

(40.2.2.7)

In addition to performing COCC duties, the Recipient Services team performs daily checks on the eligibility system to ensure the Replacement MMIS is updated with the batch eligibility data from each State entity by 7:00 AM Eastern Time. This team reviews the following eligibility reports, ensures their production by 7A.M. Eastern Time each State business day and communicates with the State to ensure the appropriate action: **(40.2.3.2)**

(40.2.3.2)

- State entities' eligibility edit/error reports by 7:00 A.M. Eastern Time **(40.2.3.1)**
- Eligibility Reconciliation Reports

(40.2.3.1)

The Replacement MMIS features automated processes to reconcile eligibility data that is received from external sources. These processes include:

- Reconciling Common Name Data System (CNDS) transactions (described in Proposal Section D.1.4.2.4, Recipient Database Maintenance, collaborations with the Common Name Data System (CNDS) with Replacement MMIS data and producing update and error reports
- Reconciling Eligibility Information Systems (EIS) data with Recipient database information on a daily basis (described in Proposal Section D.1.4.2.4, Recipient Database Maintenance, Eligibility Information Systems Updates), and producing update and error reports.

Team CSC IT staff schedules and monitors daily job execution. Each day, IT production staff reviews job execution and outputs to verify that each reconciliation process has executed successfully. The staff corrects any processing problems and confirms successful production of the error reports. The enterprise document management solution maintains the update and error reports and makes them available to designated users within the State-specified timeframes.

Team CSC will work with the State during the implementation period to define the detailed processes and procedures for job scheduling and execution, and to define the specific format, content, and delivery instructions for the CNDS and EIS update and error reports. **(40.2.2.1, 40.2.2.2)**

(40.2.2.1, 40.2.2.2)

Proposal Section D.1.4.2.5, Recipient Subsystem, DPH and ORHCC Program Updates, describes the proposed Replacement MMIS functionality to link the CNDS ID to the Recipient database and associated financial eligibility application information. These automated processes will ensure that recipient identification information is accurate and in accordance with CNDS Governance Rules and will minimize or eliminate discrepancies and manual intervention requirements. **(40.2.2.8)**

(40.2.2.8)

For State Mental Health Updates, proposal Section D.1.4.2.4, Recipient Database Maintenance, describes a process Team CSC will implement similar to that used for EIS reconciliation to reconcile specified State-entity DMH eligibility data with ASC X12N 834 transactions on a daily basis. Team CSC will update each State entity's Eligibility Data from online processes for State EIS, CNDS, LMEs, and DPH in near-real time. The automated reconciliation process will verify that all records and segments received via the 834 transaction are processed and will produce an update and error report. The IT staff will schedule and monitor daily job execution. The

enterprise document management solution will maintain the update and error reports and make them available to designated users. During the implementation effort, Team CSC will work with the State to define the details of the reconciliation process and the format, content, and delivery medium of all reports. **(40.2.2.3, 40.2.3.3)**

(40.2.2.3, 40.2.3.3)

Team CSC is aware that in certain situations some DPH recipients may be lacking a CNDS ID, and manual steps must be taken to review the demographic fields on the DPH record with the recipient data already in the MMIS. Five situations are outlined in the CNDS Governance Rules found in the Procurement Library DSD, section 3.8-38, including some that appear to result in an auto-assign of a CNDS number, and some where manual determinations must be made. Team CSC will work carefully with the State during DDI to map these business rules to our Ibis workflow application. **(Comment CSC715)**

As described in Proposal Section D.1.4.2.6, Recipient Subsystem, Processing Medicare Part A/B Enrollment and Buy-in Updates, Team CSC has an automated process to update and maintain Medicare enrollment and eligibility data. The IT staff monitors data exchanges with DIRM to obtain and process CMS Enrollment Database (EDB) and Social Security Administration (SSA) Beneficiary Data Exchange (Bendex) files. The update process produces reports that are available to the State and Team CSC to identify and resolve Medicare enrollment problems. The Team Lead in the Third Party Liability Unit follows defined procedures for determining the appropriate State entity and contacting/collaborating with designated individuals to resolve Medicare enrollment problems. **(40.2.2.4)**

(40.2.2.4)

D.2.1.3.8 Health Check

The expressed goal of the North Carolina Health Check program is to facilitate regular preventive medical care through the early and periodic screening, diagnosis, and treatment (EPSDT) of health problems for Medicaid recipients under the age of 21. The Replacement MMIS Health Check Subsystem, which meets or exceeds federal EPSDT requirements, enhances the ability of the Division of Medical Assistance to provide and improve access to preventive health services for all Health Check enrollees.

Team CSC takes advantage of Web technology, integrated systems, and intensive training to improve Health Check processing efficiencies. Operational support is provided by a dedicated CSC Health Check Unit, which serves as a centralized resource for Health Check technical and informational inquiries, telephone, and written correspondence, preparation of Health Check materials and notices, staff and provider Health Check training, and reporting.

Expanded Use of Web Technology

Team CSC emphasizes the use of the NC*Tracks* for Health Check information and verification and as an efficient replacement for the Automated Information Notification System.

The Health Check Subsystem collects and organizes the required EPSDT data elements from the Recipient, Provider, Claims, Third Party Liability, and workflow subsystems and displays this information to State and Team CSC operations staff in a

series of online pages. State Health Check Coordinators (HCCs) rely on this information to verify that eligible recipients are enrolled in the program and to track screening, diagnosis, treatment, and referral services that were received. State staff also uses this data to identify the need for additional education and to encourage program participation by recipients. The Team CSC staff accesses Health Check data online to respond to telephone and written inquiries and to identify providers that may require additional information or training. **(SOO 10.12.3-3, 10.12.5-15)**

(10.12.3-3, 10.12.5-15)

To improve flexibility and responsiveness for Health Check operations, Team CSC proposes to maximize Web usage by providers and Health Check Coordinators. A specific Health Check page on the North Carolina Medicaid Web Portal allows authorized users to verify recipient and claims information, submit and edit administrative forms, view billing and procedural manuals, obtain training materials, and request reports. The use of the technology helps the State reduce operational costs and improve timeliness and efficiency.

Team CSC also plans to replace the functionality of the Automated Information Notification System (AINS) with increased usage of Web technology. AINS is a computerized system for identifying and following eligible Medicaid children from birth through 20 years of age; it also allows for the submission of administrative data and the generation of notifications and reports. Our secure, browser-based Web application complements the Replacement MMIS and accomplishes all functions previously provided by AINS with the added benefits of being easily accessible and maintainable. This application allows Health Check Coordinators to view information for Health Check recipients in their assigned counties and enter free-form text comments about recipient interactions. State staff can also send or suppress notifications and create required administrative reports.

In addition, the Replacement MMIS employs a series of standard and updatable notification templates. The template used for each notification is determined by the reason for the notification or the child's location in a project county. The Health Check Coordinator requests standardized notification for a recipient through the Web page. After the automated notifications are generated, they are printed and mailed by Team CSC. A history of all mailed notifications is available in the integrated database.

Another key operational function of the Health Check Subsystem is the creation of all required State and federal reports**.** All federal reporting requirements, including the CMS 416 and MSIS file updates, are satisfied by the system. The Health Check Unit schedules these reports and monitors their production. Reports are stored in **NC***Tracks* where they are available to authorized users. The Health Check Unit and Quality Assurance staff reviews these reports and verify their completeness before release to the State.

In addition to these activities, the Health Check Unit furnishes the following operational support:

- Provides information to County staff regarding Health Check management fees
- Produces standard and customized letters for recipients and providers

- Records provider complaints, questions, and requests into the **NC***Tracks*.
- Revises Health Check manuals
- Instructs providers and State Health Check Coordinators in program processing
- Assists the State Health Check Coordinators in the development of materials to support the program
- Performs onsite visits with Health Check Coordinators and providers.

Team CSC performs specific functions to support the North Carolina Health Check program and meet the State's requirements, as described below. Examples of the updatable online pages and program capabilities are included in the system description in Proposal Section D.1.4.10, Health Check Subsystem.

Telephone and Written Correspondence and Technical Support

The dedicated Team CSC Health Check Unit is responsible for responding to telephone inquiries and written correspondence from HCCs concerning the Health Check program, processing, and reporting. **(40.10.2.2)** All inquiries and responses to Health Check County staff concerning the Health Check management fees are documented in **NC***Tracks* and the response is forwarded to the State. **The Health Check Unit will meet with DMA on a predetermined schedule, as deemed appropriate by the State, to ensure that our staff has the most current Health Check information for communication to the HCCs. (40.10.2.11)**

(40.10.2.2)

(40.10.2.11)

Provider requests for Health Check billing information are handled by the Provider Call Center. Requests for detailed program, policy, or billing information that cannot be immediately handled by the Call Center are forward to the Health Check Unit for response. These calls are logged and tracked within **NC***Tracks.* All requests for Health Check information are monitored by the CSC Client Services Manager to determine if additional training or educational materials are needed to improve the effectiveness of the Health Check operations. Any trends or concerns are reported to the State. Providers can also obtain information on Health Check eligibility and processing through the Automated Voice Response System (AVRS) and the Eligibility Verification System (EVS). **(40.10.2.12)**

(40.10.2.12)

Health Check Materials

Providers and HCCs must have access to current and accurate Health Check information to maximize utilization of the program. The Health Check Unit works closely with the State to produce, coordinate, and update Health Check materials that include:

- **Health Check Web-based User Manual.** This manual is used by HCCs and Health Check personnel to obtain information on EPSDT services and Health Check outreach projects, including reimbursement, HCC contact lists, agreements, technical visits, required State reporting, and standard letters. This Web application user manual is readily accessed through the Web Portal. **(40.10.2.1)**

(40.10.2.1)

- **Health Check Billing Guide.** The online billing guide advises providers on billing for EPSDT services, screening components and schedules, immunizations, and vaccines. It includes instructions on the use of proper diagnosis codes and

modifiers, preventive medical codes, and Health Check codes. It also offers tips for decreasing claim denials. Under the new contract, Team CSC will coordinate with the State to rewrite the guide; the revised version will be published to the Web according to a schedule approved by the State. **(40.10.2.4, 40.10.2.13)**

(40.10.2.4, 40.10.2.13)

- **Notifications.** Generation of notifications is one of the primary functions of the EPSDT/Health Check Subsystem. These automated notifications are sent on behalf of eligible children to the caretaker as reminders of upcoming or missed screenings, immunizations, and introductory notifications for those newly eligible. The Replacement MMIS Health Check Periodicity Schedule Table contains the business rules for establishing health screen schedules and sending automated notifications. Annual reminders are sent three months before the child's next birthday and advise of the services for which each child is eligible and should receive. HCCs rely on these communications to encourage active participation in the program. Additional notifications may be generated when follow-up services have not been received or appointments have been missed. Health Check personnel have the ability to send or suppress various notifications.

Health Check Training

To support the North Carolina initiatives for communicating and coordinating Health Check policies and procedures to Health Check stakeholders, Team CSC proposes to implement a focused training program that addresses the concerns of the State, HCCs, and providers. Working with DMA, Team CSC reviews Health Check claims denial reports and the correspondence tracking system to determine the specific discussion topics, prepares presentation materials, and assigns knowledgeable personnel to participate in the sessions. Health Check training activities are included in the overall CSC training plan and consist of:

- **State Health Check Coordinator Training Session.** The CSC Health Check staff attends the Health Check Coordinator training session held by the State in Raleigh, NC and provides instruction on CSC Health Check operations. They explain the resources available to the HCCs and provide additional training on the use of the Web Portal to file required forms and reports. **(40.10.2.3)**

(40.10.2.3)

- **Agenda Planning Meetings/Mock Workshops.** Prior to conducting the Provider Training Workshops, Team CSC meets with designated State Health Check personnel to prepare the agenda. To ensure that Health Check information is presented in a clear and comprehensive manner, Team CSC conducts a mock workshop with the State. This exercise is then used to refine the presentations and to identify areas that require additional information. Recommendations that arise from the mock workshop are incorporated into the Health Check training curriculum. **(40.10.2.5)**

(40.10.2.5)

- **Regional Provider Workshops.** Each year, CSC Provider Relations staff conducts regional provider Health Check workshops in six separate sites throughout the State. CSC will present recommended seminar locations for approval by the State. These sessions may be held in the CSC Training Center, community colleges, hotel banquet facilities, etc. Included on the agenda are the Health Check Program guidelines and the program's significance in detecting

health problems in children and in reducing Medicaid costs. CSC Health Check staff presents details on the Health Check policies and procedures and the Web application. The Health Check team also responds to provider questions and concerns. The focus of this presentation is on provider participation in the program. **(40.10.2.6, 40.10.2.12)**

(40.10.2.6 40.10.2.12)

Reporting

Health Check management reports can be requested, viewed, and downloaded through **NC***Tracks*. Access to all management reports is restricted by security procedures that limit each user's access to only that information which he or she is authorized to view. The following administrative reports are integral to the operation of the North Carolina Health Check program and provided by the Replacement MMIS:

- **Health Check Management Fee Option File Master Report.** Team CSC Health Check staff reviews this report to ascertain that claims for Health Check management fees were generated correctly. Reimbursement for HCC services is determined jointly by DMA, DPH, and the North Carolina Association of Public Health Directors; a pre-determined payment is made to an agency each month as a management fee. Since the number of Medicaid-eligible children may vary from month to month, the management fee per child is recalculated each month. Currently in North Carolina, the monthly reimbursement amount to the county is the $2,822 per month per FTE, regardless of the number of Medicaid children in the county. This report verifies that the management fee is being correctly applied and processed. **(40.10.2.9)**

(40.10.2.9)

- **Denied Claims Report.** The Denied Claims Report, generated by the Claims Subsystem, lists all EPSDT claims that were systematically denied and includes the denial reasons. The Team CSC Health Check Unit uses this report to analyze the claims and the denial reasons. Additional reporting is available from the MAR Subsystem that identifies a provider who has a denial rate of over 10 percent of submitted EPSDT claims. The Health Check Unit investigates these claims, prepares documentation, and telephones the provider to resolve any billing problems or to schedule a provider visit for additional instruction. **(40.10.2.7)**

(40.10.2.7)

- **Full Time Equivalency (FTE) Report:** The FTE Report collects information on Health Check Coordinators located in the various Health Districts to determine if the Health Check Coordinator FTE allocations or maximum allocations for a particular district are accurate. After the monthly reports are compiled, they are forwarded to the State for review and approval. The FTE Report reflects the information for all Monthly Accounting of Activity Report (MAAR) and the County Options Change Request (COCR) forms that have been submitted and approved by the State. **(40.10.2.10)**

(40.10.2.10)

For the new contract, the MAAR, COCR, and FTE Reports will be available on NC*Tracks*. State Health Check Coordinators and authorized administrative personnel will have the ability to submit, edit (enter free-form text comments), approve, and search these reports. The Web application in NC*Tracks* replaces the AINS for the submission of administrative data and the generation of notifications and reports. During the DDI Phase, Team CSC collaborates with the State to ensure that all relevant

information is collected and that the appropriate security and validation procedures are in place.

- **Health Check County Option File Master Report.** This report includes data on counties participating in the Health Check program that receive the MAAR, COCR, and FTE administrative reports. The Health Check County Option File Master Report is review by the Team CSC Health Check Coordinator to verify that the county participants have access to all the Health Check data and reports. **(40.10.2.8)**

(40.10.2.8)

- **Additional Reporting.** The Health Check Subsystem produces all required federal and State reports. Team CSC will review all available and required reports during the DDI Phase to ensure that the State has access to the all information needed to effectively and efficiently manage the Health Check program.

D.2.1.3.9 Managed Care

The Team CSC Replacement MMIS offers the State increased recipient and claims functionality that readily accommodates the managed care processing requirements associated with primary care case management programs. In North Carolina, the Community Care of NC (Carolina ACCESS and ACCESS II) and Piedmont Managed Care provide managed care services to most eligible Medicaid recipients. The Team CSC approach to Managed Care operations proactively supports the State's main objectives of cost-effectiveness, appropriate use of health care services, and improved access to primary preventive care.

Team CSC relies on integrated transaction processing, a sophisticated Web application, and a highly-trained Managed Care staff to facilitate the State's priorities. Collectively, these elements provide quality operational support for the State's managed care programs. Among the activities performed in the Operations Phase are responding to provider and State inquiries, monitoring encounter processing, tracking provider inquiries and requests, preparing managed care educational and training materials, and conducting provider billing and informational seminars.

The managed care functionality embedded in the Replacement MMIS supports primary care case management and HMO business functions. It offers enhanced provider service to the DHHS provider community participating in the ACCESS programs and can support multiple Managed Care programs, such as the pre-paid Inpatient Mental Health Plan. Managed care processing accesses data contained in the Recipient, Claims, Reference, Provider, and Finance subsystems and portrays the requested information in a series of online pages.

Managed Care staff can define and maintain Primary Care Case Management (PCCM) and HMO plan eligibility criteria, coverage, and capitation/case management fee rates for various recipient populations. The processing also accommodates auto-assignment of eligible recipients into a managed care program and the disenrollment of recipients due to loss of eligibility. Capitation/ case management payments and primary care physician rosters are also generated on a

scheduled basis. In addition, the system allows the application of specific edits/audits and online tracking of changes made to managed care financial and claims data.

Through a series of online pages, the Team CSC Managed Care staff can effect authorized changes to encounter processing and capitated payments throughout the Operations Phase. This trained team also reviews Managed Care reports to ensure that the payments and management fees are applied correctly. The staff also conducts provider training on claims and encounter submissions. Call Center personnel, and call tracking, monitoring, and workflow systems provide a cohesive structure that ensures quality support for Managed Care operations. In addition to these responsibilities, the Managed Care Unit provides the following operational support:

- Produces standard and customized letters for recipients and providers
- Researches provider and recipient complaints
- Records provider complaints, questions, and requests into the notes tracking system
- Enters provider sanction information
- Reviews enrollment, encounter processing, utilization reports
- Applies edits/audits online when required
- Assists the State Managed Care Consultants in the development of materials to support the program.

Managed Care Operational Requirements

The following section addresses the specific operational activities that Team CSC performs to support the North Carolina Managed Care requirements. Examples of the updatable online pages and program capabilities are detailed in the system description in proposal Section D.1.4.9, Managed Care System Requirements**.**

Encounter Processing, Monitoring, and Error Resolution

A major responsibility of the Team CSC Managed Care Unit is to resolve all errors, discrepancies, and issues related to capitated payments or management fees. **As part of its daily duties, the unit monitors encounter processing to ensure that no payments have been issued as a result of encounter processing. Managed Care staff also reviews a series of Claims, Managed Care and financial reports to detect any payment errors.** Using the provider number, the Managed Care Unit can determine if the provider participates in a capitated program and can view reports on paid claims. Staff can determine if payment was erroneously issued for an encounter or shadow claim. If identified, the unit contacts the State and makes the appropriate changes to the Replacement MMIS. The Managed Care Unit will also review the denial rates on the shadow claim and report to the State for an appropriate action. **(40.9.2.1, 40.9.2.2)**

(40.9.2.1, 40.9.2.2)

Providers requesting an override are referred to the Managed Care Unit. Requests can be made online, in writing, or via phone. The staff reviews the requests, makes a determination, and if granted, enters the override information into the system online. All written override approval requests are entered into Replacement MMIS within two business days of receipt; the decision is forwarded to the requesting provider

within five business days. When the override is granted, the Managed Care Unit resubmits the claim for the fee-for-service processing. In case of a telephone request for an emergency override, the information is forwarded immediately to the supervisor of the Managed Care Unit by the Automated Workflow. An alert is posted in the system with time and date. The unit responds to the requesting provider within one hour of receiving the request. All alerts are continuously monitored by the Call Center supervisor. **(40.9.2.6)**

(40.9.2.6)

Call Center

Team CSC operates and promotes a toll-free telephone number for all providers, and the Call Center serves as the initial point of contact. Those providers requesting managed care information or assistance press an additional number after calling the toll-free line. These calls are handled by trained representatives who can respond to basic enrollment and encounter-related issues. They record all information concerning the managed care request into **NC***Tracks*.

Team CSC uses the Automated Workflow and business rules technology for routing all requests that require additional response. There may be times when calls need to be transferred to the Managed Care Unit based on the urgency of the situation, such as emergency overrides or specific managed care actions. The Managed Care Unit will be available to handle these calls between 8:00 A.M. and 5:00 P.M. Eastern time each State business day. The policies and rules of the Automated Workflow identify these requests and immediately forward the inquiry to the appropriate personnel. The business rules and State-specified policies are defined during the DDI Phase. **(40.9.2.4)**

(40.9.2.4)

Data Submission Manual

To ensure that providers have access to accurate encounter processing information, the Managed Care Unit works with the State Managed Care Consultants to compile and publish the Data Submission Manual. The manual details the submission process, covered and uncovered services, override requests, contact personnel, and submission tips. The manual is reviewed annually; more frequent updates may be authorized by the State. Providers are advised of the revision within five days of the change. When State approval is received, the manual is posted to the Web Portal for immediate access by providers. **(40.9.2.3)**

(40.9.2.3)

The increased functionality offered by the Replacement MMIS includes a powerful managed care processing module that can accommodate all North Carolina primary care case management programs and help improve access to care and reduce health care costs.

D.2.1.3.10 Performance Standards

Team CSC accepts and is committed to meeting the performance standards associated with Client Services. **Exhibit D.2.1.3.10-1** lists the required operational performance standards and the corresponding actions Team CSC will perform to meet these standards.

Pages D.2.1.3-51 through D.2.1.3-55 contain confidential information.

timeliness, and reliability. Our approach describes our resources and commitment for addressing all payer program requirements, satisfying performance standards, tracking and reporting progress to DHHS, maintaining open and effective communications and access to project operations to the State, and applying comprehensive, redundant quality assurance measures to every aspect of the operation. We believe that our quality orientation, demonstrated performance, and qualified staff, documented processes and procedures, and strong work ethic will provide the State with a level of service that is virtually unmatched in the industry. Team CSC looks forward to providing the full complement of Client Services to the citizens of North Carolina.

Page D.2.1.4-1 contains confidential information.

The Health Program Services team consists of the Team CSC Medical Director, Health Program Services Manager, Supervisors of Prior Approval and Medical Policy, the Dental and Pharmacy Directors, the Drug Rebate Coordinator and staff, and Business Analyst, Policy Analyst, and other appropriately-credentialed clinical and non-clinical staff. All members of the Health Program Services team are highly-qualified resources who understand the complexities of the NC DHHS programs and the ever-changing mandates from Centers for Medicare and Medicaid Services (CMS), and will execute the responsibilities or this organization in the most effective and professional manner possible.

The Health Program Services operating area supports a broad array of stakeholders. Authorized users access services through **NC***Tracks*, the web portal using a single sign-on. The Integrated Business Information System (Ibis) routes, tracks, and optimizes workload throughout the system to support operational activities. Refer to Proposal Section D.1.4.1, General System Requirements, for a description of this capability. The Operations Excellence Committee, which includes extensive representation from State agencies and the NC DHHS Controller, oversees program operation looking for innovative improvements and continually interacts with the department to monitor quality and recommend improvements.

Although the majority of the workload in the Health Program Services Department derives from Medicaid, Team CSC recognizes the importance of allocating resources to process DMH, ORHCC, and DPH programs effectively. To that end, operating units will be staffed with individuals knowledgeable in each payer program and necessary to maintain work queues and procedures for each specific program. For example, in the Medical Policy, Prior Approval, and Pharmacy Benefits Management areas, specific clinical personnel will be knowledgeable in each of NC DHHS' program. Additionally, Team CSC will continually perform program cross-training in each agency's policies and procedures. This approach serves the dual function of maintaining business continuity for each program and providing career advancement opportunities to staff.

Throughout the Operations Phase, the Health Program Services Department will seek operational improvement opportunities. A major source of improvement recommendations will be the Operations Excellence Committee, which meets regularly and reviews performance statistics, issues, changes in the operating environment, and other factors to identify and assess potential improvements. We will implement this committee's recommendations as appropriate.

The following subsections describe the Team CSC approach to Health Program Services operations in the areas of Medical Policy Support, Non-pharmacy Prior Approval, Pharmacy Benefits Management, Drug Rebate and Performance Standards.

D.2.1.4.1 Medical Policy Support

The Medical Policy area is responsible for Medical Policy support, Reference File Maintenance, and Claims Medical Review, as discussed in the following subsections. Team CSC acknowledges that the State sets policy and approves medical criteria used in claims and prior approval adjudication. **Our clinical staff applies these policies in the decision-making and medical review processes and ensures that State policies are enforced in a consistent manner within the Fiscal Agent Operation.**

The senior medical team, consisting of the Team CSC Medical Director, the Pharmacy Director, and the Dental Director support the State by recommending additional medical policies and changes to existing policy. The Directors collaborate with their respective counterparts at DMA, DPH, DMH, and ORHCC to advise on policy changes, share information on new procedures, provide sources of evidence-based medicine data, and furnish other support as requested by the State. They also:

- Review high-cost or high-visibility cases such as requests for transplantation services
- Review appeal decisions before finalization
- Act as resources to the State in the definition, publication, and application of medical policy to State programs
- Collaborate with other entities such as the Retrospective Drug Utilization Review vendor, the Community Care of North Carolina medical directors, drug manufacturers, providers, provider associations, and other entities to remain abreast of developments with potential medical policy implications
- Update and maintain the current State-approved Medical Procedure Audit Policy (MPAP).
- Represent NC DHHS as requested in the provider community

D.2.1.4.1.1 Reference

The Medical Policy business area maintains medical policy information for all Replacement MMIS processes. Analysts research and analyze policy issues that arise during claims adjudication. Claims requiring medical policy interpretation and review, as indicated by system edits/audits, suspend to Medical Policy work queues. Analysts retrieve this work and use available reference resources and consult with physician/pharmacist consultants or Medical Director(s) to adjudicate the claim. The appropriate Medical Director (i.e., Medical, Pharmacy, or Dental) reviews and approves all such decisions prior to claim finalization. The rationale for decisions is carefully documented in claim notes. **(40.6.2.6)**

(40.6.2.6)

At NC DHHS request, Medical Policy analysts enter updates to procedure codes, and audit and edit criteria in the Replacement MMIS. **Team CSC reviews these updates for medical policy validity as an added quality assurance to NC DHHS. Should Team CSC identify a questionable policy, Team CSC contacts the appropriate individual at DMA, DPH, DMH or ORHCC to ensure the policy has been requested correctly.** The State is notified when any updates occur. **(40.6.2.3, 40.6.2.8) (Comment CSC191)**

(40.6.2.3, 40.6.2.8)

Following procedure code and ICD-9 /ICD-10 updates, Medical Policy Analysts review the appropriateness of the cross-reference between new codes and edits/audits. Analysts review the code nomenclature, determine the edits/audits that should apply to each code, and verify that these edits/audits include the code. For example, it may be appropriate for a new code to be subject to a limit edit; if the new code is outside the procedure code range specified for the edit, it will be necessary to update the procedure code range for that limit edit. Analysts also consider if any new edits/audits are indicated for the specific code. Analysts document edit/audit recommendations and submit them to the State for approval. To implement approved changes, Analysts use the MMIS online pages available for performing Reference table updates to edit/audit criteria. **(40.6.2.7)**

(40.6.2.7)

Whenever edit/audit criteria updates occur, the Medical Policy Analysts also determine what documentation is affected and must be updated. Analysts work with the Documentation Specialist to identify documentation to be updated, determine the update

information, update the documentation and review the draft, submit the draft for internal Quality Assurance signoff, publish the new documentation, and notify the State of the update. Analysts also work with other Team CSC staff, such as Provider Service Representatives and Training Specialists, to ensure that updated information is available throughout all affected areas of the Fiscal Agent operation. **(40.6.2.3, 40.6.2.8)**

(40.6.2.3, 40.6.2.8)

The Medical Policy Analysts update and maintain the State-approved MPAP. Upon receipt of updated MPAP information from NC DHHS, Analysts follow a documented process to verify that new/modified policy is implemented in the Replacement MMIS through Reference table parameters or business rules. Analysts use the MMIS online pages to perform necessary updates, which become immediately available to the Claims and other subsystems for processing. The Medical Policy area also versions the MPAP documentation and makes it available online as a reference tool for Medical Policy review and other Team CSC staff. **(40.8.2.2)**

(40.8.2.2)

Team CSC's Reference unit also processes File Maintenance Requests for the Replacement MMIS. These requests are initiated by the NC DHHS using State Memoranda. If paper Memoranda are sent to CSC, our Claims Distribution and Claims Acquisition units receive, assign document control numbers, image, and cause the permanently stored images to trigger our Ibis workflow. The State may choose to enter File Maintenance Request directly into Ibis via the NC*Tracks* portal, which immediately triggers the workflow. **(40.6.2.4) (Comment CSC 191)**

(40.6.2.4)

Either method of submission will cause Ibis to record the receipt date for the State Memo and route the Memo to the appropriate File Maintenance Analyst, who captures a *before* image of the reference table to be updated. After the update is saved, the analyst captures an image of the updated table, and causes Ibis to route the Memo and images to the unit Supervisor for validation. Once the update is validated, Ibis returns the history of the completed update (including the identity of the operator) with the *before* and *after* images to the originator of the State Memorandum. **(40.6.2.1) (Comment CSC191)**

(40.6.2.1)

Our Quality Assurance unit reviews these updates to ensure continual quality of the reference files. Additionally, the QA unit monitors completions of updates against the State Performance Standards. The State is notified in writing of any errors in updates to the Reference tables or updates not completed within the State-established performance standards. Weekly reports are generated summarizing the file maintenance activity (including timeliness and operator accuracy); these reports are posted to the State's section of the NC*Tracks* portal by 7:00 AM each Monday. **(40.6.2.2, 40.6.2.4, 40.6.2.5) (Comment CSC191) (SOO 10.12.7-1) (SOO 10.12.7-2)**

(40.6.2.2, 40.6.2.4, 40.6.2.5 10.12.7-1 10.12.7-2)

D.2.1.4.1.2 Claims Medical Review

The Medical Policy area is responsible for manual review of claims for specific services. The Reference Subsystem procedure code tables allow flags to be set for specific services that cause claims to suspend to a Medical Review work queue. **Medical Policy Analysts retrieve work from this queue during each work day and perform reviews according to State approval criteria that are documented in detailed manual review procedures available online within the work queue.** Claim edit and audit codes and their associated descriptions indicate the specific error(s) that cause the suspension for review. Analysts use the MMIS online pages to research recipient, provider, prior approval, benefit plan, and

other information to resolve the claim edit. Research may include requesting additional medical documentation from the provider. If additional documentation is needed, the Analyst will send a message to the provider via fax, online or secure email requesting the documentation. When the provider responds, the workflow systematically routes the response to the Analyst. Once all the needed documentation is received and if necessary, reviewers may consult with a physician/pharmacist resource or the appropriate Medical Director. Analysts document the rationale for the review decision in the claim notes and assign a final disposition to the claim. **(40.8.2.42 – 43)**

(40.8.2.42 – 43)

The Medical Policy area performs manual review on claims that are denied for "non-covered" services when the recipient is Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)-eligible. The Replacement MMIS edit rules suspend such claims to a specific Medical Policy work queue based on the recipient's age and the edit that failed. Analysts work these claims, reviewing the services furnished, diagnoses, and available medical documentation. It is the goal of the North Carolina DHHS to foster optimum health outcomes for children and adolescents. Therefore, although non-covered, services that are deemed medically necessary or developmentally or otherwise beneficial to the recipient may be approved. The Analyst makes a determination and submits the recommendation to the appropriate Medical Director for approval. Team CSC Medical Policy management will work with the State during implementation to define the circumstances under which these decisions can be made by Team CSC and when we are required to submit our recommendations for State approval. **(40.8.2.45) (SOO 10.12.5-13)**

(40.8.2.45, 10.12.5-13)

In certain instances, State policy dictates manual pricing of claims. For example, manual pricing may be specified for durable medical equipment purchases for items such as wheelchairs with multiple functionality and attachments. The Analyst evaluates the medical condition of the recipient, the item billed, and the invoice provided with the claim and assigns a payment amount. Another instance in which manual pricing frequently applies is unlisted procedure codes. For such claims, the Analyst evaluates the diagnoses and the specific services that were actually furnished by the provider to determine if there is a current covered procedure code that is more appropriate. If there is one, the Analyst recommends the provider rebills with the appropriate code. If there is no current procedure code matching the description, the Analyst will review the medical documentation, consult with the State, and price the claim accordingly. As with other manual reviews, the Analyst documents the rationale for the manual price decision and finalizes the claim. **(40.8.2.56)**

(40.8.2.56)

Any policy decisions that cannot be made in the context of current State program criteria are referred to the State via Ibis, the integrated workflow management tool, for a decision. **(40.8.2.44)**

(40.8.2.44)

D.2.1.4.2 Non-pharmacy Prior Approval

The Prior Approval functional area reports to the Prior Approval Manager and relies on the clinical expertise of the Medical, Pharmacy, and Dental Directors. Team CSC's goal for structuring and operating the Prior Approval function is to streamline the prior approval process for the provider community through the intelligent workflow application of the Replacement MMIS and Ibis. **Streamlining this process allows for the reduction in turnaround time, achievement of maximum quality, transparent and audited responses, and accuracy in program administration.** Refer to Proposal Section D.1.4.1, General System Requirements, for a description of this capability.

D.2.1.4.2.1 Prior Approval Customer Service Center

Team CSC will establish and operate a Prior Approval Customer Service Center at our State-approved Fiscal Agent facility within 15 miles of NC DHHS headquarters. This Service Center comprises non-pharmacy and pharmacy prior approval components, each staffed with qualified clinical personnel. Access to the Customer Service Center is available through the toll-free provider telephone inquiry number. A menu option enables the caller to transfer automatically to the Prior Approval Customer Service Center where staff is available to accept prior approval, referral, and override requests. The Customer Service Center also accepts fax requests via a toll-free number. Faxes are immediately imaged in the fax server, assigned a document control number and placed in the **NC***Tracks* prior approval queue for review **(40.7.2.19, 40.7.2.24)**

(40.7.2.19, 40.7.2.24)

The Prior Approval Customer Service Center for non-pharmacy is available as required from 7:00 a.m. until 7:00 p.m., Eastern Time, Monday through Friday, on State business days, and from 8:00 a.m. until 5:00 p.m., Eastern Time, on Saturday. **(40.7.2.17)** The non-pharmacy component is staffed with Registered Nurses (RN), Licensed Clinical Social Workers (LCSW) and other administrative staff that have the requisite knowledge and skills to process the prior approval workload. Staff receives and processes all non-pharmacy prior approval and other requests and is responsible for resolving all inquiries. Refer to Proposal Section D.2.1.2.2, Call Center, for a comprehensive description of the tools and processes used to log, track, and report inquiry and workload activity.

(40.7.2.17)

D.2.1.4.2.2 Prior Approval Processing

Team CSC implements a comprehensive process to receive, manage, enter, adjudicate, respond to, and report prior approval, referral, and override transactions for the State of North Carolina. **Prior approval clinical staff is available to consult with the State to review and help set medical policy, recommend prior approval processing approaches, and jointly develop improvement initiatives. Team CSC will work with the State to review, evaluate, and determine the optimal prior approval adjudication processes for**:

- Eye exams or refraction
- Visual aids
- Hearing aids, accessories, ear molds, FM systems, repairs
- Dental and orthodontics
- Lingual frenulum surgery
- Stereotactic pallidotomy
- Electrical osteogenic stimulators
- Keloids
- Craniofacial/facial surgeries
- Out-of-state ambulance
- Hyperbaric oxygenation therapy
- Blepharoplasty/blepharoptosis (eyelid repair)
- Panniculectomy
- Breast surgery
- Clinical severe obesity surgery
- Rhinoplasty
- Chiropractic and podiatry
- Durable medical equipment
- Orthotics and prosthetics
- Pharmacy (see D.2.1.4.3 below)
- All services for DPH payment programs.

Because the underlying prior approval processing capability is extremely flexible, it will be possible for Team CSC to expand the scope of prior approval services and support additional prior approval service categories that the State may require, such as personal care. **(40.7.2.13)**

(40.7.2.13)

Team CSC handles all prior approval cases in accordance with State-defined policies and approved procedures. We implement State prior approval policy through rules-based, table-driven functionality in the Replacement MMIS, and where possible, using rules-engine based functions within Ibis. These features enable us to accomplish the following tasks without the need for programming intervention, thereby reducing maintenance costs:

- Define edits and business rules to implement prior approval adjudication processes determined for the services listed above
- Flag authorized services (e.g., by provider, recipient, procedure code, National Drug Code (NDC), etc.), for pre-payment review by the Claims Subsystem **(40.7.2.10)**
- Flag services that NC DHHS is reviewing for new prior approval requirements. Flagging services triggers the generation of impact reports that provide the State dollars saved should the policy be changed to require prior approval.
- Define edit disposition codes that prevent automated adjudication of a prior approval transaction for a recipient having third-party liability (TPL) and suspending such transactions for manual review. **(40.7.2.23)**

(40.7.2.10)

(40.7.2.23)

Exhibit D.2.1.4.2.2-1 illustrates the high-level flow of activities associated with the prior approval function.

Online Prior Approval Requests
Providers can submit Prior Approval Requests online via ePACES, HIPAA transactions, fax or paper.

All prior approval requests, whether received via HIPAA-compliant transactions, real-time web entry, telephone in the Customer Service Center, fax, or paper, are processed in the same format. Paper requests are sent to the Mailroom for imaging, indexing, and key data entry via Viking, our indexing application. Data entered includes provider, recipient, service request detail, document control number, and other transaction information pertinent to the prior approval request. Fax requests are managed electronically using our workflow process. Keyed and faxed requests are uploaded to the Replacement MMIS and placed in Customer Service Center work queues. Electronic transactions are processed by the eCommerce Subsystem, converted to internal format, and routed to the Prior Approval Subsystem for processing. **(SOO 10.12.5-2)**

(10.12.5-2)

Requests received via phone by a Prior Approval Customer Service Representative are entered at the time of receipt into the MMIS online Prior Approval Add pages (refer to Proposal Section D.1.4.7, Prior Approval Subsystem). Data entry elements include the date of receipt, denial code, decision date, provider number, recipient ID, procedure code, diagnosis, etc. The mailing date of the Prior Approval decision letters is recorded in the MMIS. For PA requests worked via our Ibis workflow tool, the decision date and mailing date are automatically written to the MMIS system tables. **(40.7.2.2) (Comment CSC169)**

(40.7.2.2)

(40.7.2.2)

Page D.2.1.4-8 contains confidential information.

same edit and adjudication modules. This process ensures consistency and reduces the cost of maintenance since programming code is centralized and must be updated only one time. Reviewers use State-approved medical criteria and their medical judgment to make determinations. Once a reviewer makes a decision to approve or deny the prior approval, the approval will proceed through the same workflows mentioned above. Retroactive approvals can be made, triggering automatic claim adjustments as requested by the State. **(40.7.2.3 – 4)**

(40.7.2.3 – 4)

Using the workflow and table-driven edit functionality in the Replacement MMIS, **Team CSC defines the business rules for processing prior approval requests for items such as stem cell and bone marrow transplants, based on relevant procedure codes.** Flags are set in the Reference tables to indicate that prior approval is required for these services. Edit disposition codes are set through the online Edit Disposition pages that suspend these transactions for manual review and route them to a designated work queue location. A nurse with clinical expertise in stem cell and bone marrow transplantation will retrieve the request for **NC***Tracks* and review it to determine if all relevant clinical information has been furnished. If the request is complete, the Reviewer will route the request to the DMA Hospital Consultant's work queue. If incomplete, the Reviewer uses the online Prior Approval Letter Generation page to send a Missing Information notification to the provider, specifying what other documentation must be furnished. This notification can be sent to the provider's electronic inbox or via mail. Notifications include a cover page and reference number to be submitted with the requested hardcopy documentation. This reference number enables the Team CSC to associate the documentation with the prior approval transaction. Upon receipt of the documentation electronically or via mail, the system integrates the reference number and places the suspended transaction in the appropriate reviewer's work queue. The Reviewer retrieves the request, retrieves the documentation from the image, and again evaluates the request for completeness prior to routing it to the DMA Hospital Consultant. **(40.7.2.20)**

(40.7.2.20)

D.2.1.4.2.3 Reporting

The Team CSC Prior Approval Supervisor is responsible for monitoring timeliness standards for processing prior approval workload and making appropriate resource adjustments to ensure standards are met. Transactions received and entered manually (i.e., mail/paper, fax) are date-stamped in the Mailroom to record the date of receipt. Electronically-received transactions (i.e., HIPAA-compliant batched transactions, Point of Sale (POS), Web Portal, or Automated Voice Response System (AVRS)) enter the system immediately upon receipt and the data within the transaction includes the receipt date. Requests received by Prior Approval Customer Service Representatives are entered through the MMIS online pages and include the date entered/received. Team CSC will furnish the following notifications/reports to the State:

- Produce a quarterly report of the number of prior approval requests received, number entered into the system within one State business day of receipt, and the number entered into the system after more than one State business day. **(40.7.2.5)**

(40.7.2.5)

- Produce 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 in error, listing each error transaction and error reason. Refer to Proposal Section D.1.4.7.5

Tracking/Audit Trail and Reporting, for a description of the process to produce this report. **(40.7.2.6)** (40.7.2.6)

- Notify the State monthly when it takes more than one 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. **(40.7.2.7)** (40.7.2.7)
- Notify the State monthly when it takes more than one 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. **(40.7.2.8)** (40.7.2.8)
- Notify the State when it takes more than five business days to process, render a decision, and mail a status report on a prior approval request for retrospective and therapeutic days. **(40.7.2.9)** (40.7.2.9)

D.2.1.4.2.4 Appeals

Team CSC is aware of our responsibility to the State to support the hearings and appeals process for all prior approval decisions made by our staff. **We maintain comprehensive records, documented in the Prior Approval tables, notes, letters, and edit disposition indicators, and reviewers' user IDs to support and defend our decisions. We rely on the expertise of clinically-qualified personnel and State-approved medical criteria for rendering all decisions.** We carefully consider all aspects of an approval request and use best practices, all available supporting information, and a compassionate attitude toward the citizens of North Carolina.

Upon request, the Team CSC clinical personnel rendering the denial decision will attend Office of Administrative Hearings meetings to represent the State. We track the appeals process and perform appropriate updating to prior approval transactions and appeals information to reflect the results of the appeals process. **(40.7.2.11)** (40.7.2.11)

D.2.1.4.2.5 Training

Team CSC recognizes the benefits of comprehensive and effective training of the provider community and prior approval vendors in the processes and rules for submitting prior approval, referral, and override requests. We operate an aggressive and focused, multi-pronged training program that addresses the informational needs of diverse provider types. Prior Approval staff continually monitors operations to identify provider training problems; these findings are conveyed to the Provider Training Specialists who present specific training regarding these transactions at regularly-scheduled provider workshops. These Specialists also train State staff in use of MMIS online pages for inquiry and update, report availability and interpretation, submission requirements, pharmacy benefits management, and any other topics requested. Prior Approval vendors receive training in data submission requirements, processing, and responses. As needed, prior approval clinical personnel assist the Provider Training Specialists in presenting override, referral and prior approval material to providers and state staff and assist in the development of training topics and agendas related to prior approvals. **(40.7.2.14, 40.7.2.21) (SOO 10.12.4-11)** (40.7.2.14, 40.7.2.21, 10.12.4-11)

To address specific provider problems, Team CSC Provider Training Specialists perform onsite visits to long-term care facilities and other provider entities and furnish training regarding prior approvals, referrals, and overrides, and any other topics requested by providers or deemed necessary to improve provider interactions with the Replacement MMIS or compliance with State program requirements. Refer

to Proposal Sections D.2.1.2.4, Provider Training and Documentation, and D.2.1.2.5, State and Fiscal Agent Training, for a complete description of Team CSC's training approaches. Team CSC understands that the State may request a representative from the Team CSC Prior Approval Unit to help facilitate the closing of a long term care facility. In these cases, Team CSC will be on site to assist the State. **(40.7.2.12)**

(40.7.2.12)

D.2.1.4.3 Pharmacy Benefits Management

Team CSC and our partner, MemberHealth, will perform pharmacy benefits administration functions for the State of North Carolina. In addition to staffing the Pharmacy Prior Approval Customer Service Center, MemberHealth clinical personnel will support the functions discussed below, **bringing their extensive clinical and pharmacological experience from work with CCRx, one of only 10 national Medicare Part D plans serving Medicare beneficiaries in the United States, to enhance the administration of pharmacy benefits for North Carolina recipients.**

MemberHealth's expertise in this area was recognized by Wilson Health Information, one of the nation's leading independent consumer insights firms, when it named MemberHealth's CCRx Medicare Part D Prescription Drug Plan number one in overall customer satisfaction nationally.

MemberHealth Customer Comment

"MemberHealth, Inc., … have shown a strong willingness to work creatively with the state regarding multiple funding streams such as Medicare, Medicaid, and North Carolina Seniorcare plan. You have excellent problem solving skills and have always been willing to work with us under tight timeframes and challenging circumstance…"

— Michael Keough, Project Director
NC DHHS, ORHCC

The Pharmacy Prior Approval Customer Service component operates from 7:00 a.m. until 11:00 p.m., Eastern Time, Monday through Friday, on State business days, and from 7:00 a.m. until 6:00 p.m., Eastern Time, on Saturday and Sunday. **(40.7.2.16)** At least one clinical pharmacist is onsite during all mandated operating hours, including evenings and weekends. Pharmacy personnel, in numbers adequate to respond to all inquiries and process workload, will be available on-site during Call Center operating hours. **(40.7.2.18)** Staff receives and processes all pharmacy prior approval and other requests and is responsible for resolving all telephone inquiries and questions from recipients, providers, Office of Citizen Services, and drug manufacturers regarding pharmacy drug-related issues and concerns. **(40.7.2.15) Call Center staff will record telephone prior approval requests using the online pages for Pharmacy requests, which store approval information in the relational database, in the same format as paper hardcopy and fax requests. (40.7.2.1)**

(40.7.2.16)
(40.7.2.18)
(40.7.2.15)
(40.7.2.1)

Refer to Proposal Section D.2.1.3.2, Call Center, for a comprehensive description of the tools and processes used to log, track, and report inquiry and workload activity. For more information on MemberHealth, refer to Proposal Section E.7.2, Staffing Approach — Operations.

The Team CSC Pharmacy Director and other pharmacy staff attend the Drug Utilization Review Board (DUR Board) meetings supplying copies of the annual DUR Report. We utilize information and Board recommendations from these meetings to improve the effectiveness of the North Carolina Pharmacy program. We submit Board recommendations to the State for review and approval and, if desired, consult with the State to interpret the requirements and assess potential impacts. Upon approval by the State, we implement all Board recommendations in our Pharmacy POS/ProDUR program immediately. **(40.8.2.40)**

(40.8.2.40)

Team CSC recognizes that the State's Retroactive Drug Utilization Review (RetroDUR) contractor is a key resource in pharmacy benefits management. Team CSC is proactive in developing and maintaining a collaborative and mutually-supportive relationship with the RetroDUR vendor and interfaces regularly to:

- Prepare the CMS Annual DUR Report — During the Implementation Phase, Team CSC meets with the State and the RetroDUR vendor to define the detailed specifications for preparing this report. We determine the report contents, format, delivery schedule, and medium. Team CSC manages the Prospective DUR and DUR Board information. We collaborate with the RetroDUR vendor to obtain RetroDUR data needed to prepare the report and negotiate the format, timing, and delivery of the requested information. The Pharmacy Director, assisted by clinical and systems staff, prepares this report or furnishes information to the State, as requested, to support the preparation of the report. The Team CSC Quality Assurance staff participates in the process, verifying content and format prior to release. **(40.7.2.25, 40.8.2.39)**

(40.7.2.25, 40.8.2.39)

- Assure functionality of the POS business area — The Pharmacy Director and POS Supervisor, supported by other Team CSC staff as needed, coordinates with the RetroDUR contractor to continuously review the effectiveness and currency of the pharmacy POS business area. We collaborate with the RetroDUR vendor to review existing edits, evaluate potential new edits, define POS alerts, implement approved DUR Board recommendations, and determine intervention, conflict, and outcome codes in accordance with National Council for Prescription Drug Programs (NCPDP) 5.1 standards. Our joint goal is to maximize the effectiveness of pharmacy prior approval and ProDUR processing to protect the health of North Carolina recipients and help control the rising costs of the North Carolina pharmacy program. **(40.7.2.26)**

(40.7.2.26)

- Identify ProDUR alerts and collaborate at monthly meetings — Team CSC will conduct meetings with the RetroDUR vendor on at least a monthly basis. We will use these meetings as a forum to discuss known pharmacy problems, identify and agree on appropriate new alerts, explore ideas for detecting other potential drug therapy problems, set priorities for pursuing new initiatives, and define approaches for identifying improvement opportunities and implementing changes. Team CSC documents the results of these meetings in minutes that are published to all meeting attendees, and designated management and State staff. **(40.7.2.30)**

(40.7.2.30)

- Capture claim data pertinent to aberrant drug utilization patterns and collaborate at monthly meetings — Team CSC will conduct an additional monthly meeting to address processes to capture claim data that is specific to potential aberrant drug utilization. We work with the RetroDUR vendor to identify possible areas of abuse, develop criteria for claims selection, design analytical processes to uncover aberrant patterns, and create meaningful statistical results and reports for submission to the State. Team CSC prepares minutes of these meetings and distributes to all attendees and designated Team CSC and State staff. **(40.7.2.35)**

(40.7.2.35)

- Submit quarterly extract files to the RetroDUR vendor — during implementation, Team CSC meets with the vendor to define the format, content, medium, and delivery requirements. The IT support services staff schedules and executes jobs to extract data and create the required files. Quality Assurance and pharmacy staff monitor the production process and confirm that extract files were delivered within five State business days of the month following the quarter's end. **(40.8.2.41)**

(40.8.2.41)

- Provide support and assistance in performing RetroDUR functions — Team CSC clinical staff is available to collaborate with the RetroDUR vendor upon request to facilitate performance of the RetroDUR function. We believe that cooperation and effective professional working relationships among medical expert resources foster program improvement and protect the health of North Carolina citizens.

Team CSC pharmacy resources are responsible for maintaining and updating drug-related data in the Replacement MMIS. Online pages in the Replacement MMIS provide easy access for authorized users to maintain drug and ProDUR data in Reference Subsystem tables; refer to Proposal Section D.1.4.8.6, Pharmacy Point-of-Sale, ProDUR, and RetroDUR, for a detailed description of system update processes. Clinical staff updates clinical data, dosing limits to DUR alerts, changes in Generic Code Number (GCN), GCN-Sequence, and any State-selected First DataBank (FDB) data elements. We also monitor the weekly batch update of the DUR file with FDB data. The IT operations staff schedules and executes this update. **(40.7.2.27)**

(40.7.2.27)

Keeping the provider community fully informed of pharmacy program operations, changes, and processes is essential to program effectiveness. Provider access to accurate, current information, a comprehensive knowledge of policies and procedures, and ability to access and use Replacement MMIS capabilities effectively all contribute to provider satisfaction, error-free processing, and hassle-free delivery of covered prescription drugs to recipients. To that end, Team CSC continuously strives to inform providers by:

- Preparing a monthly Pharmacy Bulletin/Newsletter — during the implementation effort, Team CSC works with the State to define the format, content, media, timing, and distribution of the Newsletter. Thereafter, we meet periodically with the State to determine ongoing content. Team CSC produces the Newsletter on the schedule approved by the State. The Pharmacy Newsletters will contain information including, but not limited to, preferred drug lists and any updates, prior approval instructions, a listing of codes, which require prior approval, and other items as appropriate. The Newsletter also notifies providers of Drug Efficacy Study Implementation (DESI) drugs for which claims are denied. All Newsletters are be approved by the State prior to distribution. **(40.6.2.10, 40.7.2.28, 40.7.2.38)**

(40.6.2.10, 40.7.2.28, 40.7.2.38)

- Maintaining the Pharmacy Prior Approval Web site — The Web site is an important and powerful resource for the provider community and furnishes an effective means of disseminating program information. Team CSC pharmacy staff are responsible for determining and maintaining Web-site content, as approved by the State. The Web-site contains a broad array of information including, but not limited to: State Maximum Allowable Cost (SMAC) list, preferred drug lists, the Prescription Advantage List (PAL), evidence-based medicine (EBM) updates to the PAL clinical pearls, State drug policies, POS submission processes and submitter certification process, clinical information for prescribers, and links to other sites such as the Drug Effective Review Process (DERP) reports and the NC DHHS Web-site, to name only a few. The IT support services staff performs the actual Web-site updates, as directed by pharmacy staff. Team CSC relies on the expertise of our clinical staff, State direction, provider input, RetroDUR vendor recommendations, and industry information to recommend Web-site content for State approval. **(40.7.2.31 – 32)**

(40.7.2.31 – 32)

- Educating providers — Team CSC maintains comprehensive information regarding prior approval and pharmacy claims processing. The Pharmacy Prior Approval Customer Service center records cause-of-inquiry information that is reviewed to identify recurring themes and problems. Claims processing staff also reviews edit frequencies to identify potential problems (e.g., claim denial due to absence of a required prior approval). Team CSC pharmacy staff collaborates with Provider Training Specialists and participates in regularly-scheduled provider workshops identifying areas of training needed for pharmacy providers and educating providers regarding specific issues. We provide information regarding the PAL tiers to providers upon inquiry, and make this information available during training sessions. Refer to Proposal Section D.2.1.2.4, Provider Training and Documentation, for a complete description of our Provider Workshops. **(40.6.2.9, 40.7.2.40)**

(40.6.2.9, 40.7.2.40)

Team CSC collaborates with the Community Care of North Carolina (CCNC) Program to maintain currency on CCNC initiatives, share information, and prevent duplication of effort with respect to prior approval program operation. We monitor the progress and results of CCNC projects such as the PAL and the Polypharmacy in Ambulatory Care and Nursing Home initiatives. Team CSC meets monthly with the CCNC Clinical Directors and prepares minutes of these meetings. We distribute these minutes to all meeting attendees and the State. **(40.7.2.36)**

(40.7.2.36)

The North Carolina pharmacy program is a constantly-evolving initiative that requires monitoring, research, and analysis to identify and evaluate new drug therapies, design new edits, develop new prior approval requirements, and ensure that the program remains current with developing treatments and advances in medical and therapeutic knowledge. Team CSC relies on the extensive knowledge of our clinical pharmacy staff and input from diverse resources that include the RetroDUR contractor, the CCNC, providers and prescribers, ePrescribers, drug manufacturers, and medical and pharmacy associations.

Using these and other resources, we research and evaluate new drugs that become available on the market. Should NC DHHS decide to implement a preferred drug list in North Carolina, Team CSC makes recommendations to the State regarding drugs that should be added to the preferred drug list, based on their perceived efficacy and potential for health outcomes improvement or cost savings. We also monitor new and existing drugs to identify candidates for prior approval and define the criteria for such approval. **We recommend improvements such as step therapy when appropriate for an existing or new drug. Step therapy defines the conditions under which recipients may receive more costly drugs, usually after using lesser cost drugs and experiencing unacceptable levels of improvement in their conditions. Step therapy is often indicated if a condition, such as arthritis, can be treated with multiple drugs that vary significantly in cost. Application of step therapy has significant potential for benefit cost savings.**

For drugs in the same classes as drugs on the Prior Approval drug list and the PAL, our clinical staff prepares therapeutic criteria and protocols for each new drug. All recommendations are based on utilization patterns and consider program impact in terms of cost savings, recipient and provider convenience, and potential for health outcome improvement. We prepare a report weekly for DMA that contains our recommendations and rationale. Our recommendations are criteria-driven using information from industry-

standard sources such as FirstData Bank. Team CSC will also meet with the pharmacy provider community to discuss our recommendations, as requested by the State. Upon final approval by DMA, Team CSC adds drugs, updates therapeutic prior approval categories, and implements new prior approval types and step therapies. We update this information by using the MMIS online pages to make the changes and additions in the Reference and Prior Approval tables. These changes take place in real-time are immediately available to the processing system. We also notify the IT support group and ensure that that the Web-site is updated within 48 hours of notification of DMA approval. **(40.7.2.33 – 34, 40.7.2.41 – 42)**

(40.7.2.33 – 34, 40.7.2.41 – 42)

Team CSC also performs the administrative tasks necessary to operate the prior approval function and ensure timely and accurate processing of all requests, inquiries, and appeals. The workflow solution routes pharmacy prior approval workload to work queues assigned to prior approval processors; these queues present work in first-in/first-out order to promote timely processing of each transaction. The Pharmacy Prior Approval Supervisor monitors the work queues, dynamically adjusts workload as necessary, signoffs on each Prior Approval Representatives work queue and ensures that remaining workload is routed to queues that will be worked by the next shift. The Supervisor, working with the processing staff and Quality Assurance resources, constantly monitors inventory and workload aging to prevent development of backlogs that would jeopardize our ability to meet performance standards. (40.7.2.29)

(40.7.2.29)

We realize that providers will occasionally appeal prior approval denial decisions and we carefully document our denial reasons, both in the denial reason codes we use and the extensive free-form notes that may be entered on the prior approval online pages. Additionally, medical and other documentation that we use in reaching our decision is available through the image repository. Team CSC clinical staff adjudicate appeals and support the State in the appeals process. We follow documented processes to perform appeal reviews and ensure that the review is not conducted by the same processor who rendered the original decision. As needed, the Pharmacy Director acts as the ultimate Team CSC resource for reviewing the medical data and making the appeal determination. We thoroughly document our appeals process, findings, and rationale. **(40.7.2.37)**

(40.7.2.37)

To enable dispensing an emergency 72-hour supply of a drug that normally requires prior approval, Team CSC will implement functionality in the Replacement MMIS to override prior approval edits and bypass limit accumulation. During the requirements definition activity, we will work with the State to define the specific parameters for identifying and limiting such situations. **(40.7.2.39)**

(40.7.2.39)

Pages D.2.1.4-16 through D.2.1.4-30 contain confidential information.

D.2.1.4.6 Conclusion

The proposed Health Program Services Department has demonstrated capabilities to perform NC DHHS's Medical Policy/Review, Prior Approval, and Drug Rebate functions in a comprehensive manner that promotes accuracy, timeliness, and reliability. Our approach describes our resources and commitment for addressing all payer program requirements, satisfying performance standards, tracking and reporting progress to NC DHHS, maintaining open and effective communications and access to project operations to NC DHHS, and applying comprehensive, redundant quality assurance measures to every aspect of the operation. We believe that our quality orientation, demonstrated performance, and qualified staff, documented processes and procedures, and strong work ethic will provide NC DHHS with a level of service that is virtually unmatched in the industry and Team CSC looks forward to providing the full complement of Health Program Services to the citizens of North Carolina.

Pages D.2.1.5-1 through D.2.1.5-4 contain confidential information.

Services is responsible to ensure operations of switches; routers; firewalls; network load balancers; virtual private network devices; IVR and ACD; and other network hardware at all facilities.

The WAN includes data transport and connectivity between CSC facilities in New York and North Carolina, connectivity to the disaster recovery contractor site in New Jersey; and connectivity to the North Carolina State WAN. LAN includes data transport within the CSC data centers and within the Fiscal Agent facility in North Carolina. Voice network infrastructure is limited to the management and monitoring of the telephone network infrastructure necessary to support call center operations.

CSC's overall monitoring management is based on the ISO 9001:2000 Fault Management, Configuration, Accounting, Performance, and Security Management (FCAPS) best practice, using tools such as, CiscoWorks, HP Openview, Network Node Manager, and SMARTS to monitor and proactively forecast network events. Our approach is proactive, monitoring, and responding prior to problems being realized. Our network tools promote a cohesive monitoring environment, where network events are collected enterprise-wide for correlation of performance statistics for implementation of preventative processes as depicted in **Exhibit D.2.1.5.1.2-1**.

Fault Management	Configuration Management	Accounting Management	Performance Management	Security Management
• Alarm Handling • Trouble Detection • Trouble Correcting • Test and Acceptance • Network Recovery	• System Tune-Up • Network Provisioning • Auto Discovery • Disaster Recovery	• Track Service Usage • Asset Inventory • Timely Reporting	• Data Collection • Report Generation • Trend Analysis • Centralized Management Dashboard • SLAs/QOS	• Encryption • Access Control • Intrusion Detection/ Prevention • Audit Storage/Event Correlation • Alert/Patch Management

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Exhibit D.2.1.5.1.2-1 Team CSC Network Monitoring Processes. ***A disciplined approach is the key to a successful network management approach.***

Network Management
Team CSC will provide operational work associated with the LAN/WAN including but not limited to installation, configuration, maintenance, de-installation, marshalling, and support of active components. We will provide centralized and on premise, where necessary, LAN/WAN operations, managements, and support for all locations using a combination of Team CSC personnel and vendors as necessary.

Network Operations
Team CSC will perform operational support subject to standards and practices specified by Network operations which include: production and performance monitoring, tuning the network for efficiency problem resolution, and escalation to hardware/software vendor; network connectivity at remote locations; remote network monitoring, diagnostics, network administration, and de-installation; maintenance; marshalling; support of active components; support of horizontal infrastructure; Telco circuits and transport equipment; provide capacity information of optimization of LAN/WAN; configuring requirements; coordinating with service and supply vendors.

Network Engineering
Team CSC will perform all LAN/ WAN engineering and design functions.

Software Support
Team CSC will be responsible for initial and ongoing software and firmware maintenance on all LAN/WAN equipment. Subject to architectural standards, Team CSC will ensure that the software versions are deployed in a timely manner with the goal of ensuring network software homogeneity within the LAN/WAN environment.

Technical Support

Team CSC will provide: configuration management and reliability optimization; documentation for performance efficiency tuning; vendor coordination; circuit and equipment ordering and installation; site surveys; systems and equipment upgrading; capacity constraint avoidance recommendations; capacity reviews; LAN/WAN router software maintenance; connectivity to external locations; monitor capacity, and recommend changes for efficiency; and implement upgrades.

(40.4.3.4)

D.2.1.5.1.3 Application Support IT Services **(40.4.3.4)**

Team CSC will deploy upgrades and new installs of applications as approved by the CCB. Support includes installing and upgrading software releases, backup and recovery support, and applying security and maintenance patches as authorized by the CCB. The Application Support group also monitors availability of critical systems, such as web inquiry functionality for AVRS. This coverage will be provided by on-site and remote coverage technicians. The single point of contact for critical application support will be the help desk. Application support is accountable to resolve all incidents per agreed upon performance standards. Any problems identified will be assigned to application support teams and managed through the ITIL-aligned SDEP problem management process.

(40.1.2.8)

D.2.1.5.1.4 Desktop Support Services **(40.1.2.8)**

Team CSC Desktop Services are responsible for the management operation and maintenance of the desktop and its associated network infrastructure. These services include configuration and installation of the desktop standard operating environment, deployment of desktop applications, help desk services, desk side support, hardware and software asset management, hardware and software license management, and anti-virus management.

Team CSC will and maintain the personal computers (PCs) and desktop software issued by Team CSC for State use commensurate with Team CSC PC and software upgrades. We firmly believe that adopting a standardized approach is paramount to increasing effectiveness and decreasing the total cost of the services.

CSC Desktop Outsourcing Services is also among the leaders chosen to be recognized by The Gartner Group. The Gartner report, Magic Quadrant for Desktop Outsourcing Services, North America, 2007, positions leading vendors of information technology (IT) desktop services based on their ability to execute and their completeness of vision." CSC is pleased to be listed in the "Leaders" quadrant.

(40.1.1.17
40.1.2.10
40.1.2.50
40.1.2.109)

D.2.1.5.1.5 IT Security **(40.1.1.17, 40.1.2.10, 40.1.2.50, 40.1.2.109)**

Team CSC IT Security Services will implement and administer physical, logical and personnel access controls, procedures, and standards. Security services staff will be proficient in the use of mainframe and other computing platform security products as well

as all aspects of network security. The overall security approach for the Replacement MMIS, including IT Security, is detailed in Section H.

One of the critical aspects of our core methodology is Information Assurance. **CSC is well known for its expertise in information assurance (IA) to protect information confidentiality and integrity. We are the largest IT and security services provider for the National Security Agency (NSA) since the mid-1980s and the largest security services provider for the Defense Information Systems Agency (DISA) since the mid-1990s. The CSC approach also reflects the Federal Enterprise Architecture (FEA) Security and Privacy Profile. CSC is the only Tier 1 outsourcing company to deliver security services to all categories of clients (Government and commercial) worldwide from a single Center of Excellence at our Global Security Solutions Center (GSSC). This center enables us to deliver proven IA services by leveraging commercial best practices.** While we are renowned for security, we are driven by quality. Our IA quality record includes the following:

- CSC is the initial corporate sponsor of the System Security Engineering Capability Maturity Model (SSE-CMM) with NSA and the National Institute of Standards and Technology (NIST).
- CSC is the first organization to achieve an SSE-CMM Level 3 rating for INFOSEC assessments.
- CSC was independently appraised under the IA-CMM by NSA for INFOSEC assessments.
- CSC is the sole provider of computer forensics training services to the Department of Defense (DoD).

For the Replacement MMIS, CSC IT Security Services will:

- Adopt the State's Security Program Planning and Management, Access Controls, Application Software Development and Changes;
- Establish appropriate site-wide standards and guidelines for data security safeguards pertaining to information technology systems
- Coordinate the implementation and maintenance of data security software that provides controlled access and use of sensitive application systems, computer operating systems, communication networks, and computer hardware
- Assign user/group access to Team CSC Replacement MMIS resources including but not limited to applications, files, and data fields.
- Process batch loads of user identification/demographic records and profiles prior to Replacement MMIS implementation and throughout the life of the contract **(40.1.2.109)**

(40.1.2.109)

- Perform user-ID and password administration across all platforms
- Monitor, detect, report, and investigate breaches in computer security
- Provide consultation for technical and application development efforts involving computer data security and integrity issues
- Maintain a computer security manual for use by those responsible for security.
- Maintain a working relationship with external auditors and assist management when responding to matters involving security and control of information.
- Maintain an awareness of existing and proposed legislation and regulatory laws pertaining to information system security and privacy.

Pages D.2.1.5-8 through D.2.1.5-11 contain confidential information.

Req #	Requirement Description/Team CSC Commitment
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.
Commitment	Team CSC, consistent with its engineering methodology, will develop and maintain a complete inventory of internal and external interfaces throughout the life of the contract. Changes to interfaces and the underlying inventory will be carefully controlled through Team CSC ITIL aligned change management and configuration management process
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.
Commitment	Team CSC, consistent with its engineering methodology, will provide the specifications for all interfaces. Team CSC will conduct internal and external reviews for each specification and update the specifications upon changes to any interface. Changes to interfaces and the underlying specifications will be carefully controlled through Team CSC ITIL aligned change control process.
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.
Commitment	Team CSC will develop and maintain a data sharing capability that best suits the needs of DHSR, and enables exchange of data beginning with Early Implementation services. Following award, Team CSC will deploy a collaboration portal, NC*Tracks*. It is envisaged that this portal provide the primary means of data sharing between the Replacement NC MMIS and DHSR. The capabilities of the portal are described in detail in Section D.1.10 “Proposed Technical Architecture” and D.1.4.1 “General Systems Requirements and Related General Operational Requirements” (SOO 10.3.3-1 and 10.3.3-2)
40.1.2.62	The Fiscal Agent (Operations Phase) shall ensure that individual files, collections of files, 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.
Commitment	Team CSC will, as a standard process, conduct periodic tests of backup and recovery systems.
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.
Commitment	Team CSC will archive information per the State Record Retention Policy such that is physically separate from production information. Archive media will not be shared with production.
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.
Commitment	Refer to Section D.1.10 “Proposed Technical Architecture” and D.1.4.1 “General Systems Requirements and Related General Operational Requirements”
40.1.2.65	Fiscal Agent (DDI and Operations Phases) shall standardize all views, windows, and reports, including: • Format and content of all views • All headings and footers • Current date and time. Zip codes shall display nine digits. All references to dates shall be displayed consistently as (MM/DD/YYYY). All data labels and definitions used shall be consistent throughout the system and clearly defined in user manuals and data element dictionaries. All Replacement MMIS-generated messages shall be clear, user friendly, and sufficiently descriptive to provide enough information for problem correction. All Replacement MMIS views shall display the generating program Identification name and/or number. The display shall be consistent from view to view.
Commitment	Refer to Section D.1.10 “Proposed Technical Architecture” and D.1.4.1 “General Systems Requirements and Related General Operational Requirements”
40.1.2.66	Fiscal Agent (Operations Phase) shall perform manual workload balancing.
Commitment	Refer to Section D.1.10 “Proposed Technical Architecture” and D.1.4.1 “General Systems Requirements and Related General Operational Requirements”
40.1.2.67	Fiscal Agent (Operations Phase) shall perform work item Reassignments
Commitment	Refer to Section D.1.10 “Proposed Technical Architecture” and D.1.4.1 “General Systems Requirements and Related General Operational Requirements”
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.
Commitment	Refer to Section D.1.10 “Proposed Technical Architecture” and D.1.4.1 “General Systems Requirements and Related General Operational Requirements”
40.1.2.69	Fiscal Agent (Operations Phase) shall maintain up-to-date business rule documentation.
Commitment	Up to date business rules will be maintained by Team CSC throughout the operations phase. Documentation updates will follow the Change and Configuration management processes described in Sections E.9 and F.2.
40.1.2.70	Fiscal Agent (Operations Phase) shall perform business rule changes on a release basis.

Req #	Requirement Description/Team CSC Commitment
Commitment	Changes to business rules will follow the Team CSC Change Management process and will be performed on a release basis. The Change Management process is described in Section E.9 and F.2
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.
Commitment	Team CSC will provide office space, including desktop computers, to the State at the Team CSC facility in Raleigh NC for ITF. In addition, authorized state users will have the ability to remotely access the NC*Tracks* portal from state offices. NC*Tracks* will allow authorized users access to ITF.
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.
Commitment	Team CSC will coordinate testing as appropriate. Testing is described in Section E.4 “Master Test Process and Quality Assurance Approach” The communications channels for coordination are described in Section E.6 “Communications Approach”
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.
Commitment	Team CSC will execute testing as required by the State. Testing is described in Section E.4 “Master Test Process and Quality Assurance Approach”. The overall test schedule for DDI phase is described in the Implementation Master Plan.
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.
Commitment	Team CSC will support the ITF. An ITF environment will be deployed for DDI and Operations phase and will be maintained throughout the life of the contract.
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.
Commitment	Teams CSC will coordinate with the State and DHSR IT system vendor as required. Testing is described in Section E.4 “Master Test Process and Quality Assurance Approach” The communications channels for coordination are described in Section E.6 “Communications Approach”
40.1.2.96	Fiscal Agent (Operations Phase) shall be required to perform system maintenance to the Replacement MMIS based on State-approved CSRs.
Commitment	Team CSC will perform system maintenance as required. This maintenance will follow the change processes described in Section E.9 “Change Management Approach”
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.
Commitment	Team CSC will provide continuing engineering analysis to the State. Section D.1.3 “Software Development and Systems Engineering Methodology” describes the processes and methodologies that Team CSC will follow.
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.
Commitment	Team CSC will perform these updates following processes described in Sections E.9 “Change Management Approach” and F.2 “Change and Configuration Management Controls.”
40.1.2.99	Fiscal Agent (Operations Phase) shall perform maintenance to include, without limitation: • activities necessary for the system to meet the requirements described in the RFP; • activities related to file growth and partitioning; • support of updates to all files and databases; • software and hardware updates, as directed by the State; • RDBMS routine activities; • LAN/WAN administration and maintenance to ensure performance standards are met; • activities necessary to ensure that all data, files, programs, utilities, and system and user documentation are current and that errors found are corrected; • file maintenance, including manual table entry and programming, to support file maintenance changes, performance tuning, capacity planning, backup and recovery tasks, and archival tasks;
Commitment	Team CSC will perform these activities through the IT Service Delivery team as described in Section D.2.1.5.4 The above processes will allow MMIS to effectively provide timely and accurate software status on deployments. As it relates to maintenance periods applicable to the Services, Team CSC will: • Perform routine maintenance during regular periods and scheduled in advance • Scheduling outages for maintenance, expansions and modifications during non-peak hours so as to minimize interference or disruption to the Replacement MMIS environment • In the event that there is a need for emergency systems maintenance, providing NC DHHS with as much notice as reasonably practicable and performing such maintenance so as to minimize interference or disruption to the Replacement MMIS environment. • Maintain a test environment to evaluate software and tools configuration before integrating the same into the production environment;

Req #	Requirement Description/Team CSC Commitment
40.4.3.4	Fiscal Agent shall ensure the Web inquiry functionality is available twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year, except during State-approved maintenance periods.
Commitment	Team CSC will comply with the above requirement

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Exhibit D.2.1.5.3-1. Requirements and Commitments. *Team CSC offers full compliance with all requirements.*

D.2.1.5.4 Conclusion

Team CSC Technical Services Delivery teams will support, service, and deliver the IT Services Delivery for MMIS by using our renowned ITIL aligned SDEP processes which will be specifically tailored for the Replacement MMIS IT Services Delivery .

Team CSC will provide qualified and reliable technology experts for all phases of the Replacement MMIS life cycle. NC DHHS will benefit from Team CSC's proven experience and success in IT initiatives. We currently provide the types of IT support that the NC DHHS requires on Replacement MMIS for a very large number of both Federal and commercial customers. **CSC alone, for example, supports more than 75,000 servers and 1,000,000 LAN/WAN ports around the world. Team CSC's common toolsets and standards help our clients achieve reliable, responsive performance 24x7x365, while constantly looking for ways to improve system reliability and availability. We will use our toolsets to drive automation and achieve consistent quality improvements and reduce staffing requirements**

Our proposed IT Services Delivery methodology is based on industry standards and the team's collective corporate best practices, developed over many years and over a very large customer base. We will work closely with the NC DHHS to adapt our methodologies for the IT challenges that the Replacement MMIS faces.

D.2.2 OPERATIONS FACILITIES

We selected our work locations with two objectives in mind: Provide easy access by NC DHHS staff and provide working space for the operations staff as we assume full operations of the Replacement MMIS

During the Operations Phase of the project it is critically important that the Team CSC subject matter experts (SMEs) and technicians as well as the NC DHHS technical and functional staff have a close working relationship. We believe that such a relationship is facilitated when we are in a location convenient to you.

Team CSC agrees to perform all operations, system maintenance and modification or other work under this contract at State-approved locations. Our facilities and sites, including our data center and any subcontractor locations, will comply with appropriate State and Federal privacy and physical safeguards. **(40.1.2.1, 40.1.2.2)**

(40.1.2.1, 40.1.2.2)

We will begin the Operations Phase in the Team CSC facility housing our DDI Phase and transition to the final location after build-out. Our primary Replacement MMIS Operations work site will be located in a facility within the 15 mile requirement specified in the RFP. **(SOO 10.10-11)** Our CSC Facilities Management Group has assigned a Real Estate Agent to the Replacement MMIS team tasked to locate available building/office space in the vicinity of the Dorothea Dix Campus facilities placing the center of operations in a cost effective area.. Team CSC recognizes that the final operations facilities realistically will not be needed until the final implementation phase; therefore we will locate and signed the appropriate leases for facilities post contract award.

(10.10-11)

Our New York Operations Center will serve as the primary computing facility and will support a small portion of our network operations. **By taking advantage of in-place New York resources we are able to reduce your total cost of ownership (TCO) and offer the systems reliability enjoyed by our New York Department of Health customer. By using both North Carolina and New York facilities we are building a measure redundancy in the primary data operations function, server and network operations, and lowering the overall risk of our solution.**

We will operate our facilities in accordance with North Carolina's specific requirements and in accordance with all appropriate local, State, and Federal regulations. In preparing and operating our work locations, Team CSC will ensure that all facilities documentation is in order should auditors from NC DHHS or the federal government request to review any applicable permits, blueprints/floor plans, and leases. We will also ensure that all build-outs and renovations meet NC DHHS requirements. We realize that NC DHHS may also perform onsite inspections to monitor renovation, expansion, or construction progress. Team CSC will consult NC DHHS if there are any changes in regard to the facilities approach or plans during the implementation. In addition, we will ensure that the design for its operational workplace meets NC DHHS requirements regarding access and security for certain functional areas. We will take into account the confidential storage of existing Medicaid files and records as requested when considering facility options. We will also provide secure storage of any new or additional records and files for which NC DHHS, DPH, ORHCC, DMA, or DMH requires safe and secure off site storage.

Team CSC's primary worksite will be located within the 15 mile requirement of NC DHHS's work location in North Carolina. This will include:

(40.1.2.3) • Fiscal agent local facility (DDI and Operations Phases) **(40.1.2.3)**
(40.1.2.4) • Fiscal agent key personnel (DDI and Operations Phases) **(40.1.2.4)**
(40.1.2.4) • Fiscal agent business units (DDI and Operations Phases) **(40.1.2.4)**
(40.1.2.4) • Fiscal agent mailroom (DDI and Operations Phases) **(40.1.2.4)**
• Software development activities, design, Systems Integration Testing (SIT), User Build Acceptance Testing (UBAT), Production Simulation Testing (PST), and User Acceptance Testing (UAT) will be conducted in the dedicated test facility in our North Carolina operations building
• Software maintenance activities (Operations Phase)
• Data and Imaging Center (DDI and Operations Phases)
• Storage of physical Medicaid files (DDI and Operations Phases)
(10.10-12) • Requirements analysis staff **(SOO 10.10-12)**
• Some limited activities will be conducted at other locations:
• During the DDI Phase of the contract limited software design and development will be accomplished in NY
• Our primary Data Center will be in NY at our New York Medicaid Operations Center
• Limited network operations
• Disaster recovery operations
• Network Operations Center

Function	Location
Fiscal Agent local facility	Raleigh
Fiscal Agent key personnel	Raleigh
Fiscal Agent business units	Raleigh
Fiscal Agent mailroom	Raleigh
Distribution	Raleigh
Financial Management	Raleigh
IT Services	Raleigh
Software Development	Raleigh
Software Maintenance	Raleigh
Data and Imaging Center	Raleigh
Technical Services	Raleigh
Data Center Operations	Albany
Health Program Services	Raleigh
Provider Services	Raleigh
Contact Center	Raleigh
Outreach/Training	Raleigh
Remote Location	Asheville
Remote Location	Charlotte
Remote Location	Raleigh
Remote Location	Wilmington
Enrollment	Raleigh
Managed Care	Raleigh
Clinical Services	Raleigh
Medical Policy Support	Raleigh
Utilization Management	Raleigh
Claim Medical Review	Raleigh
PMO	Raleigh
Security	Raleigh
Quality Assurance	Raleigh
OCI Compliance	Raleigh
Medical Director	Raleigh
Claims Processing	Raleigh
Paper Intake	Raleigh
Electronic Claims Intake	Albany Data Center
Claims Resolution	Raleigh
Simple System Resolution	Albany Data Center
Complex System Resolution	Raleigh
Adjustment Processing	Raleigh

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Exhibit D.2.2-1. Team CSC Support Locations — Operations

Exhibit D.2.2-1 provides a more detailed listing of where our functions supporting the Replacement MMIS will be located.

Our North Carolina facility will comply with the facility requirements for State employees stated in the RFP to provide private office space for three (3) state employees. Team CSC will also provide assistance and access to operations, information, and data set elements necessary. The office space will include: secure, private, appropriately securable desks and file cabinets. Team CSC will provide IBM-compatible PCs, monitors, and printers with appropriate connection to the contractor's WAN/LAN and internet access. **(SOO**
(10.9-25) **10.9-25)** Telephone service as well as office supplies will also be provided. Team CSC will, for the length of the contract, provide and maintain all equipment as well as upgrade both

equipment and software for State employee's operating at our site. We will also provide copier, scanner, and fax services to State employees operating at our location. **(40.1.2.5 – 40.1.2.9)**

(40.1.2.5 – 40.1.2.9)

During the Operations Phase, Team CSC will provide equipment for traveling Fiscal Agent representatives to include PC compatible laptop and printers as well as cellular telephones that comply with the Fiscal Agent's security plan. **(40.1.2.10)**

(40.1.2.10)

D.2.2.1 Facility Security and Controls

The Replacement MMIS facilities will be configured as secured trusted user/trusted sites and will have the following security controls implemented to protect and safeguard NC DHHS Sensitive Information and MMIS activities conducted at these facilities:

(40.1.2.44 – 48) **(40.1.2.44 – 40.1.2.48)**

- Where practical, facility entrances will be locked and secured at all times. Entrances to MMIS operations areas will be configured with swipe card readers that record the user ID, time, date, and entranceway in an access control system database. This database will be examined each morning to review the previous 24 hours of activity.
- Facilities will be configured with an after-hours physical intrusion detection system (i.e., burglar alarm system) consisting of electronic or magnetic door locks, motion detectors, and glass break sensors where appropriate.
- All facilities and security rooms will be prominently posted as Restricted Areas and are separated from non-restricted areas by physical barriers that control access.
- All facilities and security rooms will be limited to those individuals who routinely need access through the use of guards, ID badges, or entry devices such as key cards.
- All facilities will have procedures for verifying access authorizations before granting physical access (i.e., formal, documented policies, procedures, and instructions for validating the access requirements of an individual before granting those privileges). The appropriate management level will certify the need for physical access and authorize (by signature) access to a facility or security room.
- The Site Security Administrator or Systems Security Officer will maintain access authorization forms for each authorized individual and review the access authorization list with the appropriate managers monthly. These monthly reviews are to be documented in an Access Authorization Review Log and signed by the reviewing manager.
- Unauthorized personnel will be denied access to areas containing MMIS sensitive information by the use of restricted areas, security rooms, and locked doors.
- All authorized staff will provide the required identification every time they enter a facility or security room. Tailgating – the act of following another authorized person entering a facility or security room will be prohibited.
- Non-authorized employees, visitors, delivery service, maintenance personnel, and authorized employees that do not possess IDs will be required to sign a register or visitor sign-in log and will be escorted or monitored by authorized staff at all times while in the facility or security room.
- All facilities and security rooms maintain will maintain a register or Visitor Sign-In Log that is used to record:
  - The visitor's name
  - Date

  - Time of entry
  - Time of departures
  - Purpose of visit
  - Person(s) visited
- Visitor logs will be used to record visitor access and access for authorized staff that have lost or forgotten their access card, keys, or any other security mechanism.
- The Site Security Administrator or Systems Security Officer will close out the visitor sign-in logs at the end of each month and review them with the appropriate managers monthly. These monthly reviews are to be documented in a Visitor Log Review Log and signed by the reviewing manager.
- All visitors will display a visitor or guest badge at all times while in a facility or security room.
- All facilities will be cleaned during working hours in the presence of a regularly assigned employee or staff person.
- For a restricted area, the identities of visitors will be verified, and a new authorized access list will be issued monthly.
- The Site Security Administrator or Systems Security Officer will ensure that the security system activation/deactivation codes are changed quarterly and every time an individual who has been given the activation/deactivation codes is terminated or transferred. This will occur within 24 hours of a termination.
- All authorized staff that possesses a facility access card must report a missing or stolen card immediately to the Site Security Administrator or System Security Officer. The missing or stolen card will be deactivated immediately upon being reported. The individual will be issued a new replacement card.
- Facility access control systems will be used to manage and authorize access to the facility and to provide weekly and/or monthly Facility Access Reports and maintain security audit logs.
- The Site Security Administrator or the Systems Security Officer will review the facility access reports at least once a month to determine whether suspicious or unusual activities have occurred. The Site Security Administrator or the Systems Security Officer will document the monthly review of the facility access reports in a Facility Access Review Log as well as document and report any unusual or suspicious activity to the appropriate managers.
- Emergency exit and re-entry procedures will exist for each facility to ensure that only authorized personnel are allowed to reenter restricted and/or other MAC security areas after fire drills or other evacuation procedures.

Specific areas of security, integrity, and reliability include:

- Fault tolerance systems
  - RAID disk arrays
  - Redundant power supplies
  - Dual processor computers
  - Redundant cooling fans
  - Redundant computer room air conditioning
- Tape backup systems and procedures
  - Off-site storage of backup tapes
  - Recycling/retirement policy for backup tapes

- Uninterruptible power supplies (UPS)
- Secured storage of sensitive data/information
  - Locked file cabinets/desks/offices
  - Secured (limited access) storage rooms
  - Logging procedures for check-out of sensitive information
- User access requirements
  - Types or roles of users and requirements for access to sensitive information
- Computer room security requirements

The entrances to the Replacement MMIS operations building will be securely locked at all times. The facilities are to be configured with a security alarm system that alerts the local police department and the security company in the event of an unauthorized entry after working hours.

Our facility will have all necessary office space, conference room, training room(s) and an area for the servers that will be supporting the program office.. Our North Carolina operations will also house our operational team including our Program Management Office, Human Resources office, Quality Assurance staff, IT Support staff, Systems Architects, Senior Software Engineers, Business Analysts, Client Services, Health Program Services, Financial Management, and Claims Management operational offices, and space sufficient for hosting large meetings. **(SOO 10.10-13)**

(10.10-13)

D.2.2.2 Classroom Training

Team CSC will build out and maintain a suitable classroom training facility to reasonably accommodate at least 50 persons. We will present a schedule of pre-approved classes for the following fiscal year for NC DHHS approval. This schedule will be considered the minimum schedule for the following year to be augmented by ad hoc classes or special scheduled classes at the request of NC DHHS based on changing user requirements. There will also be classes held if Team CSC determines through analysis of Call Center data that there is subject matter that needs to be augmented through personal classroom training. Refer to Client Services section D.2.1.3 **(40.1.2.80, 40.1.2.81)**

(40.1.2.80, 40.1.2.81)

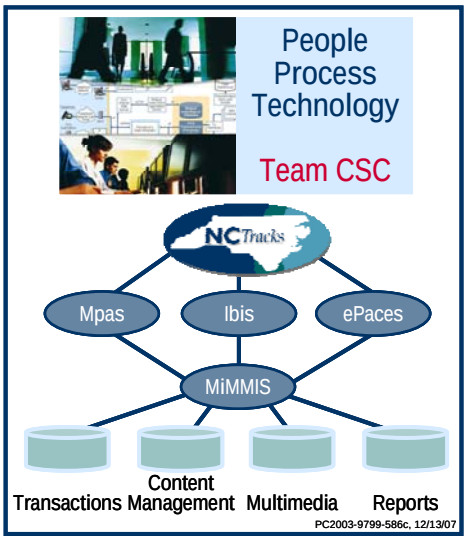
Pages D.3-1 through D.3-104 contain confidential information.

D.4 Training Approach

A comprehensive training plan for all users will be developed and executed to create knowledgeable users and promote a smooth transition to the replacement MMIS. ***As New York's Fiscal Agent for Medicaid processing, CSC brings over 30 years of experience in design and delivery of multi-stakeholder training programs. During our successful New York MMIS Replacement and Operations Phases, we developed online training tools and clearly measurable instructor-led training classes for all users of the eMedNY system resulting in 97% of providers' transactions being submitted electronically. For the State of North Carolina, Team CSC will leverage technological advances in multi-media based training that are proven to help people learn and retain more in less time. In addition, for stakeholders or topics that require a different level of training, knowledgeable, flexible training staff will deliver face-to-face training to achieve the State's goal of having a cohesive and responsive training program where all users will understand State policies and procedures and cost-effectively use the Replacement MMIS.*** **(SOO 10.10-5)**

(10.10-5)

All users of the new multi-payer Replacement MMIS will benefit from the enhanced functionality and improved productivity features provided by the new system. Whether a NC DHHS user needs to request a Certificate of Credible Coverage, a Fiscal Agent enrollment specialist is updating a provider record or a provider is entering the **NC***Tracks* web portal to request information, Team CSC recognizes the importance of a comprehensive training program to ensure proficient users ready to successfully utilize the new system from the day it is implemented and throughout the Operations Phase.



Team CSC's initial analysis of potential users who require Replacement or Operations Phase training in North Carolina are depicted in Exhibit F.6-1 of Section F.6, Communications Process/Procedures. These user groups include NC DHHS MMIS stakeholders, MMIS Contract Management staff, State and county stakeholders, providers and other State Medicaid contractors representing over 30 State agencies, 25 public and private provider types and 15 other State MMIS contractors. In addition, there are over 15 types of provider associations we believe need to be kept informed and with State verification, trained. **(SOO 10.10-6)**

(10.10-6)

In Section E.6, Communications Approach, Team CSC introduces the foundation of how we will augment important instructor-led and personal visit training with our NC*Tracks* Web portal. This is our multimedia portal providing public and secure access to each training community enabling users, on a self-service basis, to view educational materials, training course calendars, enroll in

scheduled courses, take advantage of self-paced training at any time, and create and manage their own training record.

Through the online self-test and survey capability we intend to make MMIS training in the State of North Carolina a showcase, delivering educational and training materials that receive high quality user experience scores as well as high user proficiency scores from self-tests users take to prove to themselves and our training evaluators that the user understood the training we deliver.

> *"The presenter delivered the information in an excellent way. He was very willing to answer questions and had a great knowledge base of information to be delivered."*
> A New York State Provider

CSC is proud of our successes with MMIS training in New York. We understand that the North Carolina multi-payer environment will require us to deliver a broader curriculum. Even so, we intend to surpass the level of our New York achievements for North Carolina by working collaboratively with the State to review our initial estimate of user categories, identify a curriculum for each that meets the full intent of the State's multi-payer environment, and implementing a culturally sensitive, multilingual training program that improves MMIS operations across the State's government while systematically reducing the total cost of operations.

Although Team CSC will facilitate an intuitive self-help learning process for many of the new tools and functions of the Replacement MMIS, initial implementation of the Replacement MMIS will require extensive instructor-led user training. Essentially, all users will need to know everything about how to perform their existing functions in a new environment. In order to develop effective training, the users' interactions with the existing MMIS system must be understood. Team CSC will develop multiple training tools and opportunities to educate users how to perform their required activities using the new system and how to understand and use new functionality that the Replacement MMIS provides. These tools and opportunities are discussed throughout this response to Team CSC's training approach. More information about the technology being proposed to support training efforts can be found in section D.1.4.5, Provider Subsystem.

The North Carolina Replacement MMIS Training Plan will require structured planning and oversight to ensure major tasks, especially those dependent on other milestones during the DDI phase, will be completed within required time frames. Built into the plan will be a margin for delayed milestones due to unforeseen disruptions or delays. Team CSC will make sure all users are trained in advance of implementation to ready them to be effective and efficient users. Team CSC is committed to meeting or exceeding every State requirement for training users as put forth in Section D.3, NC MMIS Statement of Work (SOW) for both the DDI Phase, Section 1.3.6 and Operations Phase, Sections 3.3.3.4 and 3.3.3.5 of the SOW.

State and FA staff will be trained in advance and with sufficient time to run practice scenarios to create efficiencies at implementation. Provider procedural and billing training will be delivered in advance of implementation but close enough to minimize diminishing knowledge that increases over time when not applied to job tasks.

Page D.4-3 contains confidential information.

The initial assessment of users needs will be presented to the State for validation and will be revised periodically throughout the DDI phase. Announcements will be developed and published via direct mail, website bulletins and announcements, and through provider associations. Early announcements will be especially important for changes impacting electronic submitters.

Training materials including CBTs, instructor-led PowerPoint presentations and handouts, desk top procedures, etc., will be developed and ready for State review in time to support testing and throughout the Operations Phase. Mock training sessions will be offered to the State so comments can be incorporated into final revisions to training materials and desk top procedures manuals prior to user training. **(10.10, SOO 10.10-7)**

(10.10, 10.10-7)

D.4.2 IMPLEMENTATION TRAINING COMMITTEE

It is Team CSC's belief that to train DMA, DPH, DMH, and ORHCC Staff, the provider community, and local DSS offices, it is critical to understand and meet the training needs of the varying stakeholders. Team CSC also knows that no one knows better than the stakeholder themselves what those needs are. As such, Team CSC proposes to NC DHHS the development of an Implementation Training Committee. This Implementation Training Committee should include:

- DMA Representatives
- DPH Representatives
- DMH Representatives
- ORHCC Representatives
- Provider Association Representatives
- A cross section of providers with varying specialties
- CSC Training Staff
- Vendors

The Implementation Training Committee's charter is to provide input, review and feedback on the topics and agendas for stakeholder trainings and communications, the location of training, and the CBTs used in training. The Implementation Training Committee will be the first to receive training. While Team CSC training staff will conduct the training, with State validation, all other members of the Implementation Training Committee will receive the training material (i.e. CBTs, Training Center of Excellence website, Instructor led training, handouts, etc) first and provide feedback that best represents their respective division, association, or communities needs.

Team CSC wants each division and each provider group to be part of the solution to help ensure a successful transition from Implementation to go live. We envision this committee to continue beyond the Implementation Phase to provide valuable input for operations training and communications as well.

D.4.2.1 Training Professionals

Key participants of the Implementation Training Committee are the trainers them selves. They will listen to the input from the committee and incorporate approved

feedback into training sessions. Team CSC will bring the right trainers on board prior to go live.

Team CSC has a solid history of hiring, training and retaining professional trainers in our New York Medicaid Contract. In New York we have 8 trainers and an Outreach Manager with over 100 years experience servicing the State, the State's Medicaid providers, county representatives, provider associations, providers' vendors and local Department of Health staff. Regional Trainers work closely with State and county representatives on many initiatives including, for example, promoting EPSDT services and managed care.

Team CSC will employ sufficient trainers to develop and complete the implementation training plan. All trainers will be thoroughly trained on the aspects of the Replacement MMIS needed to perform training tasks. Trainers' knowledge and proficiencies will be tested prior to performing customer training.

Team CSC's training staff will undergo intensive subject area instruction that will include:

"Every time we ask assistance of Gloria Howe's Unit, they step up and meet and exceed our requests for training." NYS Department of Health Representative

- Review of pertinent procedure manuals and reference periodicals
- Review of North Carolina DMA, DPH, DMH, and ORHCC policy, billing manuals and bulletins
- Review of the Replacement MMIS development documentation
- Discussions with DMA, DPH, DMH, and ORHCC subject matter experts
- Training in the use of the Replacement MMIS screens, forms, reports and the **NC***Tracks* Web portal
- Training for claim submission and processing
- HIPAA privacy, protection of information, and Security awareness training

When hiring training staff, Team CSC concentrates on identifying candidates with strong core competencies in health care, public speaking, and information technology systems, coupled with solid customer service credentials.

The training staff will maintain a continuing focus on quality customer service principles and delivery, and customer service training manuals will be developed and issued to all employees who are directly involved in customer contact. To supplement the initial and ongoing training received in the specific customer service aspects of their positions, employees will be monitored regularly. Feedback mechanisms will be developed for each type of customer contact, allowing the employee and manager to promptly identify any area in need of adjustment. These feedback mechanisms include, but not be limited to, emailed customer surveys, outgoing provider survey calls, provider incoming calls, and other customer satisfaction measurement tools. These tools will be designed to quantify and qualify customer contacts for reporting customer satisfaction levels to the State.

Continuous Improvement Training is a CSC program that identifies and reinforces problem solving and interaction skills. This program has been used successfully within CSC in the past, and will be applied to the North Carolina

Medicaid project as well. This program encourages employees to be flexible and responsive to changing conditions, and to work together cooperatively. This fosters swift adaptation to dynamically developing situations. In order to promote consistent delivery of outstanding customer service, CSC employees at all organizational levels will be involved in this quality training program on an ongoing basis.

Team CSC will employ professional trainers who are dedicated to tasks specifically related to State and Fiscal Agent training. These trainers will work with Team CSC Systems Development staff and with State validation, the Implementation Training Committee members, to develop training materials and conduct instructor-led classes for State staff in Raleigh. The training facility will be equipped with PCs and access to the training system sufficient to train up to 50 people at each session. These trainers will also develop training materials and testing tools for FA staff to qualify each person's job efficiency prior to implementation and ongoing throughout operations. The trainers will work with Team CSC management from various departments to conduct training. The trainers will administer and score tests for Fiscal Agent staff. Staff that do not meet approved efficiency standards will be afforded more training to bring their knowledge up to the required standard. **(40.1.2.81)**

(40.1.2.81)

In order to better serve NC DHHS, the providers, providers' vendors, local agencies, provider associations and other users throughout the State, Team CSC will position sufficient training staff to cover specific territories in the State based on the largest population densities: two (2) regional representatives will represent the Charlotte areas, one (1) the Greensboro area, one (1) the Wilmington area and one (1) for the Asheville area, in addition to two (2) local representatives for the Raleigh area. The training staff will conduct instructor-led classes in these areas, and they will be available to dispatch to users' premises when special one-on-one training is needed. These representatives will also be available for consultations with remote local and State agency staff, and they will be available for on-site visits to educate providers and their vendors on various topics including but not limited to encounter claim submission process and the Health Check Program. **(40.9.2.5, SOO 10.12.4-12)**

Number of Staff	Location	Population Density
2	Charlotte	610K
2	Raleigh/Durham	544K
1	Greensboro	231K
1	Wilmington	96K
1	Asheville	72K

(40.9.2.5, 10.12.4-12)

D.4.3 USER NEEDS ASSESSMENT

Before Trainers begin any training, it is important to assess the needs of those who will be trained. **Training based on individual users' needs sets the stage for successful training opportunities. Understanding the specific needs of the trainees is critical in developing successful training venues. In-depth interviews allow an interviewer to obtain specific, detailed information about customer needs and requirements. The feedback from these interviews will be used to drive the development of Team CSC's Training Plan.**

Team CSC will perform Customer Needs assessments in the provider community, with DMA, DPH, DMH and ORHCC, and within CSC. A Customer Needs Assessment will provide the following information:

- Discover existing challenges
- Quantify current problems, and whether they are expected to increase, decrease, or stay the same in the future
- Define how users currently interface with the system and if and how their procedures will be changed with the Replacement MMIS
- Determine which processes currently used are the most successful and why
- Obtain reactions to planned strategies

To assist in completing the Customer Needs Assessment, sample representatives from each user group, including NC DHHS, providers, vendors, provider associations, etc) are interviewed and surveys distributed to a larger group of users. Survey tools will be analyzed to help define and deliver meaningful training information and events.

Team CSC's implementation team will meet regularly with the Implementation Training Committee, the CSC development staff and NC DHHS users to assess the needs of each type of audience. In addition, Team CSC will meet with a number of providers and/or provider associations to gain insight to their expectations and requirements. This will form the basis for designing a needs-based training plan and help formulate measurable goals, the success of which will be reported to the State as required by the contract. **(SOO 10.10-10)**

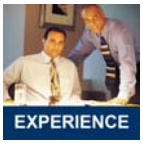
(10.10-10)

Information gathered from each customer group is thoroughly examined in light of the completed requirements of the Replacement MMIS to define areas to be stressed during training, including efficiencies and enhancements of the new system and inhibitors to electronic transaction processing.

The results of the feedback will be analyzed by Team CSC's implementation team and delivered to the State for approval and revision of the Training Plan. The approved feedback will be used in the development of training materials and user notifications.

Early announcements will be developed and distributed to users, after State approval, as far in advance of implementation as possible. It will be especially important to send early announcements to providers and vendors submitting electronic transactions to allow sufficient time for these users to make adjustments to their electronic-based systems. State-approved announcements will be delivered via State Bulletins, direct mail and the website.

D.4.4 INSTRUCTOR LED CLASSES



CSC delivered over 200 targeted instructor-led training classes for providers and State and local representatives to create knowledgeable and efficient users of the New York replacement system in 2005.

Prior to implementation, users of the North Carolina Replacement MMIS will have an opportunity to attend several instructor-led classes on pertinent topics. Mock training

sessions will be conducted with the Implementation Training Committee for approval prior to conducting training workshops.

Developing the curriculum and content for training all users on the new system will require a substantial effort over a minimum of nine months to be completed at least 90 days prior to implementation so instructor-led classes can commence. This effort will take place concurrent to the systems design and development process. **(40.1.2.79)**

(40.1.2.79)

In developing the training materials, the unique needs of each user group must be taken into consideration. The training will target the specific changes that the user will experience when the new system is implemented. Training should take place as early as practical to allow time for the user to prepare to make the appropriate changes to his/her internal systems to adjust to the new system's requirements. However, training material cannot be completed until the exact design of the new system has been finalized to avoid confusion which may result from modifications implemented during the training process.

Many times the subject matter is the same for multiple user communities, but the emphasis may be different. Team CSC will consider the changes from each user's perspective and develop specific training for that group.

D.4.4.1 State/CSC Instructor-led Classes

Team CSC will secure sites for user training 6 months prior to implementation. Provider class sites will be approved by the State. State training will take place in the CSC training classrooms located in the CSC offices. Classrooms will be PC-equipped for users to practice accessing and performing mock transactions and updates via a test system that mirrors the production MMIS online system. **(40.1.2.36, 40.1.2.81, 40.5.2.50, SOO 10.10-8)**

(40.1.2.36, 40.1.2.81, 40.5.2.50, 10.10-8)

Training will be led by CSC training staff and development staff. Classes will be scheduled for each subsystem so State users will be invited to sign-up for the specific subsystems and functionality that affect their particular job functions. These trainings will be blended and consistent to meet the needs of the State, local agencies and CSC staff. Training will include some of the following: **(40.1.2.83)**

(40.1.2.83)

- Class Objectives
- Overview of Replacement System
- **NC***Tracks* Navigation
- Subsystem Functionality
- System Navigation
- Updating Functionality
- Practice Scenarios
- Documentation/reports creation and access

- HIPAA privacy and security policy and procedure awareness

All Team CSC staff responsible for updating or viewing information in the Replacement MMIS will be scheduled for training in their particular job functions. Training will be monitored and tracked online in the Training Center of Excellence. CSC staff will be provided on line tests of training courses taken. Classes and tests scores can be viewed by management within the Training Center of Excellence and the results are reported to the State monthly. **(40.1.2.82, 40.1.2.84)**

(40.1.2.82, 40.1.2.84)

The length of instructor-led classes will vary for subsystem and user requirements to be determined during the development phase.

State-approved evaluations will be administered to all participants, the results of which will be tabulated and reported to the State. **(40.1.2.82)**

(40.1.2.82)

"Jason and Theresa were friendly, approachable, helpful, knowledgeable and kept everyone interested during the training session."
NYS Department of Health Representative:

In addition to the above "per MMIS Implementation" training, CSC training staff will address training needs throughout the life of the contract. This may be refresher training, new release training, or other training dictated by policy or business rule changes. This training will be conducted in instructor led classrooms. The monitoring, tracking, and reporting previously described will also occur for this training. **(40.1.2.80)** When appropriate and approved by the state, some training may be delivered via the **NC***Tracks* portal.

(40.1.2.80)

D.4.4.2 Provider And Local Agency Instructor-led Statewide Training

Team CSC proposes that Provider and local agency staff training sites should be secured statewide in the following populated areas to make it convenient for users to attend: Raleigh, Greensboro, Charlotte, Asheville, and Wilmington.

Statewide regional training classes will begin 3 months prior to implementation and will be completed prior to implementation. For implementation of the New York replacement Medicaid system in 2005, CSC planned and conducted over 200 classroom sessions for providers statewide and State and county staff in a 2-month timeframe that ended one month before implementation.

North Carolina provider training classes will be held in spaces with internet access for demonstrating the new Web Portal known as **NC***Tracks* and the electronic Provider Assisted Claim Entry System (ePACES). Each person responsible to deliver instructor-led classes for providers will be equipped with a laptop and projector for displaying materials and performing demonstrations during the classes. Hard-copy handouts will be available for participants. Participants will be able to access training materials, including any CBTs, on line or order CD-ROM versions of training materials by contacting the Team CSC Call Center.

Provider training classes will last approximately 3 hours and participants will be allowed unlimited time to ask questions. Providers will be offered a choice of dates and times for each of the above locations over a 2 and 1/2 month period and can enroll for these courses on line or via fax or phone. Additionally, providers will be

grouped by three classifications as illustrated in **Exhibit D.4.4.2-1** which will allow like providers to attend classes specifically designed for their unique needs. These classifications will be subject to further delineation as the replacement system is developed and with guidance from the State.

Classification: Practitioners			
Ambulatory Surgery	Eye Care	Public School Health Services	Nurse Midwife
Anesthesiology	Head Start	Independent Diagnostic Testing Facilities	Nurse Practitioner
Chiropractor	Health Check	Independent Mental Health	Physician
Nurse Anesthetist	Health Department	Independent Practitioner Program	Planned Parenthood
Classification: Hospitals			
Area Mental Health	Dialysis	Hospital	Psychiatric Residential Treatment Facility
CISA	Hearing Aid	Nursing Facility	Residential Child Care Facility
Classification: Community Care			
Adult Care Home	Dental	Home Health	Pharmacy
Ambulance	DME	Home Infusion Therapy	Private Duty Nursing
At-risk Case Management	FQHC/Rural Health	Hospice	
CAP	HIV Case Management	Personal Care Services	

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Exhibit D.4.4.2-1. Provider Training Classifications

Because direct mail is proven to be the most effective means of reaching a target audience, providers will be sent direct mail invitations to the class schedule. Providers will be asked to register participants via fax or mail and via the website. The invitations will also include information about the major topics to be covered during the classes and a toll-free telephone number to call if there are questions.

Registration information on all participants will be maintained and made available to the State. The registration documents which will include the provider's ID number will be used as sign-in sheets at instructor-led classes so providers will not need to have their ID numbers available on the day of the class. This information will allow CSC to link those providers who attended classes to the scanned materials being distributed during the class. These materials will then be available as scanned images as part of the provider record.

Team CSC will plan a sufficient number of classes based on the number of enrolled providers for each group. The days and times will vary for the convenience of the providers to select a class that fits their schedules.

The Training Plan will identify how each group of users will receive the training necessary to be proficient on the new Replacement MMIS and how their unique concerns and interests will be addressed.

Training will be goal-oriented, with specific objectives established and results measured. Objectives will include such items as reducing the transaction error rates, reducing problem calls to the Call Center, higher adoption of electronic methods over paper based methods, and greater efficiencies in users' work processes.

(40.1.2.76) Provider instructor-led classes will consist of the following major topics if approved by the State: **(40.1.2.76)**

- Class Objectives

- Overview of Replacement System
- AVRS Functionality
- Changes Impacting Provider Submissions
- Submission Methods (electronic and paper)
- **NC***Tracks* Functionality
- Available Documentation (CBTs and Forms)
- electronic Provider Automated Claim Entry System (ePACES)
- Remittance Options (electronic and paper)
- Prior Approvals
- State policies and procedures
- Regulatory guidelines
- Business rules and claims processing
- Contact Information including how to request an onsite visit and sign-up for listservs

Provider classroom training will consist of a demonstration for maneuvering the new replacement MMIS website including: signing up for **NC***Tracks* access, electronic submission of forms, accessing ePACES, Manuals, CBTs and other news.

(40.1.1.128) **(40.1.1.128)**

The provider training will emphasize the new Web Portal, **NC***Tracks*, that will be a centerpiece of information about the new system and a primary resource for accessing information about the various training opportunities. **NC***Tracks*, which will be built using SharePoint's advanced web sourcing technology, will be customized for the unique requirements of each user community. The advantages allow each user group access to information that is pertinent to their business needs and minimize search time for finding information.

Local agency training will be provided to county, LME and other staff that will need to access the MMIS online system for updating or queries. Classes will be set up in Raleigh and regionally to accommodate the needs of these customers.

Subsystem training will be much like the State training described above in Section D.4.4.1. Training will also focus on **NC***Tracks* and what information is available to these users based on their agencies' security access.

Evaluation forms will be given to each instructor-led class participant and sent via email. Participants will be asked to rate and comment on class structure, content, the materials and the instructor. The evaluation form will be based on the most widely used Likert Scale. Participants will be asked to indicate their degree of agreement with pertinent statements related to such things as the effectiveness of training materials, the course objectives and delivery and the performance of the trainer. A five-point scale will be used to measure participants' positive or negative responses. Completed evaluation forms will be forwarded to Customer Services management where each statement from completed questionnaires will be analyzed and summed to

Pages D.4-12 through D.4-14 contain confidential information.

(40.1.2.87, 40.1.2.88, 10.12.4-12) conduct the annual Medicaid Fair. **(40.1.2.87 – 88, SOO 10.12.4-12)**

CSC's outreach representatives will respond to on-site requests from providers with priority given to requests that will come from DMA, DPH and DMH representatives. On-site training will be delivered to providers for all aspects of the replacement system. Hands-on training for the ePACES program will be offered to providers in their offices upon request, in addition to the instructor-led classes that will be offered by provider groups for the ePACES application.

Team CSC's outreach representatives, in addition to the meetings and fairs required by the RFP, will liaison with the local representatives in their respective regions to be a point of contact for resolving complaints as quickly as possible. The staff will also attend any regularly scheduled meetings of provider associations, committees or consortiums. Outreach representatives will be available, upon request to make presentations at these meetings or to act as a liaison to the replacement Medicaid system.

Ongoing State instructor-led training will be scheduled and performed regularly according the State requirements in the PC-equipped training facility located in Raleigh.

A standard component of change management is to update the training material for the new changes. The systems changes will also need to be applied to the hands on (10.12.1-15) training system for users who access the replacement system. **(SOO 10.12.1-15)**

More details about Team CSC's training plan can be found in the Client Operations section, Section D.2.1.3.

D.4.6.1 Fostering Users That Will Be Efficient and Effective While Using the System

Staff turnover and system changes create a requirement to have up to date training classes, based on user feedback, available during the Operations Phase of the Replacement MMIS. Refresher training is also important to allow users to sharpen their skills with interacting with the new system. Ongoing CSC staff proficiency (50.2.2.4, 40.1.1.131) evaluations will be mandatory for all newly hired staff and for ongoing staff periodically. **(50.2.2.4, 40.1.1.131)**

Management will refer staff for training and testing prior to job placement. CSC training and testing specialists will communicate test result back to management and authorize job placement or retraining and testing depending on test results.

Utilizing the Training Center of Excellence, authorized users are able to monitor the courses taken by their staff and assess their needs for additional training.

D.4.6.2 Relative Lead-Time to Develop Training Materials Prior to Conducting Training Classes

Most of the modifications to training content will be the result of changes being made to the system or for newly implemented procedures and policies. The appropriate changes will be applied to the training material, including instructor-led course material, web based classes, and computer based classes at a minimum of 30 days prior to deployment to seek State approval for updates.

Changes that result from class evaluations will be a part of the ongoing review and updating of materials.

D.4.6.3 How Users' Skills Remain Current Throughout The Operations Phase

During the Operations Phase, it is crucial that user's skills remain current. To assist in this area, Team CSC will utilize the Training Specialists and **NC***Tracks.* **(50.2.4.4, 40.1.1.133)**

(50.2.4.4, 40.1.1.133)

Training Specialists will conduct classes for changes with significant impact to the MMIS online system for both State and CSC staff impacted by the changes. In addition, these Training Specialists will provide monthly refresher courses and new hire courses in which NC DHHS and CSC staff can enroll.

Some users may not be able to arrange time out of their office to attend the scheduled classes. Users will be able to take advantage of self-study web classes and computer based training classes on their own schedule. CBT courses will also be available for self-paced learning for each Replacement MMIS application within the MMIS online system. As with any training, self-study classes will be registered and reported to the State in the monthly training summary. **(40.1.1.129, 40.1.1.130)**

(40.1.1.129, 40.1.1.130)

CSC's Provider Representatives will conduct onsite visits in providers' offices and/or telephone consults, as appropriate, to maintain an educated provider population. The onsites will be in response to requests from providers, billing groups, or State/local representatives or a proactive outreach to providers whose claim denial rates are in excess of 20 percent. Providers will be able to request onsite training at any time. **(40.1.2.89)**

(40.1.2.89)

In addition, Team CSC's Provider Representatives will receive individual provider on-site requests from many sources, including the CSC Call Center, State and local agency representatives or though contacts made with providers during instructor-led classes. The Provider Representative will contact the provider, usually via telephone to research whether an on-site visit is needed. If problems can be resolved through telephone consults, no on-site may be necessary. For providers who require onsite training, the Provider Representative will schedule an on-site visit with the provider or alert the provider to other training classes or material on the **NC***Tracks* that will be helpful.

NC*Tracks* will continue to be a primary source of news and information throughout the operations phase of the replacement MMIS. Information about the Replacement MMIS' rules and operations may easily be located on the **NC***Tracks* by using a powerful search engine which will provide access to pertinent documents by queries matching words in their content. Documents that are subject to update will be managed by version control, so users may retrieve a previous outdated documents based on an earlier time frame.

Users may also sign up for email notices about topics of their interests by signing up for listservs on **NC***Tracks*.

Users may take web based training classes that are available, or they may choose to sign up for instructor-led courses via the Training Center of Excellence within **NC***Tracks*.

All training events will be tracked and reported on a monthly training summary report provided by Team CSC to the State. The following documentation will be stored as part of the providers' records:

- Training materials distributed during instructor-led classes
- Participant records for instructor-led classes
- Evaluations completed by class participants
- Survey responses
- Onsite request reports

D.4.6.4 Building and Maintaining the Training Environment

The training environment for users who have access to the Replacement MMIS will be built prior to implementation. Changes to the production MMIS will be migrated to the training environment.

CSC's will utilize the training environments for newly hired Fiscal Agent staff that will be instructed and coached for proficiency in job functions. Once staff passes testing, they will be migrated to the production environment to perform job related tasks.

D.4.6.5 Process to Identify and Track Training Needs

In order for the training program to be effective, it will be frequently updated. User needs for additional training will be constantly evaluated and the training plan adjusted to meet changing requirements. One of the key items to evaluate for impact to the training plan will be the planned implementation of system changes. Based on the requirements of the change, the training need will be anticipated and developed before the change is implemented.

Other training needs will be determined from issues that are identified with certain types of users in working with the system. For example, if certain denials codes are excessive, training needs to be adjusted to address why these errors are occurring and changes made to the training material to help providers avoid these errors. Also, the Call Center traffic will be monitored on a regular basis. If providers calling the Call Center are reporting the same issues frequently, then training will be enhanced to instruct the providers on how to avoid these problems. Similarly, if State, local, or State agency personnel are calling the user help desk with similar problems, training needs to be addressed to explain these topics more clearly.

Class evaluations and ongoing provider surveys will be reviewed to determine weaknesses in the training, if any, and the need for specific training. Specific user' comments will be taken in consideration and courses updated as appropriate. The training process will be adjusted to deal with issues as they arise, and some of these issues may impact the Training Plan that is constructed for the next contract year.

D.4.6.6 Delivery Media to Be Used For Each Training Activity

Each training activity will be evaluated to determine the most effective media to be used to deliver the specific messages for the topics. For large instructor-led classroom settings, commonly a PowerPoint presentation will be used along with web-based demonstration and hard-copy handouts will be distributed during the classes. (50.2.4.4) **(50.2.4.4)**

However, web based training will be developed for some topics, and these will be interactive HTML pages delivered over the web. Users will be able to take the web based training at their own pace, even stopping, and returning later to complete the topic. Typically, the topics selected for web based training will be based primarily on the number of users that require the training and the difficulty of getting them all together in a few organized sessions.

Computer based training (CBT) will be available on a CD Rom or by downloaded from **NC***Tracks*.

D.4.6.7 Accessibility of Training Materials/Training News Before, During and After Training

NC*Tracks* will be a primary source for users to access training materials on their own. Users will be able to access instructions for **NC***Tracks* navigation via the web or by contacting the Call Center. Notices will be posted on changes that may impact users prior to the changes being implemented. Some classes will be available on the web, but even for instructor-led classes, the material and/or PowerPoint presentations will be placed on the web for users to download. (10.10-9) **(SOO 10.10-9)**

For changes that are being implemented that have a direct impact on certain users, Team CSC will not wait for the users to find the information via the Web Portal, **NC***Tracks*. **We will push the pertinent information pertaining to the change to these users via emails based on listservs. And in some cases, it may be necessary to mass mail notices to users about the change or to send notices to targeted user groups.**

D.4.6.8 Evaluating Trainee Feedback to Improve Course Materials and Methods

User feedback is valuable for determining the effectiveness of training classes. Each user will be asked to complete a course evaluation on how well the instructor led class met his/her needs. All user evaluations will be scored to determine overall strengths and weaknesses of the class, and adjustments will be made to the course material to improve the class. Individual comments will be reviewed by CSC management and available for review by NC DHHS. The appropriate action will be taken where warranted. Future training plans will highlight any changes incorporated based on feedback. (50.2.4.4, 10.10-10) **(50.2.4.4, SOO 10.10-10)**

The evaluation tool will be based on based on the most widely used tool, the Likert Scale. Participants will be asked to indicate their degree of agreement with pertinent statements related to such things as the effectiveness of materials, the performance of the trainer and course objectives. A five-point scale will used to measure participants' positive or negative responses. Each statement from completed questionnaires will be

(40.1.1.136, 40.5.2.54, 40.5.2.55)

analyzed and summed to create a score for reporting to the State within 5 business days from the training seminar date along with a list of training participants. **(40.1.1.136, 40.5.2.54, 40.5.2.55)**

Computer based training (CBT) will be available on a CD Rom or by downloaded from **NC***Tracks*. Upon the completion of training, users can elect to test what they learned by taking an online test. Test scores and user evaluation information will be available to training staff via **NC***Tracks*. The results of test scores and evaluations will be monitored and used to update CBTs and for reporting to the State.

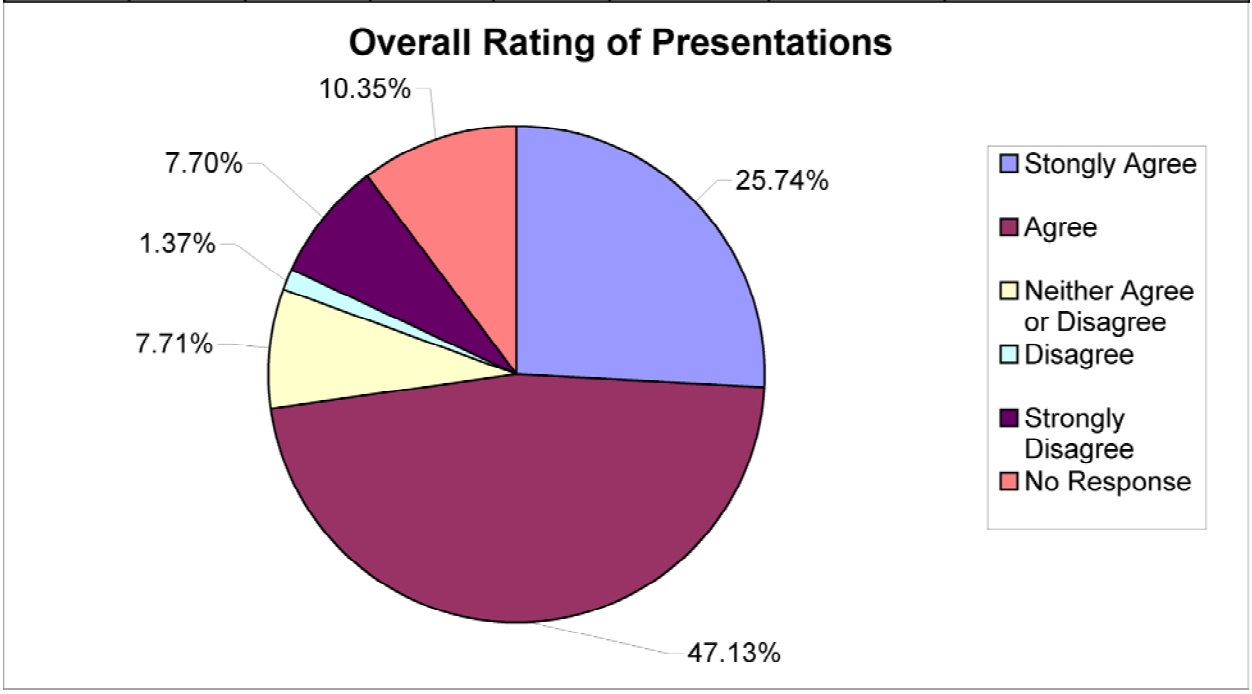
Team CSC will report evaluation responses in a quantitative format as depicted in **Exhibit D.4.6.8-1**, North Carolina MMIS Evaluations Summary Prototype. Further, Team CSC will provide a spreadsheet along with this summary of all written comments from the evaluation forms. The reports will be provided for each user type. The evaluation forms, after imaging, will be sent with the report at the request of the State.

Additionally, users will be encouraged to submit suggestions or ideas for training improvements via **NC***Tracks*. This information will be forwarded to the appropriate CSC training representatives for incorporation into subsequent training materials and events.

Evaluation scores, including comments will be reported to the State on a monthly basis.

With Team CSC's experience, specifically in the area of training and more specifically in the training of providers and State users for implementation of the New York Replacement MMIS System, the State of North Carolina and its partners in the Medicaid System will acquire a low risk solution for ensuring an efficient and effective user community. CSC's knowledgeable and flexible training staff will partner with the State as well as representative from all user communities to design and execute the best tested training approaches that will embrace the individual needs of user communities.

North Carolina Evaluations Summary							
APRIL 2008 - REPLACEMENT MMIS TRAINING FOR INSTITUTIONAL PROVIDERS							
Question Number	Response						Total
	Stongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree	No Response	
One	425	721	112	11	3	8	1280
	33.20%	56.33%	8.75%	0.86%	0.23%	0.63%	
The material unfolded in a logical, easy to follow manner?							
Two	380	657	102	17	30	94	1280
	29.69%	51.33%	7.97%	1.33%	2.34%	7.34%	
The material was presented at an appropriate pace?							
Three	149	359	80	21	334	337	1280
	11.64%	28.05%	6.25%	1.64%	26.09%	26.33%	
The course objectives were clearly defined?							
Four	364	676	101	21	27	91	1280
	28.44%	52.81%	7.89%	1.64%	2.11%	7.11%	
The course contained an appropriate level of detail?							
Overall Rating	1318	2413	395	70	394	530	5120
	25.74%	47.13%	7.71%	1.37%	7.70%	10.35%	



9799-999

Exhibit D.4.6.8-1. North Carolina MMIS Evaluations Summary Prototype.

North Carolina Replacement Medicaid Management Information System (MMIS)

RFP Number: 30-DHHS-1228-08

Prepared for:
North Carolina Department of Health and Human Services

Office of Medicaid Management Information System Services

Prepared by:
Computer Sciences Corporation

30 May 2008
Volume I — Technical Proposal

Book 3 of 4
Sections E-I

Best and Final Offer

Copy

Redacted Version

With Confidential Pages Removed

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List of Exhibits

List of Abbreviations

AARP	American Association of Retired Persons
ABEND	Abnormal Ending
ABTC	Asia Pacific Economic Council Business Travel Card
ACCP	American College of Clinical Pharmacy
ACD	Automatic Call DistributionDistributor
ACH	Automated Clearing House
ACII	Allergy and Clinical Immunology International
ACTS	Automated Collection and Tracking System
ACWP	Actual Cost of Work Performed
ADA	American Dental Association, American Diabetes Association, Americans with Disabilities Act of 1990 (US), American Dietetic Association
ADAO	Adult Developmental Disability Assessment and Outreach
ADC	Application Development Completion
ADCEP	Adult Developmental Disability Community Enhancement Program
ADD	Application Detailed Design
ADP	Application Design and Prototyping
AEDC	After Effective Date of Contract
AFTP	Anonymous File Transfer Protocol
AHF	American Hospital Formulary
AHFS	American Hospital Formulary Service
AHIC	American Health Information Community
AHIMA	American Health Information Management Association
AHIP	America's Health Insurance Plan
AIAN	American Indian Alaskan Native
AIDS	Acquired Immune Deficiency Syndrome
AIM	Application Implementation
AINS	Automated Information Notification System
ALM	Application Life-Cycle Management
AMCP	Academy of Managed Care Pharmacy
ANSI	American National Standards Institute
AP	Area Program, Accounts Payable

AP	Accounts Payable
APC	Application Preliminary Design
APEC	Asia-Pacific Economic Cooperation
API	Application Program Interface
AQT	Application Qualification Testing
AR	Accounts Receivable
ARA	Application Requirements Analysis
ASAO	Adult Substance Abuse Assertive Outreach and Screening
ASC	Accredited Standards Committee, Ambulatory Surgery Center
ASCDR	Adult Substance Abuse IV Drug User/Communicable Disease
ASCP	American Society of Consultant Pharmacists
ASHP	American Society of Health Systems Pharmacists
ASP	Automated Support Package
AV	Actual Value
AVRS	Automated Voice Response System
AVRU	Automatic Automated Voice Response Unit
AWP	Average Wholesale Price
BA	Business Analysis, Business Analyst
BAC	Budget at Completion
BCBS	Blue Cross Blue Shield
BCCM	Breast and Cervical Cancer Medicaid
BCP	Business Continuity Plan
BCWP	Budgeted Cost of Work Performed
BCWS	Budgeted Cost of Work Scheduled
BENDEX	Beneficiary Data Exchange
BI	Business Intelligence
BIA	Business Impact Analysis
BPEL	Business Process Execution Language
BPM	Business Process Management
BPMO	Business Process Management Office
BPMS	Behavioral Pharmacy Management System
BPO	Business Process Outsourcing

BRIDG	Biomedical Research Integrated Domain Group
BSD	Business System Design
BV	Budget Variance
C&A	Certification and Accreditation
C&KM	Collaborative and Knowledge Management
C&SI	Consulting and System Integration
CA	Computer Associates, Control Accounts
CA	Control Accounts
CAFM	Computer-Aided Facilities Management
CAM	Control Account Managers
CAP	Community Alternatives Program, Competitive Acquisition Program, Corrective Action Plan
CAP	Community Alternatives Program
CASE	Computer-Aided Software Engineering
CAT	Contingency Assessment Team
CBT	Computer-Based Training
CCAS	Certified Clinical Addiction Specialist
CCS	Certified Clinical Supervisor
CCB	Change Control Board , Configuration Control Board
CCB	Change Control Board
CCI	Correct Coding Initiative
CCM	Child Case Management
CCNC	Community Care of North Carolina
CCSP	Claims Customer Service Program
CDAO	Child Developmental Disability Assessment and Outreach
CDHP	Consumer Driven Healthcare Plan
CDHS	California Department of Health Services
CDISC	Clinical Data Interchange Standards Consortium
CDR	Critical Design Review
CDRL	Contract Data Requirements List
CDS	Controlled Dangerous Substance
CDSA	Children's Developmental Services Agencies

CDW	Client Data Warehouse
CEO	Chief Executive Officer
CERT	Comprehensive Error Rate Testing, Computer Emergency Readiness Team
CERT	Computer Emergency Readiness Team
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CHECK	NC State Departments of Health and Office of State Controller
CI	Configuration Item
CICS	Customer Information Control System (IBM)
CIO	Chief Information Officer
CISSP	Certified Information Systems Security Professional
CLIA	Clinical Laboratory Improvement Amendments, Clinical Laboratory Improvement Act
CLIN	Contract Line Item Number
CM	Configuration Management
CMM	Capability Maturity Model , Center for Medicare Management
CMM	Capability Maturity Model
CMMI	Capability Maturity Model Integration
CMOS	Configuration Memory Operating System
CMP	Change Management Plan
CMS	Call Management System, Centers for Medicare and Medicaid Services
CMS	Centers for Medicare and Medicaid Services
CNDS	Common Name Data System or Service
CNS	Comprehensive Neuroscience
CO	Contracting Officer
COB	Coordination of Benefit
COCC	Certificates of Creditable Coverage
COCR	County Options Change Request
COE	Center of Excellence
COOP	Continuity of Operations
COR	Contracting Officer's Representative
CORI	Criminal Offender Record Information

COS	Category of Service
COTR	Contracting Officer's Technical Representative
COTS	Commercial Off-the-Shelf
CP	Claims Processor, Communication Plan
CPA	Certified Public Accountant
CP	Claims Processor
CPAF	Cost Plus Award Fee
CPAR	Customer Performance Assessment Review
CPAS	Claims Processing Assessment System
CPE	Current Production Environment
CPFF	Cost Plus Fixed Fee
CPI	Cost Performance Index
CPM	Critical Path Methodology
CPR	Contract Performance Reporting, Cost Performance Report
CPR	Cost Performance Report
CPSW	Claims Processor Switch
CPT	Current Procedural Terminology
CPU	Central Processing Unit
CR	Change Request
CRIS	Clinical Research Information System
CRM	Customer Relationship Management
CRNA	Certified Registered Nurse Anesthetist
CROWD	Center for Research on Women with Disabilities
C-RUP	Catalyst Extended RUP
CRP	Conference Room Pilot
CS	Commercial Service
CSC	Computer Sciences Corporation
CSDW	Client Services Data Warehouse
CSE	Child Support Enforcement
CSIRT	Computer Security Incident Response Team
CSR	Customer Service Representative, Customer Service Request
CSSC	Customer Support and Service Center

CSV	Comma Separated Value
CTI	Computer Telephony Integration
CV	Cost Variance
CWBS	Contract Work Breakdown Structure
CWF	Common Working File
DA	Delivery Assurance
DAL	Data Accession List
DASD	Direct Access Storage Device
DAW	Dispense As Written
DB2	IBM Relational Database Management SsytemSystem
DBA	Database Administrator
DBAR	Disaster Backup and Recovery
DBMS	Database Management System
DCEU	Data Cleansing and Entry Utility
DCMWC	Division of Coal Mine Workers' Compensation
DCN	Document Control Number
DD	Developmental Disabilities
DDC	Drug Discount Card
DDI	Design, Development, and Implementation
DEA	Drug Enforcement AdministrationAgency
DEC	Developmental Evaluation Centers
DED	Data Element Dictionary
DEERS	Defense Enrollment Eligibility Reporting System
DEP	Release Deployment
DERP	Drug Effectiveness Review Project
DESI	Drug Efficacy Study Implementation
DHH	Department of Health and Hospitals
DHHS	Department of Health and Human Services
DHMH	Department of Health and Mental Hygiene
DHSR	Division of Health Service and Regulation
DIACAP	DOD Information Assurance Certification and Accreditation Process
DIRM	Division of Information Resource Management

DLP	Derived Logical Process
DMA	Division of Medical Assistance
DME	Durable Medical Equipment
DMECS	Durable Medical Equipment Coding System
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
DMERC	Durable Medical Equipment Regional Carrier
DMH	Division of Mental Health
DMH/DD/SAS	Division of Mental Health, Developmental Disabilities, and Substance Abuse Services – May be referred to as DMH
DMZ	Demilitarized Zone
DNS	Domain Name Server
DOB	Date of Birth
DoD	Department of Defense
DOH	Department of Health
DOJ	Department of Justice
DOL	Department of Labor
DOORS	Data Object Oriented Repository System
DOR	Department of Revenue
DPH	Division of Public Health
DPM	Deputy Program Manager
DR	Disaster Recovery
DRG	Diagnosis-Related Group
DSD	Detailed System Design
DSH	Disproportionate Share Hospital
DSR	Daily Service Review
DSS	Division of Social Services (organization within NC DHHS)
DSS	Decision Support System, Department of Social Services (as part of county government), Division of Social Services (organization within NC DHHS)
DSS	Decision Support System
DUR	Drug Utilization Review
EA	Enterprise Architecture
EAC	Estimate at Completion
EBM	Evidence-Based Medicine

EBP	Elementary Business Process
ECS	Electronic Claims Submission
EDB	Enrollment Database
EDI	Electronic Data Interchange
EDITPS	Electronic Data Interchange Transaction Processing System
EDMS	Electronic Document Management System
EDP	Electronic Data Processing
EDS	Electronic Data Systems
EEOICP	Energy Employees Occupational Illness Compensation Program
EFT	Electronic Funds Transfer
EHR	Electronic Health Record
EI	External Input , External Inquiry
EI	External Input
EIA	Electronic Industries Alliance
EIN	Employer Identification Number
EIS	Eligibility Information System
ELA	Enterprise License Agreement
EMC	Electronic Media Claim
eMedNY	New York MMIS
EMEVS	Electronic Medicaid Eligibility Verification System
EMR	Electronic Medical Record
ENM	Enterprise Network Management
ENV	Environment
EO	External Output
EOB	Explanation of Benefits
EOMB	Explanation of Medicaid(Medicare)(Medical) Benefits
EPA	Environmental Protection Agency
ePACES	Electronic Provider Automated Claims Entry System
EPAL	Enterprise Privacy Assertion Language
EPC	Evidence-based Practice Center
EPMO	Enterprise Program Management Office
EPMR	Executive Level Project Management Review

EPS	Energy Processing System
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment (Aaka Health Check)
EQ	External Query
ER	Emergency Room
ERA	Electronic Remittance Advisory
ERE	Estate Recovery Evaluation
ESRD	End Stage Renal Disease
ETC	Estimate to Completion
ETIN	Electronic Transmitter Identification Number
ETL	Extract, Transform, Load
ETN	Enrollment Tracking Number
EV	Earned Value
EVMS	Earned Value Management System
EVS	Eligibility Verification System
FA	Fiscal Agent
FADS	Fraud and Abuse Detection System
FAO	Fiscal Agent Operations
FAQ	Frequently Asked Questions
FARO	Finance and Reimbursement OfficerOrganization
FAS	Fiscal Agent Staff
FBI	Federal Bureau of Investigation
FBLP	Federal Black Lung Program
FCA	Functional Configuration Audit
FCAPS	Fault Management, Configuration, Accounting, Performance, and Security Management
FCN	Financial Control Number
FDA	Food and Drug Administration
FDB	First DataBank
FDDI	Fiber Distributed Data Interface
FedEx	Federal Express
FFP	Federal Financial Participation, Firm Fixed Price

FFP	Firm Fixed Price
FFS	Fee-For-Service
FFY	Federal Fiscal Year
FIFO	First-In/First-Out
FIPS	Federal Information Processing Standards
FISMA	Federal Information Security Management Act of 2002
FMAP	Federal Medical Assistance Percentage
FMC	Federal Management Center
FP	Function Point
FTE	Full-Time Equivalent
FTP	File Transfer Protocol
FUL	Federal Upper Limit
FYE	Fiscal Year Ended
GAAP	Generally Accepted Accounting Principles
GAO	General Accounting Office
GC3	Generic Classification Code
GCN	Generic Code Number
GEMNAC	Graduate Medical Education National Advisory Committee
GHS	Government Health Services
GIAC	Global Information Assurance Certification
GIS	Global Infrastructure Services
GUI	Graphical User Interface
GL	General Ledger
GMC	Global Management Center
GME	Graduate Medical Education
GMENAC	Graduate Medical Education National Advisory Committee
GMP	General Management Process
GNN	Generic Name
GSS	Global Security Solutions
GTEDS	GTE Data Services
H.E.A.T.	Hydra Expert Assessment Technology
HCC	Health Check Coordinator

HCCR	Health Check Coordinator Reporting
HCCS	Health Check Coordinator System
HCFA	Health Care Financing Administration (predecessor to CMS)
HCPCS	Healthcare Common Procedure Coding System
HCPR	Health Care Personnel Registry
HCSC	Health Care Service Corporation
HETS	HIPAA Eligibility Transaction System
HFMA	Healthcare Finance Financial Management Association
HHA	Home Health Aide
HIC	Health Insurance Claim
HICL	Health Insurance Contract Language
HIE	Health Information Exchange
HIGLAS	Health Integrated General Ledger and Accounting System
HIM	Health Information Management
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIPDB	Healthcare Integrity and Protection Data Bank
HIPP	Health Insurance Premium Payment
HIS	Health Information System
HIT	Healthcare Information Technology
HIV	Human Immunodeficiency Virus
HL7	Health Level 7 (Format and protocol standard)
HMA	Health Management Academy
HMO	Health Maintenance Organization
HP	Hewlett Packard
HPII	High Performance Image Import
HRSA	Health Resources and Services Administration
HSIS	Health Services Information System
HUB	Historical Underutilized Business
HW	Hardware
I/O	Input/Output
IA	Information Assurance
IAD	Incremental Application Development

IAVA	Information Assurance Vulnerability Alert
IAW	In Accordance With
Ibis	Integrated Business Information System
IBR	Initial Baseline Review
IBS	Integrated Business Solution
ICD	International Classification of Diseases , Iterative Custom Development
ICD	International Classification of Diseases
ICF-MR	Intermediate Care Facilities for the Mentally Retarded
ICR	Intelligent Character Recognition
ID	Identification
IDS	Intrusion Detection System
IEEE	Institute of Electrical and Electronics Engineers
IFPUG	International Function Point Users Group
IGN	Integrated Global Network
IIHI	Individually Identifiable Health Information
ILM	Information Life-Cycle Management
IM	Information Management
IMP	Integrated Master Plan
IMS	Integrated Master Schedule
Ind HC	Independent Health Care
IOM	Institute of Medicine
IP	Internet Protocol
IPGW	Internet Protocol Gateway
IPL	Initial Program Load
IPMD	Integrated Program Management Database
IPR	In-Progress Review
IPRS	Integrated Payment and Reporting System
IPT	Integrated Product Team
IRS	Internal Revenue Service
ISO	International Standards Organization
ISPTA	International Security, Trust and Privacy Alliance
ISVM	Information Security Vulnerability Management

IT	Information Technology
ITIS	Integrated Taxonomic Information System
ITF	Integrated Test Facility
ITIL	Information Technology Infrastructure Library
ITIS	Integrated Taxonomic Information System
ITS	Information Technology Solutions
IV&V	Independent Verification and Validation
IVR	Interactive Voice Response
JAD	Joint Application Development
JCL	Job Control Language
KE	Knowledge Engineer
KFI	Key From Imaging
KM	Knowledge Management
KPI	Key Performance Indicator
KPP	Key Performance Parameter
LAN	Local Area Network
LDAP	Lightweight Directory Access Protocol
LDSS	Local Department of Social Services
LEP	Limited English Proficiency
LHD	Local Health Department
LME	Local Managing Entity
LMFT	Licensed Marriage and Family Therapist
LOB	Line of Business
LOE	Level of Effort
LPA	Licensed Psychological Associates
LPC	Licensed Professional Counselors
LMFT	Licensed Marriage and Family Therapists
LPN	Licensed Practical Nurse
LST	Legacy Systems Transformation
LTC	Long-Term Care
MA	Medicare Advantage
MAAR	Monthly Accounting of Activities Report

MAC	Maximum Allowable Cost
MAR	Management and Administrative Reporting
MARS	Management and Administrative Reporting Subsystem
MARx	Medicare Advantage Prescription Drug Program
MAS	Medicaid Accounting System
MA-SHARE	Massachusetts — Simplifying Healthcare Among Regional Entities
MCE	Medicare Code Editor
MCHP	Maryland Children's Health Program
MCO	Managed Care Organization
MDCN	Medicare Data Communications Network
MDME	Medicare Durable Medical Equipment
MEQC	Medicaid Eligibility Quality Control
MES	Managed Encryption Service
MEVS	Medicaid Eligibility Verification System
MIME	Multipurpose Internet Mail Extensions
MiMMIS	Multi-Payer Medicaid Management Information System
MIP	Medicare Integrity Program
MIS	Management Information System
MITA	Medicaid Information Technology Architecture
MM	Meeting Minutes
MMA	Medicare Modernization Act
MMCS	Medicare Managed Care System
MMIS	Medicaid Management Information System
MOAS	Medicaid Override Application System
MOF	Meta Object Facility
MPAP	Maryland Pharmacy Assistance Programs , Medical Procedure Audit Policy
MPAP	Maryland Pharmacy Assistance Programs
Mpas	Multi-Payer Administrator System
MPLS	Multi-Protocol Label Switching
MPP	Media Processing Platform
MPW	Medicaid for Pregnant Women

MS	Microsoft
MSIS	Medicaid Statistical Information System
MSMA	Monthly Status Meeting Agenda
MSP	Medicare Secondary Payer
MSR	Monthly Status Report
MT	Management Team
MTBF	Mean Time Between Failures
MTF	Medical Treatment Facility
MTQAP	Master Test and Quality Assurance Plan
MTS	Medicare Transaction System
NAHIT	National Association for Health Information Technology
NAS	Network Authentication Server
NASMD	National Association of State Medicaid Directors
NAT	Network Address Translation
NATRA	Nurse Aide Training and Registry
NC	North Carolina
NCAMES	North Carolina Association for Medical Equipment Services
NCAS	North Carolina Accounting System
NCHA	North Carolina Hospital Association
NCHC	North Carolina Health Choice for Children
NCHCFA	North Carolina Health Care Facilities Association
NCID	North Carolina Identity Service
NCMGMA	North Carolina Medical Group Manager's Association
NCMMIS+	North Carolina Medicaid Management Information System (Legacy system)
NCP	Non-Custodial Parent
NCPDP	National Council for Prescription Drug Programs
NCQA	National Committee on Quality Assurance
NCSC	North Carolina Senior Care
NCSTA	North Carolina Statewide Technical Architecture
NC*Tracks*	North Carolina Transparent Reporting, Accounting, Collaboration, and Knowledge Management System
NDC	National Drug Code

NDM	Network Data Mover
NEDSS	National Electronic Disease Surveillance System
NEHEN	New England Healthcare EDI Network
NGD	Next Generation Desktop
NHA	North Carolina Hospital Association
NHIN	National Health Information Network
NHSCHP	National Health Service Connecting for Health Program
NIACAP	National Information Assurance Certification and Accreditation Process
NIH	National Institutes of Health
NIST	National Institute of Standards and Technology
NNRP	Non-Network Retail Pharmacy
NOC	Network Operations Center
NPDB	National Practitioner Data Bank
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
NPS	North American Public Sector
NSC	National Supplier Clearinghouse
NYeC	New York eHealth CollabortaiveCollaborative
NYS	New York State
O&M	Operations and Maintenance
O&P	Orthotics and Prosthetics
OAC	Office of Actuary
OBRA-90	Omnibus Budget Reconciliation Act of 1990
OBS	Organizational Breakdown Structure
OCI	Organizational Conflict of Interest, Organizational Change Implementation
OCR	Optical Character Recognition
OCSQ	Office of Clinical Standards and Quality
ODS	Operational Data Store
OIG	Office of the Inspector General
OLAP	Online Analytical Processing
OLTP	Online Transaction Processing
OMB	Office of Management and Budget

OMMISS	Office of MMIS Services
ONC	Office of the National Coordinator
ONCHIT	Office of the National Coordinator for Health Information Technology
OP	Operations Management Plan
OPA	Ohio Pharmacists Association
ORDI	Office of Research and Development
ORHCC	Office of Rural Health and Community Care
OS	Operating System
OSC	Office of the State Comptroller
OSCAR	Online, Survey, Certification, and Reporting
OTC	Over the Counter
OWCP	Office of Workers' Compensation Programs
P&L	Profit and Loss
PA	Prior Approval
PAC	Pricing Action Code
PAL	Prescription Advantage List
PASARR	Pre-Admission Screening and Annual Resident Review
PBAC	Policy-Based Access Control
PBC	Performance-Based Contract, Package Design and Prototyping
PBD	Package-Based Development
PBM	Pharmacy Benefits Management
PBX	Private Branch Exchange
PC	Personal Computer
PCA	Physical Configuration Audit
PCCM	Primary Care Case Management
PCP	Primary Care Physician , Primary Care Provider
PCP	Primary Care Physician
PCS	Personal Care Service
PDA	Personal Digital Assistant
PDC	Package Development Completion
PDF	Portable Document Format
PDP	Prescription Drug Plans

PDTS	Pharmacy Data Transaction System or Service
PDTS	Pharmacy Data Transaction Service
PEND	Slang for suspend
PERM	Payment Error Rate Measurement
PES	Package Evaluation and Selection
PHI	Protected Health Information
PHSS	Population Health Summary System
PIHP	Pre-Paid Inpatient Mental Health Plan
PIM	Personal Information Management
PIR	Problem Investigation Review , Process Improvement Request
PIR	Problem Investigation Review
PMB	Performance Measurement Baseline
PMBOK	Project Management Body of Knowledge
PMI	Project Management Institute
PML	Patient Monthly Liability
PMO	Project Management Office
PMP	Project Management Plan, Project Management Professional
PMP	Project Management Professional
PMPM	Per Member Per Month
PMR	Performance Metrics Report, Program Management Review, Project Management Review
PMR	Program Management Review
PMR	Performance Metrics Report
POA&M	Plan of Action and Milestones
POMCS	Purchase of Medical Care Services
POP	Point of Presence
POS	Point of Sale (Pharmacy), Point of Service
POS	Point of Service
PPA	Prior Period Adjustment
PQAS	Prior Quarter Adjustment Statement
PRE	Release Preparation
PreDR	Preliminary Design Review

PREMO	Process Engineering and Management Office
PRIME	Prime Systems Integration Services
PrISMS	Program Information Systems Mission Services
ProDR	Production Readiness Review
ProDUR	Prospective Drug Utilization Review
PRPC	Pega Rules Process Commander
PSC	Program Safeguard Contractor
PSD	Package System Design
PST	Production Simulation Test or Testing
PST	Production Simulation Testing
PV	Planned Value
PVCS	Polytron Version Control System
QA	Quality Assurance
QAP	Quality Assurance Plan
QASP	Quality Assurance Surveillance Plan
QC	Quality Control
QCP	Quality Control Plan
QIC	Qualified Independent Contractor
QMB	Qualified Medicare Beneficiary
QMO	Quality Management Organization
QMP	Quality Management Plan
QMS	Quality Management System
R&A	Reporting and Analytics
RA	Remittance Advice
RACI	Responsibility, Accountability, Coordination, and Informing Requirements
RADD	Rapid Application Development and Deployment
RAID	Redundant Array of Inexpensive Disks
RAM	Responsibility Assignment Matrix
RAS	Remote Access Server
RBM	Release-Based Maintenance
RBRVS	Resource-Based Relative Value Scale
RCA	Root Cause Analysis

RDBMS	Relational Database Management System
REMIS	Renal Management Information System
REOMB	Recipient Explanation of Medicaid Benefits
Retro-DUR	Retroactive Drug Utilization Review
RFI	Request For Information
RFP	Request for Proposals
RHH&H	Regional Home Health and Hospice
RHHI	Regional Home Health and Hospice Intermediaries
RHIO	Regional Health Information Organization
RIA	Rich Internet Application
RICE	Reports, Interfaces, Conversions, and Extensions
RIMP	Risk and Issue Management Plan
RM	Risk Manager
RMP	Risk Management Plan
RN	Registered Nurse
ROI	Return on Investment
ROSI	Reconciliation of State Invoice
RPN	Retail Pharmacy Network
RPO	Recovery Point Objective
RRB	Railroad Retirement Board
RSS	Really Simple Syndication
RTM	Requirements Traceability Matrix
RTO	Recovery Time Objectives
RTP	Return to Provider
SA	System Architect
SADMERC	Statistical Analysis Durable Medical Equipment Carrier
SAN	Storage Area Network
SANS	System Administration, Networking and Security Institute
SAP	Systems Acceptance Plan
SAS	Statement on Auditing Standards, Statistical Analysis Software
SCC	Security Control Center
SCHIP	State Children's Health Insurance Program

SD	Software Development, System Development
SD	Software Development
SDB	Small Disadvantaged Business
SDEP	Service Delivery Excellence Program
SDLC	Software Development Life Cycle
SDM	Service Delivery Manager
SE	Software Engineering, System Engineering
SE	Software Engineering
SEC	IT Security
SEI	Software Engineering Institute
SEPG	Software Engineering Process Group
SFY	State Fiscal Year
SIMS	Security Information Management Systems
SIT	Systems Integration Testing
SIU	Special Investigations Unit
SLA	Service Level Agreement
SMAC	State Maximum Allowable Charge
SME	Subject Matter Expert
SMR	Senior Management Reviews
SMTP	Simple Mail Transfer Protocol
SNIP	Strategic National Implementation Process
SOA	Service-Oriented Architecture
SOAP	Simple Object Access Protocol
SOB	Scope of Benefit
SOC	Security Operations Center
SOCC	Secure One Communications Center
SOO	Statement of Objectives
SP	Security Plan
SPAP	State Pharmacy Assistance Plan
SPI	Schedule Performance Index
SPOE	Service Point of Entry
SRR	System Readiness Review

SRT	Service Restoration Team
SRTM	Security Requirements Traceability Matrix
S*S	Sure*Start
SSA	Social Security Administration
SSL	Secure Socket Layer
SSN	Social Security Number
SSO	System Security Officer
SSP	System Security Plan
STD	Standard
STA	Statewide Technical Architecture
STD	Standard
STest	String Test
STP	Staffing Plan
SURS	Surveillance and Utilization Review Subsystem
SV	Schedule Variance
SW	Software
T&M	Time and Materials
TBD	To Be Determined
TCE	Training Center of Excellence
TCN	Transaction Control Number
TCO	Total Cost of Ownership
TCP	Transmission Control Protocol
TDD	Technical Design Document, Telecommunication Device for the Deaf
TDD	Technical Design Document
TED	TRICARE Encounter Data
TES	Time Entry System
TIA	Technical Infrastructure Acquisition
TMA	TRICARE Management Activity
TMOP	TRICARE Mail Order Pharmacy
TOA	Threshold Override Applications
TP	Turnover Plan
TPA	Third Party Administrator

TPAR	Transactional Performance Assessment Review
TPCI	To Complete Performance Index
TPL	Third-Party Liability
TRR	Test Readiness Review
TRRx	TRICARE Retail Pharmacy
TRScan	Transform Remote Scan
TSN	Transmission Supplier Number
TTY	Text Telephone
TxCL	Therapeutic Class Code
UAT	User Acceptance Test
UBAT	User Build Acceptance Test
UDDI	Universal, Description, Discovery, and Integration
UI	User Interface
UPC	Universal Product Code
UPIN	Unique Provider Identification Number
UPS	Uninterruptible Power Supply, United Parcel Service
UPS	United Parcel Service
UR	Utilization Review
URA	Unit Rebate Amount
USB	Universal Serial Bus
US-CERT	United States Computer Emergency Readiness Team
USD	Unicenter Service Desk
USI	User-System Interface
USPS	United States Postal Service
UT	User Testing
V&V	Verification and Validation
VAC	Variance at Completion
VAF	Value Adjustment Factor
VAN	Value Added Network
VAR	Variance Analysis Report
VAT	Vulnerability Assessment Tools
VoIP	Voice Over Internet Protocol

VP	Vice President
VPMS	Voice Portal Management System
VPN	Virtual Private Network
VSAM	Virtual Storage Access Method
WAN	Wide Area Network
WBS	Work Breakdown Structure
WEDI	Workgroup for Electronic Data Interchange
WFM	Workflow Management
WSDL	Web Services Description Language
WSMF	Web Services Management Framework
XAD	Accelerated Application Development
XAP	Accelerated Application Prototyping
XBD	Accelerated Business Process Design
XML	Extensible Markup Language
XPDL	XML Process Definition Language
XTC	Accelerated Timebox Completion

E.1 Project Management Plan

RFP Number: 30-DHHS-1228-08

Prepared for:
North Carolina Department of Health and Human Services

Office of Medicaid Management Information System Services

Prepared by:
Computer Sciences Corporation

30 May 2008

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Pages E.1-1 through E.1-6 contain confidential information.

Document History/Release Authorization

Change History

Version	Date	Description of Changes
v1	15 November 2007	Initial draft submission
v2	30 May 2008	BAFO Update

Reference Documents

Document Number	Document Name

Pages E.1-8 through E.1-33 contain confidential information.

Pages E.1.App. A-1 through E.1.App. A-70 contain confidential information.

E.2 Integrated Master Plan

RFP Number: 30-DHHS-1228-08

Prepared for:
North Carolina Department of Health and Human Services

Office of Medicaid Management Information System Services

Prepared by:
Computer Sciences Corporation

30 May 2008

Best and Final Offer

Volume I — Technical Proposal

Document History/Release Authorization

Change History

Version	Date	Description of Changes
v1	20 December 2007	Initial draft submission

Reference Documents

Document Number	Document Name

Pages E.2-2 through E.2-31 contain confidential information.

E.3 Integrated Master Schedule

RFP Number: 30-DHHS-1228-08

Prepared for:
North Carolina Department of Health and Human Services

Office of Medicaid Management Information System Services

Prepared by:
Computer Sciences Corporation

30 May 2008

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Volume I — Technical Proposal

Pages E.3-1 through E.3-15/16 contain confidential information.

E.3.7 Integrated Master Schedule Entry Legend

Team CSC has developed the IMS using MS Project and have provided it in its electronic native format. We will maintain the IMS and provide monthly updates or as required throughout the life of the Replacement MMIS Contract. We have use the following Notes, Comments, Assumptions regarding the IMS apply:

- Each deliverable is given a unique CDRL number that correlates to the NC Replacement MMIS phases as follows:
  - M00XX = Program Management (PMO)
  - D00XX = Design, Development, and Installation
  - P00XX = Operations
  - T00XX = Turnover

Early Implementation has not been assigned a unique CDRL number since deliverables during that phase have been included in the operations phase as program management deliverables. Each identified CDRL is listed in our Statement of Work (SOW), Integrated Master Schedule (IMS), and Integrated Master Plan (IMP) and are provided in proposal sections D.3 SOW, E.2 IMP, and E.3 IMS. Several CDRL deliverables that are submitted more than once during DDI have been given a unique suffix to the CDRL number to identify each of the recurring documents separately. For instance, Team CSC will prepare and deliver CDRL D0008 Technical Design Document a total of 15 times, one for each of the proposed solution Builds. The assigned CDRL number is presented as D0008-01, D0008-02, D0008-03, etc. to distinguish which CDRL should be associated with each system Build. All deliverables are listed in the IMS, IMP, and SOW.

- CWBS 1.1 Project Management Deliverables start with M
- Project management plans/deliverables are only shown once for the initial submission, however, they are subject to redelivery whenever appropriate and annually at a minimum.
- Repeating Technical deliverables for DDI (i.e. each Build) have a suffix after the CDRL number containing the Build number (effects deliverables D0006-D0017)
- CWBS 1.0 DDI deliverables start with D
- CWBS 2.0 and 3.0 Operations deliverables start with P
- CWBS 4.0 Turnover Deliverables start with T
- Project Management is shown in detail only once (1.1), however, it applies to 2.0, 3.0 and 4.0.
- CWBS 1.1 Project Management detail activities are only shown for 1 year (initial year). However, they repeat annually and will be updated when the IMS is updated to reflect at least 3 months into the future.
- CWBS 4.0 Turnover detail activities are shown as starting 64 months after contract start, however, Team CSC understands that they start upon notification by the State.
- This version only shows dates for Operations out to 01/04/2013, however, once awarded and updated, these will continue through to the end of the contract.

The IMS contains the following fields:

- **Column 1: ID**: This field is a sequential field assigned automatically by MS Project. This field is used as the activity identifier for predecessors (dependencies).
- **Column 2: CWBS Number/SOW Number:** This field is the standard WBS field supplied by MS Project. Team CSC lets MS Project generate the CWBS numbers automatically within certain parameters to easily facilitate updates and changes. The CWBS number is the key code used throughout this proposal and is used to identify the SOW. Operational, system and performance requirements are also assigned to the SOW via this number.
- **Column 3: Task Name:** This field is the standard Name field supplied by MS Project. This field contains the Summary, mid-level task/activity name and the CDRL name.
- **Column 4: Duration**: This field is the standard Duration field supplied by MS Project. This field contains the duration of each activity and is used to calculate the Finish date of an activity based upon the Start Date plus Duration
- **Column 5: Start:** This field is the standard Start field supplied by MS Project. This field contains the start date of each activity based upon either the previous activity or the Dependency.
- **Column 6: Finish**: This field is the standard Finish field supplied by MS Project. This field contains the finish date of each activity based upon the start date plus duration.
- **Column 7: Dependencies:** This field is the standard Predecessor field supplied by MS Project. This field contains the ID numbers for activities that are dependent upon others.
- **Column 8**: **CDRL Number:** This field is the standard "Text4" field supplied by MS Project and modified by Team CSC to contain the CDRL Number. The CDRL number is used to indicate deliverables. All deliverables are considered CDRLs by Team CSC. All CDRLs have a duration of 0 days.
- **Column 9**: **Event or CDRL or Milestone:** This field is the standard "Milestone" field supplied by MS Project and modified by Team CSC to indicate whether the Task or activity is a Project Event or a delivery of the CDRL or a Project Milestone.
- **Column 10**: **Level of Effort**: This field is the standard "Number1" field supplied by MS Project and modified by Team CSC to contain the estimated level of effort in hours for detail and summary activities.
- **Column 11: DHHS:** This field is the standard "Text1" field supplied by MS Project and modified by Team CSC to contain a "DHHS" for all activities that NC DHHS will participate in. It includes:
  - Activities where Team CSC submits a deliverable;
  - Activities where NC DHHS personnel lead or perform;
  - Activities where NC DHHS personnel review deliverables;
  - Activities where NC DHHS personnel approve deliverables;

  - Activities where NC DHHS personnel participate such as BSD sessions and workshops; and
  - Any activities of which NC DHHS personnel should be aware.
- **Gantt Chart**: This section of the chart shows Summary Rollups and detail tasks in accordance with the standard MS Project reporting. It also contains start and end dates for all detail activities. It shows CDRLs as diamonds with due dates.

No other fields are used at this time. NC DHHS should focus on these described and displayed fields. Hidden fields in the electronic version of this MS Project schedule should not be opened. They will be used by Team CSC as needed to be responsive to special information requests from the State.

E.3.8 Summary

In summary, the Team CSC IMS represents the output of the application of best estimating and planning practices, to provide the State with a realistic schedule that Team CSC can accelerate or decelerate working in partnership with the State to meet State priorities, opportunities and constraints while still satisfying the operational needs of all DHHS MMIS Stakeholders.

Pages E.3-21 through E.3-146 contain confidential information.

Pages E.4-1 through E.4-20 contain confidential information.

Pages E.5-1 through E.5-26, including E.5 DDI Organizational Chart and E.5 Operations Organizational Chart contain confidential information.

Pages E.5 Key Resumes-1 through E.5 Named Resumes-81 contain confidential information.

Team CSC Job Descriptions

Pages E.5 Job Descriptions-2 through E.5 Job Descriptions-22 contain confidential information.

Pages E.6-1 through E.6-3 contain
confidential information.

In **Exhibit E.6.2-1**, Team CSC shares in greater detail our understanding of broad communication requirements that must be met in the process of executing each of these four primary, phase-specific project management responsibilities. The communication methods used to meet these requirements and the customers/ recipients of the required communication are cited as well.

Communication Requirement	Communication Method	Customer/Recipient
DDI Project Task: Assumption and Execution of Project Management Responsibilities		
Communicate information to facilitate NC DHHS insight into project planning and issues	• Distributing Project Management Plans, status reports, other deliverables • NC*Tracks*-based Communications Management Center and other portal sites (see E.6.4 below) • Informal contact and updates PRN	Designated NC DHHS officials
Develop and distribute agendas and minutes for all formal project planning, coordination, and software development team meetings	• Minutes recorded by assigned Team members • Agendas and minutes distributed by e-mail • Agendas and minutes posted to Web Portal	Team / committee-specific distribution list, approved by NC DHHS
Develop (in collaboration with NC DHHS) all required Plans, distribute these Plans, and post them to NC*Tracks*	• Distributed in electronic version by e-mail • Posted to Portal in appropriate site/location	Approved, Plan-specific NC DHHS distribution list
Provide continuous, consistent, and routine updates on PMP status and progress	• NC*Tracks* PM Extranet, • Project status reports (stored on NC*Tracks*) • Reviews at Project Plan Meetings and Executive Committee • Project staff meetings	Designated NC DHHS project officials and Team CSC members Team/Committee members Team CSC
DDI Project Task: Technical Development, Consultation, and Collaboration		
Confirm understandings and baseline information needed to perform requirements analysis	• Request, confirm receipt of, and post system requirements on secure Web Portal	NC DHHS technical staff and system engineers
Document and communicate SW testing results	• Reports distributed for review and approval by teams and NC DHHS	Technical teams, NC DHHS-designated officials
Prompt and provide input on Change Requests that reflect outcomes/solution developed by SW build teams, for supporting action by Change Control Boards	• Input within Change Request documentation workflow, housed on Web Portal	Designated officials responsible to assess and ultimately approve/deny Change Requests
Share design documentation	• Request, confirm receipt of relevant design documents	SW development and testing team
DDI Project Task: Provider Enrollment/Re-enrollment/Credentialing		
Assume all routine communication responsibilities to perform provider enrollment (responding to applications, status notifications, approvals/denials, appeals, credentialing)	• Written correspondence using pre-approved standard provider enrollment responses, credentialing packets, mailings, email correspondence, faxing of credentialing materials	Applying providers
Disseminate any new enrollment procedures mandated by CMS or NC DHHS	• Written form letter developed and approved by NC DHHS/CMS	Universe of providers in NC DHHS provider database
Announce provider training events or other outreach forums, Open Houses, training events.	• Correspondence / announcements distributed via e-mail and US Mail • Web Portal posting/ announcement	Enrolled and applying providers
DDI Project Task: Support for Cutover to Operational Phase		
Same as those listed above in Project Management Task, but with focus on project transition and cutover to Operations phase	• Same methods as those cited in Project Management Task; in essence, the continuation of our project communications methods helps facilitate a seamless transition to Operations	Same as those listed above in Project Management Task

9799-999

Exhibit E.6.2-1. Communication Requirements in DDI Phase. *Team CSC understands communication requirements within the DDI phase of the Replacement MMIS project.*

E.6.3 DDI PHASE COMMUNICATIONS STRATEGIES

Team CSC's relationship management-focused, customer-centric, and phase-specific communications strategies in the DDI phase of the project are developed to add value, efficiency, and effectiveness to our overall project management approach. These communication strategies are aligned with the tasks to be performed in this phase. Our Team's communication strategies during the DDI phase are summarized in **Exhibit E.6.3-1.**

Team CSC's Communication Strategies in DDI Phase of Replacement MMIS Project	Value-Added Benefit to NC DHHS Derived From This Communication Strategy
Establish project management communication structures, methods, responsibilities, and relationships early in project implementation effort, to foster a collaborative working partnership between Team CSC and NC DHHS	• NC DHHS gains a full understanding about project information that will be shared, how it will be shared, to whom it will be shared, and when it will be shared • Relationship between NC DHHS and Team CSC is built that fosters a spirit of partnership about how project objectives and tasks are to be accomplished
Confirm and implement communication structures and methods for sharing information between Team CSC and NC DHHS about MMIS system and software requirements,	• Analysis efforts that contribute to superior Replacement MMIS solution are built upon communication that promotes mutual understanding of system requirements • Software development is performed efficiently and collaboratively
Establish software development teams, to enhance communication efforts within the groups assigned to application development and testing	• Teams leverage the expertise and efforts of their members • Quality of solution is enhanced through effective communication within teams
Establish communication channels, responsibilities, and systems to promote effective transition of provider enrollment responsibilities to Team CSC.	• Transition of provider enrollment responsibilities is seamless • Processing of applications under review at time of transition are not delayed • New provider complaints and appeals are minimized
Communicate information and provide superior technical consultations to NC DHHS Change Control Boards, throughout the lifecycle of Change Requests (CR)	• Superior support provided to NC DHHS during the interim steps in evaluating Change Requests • Approval/denial decisions about Change Requests are based on quality information and communication throughout the CR lifecycle

9799-999

Exhibit E.6.3-1. Team CSC's Communication Strategies. *Our communications approach adds value for NC DHHS by being focused on strategies that produce superior project outcomes.*

E.6.4 COMMUNICATION METHODS: HOW, WHERE, AND WHEN COMMUNICATIONS WILL OCCUR

Team CSC will utilize a variety of methods to execute these strategies and meet the project's DDI phase-specific communication requirements. These include verbal, organizational (e.g., meetings, forums, committees), written, and virtual means of communicating information, **Exhibit E.6.4-1** outlines the range of communication methods Team CSC will use and how our Team employs these respective methods to disseminate project information.

Method	Project Function	Communication Approach	
Written	Project management communications	• Meeting Agenda and Minutes • Plans (PMP and component Plans) • Fax blast (simultaneous faxed document sent to broad distribution list)	• Reports • White papers • Correspondence sent via US Mail and e-mail
	Provider / stakeholder communications	• Correspondence associated with application responses, enrollment, eligibility, appeals, and other enrollment administrative activities	• Alerts, notifications / updates tied to enrollment procedural changes or other new requirements

Method	Project Function	Communication Approach	
Organizational Provider	Project management communications	• Standing meetings • Steering Committee • Executive Committee	• Task software development project team meetings • Boards (e.g., Change Control)
	Provider / stakeholder communications	• Open Houses/Provider Training Sessions	• Advisory Committees
Verbal	Project management communications	• In-Person project updates for NC DHHS officials (formal and informal)	• Formal briefings • Telephone calls
	Provider / stakeholder communications	• Call Center-based exchanges	
Virtual: Collaboration	Project management communications	NC*Tracks* (see Section E.6.4.1, below, for overview of our Web-based communication and collaboration platform). This Website offers collaboration tools (e.g., IM, WebMeeting, Web e-mail forms, and change management software), scanned versions of important documents (e.g., correspondence, meeting Minutes, reports, plans, and forms). The site allows users to self-subscribe to receive certain information, reinforcing the "Client Focus" principle that seeks to communicate desired information to those who desire it	
	Provider / stakeholder communications	• Provider-specific site within NC*Tracks*.	

Exhibit E.6.4-1. Team CSC's Communication Methods. *Our communication approach is multi-faceted and comprehensive.*

Each of the specific communication methods — written, organizational, verbal, and virtual collaboration — includes specific communication activities that execute Team CSC's communications strategies during the DDI phase of the Replacement MMIS project. **Exhibit E.6.4-2** defines with greater specificity these communication activities, their primary customer/ communication recipient, their frequency, and how they enhance project communication.

Communication Activity	Customer/ Recipient	Frequency	Additional Comments: Project Communication Tactics and How They are Implemented
Development and distribution of Meeting Agenda	Respective team, committee, or meeting membership / invitees	Every meeting	• All meetings are driven by an agenda, identifying items for discussion or decision-making • Agenda are distributed in advance for comment • Agendas (as with all written meeting documents) are posted and archived on the Portal
Development and distribution of Meeting Minutes	NC DHHS and meeting participants, and other designated parties	Following formal meetings	• Minutes document meeting attendance, issues, decisions, and follow-up actions and responsibilities. This communication vehicle is a valuable tool for understanding respective responsibilities and accountabilities (persons and completions dates).
Development and distribution of Plans (see Section E.1, Project Management Plan, for list)	NC DHHS	Varies by Plan (see PMP)	• Plans communicate Team CSC's approach to important project functions, as well as schedules, milestones, measurement methods. These documents are critical to communicating PM approach in DDI phase
Development and distribution of Reports	NC DHHS	Varies (e.g., Status Reports, EVMS, management dashboard)	• Reports summarize findings of software testing and other technical activity • Quality reports summarize performance against SLAs and other quality benchmarks • Reports drive discussion about corrective actions and quality improvements
Development and distribution of White Papers	NC DHHS	As needed	• Used to communicate approaches to specific technical challenges, which require careful consideration of latest thinking and best practices.

Pages E.6-7 through E.6-9/10 contain
confidential information.

E.6.5 MEETING COMMUNICATIONS PROTOCOLS

Team CSC communicates the agenda, discussion, and decisions made at formal meetings to a pre-approved list of recipients (meeting participants and others designated for distribution of meeting communication). This communications approach is followed at the Monthly Project Status Meeting, where meeting Minutes are a required CDRL (#M0005). The procedures and protocols for Minutes-taking and distribution are identical for all other for Meetings authorized by Executive Account Director, John Singleton (e.g., Team CSC Senior Staff Meetings). The protocols are summarized below:

- **Frequency of Minutes Distribution**: Monthly, submitted by close-of-business on day following the Monthly Project Status Meeting
- **Person(s) Responsible**: Team CSC's Executive Account Director and PMO Director
- **Delivered to**: NC DHHS COTR, and to the COTR's approved list of recipients.
- **Portal Posting**: Once delivered, Minutes are posted on the Project Management Center of **NC**Tracks
- **Minutes Structure:**
  - Date, Meeting location, Meeting start time
  - Name of individual chairing the Meeting, meeting attendees, list of absent members
  - Report on motion to approve previous Meeting's published Minutes
  - Summary of general announcements
  - Summary of meeting discussion and action item outcomes, by individual agenda item
  - Summary of meeting discussion and action item outcomes for non-agenda items ("Other issues" on agenda)
  - Announcement of Date, time, and location of next scheduled Monthly Project Status Meeting
  - Time of meeting adjournment
- **Minutes-taking, Minutes Approval, and Minutes Dissemination Protocols:** Minutes are taken during the Meeting by PMO Director or his designee. An initial draft of the Minutes document is submitted by the PMO Director to Team CSC's Executive Account Director (Meeting Chair) for approval, prior to dissemination to NC DHHS' project COTR. Executive Account Director-approved Minutes are due to the COTR by close-of-business on day following Project Planning Meeting. Requested changes to Minutes are typically held pending response to motion to approve Minutes at following Project Planning Meeting. However, a significant problem with the Minutes by the State would be negotiated with the Meeting Chair (Team CSC Executive Account Director). The Minutes are delivered to the COTR and to those on the COTR's approved distribution list (meeting attendees and others designated for Minutes distribution. Once delivered, Minutes are posted

sequentially and in chronological order within the Project Management Center on **NC***Tracks*.

E.6.6 PROVIDER COMMUNICATIONS PLAN

Team CSC is keenly aware that the provider community represents an integral component of the North Carolina medical assistance programs and that effective communications are paramount in successfully deploying a new system and fiscal agent operation. North Carolina providers have had a long-standing association with the current fiscal agent and have become accustomed to conducting State business in a specific manner. We understand that there is a natural tendency to resist change and our goal is to minimize disruption to provider business and win the provider community's confidence and cooperation as early in the contract life as possible.

To achieve this goal, Team CSC will begin provider communications immediately upon project start-up and work closely with the State to refine our Provider Communications Plan and obtain State approval of the plan, timeline, materials, communications content, and distribution. The major objective in all preliminary provider communications will be to gain active participation by the provider community and furnish sufficient information and educational opportunities to make the provider community's transition to the Replacement MMIS as convenient as possible. Input from the provider community will also identify their requirements and will help us determine the most effective methods for communicating with providers. **(SOO 10.8-17)**

(10.8-17)

The Provider Communications Plan is a detailed document that sets forth all activities, responsibilities, roles, quality criteria, schedules, tools, and methods that comprise the provider communications effort. We will develop the detailed approach and granular plan components after contract award in accordance with the Integrated Master Schedule. The following major activities will be included in Team CSC's Provider Communications:

- Press release upon contract award (with State approval)
- Kickoff meeting with designated State staff to introduce provider management personnel and discuss communications plan development
- Initial contact and meetings with:
  - The major North Carolina providers including the four teaching schools/hospitals: University of North Carolina at Chapel Hill, Duke University, East Carolina University, and Wake Forest University
  - North Carolina provider associations
  - Public health departments
  - Area Programs/Local Managing Entities (AP/LME)
  - Community Care Networks
  - State-approved North Carolina Value–added Networks (VAN)

- Early implementation of **NC***Tracks* public sector information portion of the Web portal which will contain initial public and provider information about the new contract
- Provider announcements on the EDS customer service hold message (with State approval)
- Inclusion of information on the monthly North Carolina Provider Bulletins (with State approval)
- Publication of information in provider associations' newsletters
- Contact with individual providers through blast fax, email, and US Mail (Team CSC will obtain provider contact information from the Provider File furnished to Team CSC for early implementation)
- Provision of **NC***Tracks* user ID and password (at recredentialing), enabling providers to access the provider Web-site for dissemination of provider-specific information
- Initial staffing and training of Provider Relations and Call Center staff to handle pre-implementation provider inquiries and visit requests
- Development of provider training and educational materials
- Scheduling and conducting meetings and workshops at selected locations throughout the State (refer to Proposal Section D.4, Training Approach, which describes provider educational opportunities)
- Availability of Call Center at a mutually agreed-upon time prior to implementation to receive and answer provider inquiries
- Selection of specific providers for participation in the Production Simulation Test (PST) -- information learned from their experiences will help Team CSC in planning for the migration of all providers to the Replacement MMIS.

Team CSC's experience working with vendors and clearinghouses is very important, especially in regard to the education and promotion of electronic forms of communications. Many providers rely heavily on these agencies to conduct their electronic business, thus they will be an important community to listen to and educate. Early announcements regarding changes to electronic communication standards will be critical, affording submitters enough time to make necessary changes to their own systems. Listservs will provide a valuable communication option for getting information to the right people very quickly, and targeted direct mail notices will provide the best method for engaging stakeholders when important time-sensitive information must reach the greatest numbers.

Additionally, Team CSC believes the formation of an Implementation Training Committee made up of members from each stakeholder community, including providers, will yield valuable input and feedback not only on training-related issues, but also the key communications and their timing which will be so crucial to keeping all communities up to date with the latest news and information.

Team CSC will conduct constant communication with the State and modify the Provider Communications Plan as needed to address informational needs, issues, and concerns throughout the DDI phase. CSC enjoys an excellent relationship with

providers in the State of New York and we look forward to building a relationship of trust and mutual support with the North Carolina provider constituency.

E.6.7 APPROACH TO DEVELOPING A PRELIMINARY COMMUNICATIONS PLAN AND THE JOINT DDI COMMUNICATIONS PLAN

One month after contract award, Team CSC will present to NC DHHS a Team CSC Communications Plan. This document will serve as the baseline for focused discussions and decisions about the components of a final Joint DDI Communications Plan. **This sequential process of developing the Joint Communications Plan offers both time-saving efficiencies and an opportunity to leverage Team CSC's valuable experience in communications management within projects similar in size, scope, and complexity to the Replacement MMIS.** Ultimately, the Joint Communications Plan will integrate Team CSC's recommendations about best practices in project communication with NC DHHS' knowledge of existing systems and what communications strategies and methods are most effective and required for the Replacement MMIS project.

The Communications Plan that Team CSC will present to NC DHHS in the context of developing a Joint Communications Plan includes descriptions, approaches, and actions including:

- Project communications requirements
- Communications objectives and principles
- Communication strategies
- Communication methods
- Provider communications plan
- Communications action plans, identifying the methods, frequency, and recipients/ customers of project communication efforts
- Quality measurement/quality improvement methods associated with the communications approach.

The process of developing the Joint Communications Plan will include extensive collaboration with NC DHHS and sufficient time for internal review. NC DHHS' suggested modifications will be incorporated into the baseline Communications Plan document, as mutually agreed, and a revised version will be developed, distributed, and posted on the **NC***Tracks*. This process will be followed until all issues have been resolved and the final Joint Communications Plan is published and posted to **NC***Tracks.* **(SOO 10.8-18)**

(10.8-18)

Once approved, the Joint Communications Plan serves as the blueprint for communication strategy and activity within the DDI phase of the Replacement MMIS project. This Joint Plan will be updated or modified, as mutually agreed, as the need occurs.

E.6.8 INCIDENT REPORTING AND ESCALATION-RELATED COMMUNICATIONS

When any type of incident or serious risk within the project is identified, it is important that the threat be communicated promptly, efficiently, and effectively. Team CSC applies a range of sensible and technologically-facilitated communications strategies to mitigate project threats. Issues are escalated verbally through the project chain of command, beginning with the individual identifying the threat on to direct supervisors, their relevant senior manager, then on to Executive Account Director, John Singleton, who owns the responsibility to contact NC DHHS' COTR and other designated officials about the existence of an incident, serious risk, or threat. In the event of a serious incident or security threat, this notification of designated NC DHHS officials of project incidents and threats is verbal and immediate.

In the event of a network, system, or other security incident, Team CSC follows communications procedures outlined in our Replacement MMIS Security Plan. Team CSC staff are trained to contact their supervisor or Team CSC's Security Manager if they witness or become aware of a security incident or threat. The next round of notifications will from the Security Manager to Team CSC's Executive Account Director, who will notify the NC DHHS Secure One Communications Center (SOCC) and other designated NC DHHS officials verbally of the incident, as per the approved Security Plan.

Post-incident reports are developed by the Security Manger to review the incident, the communication during the incident, and lessons learned. Refer to Proposal Section H, Security Approach, for a summary of communications approaches during and following a security-related incident.

E.6.9 CONCLUSION

Team CSC's approach to project communication utilizes the most efficient and effective means to share information with individuals and groups who need it, when they need it, and at the frequency that they expect it. While a variety of methods — written, verbal, organizational, and virtual — is used, our **NC***Tracks* Web Portal provides a comprehensive, multi-faceted tool that enhances communications and will serve as a repository for ensuring transparency/traceability of communications and documentation**. Team CSC's communications strategy pays special attention to the provider community and focuses on the development of positive relationships and a minimization of disruption to business operations. Our approach will be developed and embodied within a Joint Communications Plan, a document that establishes the collaborative effort to manage and execute comprehensive, effective project communications strategies.**

E.7 – Risk and Issue Management Plan

RFP Number: 30-DHHS-1228-08

Prepared for:
North Carolina Department of Health and Human Services

Office of Medicaid Management Information System Services

Prepared by:
Computer Sciences Corporation

30 May 2008

Best and Final Offer

Volume I — Technical Proposal

Document History/Release Authorization

Change History

Version	Date	Description of Changes
v1	20 December 2007	draft submission with proposal
v2	23 May 2008	BAFO update

Reference Documents

Document Number	Document Name

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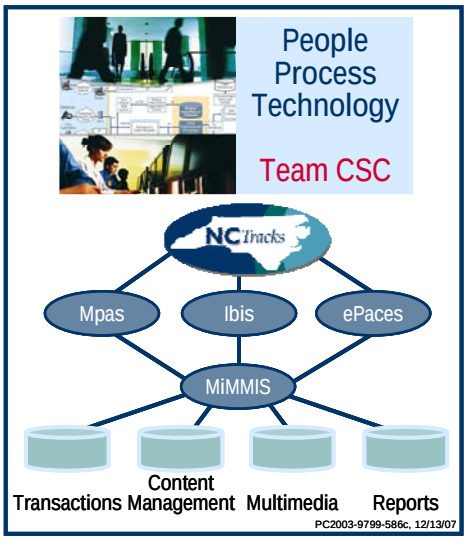
Pages E.7-3 through E.7-21 contain confidential information.

Pages E.8-1 through E.8-20 contain confidential information.

E.9 Change Management Approach

Our change management approach applies proven processes and tools to ensure the timely identification, review, processing, implementation, approval, and documentation of requested changes to systems and business processes, with specified CSC Team and customer involvement, oversight, and approval. Our change management program will be tailored and updated to fit the specific Replacement MMIS project needs, both in the DDI and Operational phases. Change management is integral to our Catalyst methodology, quality assurance approach and our strong commitment to transparency and involvement of stakeholders. Change management is tightly linked with our Configuration Management approach discussed in this section at paragraph E.9.5.

E.9.1 PURPOSE AND BACKGROUND



The Replacement MMIS introduces new technologies, enables more effective and efficient business processes and changes the interactions and the service delivery for all of the stakeholders. While long awaited changes such as this effort may seem to assure the organization is ready for the changes, it is critical that the change management activities not be slighted. Far too often designs and the operational changes become surprises. Change Management is about managing the journey and controlling the evolution of systems and processes. We think of change as a multi-dimensional problem. We think of it from a goal and outcome point of view and not merely about the technologies. Change has people, process, and perspective issues. In the CSC approach, people are engaged and involved with clear assignments and roles. We will define who is responsible and accountable for each activity and partner with the State to ensure agreement on the role of state representatives. We will define the activities and verify who needs to participate in, be consulted with, and informed before any change. We will make these relationships and communications requirements explicit and assure that as Team CSC and State personnel change, roles and responsibilities will be smoothly transferred to the new owners.

We define a change process that integrates throughout DDI phase and establishes a process that is ready for the evolutionary steps beyond the initial Replacement MMIS DDI phase into and throughout the Fiscal Agent Operations phase. **(SOO 10.12.1-14)** CSC's process efficiently and effectively manages technical, programmatic, and operational changes across the overall program. **(SOO 10.8-21)** Change is also a social engineering and perspective issue. We will partner with the State to encourage both staff groups practice open communication. Sometimes problems with changes are not voiced because there is a feeling that "everyone knows that is a problem" or someone doesn't want to "rock the boat." We foster a culture which encourages

(10.12.1-14)

(10.8-21)

Pages E.9-2 through E.9-8 contain confidential information.

E.9.3 TEAM CSC'S CHANGE MANAGEMENT PLAN

Team CSC will prepare a Change Management Plan (CMP) to define and guide the change management activities on the Replacement MMIS contract. The plan is a living document and will be updated throughout the lifecycle to support DHHS-approved changes. The Plan includes Catalyst-based concepts, project-specific objectives and management roles, and change-specific plans that drive change implementation. The initial outline for the CMP is summarized in **Exhibit E.9.3-1.** The delivery of the DDI phase CMP will be a collaborative effort with DHHS, reflecting shared priorities, objectives, planning/scheduling, and resource allocation decisions.

Outline of Team CSC's Change Management Plan		
Section	Section Title	Description of Section Contents
1.	*Change Management Plan Introduction*	• A broad summary of the Plan's components and overall purpose.
2.	*Objectives and Scope*	• A listing of the Plan's goals and the scope for which the Plan's change management action are formulated.
3.	*Change Management Team*	• A description of the Team that will administer and implement the Plan, and how the Team will govern the Plan's execution. This section also reviews the relation of the Team to other Replacement MMIS project elements and to DHHS stakeholders.
4.	*Concepts*	• Catalyst-driven change management concepts around which the Plan is developed • Value systems that facilitate change – Resistance versus comfort with change – Incremental versus radical change
5.	*Functions/Roles*	• Plan sponsorship • Participants who contributed to development of the Plan, including any external stakeholders/organizations. • Key change management roles and role descriptions • Change initiator and receiver functions descriptions
6.	*Change Management Processes*	• Clarification of business goals with which the change management processes must align • Assessment and analysis methods of: – Current state – Organizational redesign – Location • Communication and education of change within Team, agency, and with stakeholders • Methods for preparing change management team and relevant receivers for upcoming change
7.	*Change Implementation*	• Managing the change as it is implemented: – Developing change-specific CMPs (actions, schedules, milestones, assessment, persons responsible, evaluation metrics for major changes) – Developing change-specific communication plan – Establishing sponsorship roadmap – Creating and assigning responsibility for change-specific coaching and training of change receivers (feeds into project Training Plan) – Ensuring security risks of change are managed
8	*Configuration Management*	• Identification of Configuration Classification and Taxonomy • Change Request Policy • Tracking Change Requests and related recommendations such a Recommended Improvement Opportunities • Requirements-Capabilities Traceability and Dependency Tracking • Configuration Review Board – Responsibilities and Decision Making Process • Configuration Change Dashboard and workflow for decision resolution and escalation • Change requests- responsibility, approvals, consultations, and informed reviews
9.	*Reinforcing the Change*	• Actions and schedules for assessing impacts of change • Other actions that reinforce change after implementation
10.	*Schedule*	• Summary of change-specific CMPs timetables and milestones

Outline of Team CSC's Change Management Plan		
Section	Section Title	Description of Section Contents
11.	*Metrics*	• Summary of change-specific metrics being collected, organized, and evaluated • Feeding change-specific metrics into SLA performance data and evaluation

9799-999

Exhibit E.9.3-1. Team CSC's Change Management and Configuration Management Plan Outline. *Our CMP provides both the framework for change management processes and project-specific, change-specific planning elements.*

The CMP will apply (but not be limited) to the following changes to the Replacement MMIS project environment:

- New requirements to be accommodated by software developers during DDI phase
- Addition/deletion of servers
- Network changes (i.e. addition of routers, circuits, etc.)
- Operating systems (i.e. upgrades or significant configuration changes)
- Associated devices which are shared with other environments
- Production application roll-outs and any upgrades to production binaries
- Business process changes
- Facilities where the technology resides (e.g. electrical, emergency systems, under floor cleaning, etc.)
- Any emergency changes that are made in response to a trouble ticket
- Any introduction of new equipment, operating systems, in-house applications or third party software into the production environment.

The transparency of change management planning is maintained through shared access by DHHS and Team CSC to change management documentation in the project management Portal. Through access to all relevant data about system changes, DHHS is able to achieve and maintain a full understanding of changes under consideration and already made.

Team CSC's change management, communications management, and risk management planning are intrinsically intertwined. Shared understanding of potentially adverse effects of new changes facilitates the tracking of risks to the environment and how these risks must be managed. Retrieval of data from the Portal about changes made promotes the development and implementation of contingency plans that need to be maintained (and potentially implemented) in the event that anticipated risks from the implementation of changes materialize, and have a negative impact on the environment.

E.9.3.1 Responsibility for Implementing Change Management Plans

The Executive Account Director (EAD) is responsible for ensuring that all contractual requirements are fulfilled, including development and implementation of the CMP. To accomplish this, the AED collaborates with DHHS to allocate project resources to the execution of the CMP and related support activities. The AED supervises and delegates substantial change management responsibilities to change-

specific Change Management Teams. This team is an extension of the PMO and serves a QA role for the project, focusing specifically on monitoring the implementation and impact of changes. The Change Management Team's role includes:

- Measuring, auditing, and evaluating major change products and processes and supporting procedures using contract-required metrics and company-established quality criteria for best practices
- Reviewing, approving, and tracking through closure all proposed and completed quality-related corrective and preventive change action items, verifying root cause analysis was performed and that actions were effective in the disposition of process and product noncompliance
- Escalating overdue or ineffective non-compliance resolutions to appropriate management levels
- Collecting and analyzing quality data on changes, verify its accuracy, and report quality metrics and trends
- Ensuring that change management processes align with the QMP

E.9.4 CHANGE-SPECIFIC TRAINING

Team CSC uses targeted communication and learning opportunities to provide information and enhance skill-building relevant to system changes. We identify change agents to work with, coach, and train those who will be impacted by changes. While the processes for project-based training are discussed in depth in Section E.8, our change management approach understands and incorporates a training phase to support the proper and efficient implementation of approved changes. Team CSC will create develop customized training solutions tied to achieving the desired change outcomes. Training delivery strategies will vary, contingent on the type of change being implemented and the needs of the groups most affected by the change. Change-related training efforts will be coordinated and implemented through the training Zone of the project's Web Portal. There, project user groups can view upcoming training activities, enroll in courses or Webinars, download relevant content, and participate in discussion groups tied to the change being implemented.

Curricula for change management-related training will result from needs assessments that drive the training content and delivery strategy. These needs assessments have two primary objectives:

1. Identifying the user groups and influencers with low Replacement MMIS awareness, understanding or commitment, to focus in on the groups that require training
2. Identifying the knowledge needed to implement approved changes.

Change management-related training activities are incorporated within the project's overall project Training Plan.

E.9.5 CHANGE AND CONFIGURATION MANAGEMENT

Team CSC's comprehensive solution for change and configuration management is comprised of integrating robust change and configuration management processes into the design, build, procurement, installation, and operation of management systems and processes. Our Change and Configuration Management solution is implemented in the initial DDI stage and transforms to provide the same rigor and control during the Operational phase. It will continue to be used throughout the life of the Replacement MMIS and provide necessary discipline to the Replacement MMIS. We have also integrated it with multi-payer requirements to assure that end users have a key role in the change and configuration management process.

(40.1.1.153 – 40.1.1.158)

This section addresses the requirements for both 50.2.5.8 with this section emphasizing the configuration management aspects and the technical change collaboration efforts including managing "Recommending Opportunities for Improvements and any changes directly from other benefits programs within. (**40.1.1.153 – 40.1.1.158)**

The Change and Configuration Management approach is integrated with our overall Software Engineering and System Engineering Methodology (D.1.3) and our overall contract management process. Our focus provides a transparent and business driven decision making process with extensive involvement with State personnel. The Change and Configuration Management overview is shown in **Exhibit E.9.5-1.** There are outside elements from contract changes and baselining the initial design to changes that occur throughout the DDI process. The inner circle of the exhibit shows the central core circle of change and configuration management activities. CM collects artifacts and manages them. Our artifacts will be related to the contract SOW and master CDRL and organized into three groups. Those that relate to Program/Project/Governance, those involved with Requirements-Architecture-Design(Front End Elements) and the Software-Components-Services- Deployment Descriptions and Operational Procedures (Back End Elements). A taxonomy and master information model will act as a meta models for all elements and the links and dependencies between artifacts. CSC will ensure that all artifacts required to maintain the systems and properly perform operations and training are updated as part of the change management process. **(SOO 10.12.1-15)**

(10.12.1-15)

Many contracts start from scratch with little in the Baseline level. We will have many architecture elements, requirements, elements ready for entry upon contract award.

The Replacement MMIS will begin with many elements that will be placed under "baseline" control and configuration control of all changes including recommendations for improvements discussed under the Total Cost of Ownership and Continuous Improvement in D.1.12 will begin immediately. Some of the baseline elements will include the RFP, BSD, DSD but the initial Vision and Strategy, Architecture, Gap Analysis, Selection of COTS and their Capabilities, and key elements from the Legacy MMIS. These elements and other inputs to the change and configuration management will continuously occur throughout the DDI Life Cycle and be linked to not only the DDI but our Continuous Improvement activities.

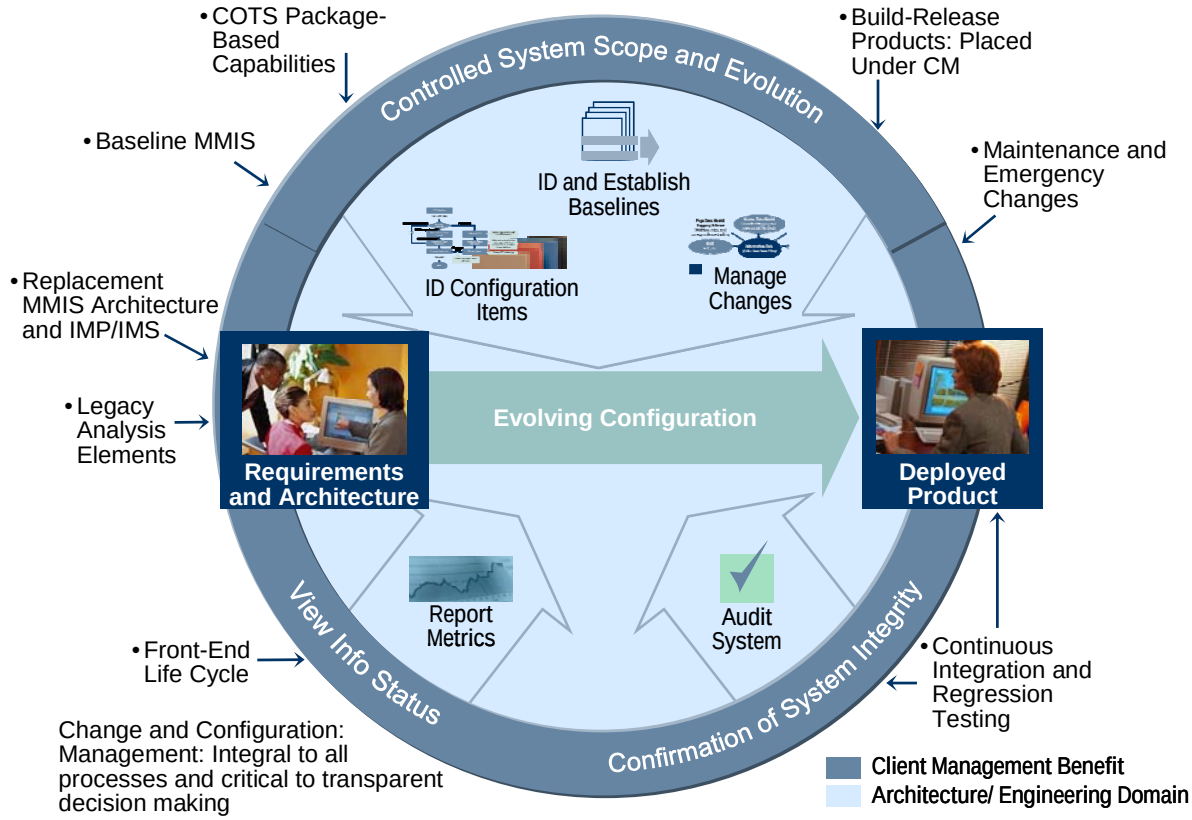


Exhibit E.9.5-1 Change and Configuration Management. *Integrated all Elements of DDI and Ready for Operations with Transparency and Collaboration*

E.9.6 CHANGE MANAGEMENT PROCESS AND WORKFLOW

The Replacement MMIS contract will include an initial formation of the State and Team CSC boards, establishment of collaboration change management processes, training and review of the proposal phase design activities.

A configuration baseline review will involve the "baselining" of the proposal developed material and the baseline replacement system, the COTS and Capabilities and the CM process itself. Also a CM Plan that aligns with the IMP/IMS schedule is baselined to have a projected set of events and opportunities for entering material within configuration management and tying to "configuration reviews" and approvals. The Software Development and System Engineering Methodology (D.1.14) defines the roles and responsibilities of the State. A set of activities will be aligned with when the State is **responsible** for, those they **accept**, those where there is more of a **collaborative** team approach used for and other areas where Team CSC is working on and provides opportunities for **involvement** but recognizes that the State personnel may not always be available to participate. CSC will establish a specific change management entry point for each of multi-payer stakeholders so that all changes including rules, workflows, parameter driven edits so that changes can be done eventually while also assuring that all the business analysis, quality assurance, configuration tracking, testing steps and deployment activities are completed. **(40.1.1.153 – 40.1.1.158)**

(40.1.1.153 – 40.1.1.158)

Throughout the DDI life cycle many new baseline elements will be produced. Change management and configuration management will align with the Program/project management and governance activities and the requirements analysis and design activities described in Software Development and Systems Engineering Methodology (section D.1.3).

Each of the changes to baseline requirements and artifacts will follow these basic steps or sub-processes:

- **Change Request (CR) or Change Service Request (CSR).** When the need for a system change is evident, a CR is created in the Change Management Portal in NCTracks. The Change Management portal provides online tracking and automated workflow for CSRs. The CSR is linked to all associated life cycle artifacts in the Portal. All the appropriate personnel are notified. **Approvals.** Interim approvals are prompted, gained, and documented through the Change Management Portal throughout the CSR lifecycle. Once these interim approvals are gained, the CSR is brought to the Change Control Board for consideration and final approval.
- **Scheduling.** All approved changes are scheduled on the master production schedule.
- **Implementation.** An assigned team is empowered to implement the approved change.
- **Review.** The Change Management Action Team assesses the success and anticipated outcomes of the change.

Appropriate, designated officials within DMA/DMH/DPH/ORHCC, OMMISS, or other DHHS divisions may initiate a Change Request (CR), which is the mechanism to any changes made to a baselined artifact. The appropriate DHHS official within the affected office(s) prepares the initial CSR, using a Change Service Request Form within the Change Management Portal that Team CSC will use to support change management activities within the Replacement MMIS project. **(Comment CSC646)**

The Borland® change management process is an integral part of our integrated requirements-design-cm and testing framework and our links to the portals. The integration is shown in **Exhibit E.9.6-1**. Our tools framework is accessible on the program/ project management/governance Portal, along with the front-end and back end portals. Each portal has its own set of stakeholders with portions of the repository for storage, documentation, and collaboration on CRs. The environment is redundant, integrated with our business continuity and disaster recovery and supports real-time access anytime and anywhere. The environment also allows users to be notified of changes that they are interested in and has a workflow approach at each of the levels to assure that people who need to respond, approve, consult and be informed of any change are “in the loop” or the issue is escalated. CM is often lab intensive and error prone and there are often gaps between tools. Our environment addresses this and has had a strong focus on continuous integration and regression testing. The environment provides the following overall capabilities:

- Online tracking and workflow actions for initiated CRs

Pages E.9-15 through E.9-17 contain confidential information.

Moreover, it brings focus to the scheduled release of system upgrades, thereby meeting the project's overall change management objective of efficiency through integrating many changes in one change action.

E.9.9 RELEASE MANAGEMENT AND RELEASE-BASED MAINTENANCE

In the type of new application development that will be performed in the Replacement MMIS project's DDI phase, the present state is treated both as a problem of transition, and as a possible resource. CSC uses the term "sustaining engineering" to encompass both system maintenance and system reengineering. Sustaining engineering describes the future in terms of changes to the present. The present state is treated as a constraining baseline and starting point.

New development focuses on a new structure to meet new and/or existing requirements. Sustaining engineering focuses on retaining the existing structure while artfully making changes or repairs as necessary to meet new requirements and to continue the life of the system in a dynamic environment of new technology and new operating systems.

CSC incorporates *release-based maintenance* — grouping changes into larger releases that undergo a controlled development process from requirements through specific configuration item. Release-based maintenance is preferable to a disconnected series of small changes in that it permits grouping for effectiveness and efficiency and lends itself to more complete requirements analysis, design, review, and testing.

Changes are generally allocated to pre-scheduled maintenance releases. The scope of a single maintenance release can be dynamically managed, allowing change items to be added in or transferred out to another release to improve efficiency and effectiveness. Releases can be hybrids of maintenance and new development. **Exhibit E.9.9-1** illustrates the aggregation of the change requests into change packages, allocation of change packages into releases, division of releases into work packages, and eventual integration of the completed work packages to form the release.

Page E.9-19 contains confidential information.

be a base of both the initial systems integration tests and be integrated into an automated library of regression tests. We have found that the continuous backend software CM, integration and regression testing detects problems early and prevents the accumulation of a set of small problems that become part of a big bang "CM" problem. The overall process is shown in **Exhibit E.9.10-1.**

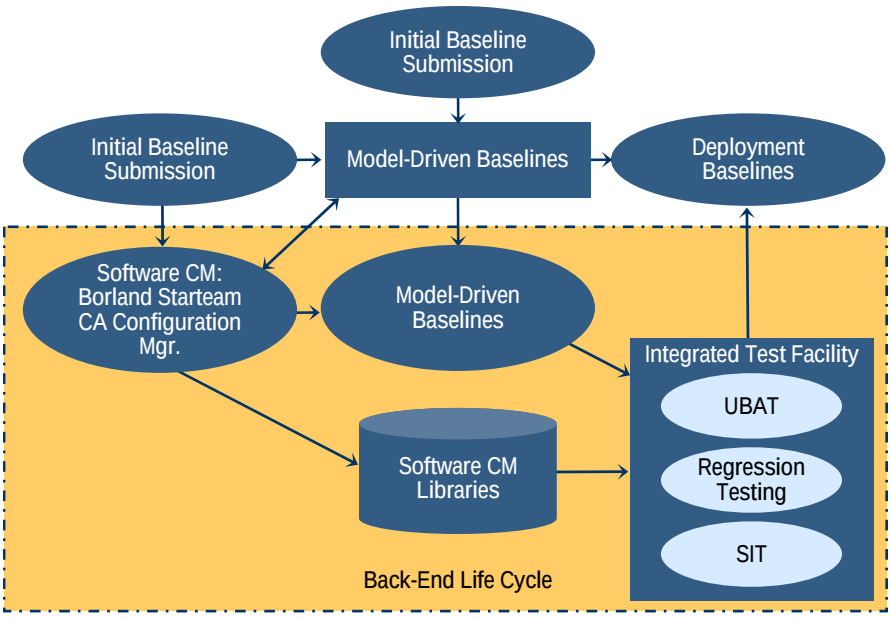


Exhibit E.9.10-1. Front-end to Back-end CM Connection with Model-Based Approach. *Team CSC brings a process for semi-automated model-based software CM, Integration and Testing that find problems early and creates "reusable regression test" library.*

E.9.12 CONCLUSIONS

Change is an intrinsic aspect of the Replacement MMIS project. Team CSC offers a proven framework-based approach to change management that is linked to our configuration management, CM workflow and CM Dashboard approach. We address the people, process, and mechanical aspects of change and configuration management. We have integrated and automated those tools to reduce complexity and close the link between people and process. Our approach places a high value on collaboration, communication, post-change evaluation, and user training with DHHS, to support the success of all change management efforts and activities will be tracked and the outcome, results and feedbacks will be integrated into our Change Tracking and Dashboard.

Page F.1-1 contains confidential information.

In this Section, we will describe our Operations Management approach and how it will succeed, driven by a strategy customized to the State's objectives. We respond to the requirements of the contents of the Operations Management Plan CDRL, which we will develop with the State's input. Our approach demonstrates Team CSC's readiness to:

- Assume the Medicaid Fiscal Agent contract and perform the Operations Phase role for a contract term of four (4) years with an additional one (1) year option
- Deliver and support all required Fiscal Agent services
- Schedule Fiscal Agent events, such as system job flow activities, distribution activities, reporting activities, quality assurance reviews, external audits, and training events
- Ensure the ongoing quality and success of the overall project
- (10.4-3, 10.10-15, 10.12.1-22) Be responsible for all costs (except for pass-thru costs) associated with operating and maintaining the Fiscal Agent Operations. **(SOO 10.4-3) (SOO 10.10-15) (SOO 10.12.1-22)**
- (10.12.1-27) Be responsible for submitting accurate monthly invoices detailing costs by DHHS payer, program and budget codes reflecting any FFP splits. **(SOO 10.12.1-27)**

Management's Approach To Operations:
• Meet or exceed established performance standards
• Plan sufficiently granular metrics to effectively manage operations
• Create culture focusing on quality.
• Implement change and configuration management to ensure participation and visibility across the entire organization
• Hire sufficient and adequate staff to meet the workload (SOO 10.10-14)
• Train stakeholders on systems, processes, and policies
• Ensure communications among State, Team CSC, providers, and recipients
• Conduct daily, weekly and monthly operations management reviews

(10.12.1-2) **(SOO 10.12.1-2)**

Operations excellence is deeply engrained in Team CSC's project management culture. We manage people, processes, and technology to achieve zero defects. Our emphasis on a "zero defect" operations management process is the foundation for ensuring success in operating Medicaid Fiscal Agent services for the State of North Carolina.

Please refer to proposal Sections D.1.2.6 (Work Site Locations) and D.1.2.7 (Proposed Technical Architecture) for additional aspects of operations phase project management (facility-related and IT support).

Team CSC appreciates the value of career fiscal agent personnel who may now be working the legacy operations. We hope to work with the State and the incumbent to offer meaningful opportunities for these individuals in our new operation. If insufficient incumbent staff are made available, we will utilize our extensive corporate recruiters and job fairs to onboard the required staff necessary to perform all fiscal agent duties. **(SOO 10.12.1-3)** (10.12.1-3)

Pages F.1-3 through F.1-8 contain confidential information.

CSC's approach to project improvements is facilitated by the corporate-wide Knowledge Management program. CSC has long recognized that its intellectual capital — knowledge that its employees have gained from their education and experience — is one of its most valuable assets and instrumental in the company's ability to maintain a competitive edge in its marketplace. A dozen years ago, the company made a significant investment in creating a global knowledge environment as a means to leverage this intellectual capital and to strengthen its position as a market leader - to make this knowledge available across organizational boundaries on request. The CSC Knowledge Program (CKP) is organized into services that facilitate development, deployment, and operation. It has management responsibility for building, operating, maintaining, and proliferating CSC's global knowledge environment. All CSC employees have access to this wealth of global expertise, best practices and experience, and can access it from any desktop via the Web-based CSC Portal.

Our knowledge communities, in keeping with CSC's long tradition of collaboration across a wide range of business and technology topics, provide a means for CSC professionals to exchange ideas, information, and experience around proven resources as they develop and deploy promising new techniques and technologies. Ranging in size from just a few members to hundreds, these groups connect and collaborate around today's leading business topics, staying abreast of the latest innovations. Through our communities, the collective knowledge of CSC subject matter experts can be brought to bear on client solutions regardless of the geography, industry or organization. Among the current communities are e-commerce, project management, network security, customer relationship management and others across the broad spectrum of our core competencies.

During the Operations phase, Team CSC will organize and conduct an Operations Excellence Committee, focused on:

- Process improvement
- Error prevention
- Root cause analysis
- Total Cost of Ownership

The CSC Team will provide state-of-the-art processes, skills, products, tools, training, methodologies, and operations management services. Process improvement follows an ITIL-aligned and ISO9000:2001 compliant integrated service delivery model (SDEP). This framework's evolution continuously tracks service delivery best practices, not only within CSC, but also those driven by external standards development organizations, including ITIL, ISO, the Software Engineering Institute (SEI), Gartner, META Group, and the Help Desk Institute, as well as those developed internally by our own clients.

Process improvement function focuses on:

- Assessing operational processes in a continuous, disciplined manner

- Identifying operational processes that warrant evaluation and monitoring for improvement. This identification effort is conducted routinely and is well-integrated within the Team's overall execution of operational management plans
- Owning the authority to implement value-adding process improvement resulting from the Team's quality assessments, performance measurements, and operations monitoring efforts
- Reducing the Total Cost of Ownership (TCO) for the MMIS. Team CSC understands that operations-specific process improvements must be integrated into our overall project management approach.

While all operational management components are responsible for quality management and process improvement efforts, Team CSC will create an Operations Excellence Committee and Innovations Council to provide forums for highly-focused, collaborative efforts to monitor and achieve process improvement.

Operations Excellence Committee
Purpose: To promote continuous excellence within Fiscal Agent operations through a focused review of issues and measures impacting Team CSC's achievement of standards-exceeding operational processes. The Committee serves as a centralized forum for a concerted operations management focus on process improvements and reduction in the Total Cost of Ownership.

Committee Chair: Deputy EAD

Committee Membership:
- Medical Director
- Security Director **(Comment CSC162)**
- Client Services Manager
- Claims Manager
- Health Program Services Manager
- Quality Assurance Manager
- MMIS Financial Manager
- Operations supervisory-level staff
- Training Manager
- DHHS designee

Meeting Frequency: 2X / Month

Standing Agenda:
- Review of existing process improvement items (issues and performance metrics being monitored in focused manner by Committee)
- New process improvement ideas to evaluate
- Development of process improvement recommendations
- Change management processes to invoke
- Staff training needs/plans attendant to implementation of process improvement recommendations

Committee Minutes Development and Distribution: Minutes are taken and distributed to Committee participants, with a copy routed to the EAD and DHHS COTR. An electronic version of the Minutes is posted on NC TRACKS

Committee Authority: Through the authority given to the Committee Chair, Team CSC's Deputy EAD, from project EAD John Singleton, the Committee is empowered to:

- Identify process improvements that offer value/savings from a TCO perspective
- Conduct special studies to assess cost/benefit impact of prospective process improvements
- Develop recommendations for process improvements and integrate appropriate recommendations into the overall PMP (particularly the Change Management process, when necessary)
- Create process improvement implementation plans, including staff training when necessary, to effect the needed process improvements
- Monitor the impact of implemented process improvements

Process improvement is also integrated within other project planning and status reporting procedures, particularly the Project Planning Meeting conducted with DHHS each month. This meeting may generate ideas for the Operations Excellence Committee to investigate and develop recommendations for value-adding changes.

Innovation Council
Purpose: To serve as forum for gathering information, hearing industry vendor presentations, and holding discussions about existing and future technology solutions that may inure to the benefit of the Replacement MMIS project.

Council Chair: Director, Implementation for Team CSC; in Operations Phase, Chair will be IT Director

Council Membership:
- EAD and Deputy EAD
- DHHS CIO, COTR, and designated technology leads from State
- Team CSC's senior management team for Fiscal Agent Operations
- Technology SMEs from Team CSC and DHHS
- Others by invitation

Standing Agenda:
- Committee Chair: Technology innovation briefing / update (update of prior discussions in Council, new relevant innovations being promulgated by CSC
- Presentation by industry vendor or other invited guest

Frequency Bi-monthly (6 times per year)

Council Charge / Authority
- Learning or relevant developments in range of technological areas, from infrastructure to applications, COTS products, clinical infomatics

- Discussing viability of new and emerging technologies, for possible leveraging by Replacement MMIS project

F.1.7 QUALITY MANAGEMENT

We understand that delivery of quality services and products is integral to our project management responsibilities, in both project phases. Consistent attainment of performance objectives is a top priority for the Replacement MMIS project. Our Quality Management approach starts in the DDI phase and transforms its emphasis as the project moves into the Operational Management phase.

Key elements of our quality program through both phases include:

- Executive level management commitment at the Program level, division President level, and Corporate CEO level
- Independent corporate quality assurance reviews (Delivery Assurance Reviews) in which corporate staff review program operations and report results directly to corporate President and CEO levels
- Structured processes and standards, including our CATALYST methodology, ITIL, CMMI, ISO, and Service Delivery Excellence Program (SDEP)
- Dedicated quality assurance staff reporting directly to the Account Executive
- Frequent internal reviews, quality checkpoints, and reporting
- Proven tools and processes for workflow management, change management, configuration management, testing, customer acceptance, documentation, and traceability
- Audits of the change management process
- Innovation Council and Operations Excellence Committee

An independent Quality Assurance Team reports to the Executive Account Director and is in place **to support defect prevention, identification, and resolution but also continuous improvement and innovation**. The QA team audits processes against quality metrics and aligns them against the operations strategic goals and objectives. These measures include process execution, performance evaluation, product quality, and schedule variance among others.

Failure to meet any metric will initiate a ‘root-cause’ analysis to determine why the failure occurred and suggest corrective action.

Team CSC has included two other organizational entities that support a continuous improvement culture. These are the Innovations Council and the CSC Advisory Council. The Innovations Council includes industry input with members from the Sheps Center, SAS Institute, Strategic Partners (Borland, Pega, Microsoft, IBM, Pervasive) and CSC Centers of Excellence, as well as DHHS meet on a periodic basis to offer new ideas from industry and technology. These ideas are formed into Business Cases that detail the areas affected, impact on quality and the opportunity to reduce TCO. These business cases are brought to the DHHS Change Control Board for appropriate disposition.

Pages F.1-13 through F.1-14 contain confidential information.

program the dashboard views to show incremental, color-coded status designations, which reflect the degree of focused attention that Team CSC's operations management must dedicate to performance against pre-set metrics. When this automated process creates a negative change, showing that performance is nearing the SLA performance metric, alerts are distributed automatically by e-mail to operations management leadership. By taking this type of proactive approach, addressing performance issues before performance drops below pre-set standards, our team can take corrective actions well before any issues pose a threat to project operations management success.

Team CSC's operations management approach is to maintain full transparency about project performance against pre-set metrics. This transparency is enhanced through use of a Project Information Center, which is established within a designated conference room where DHHS and Team are collocated, It is the physical space where Team CSC management and approved DHHS officials meet to review operations performance data (see **Exhibit F.1-8**). Our automated performance monitoring tools accessible at this Center promote project coordination, value-added communication, timely risk escalations, and real time status updates on Fiscal Agent operations. **(SOO 10.12.1-8)**

(10.12.1-8)

PC2003-9799-702a, 12/13/07

Exhibit F.1-8. Project Information Center. *A conference room will be established where State is collocated with Team CSC, to promote a centralized site for project reviews.*

- Our NC*Tracks* portal provides an on-line view into our Fiscal Agent operations, displaying current versions of State performance metrics, as well as other internal performance metrics developed by Team CSC. **(SOO 10.12.1-9)**

(10.12.1-9)

F.1.9 OPERATIONS MANAGEMENT REVIEWS

Project planning and status reviews during the Operations phase will be a continuation of the types of management reviews that Team CSC establishes throughout the life of the project. The PMO updates the PMP and all component plans, and develops required reports and other CDRLs. This project management activity is the result of the routine collection and analysis of project performance information by the PMO. Operations Management reviews also occur or are prompted by the occurrence of and/or development of:

- Monthly Project Status Meetings with DHHS (see Section E.1.2.13 and E.1.2.14)
- Weekly Team CSC Management Meetings (see E.1.2.14)
- Operations Management Reports (new to Operations Phase – see Section E.1.2.13))
- Operations Excellence Committees (new to Operations Phase, focused on process improvements, described in earlier paragraph F.1.3)
- Automated tracking summaries of performance, through dashboards viewable on **NC***Tracks*.

(10.12.1-6, 10.12.1-8)

Our approach to project reviews remains the same throughout both phases of the Replacement MMIS project. The emphasis will change in the Operations phase to performance of the Medicaid Fiscal Agent. **(SOO 10.12.1-6) (SOO 10.12.1-8)**

(50.2.6.1)

F.1.10 CHANGE AND CONFIGURATION MANAGEMENT (RFP 50.2.6.1)

Any changes to baseline requirements need to be assessed and implemented in a disciplined, well-documented, and traceable manner. The Change and Configuration Management Plan for Operations is described in Sections E.9 and F.2.

(50.2.6.2)

F.1.11 RISK AND ISSUE MANAGEMENT (RFP 50.2.6.2)

Threats to project success must be identified and managed in full coordination with the State. The risk management strategy and processes for the Operations are summarized in a Risk and Issue Management Plan, which is located in Section F.3.

F.1.12 RESOURCE MANAGEMENT

Operations management includes an Earned Value Management System that tracks resources allocated to the project and the project's cost-effectiveness. Our Earned Value Management System is described in Section E.1.11.

F.1.13 SECURITY

The security processes, including how system threats are prevented or, if identified, how they are communicated to the State, are summarized in our Security Plan (Section H).

(50.2.6.3)

F.1.14 BUSINESS CONTINUITY/DISASTER RECOVERY APPROACH (RFP 50.2.6.3)

The Business Continuity/Disaster Recovery Plan for the Operations Phase is provided in Section F.4.

(50.2.6.4)

F.1.15 ONGOING TRAINING/TRAINING PLAN (RFP 50.2.6.4)

Operations Phase training of Team CSC staff and system users is summarized in our Training Plan, provided in Section D.4.

(50.2.6.5)

F.1.16 COMMUNICATIONS PROCESS/PROCEDURES (RFP 50.2.6.5)

Project communication challenges in the Operations Phase will be focused on a wide range of internal and external project stakeholders. The Operations Phase Communications Process/Procedures are summarized in Section F.6.

(10.12)

F.1.17 SAS 70 AUDIT COMPLIANCE (RFP 10.12)

CSC will annually contract for a Statement on Auditing Standards No.70 (SAS 70) Type 2 review, conducted by an independent and qualified audit firm. This firm will comply with the specific requirements found in RFP Appendix 40, Attachment D. As noted in that RFP section, the audit sites covered by the report will include all sites used for North Carolina Fiscal Agent operations activities. The SAS 70 report will be provided to the State on or before September 30 of each year. **(SOO 10.12.1-28) (SOO 10.12.1-29)**

(10.12.1-28, 10.12.1-29)

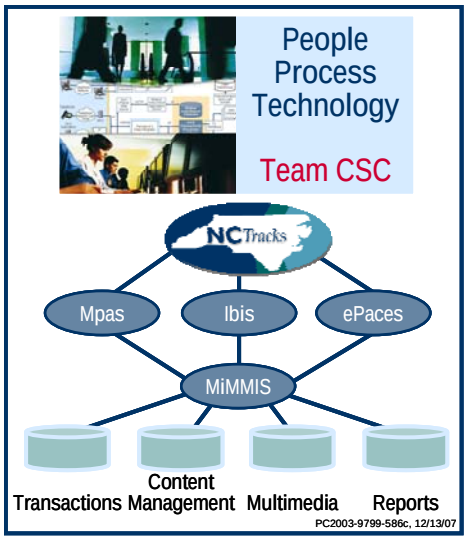
F.1.18 CONCLUSIONS

This Operations Management Approach reduces the amount of work the State and Team CSC will have to do to transfer from the DDI phase to the Fiscal Agent Operations phase. We will have the same team, with a new emphasis. We will be continuing the same staffing, processes, control methods, and collaboration tools, making them available at any time from any DHHS office that has Web access via the NC Tracks portal. This approach will improve productivity and reduce risks during day-to-day activities and during any emergency that may arise.

Our approach to the Operations Management phase of this project is to produce and reinforce the “zero defect” threshold, which ensures that claims are processed and paid on a timely basis, fraud is eliminated, health information is secure, and the Total Cost of Ownership is reduced.

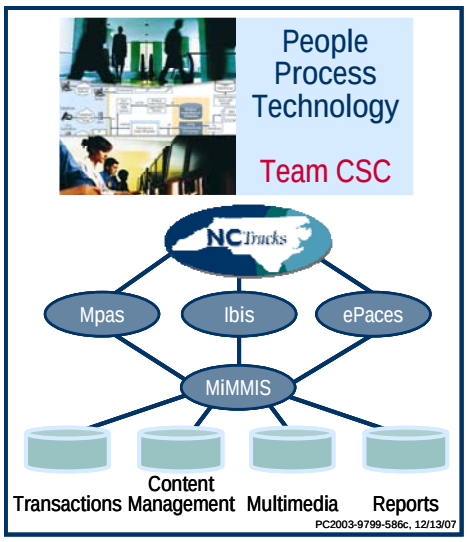
F.2 – Change and Configuration Management

To eliminate redundancy and adhere to the RFP directions, CSC combined responses to RFP 50.2.5.8, Change Management Approach and 50.2.6.1, Change and Configuration Management. Our consolidated discussion is presented in E.9, Change Management Approach.



F.3 – Risk and Issue Management

Risk and Issue Management for Operations is contained in Section E.7 (Risk and Issue Management Plan) of this proposal.



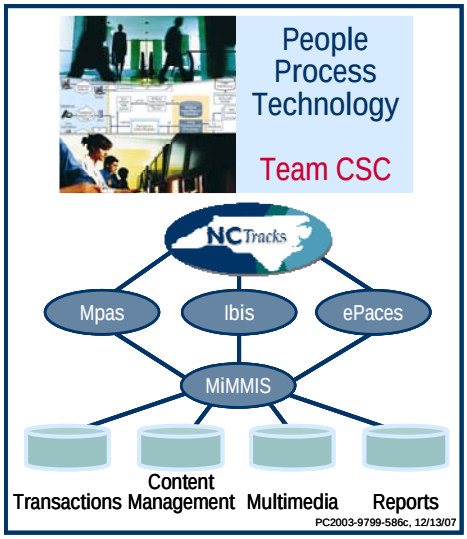
F.4. Business Continuity/Disaster Recovery Approach

The State's management of Medicaid is of vital importance to recipients, providers, and other stakeholders. CSC will design a Business Continuity and Disaster Recovery Plan to restore business operations and to recover operations in the event of a disruption to the critical systems, the loss of key personnel, and/or the loss of facilities supporting North Carolina.

F.4.1 OVERVIEW

(10.12.1-12)

CSC goes beyond the industry standards in our approach toward creating unified Business Continuity and Disaster Recovery (BCDR) programs, structuring our recovery plans and processes to ISO 20000 (ITIL), CMMI, and ISO 9001 Standards, and with the requirements of our customers firmly in mind. Our plans are maintained and tested on a mutually defined schedule. (SOO 10.12.1-12)



We combine business impact analysis (BIA), business process management, and systems engineering in developing our BCDR plans. The CSC strategy is to deploy a Replacement MMIS solution that reduces the threat of a disruption through planned mitigations to identifiable risks. In the event of a disaster, our first priority is to prevent the loss of life and safeguard personnel during any type of disruption. Our second priority is to safeguard the assets with which we are entrusted and maintain the integrity of the systems involved. A guiding principle is that if you haven't written it down, trained to it, and tested it under conditions that approximate reality, you don't have an executable plan.

In designing the existing environment for the Replacement MMIS, we planned the infrastructure to minimize and mitigate risk through multiple levels of redundancy built into the computing systems, servers, power, storage systems, communications systems, Automatic Voice Response Units (AVRS), and the LAN/WAN. It is important to note that CSC has global contracts with SunGard, to provide recovery sites and technical assistance, wherever and whenever needed. We also have a global contract with Iron Mountain to provide off-site software and data storage at multiple locations. These contracts are not unique to this program, but are indigenous to CSC's global operations.

CSC enabled the Security and Exchange Commission's Manhattan office to recover operations within two days after losing all facilities and equipment on 9/11. We recovered operations in the interim, and occupied new offices a few blocks away, to become the first Federal Government Agency to return to full service after 9/11.

Team CSC will provide a Replacement MMIS Disaster Recovery Plan that clearly describes the equipment, software, functions, roles, responsibilities, and operational restoration procedures that are critical at all locations. The proposed Plan will be

developed in coordination with the State. Too many DR plans focus on technology. A key objective of our jointly developed DR Plan will be not only to recover the technology supporting the business operation, but to ensure the true objective of business continuity is achieved: the restoration of Fiscal Agent services to healthcare providers and recipients throughout the State of North Carolina.

It is important to note that for the Replacement MMIS, there are two key locations that need to be considered: the Fiscal Agent Operations Center located in Raleigh, North Carolina and the Data Center located in Albany, NY. Either one or both may potentially be involved in an event that would necessitate the execution of the BCDR Plan. As such, the BCDR Plan needs to account for these two locations separately. For example, an ice storm that strikes the Raleigh location and causes extensive damage to the infrastructure would probably not affect the Albany location. Likewise, a major power outage in Albany would probably not affect the Raleigh area. For this reason, the BCDR Plan needs to consider both locations and provide for a full recovery at either or both locations. The Plan will also have to be separately tested for these locations.

F.4.2 ROLES AND RESPONSIBILITIES OF PARTICIPANTS

CSC and NC DHHS will assign roles and responsibilities to clearly identify all parties by position who are required for successful plan execution, including the command structure and supporting roles. The command structure must be clearly defined so that everyone involved in the recovery effort knows the chain of command and exactly who has the authority to accomplish every identified task. Because every action is time sensitive, no ambiguity can exist. These personnel might participate from the beginning of the Notification/Activation Phase through to successful system recovery and operations. Some examples of these roles would be:

Initial Actions	Recovery Teams
• Executive Management (authorized to declare a disaster) • Damage Assessment Team • Alternate Site Recovery Coordination Team • Physical/Personnel Security Team • Media Relations Team	• Business Process Recovery Team • Operating System Administration Team • Database Recovery Team • Application Recovery Team(s) • LAN/WAN Recovery Team • Administrative Support Team • Test Team

Exhibit F.4-1. Disaster Recovery Teams. *Our teams will take immediate, clearly-defined actions to recover the site as quickly as possible.*

The plan will clearly identify individuals and their designees who have the authority to declare a disaster. We assume that NC DHHS will have ultimate authority for declaration of a disaster and activation of the business continuity/disaster recovery plan, while CSC, as the Replacement MMIS contractor and owner of the contract with SunGard and other providers, is the party that can engage recovery facilities.

F.4.3 PROCESS THAT ADDRESS PREPARATION AND PLANNING

Team CSC follows Federal guidelines and legislation and Disaster Recovery International guidance in our plan development. The steps and documents described in the following come largely from The National Institute of Standards and

Technology (NIST). NIST outlines steps for planning BCDR in its Special Publication 800-34, *Continuity Planning Guide for Information Technology Systems.*

Exhibit F.4-2 illustrates the NIST processes for complete BCDR planning.

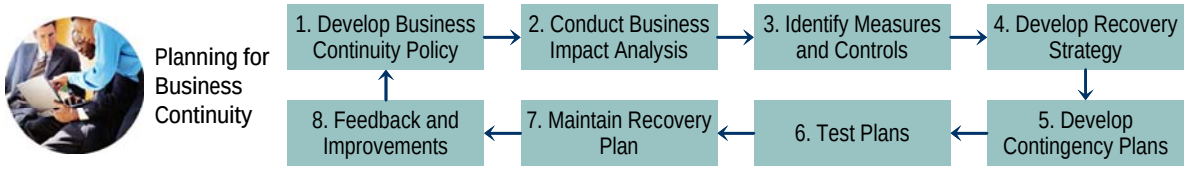


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Exhibit F.4-2. Planning for Business Continuity and Disaster Recovery. *Thorough, timely planning for all contingencies.*

We expect that the BCDR planning process will involve a review of existing legacy MMIS+ BCDR plans and related documentation. Team CSC is fully prepared, however, to start some or all facets of BCDR from the beginning when dictated. The planning process will consist of the following steps: (**40.1.2.38)** (40.1.2.38)

1. **Develop or validate the business continuity and disaster recovery planning policy statement.** NC DHHS senior management and CSC BCDR planners develop or validate an existing policy statement to provide the over-arching guidance, authorization, and framework within which to develop and administer a BCDR program. NC and Team CSC will review and may revise this annually, depending upon requirements.
2. **Conduct the business impact analysis (BIA) or validate and update an existing one.** Team CSC and the State will identify critical business functions and their supporting technical architecture and systems, and then prioritize them based on their impact to the organization. We will establish the Recovery Time Objective (RTO) within which we must recover operations and the Recovery Point Objective (RPO) to the point to which we must restore. CSC will prepare an IT Contingency Plan for the IT Infrastructure – facility space, WAN, LAN, Telecommunications, Servers, Storage, etc – that identifies and prioritizes all sub-systems within the Business Impact Analysis. CSC will validate and revise the BIA annually as necessary in concert with all functions involved with conducting a Business Criticality Analysis (BCA) throughout the business and technical architecture. CSC will revise RTO and RPO accordingly as approved by the State.
3. **Identify preventive controls.** Identify controls and countermeasures to reduce risk in an economical manner consistent with the parameters set by the NC DHHS CIO and other stakeholders in the BCDR Planning Policy Statement.
4. **Develop recovery strategies.** Create methods to bring operations, systems, and critical functions online quickly, to restore business operations capability.
5. **Develop BCDR plan.** Write procedures and develop the guidance for how to sustain Fiscal Agent operations and recover to an alternate facility potentially located at SunGard in New Jersey and ultimately return to the original or new facility.
6. **Test the plan and conduct training and exercises.** Test the Plan to create awareness and train participants and to identify deficiencies in the BCDR plans. Conduct quarterly training to train individuals on their expected tasks, identify

holes in the plans and procedures, and incorporate findings into plan updates and future revisions. Quarterly training would be conducted as a desktop walkthrough of the planned actions. The hands-on annual exercise will require an actual movement to alternate facilities for both facilities.

7. **Maintain plan.** Continually update work flows, processes, and other ancillary supporting documentation and resources to ensure that the BCDR is a living and executable document.
8. **Feedback and improvements.** Identify areas for improvement and provide recommendations to refine the policy, plans, and other supporting resources.

For the Replacement MMIS, the BCDR planning process will involve a complete review of the existing Business Impact Analysis (BIA), the BCDR plans, and all related documentation, to include the notes and debriefing information from the last two disaster recovery exercises. Team CSC will expand on those plans and processes to address the additional scope. We will thoroughly review the BCDR plans currently in place to recover the eMedNY environment. We will further address the additional locations that will be involved with and support the NC DHHS system to include the Fiscal Agent Operations Center in Raleigh, NC.

F.4.4 AWARENESS AND RECOGNITION TRAINING

Team CSC will conduct awareness seminars, quarterly tabletop, and functional tests, across the entire operations at least once a year to create awareness of BCDR requirements and train contingency participants. Because there are two locations involved, recovery actions must be planned in detail for both locations. For example, in the case of a short-term interruption to Fiscal Agent operations in North Carolina, Team CSC will use personnel who have parallel responsibilities in New York cross-trained to act as Fiscal Agents for North Carolina. For interruptions in data center operations at the Albany Data Center, assigned personnel will be trained to recover both operations centers and move operations to the alternate SunGard facility. Policies and detailed procedures will be in place to provide for that contingency should the need arise. This cross-training strategy will accelerate the recovery period for a disaster at either end of the system.

F.4.5 BUSINESS SERVICE AND PROCESS RELOCATION

In partnership with NC DHHS, Team CSC will create the Business Continuity and Disaster Recovery Plan, to include the Raleigh, NC call center, the SunGard facility, Iron Mountain, and the Albany, NY campus. We can most efficiently articulate our approach by providing the table of contents, for the plan currently supporting the eMedNY system, as it appears at the end of this section.

In general, the current plan utilizes SunGard facilities, with a duplicate of production equipment and network resources. For the NC Replacement MMIS, this design and strategy would be maintained and enhanced to include the specific hardware and software requirements to support the NC DHHS platforms.

Because the North Carolina Replacement MMIS will share somethe equipment (i.e., network components, facility infrastructure such as power, partitioned enterprise servers, cooling, etc) located at the CSC Data Center in Albany, NY it is important to

note several key features of that center. First, the data is mirrored on a real-time basis with our back-up facility in New Jersey. This real-time operation means that the New Jersey facility is only seconds behind the operational facility at any moment in time. This strategy allows a much quicker recovery time because we do not have to resort to the movement of tapes or other back-up media to restore operations. However, tapes and other media are available should there be a problem with the mirrored device. The enterprise servers are clearly partitioned, and if processors serving another customer should fail, that has no effect on our operation; there is automatic shift of the work to other processors within that server and / or failover to another enterprise server. All other servers for the Replacement MMIS are dedicated solely to the Replacement MMIS.

Redundancy / failover A like situation is true with the communications pathwaysfacilities between New York and New Jersey. CSC provides dual OC-3 circuits with alternative routings between the two sites. These circuits are currently only at 20 percent capacity during peak transmission times and are more than sufficient to carry the additional load ascribed to North Carolina. There will likewise be dual circuits between Raleigh and New York and New Jersey for the North Carolina facility.

F.4.6 NOTIFICATION AND COMMUNICATION

Team CSC will document the formal process for managing notifications and communication. The notification and communications framework will be developed in collaboration with the State to assure alignment with State policies and the established chain of command for BCDR. Objectives of the notification and communications process are:

- Disaster's impact on the NC DHHS business/mission is minimized and that service is restored within the shortest possible time frame;
- All participants in the DR effort are activated appropriately and can provide/obtain status updates efficiently;
- State and federal stakeholders are apprised in a of status and impacts as efficiently as possible;
- Customers — providers, recipients, VANs — are apprised in a timely manner of status and impacts as efficiently as possible.

The most critical point of notification and communication will be between the NC DHHS and the CSC Account Executive regarding declaration of a disaster. Multiple communication channels will be established – office phone, cell phone, home phone, pager, office email, personal email, etc – to ensure that the appropriate decision makers within the chain of command can be reached within a proscribed time frame.

Upon declaration of a disaster, Team CSC and State personnel will be notified through their multiple communications channels. All personnel will be informed of which standard procedure to follow for the disaster or of special instructions. Providers, most notably SunGard, will be notified through their DR activation interface which is typically this is a nationwide toll free phone number. IronMountain may be notified to prepare and courier tapes to the SunGard facility.

Telecommunications carriers may be notified to re-route service to the disaster recovery sites.

Providers will also be notified of pertinent modifications to operating procedures. Team members will also assist with notification to subcontractors, suppliers, vendors and service bureaus that a disaster has been declared and whether/how they will be affected.

(40.1.2.26, 40.1.2.42)

F.4.7 TESTING AND AUDITING PROCESSES FOR ENSURING THE CURRENCY OF THE PLAN (40.1.2.26, 40.1.2.42)

The most critical part of planning for Disaster Recovery is actually testing the Plan. This is done to validate that each section remains viable as to the information contained within and that the actions enumerated produce the desired result. Requirements for testing are decided mutually between client and CSC, but it is recommended that actual physical testing occur not less than every 2 years. It is highly recommended that an actual test of the BCDR Plan be conducted annually for at least the first few years to ensure all aspects of the plan are tested and proven, that the documentation is sufficient, and that sufficient members of the staff are fully trained in their responsibilities.

The Disaster Recovery Plan will be reviewed at least once per year and updated as required to account for new policies or procedures. Updates to reflect new equipment, software, and/or operational procedures will be made as soon as the required change is identified to ensure that the Disaster Recovery Plan reflects the real world as soon as possible.

F.4.8 RESPONSE PLANS FOR EPIDEMIOLOGICAL DISASTERS

Because in today's world the possibility of an attack against an American target involving an epidemiological agent is a very real possibility, it is necessary to plan for such an event. CSC played a very large role in the recovery of the Security Exchange Commission as a result of the attack on the 11th of September. We are headquartered in Falls Church, Virginia just outside the Washington D.C. beltway and were a part of the anthrax scare a short time ago. We realize all too well what the possibilities are and are ready to work with State staff to create a robust DR Plan provide business continuity for the North Carolina Replacement MMIS in such an event.

CSC brings experience working with the Department of Defense, National Institutes of Health and other Government entities to automate biological and chemical identification. We have a subsidiary that develops vaccines used worldwide as a preventive and train officials from numerous nations how to react to epidemiological disasters. That experience is available to the State.

The eMedNY Disaster Recovery plan was tested in Apr 03 using only alternate personnel, to verify the validity of our assumptions, planning factors, and checklists. The result of this exercise was an outstanding success. All systems were recovered within the time limits allowed.

Our plans have built-in provisions to address situations where the current supporting personnel are unavailable to participate in the recovery process for whatever reasons including mass fatalities. By combining CSC's pool of top-level technical and operational support personnel, together with SunGard's capabilities and recovery

expertise the plan allows for personnel with little to no system specific expertise to recover the full operations of the disabled system. If the situation is such that Internet, phone, and other teleprocessing or telecommuting functions are available, our options are even greater and the recovery time is shortened.

In the instance where the epidemiological agent is dispersed at the CSC Team's Raleigh facility disabling use of the facility and/or personnel, our BCDR Plan will account for recovery of the Fiscal Agent responsibilities in the Raleigh area. It will provide for an alternate facility, equipment, and telecommunications. Documentation will be stored off-site and detailed to a level that will allow alternative personnel to accomplish the Fiscal Agent responsibilities. Personnel will be made available from other CSC Team facilities to immediately conduct the BC recovery actions and assume responsibility for the operations. For example, PhyAmerica has personnel not associated with the Replacement MMIS, who are trained and certified credentialing agents who could be used in a disaster response.

F.4.9 RECOVERY PRIORITY FOR CRITICAL RESOURCES

As discussed previously, Team CSC in collaboration with the State will identify critical business functions and their supporting technical architecture, systems, and processes and then prioritize them based on their impact to the organization during the BIA.

Generally, underlying infrastructure components may have the highest priority in order to facilitate connectivity and communications between computing systems in the CSC technical architecture. The prioritization, however, will be driven by the business criticality of the business/functional area to be recovered. If, for example, through collaboration with the State, the Claims Business/Functional area is determined to have the highest priority for recovery, then those technical components supporting claims would be considered critical resources for recovery. Priorities will be established not only for each business/functional area but also within each business/functional area. Using the Claims example, the priority may be high for pending electronic claims but low for paper claims. In this case the recovery priority would be given to the computing and network components supporting electronic Claims while scanning and OCR components, supporting Paper Claims, may have low recovery priority.

F.4.10 PROCESSES FOR DATA RELOCATION AND RECOVERY

In Team CSC's approach, data relocation and recovery is facilitated by:

- Mirroring data at the SunGard DR site
- Daily incremental and weekly full backups, with backup tapes moved daily to the Iron Mountain off-site storage facility
- Contract with SunGard for disaster recovery services
- Detailed BCDR plan, tested annually

One of the most critical pieces of information that is required to establish a Business Continuity/Disaster Recovery program is to identify the Recovery Time Objective (RTO) and Recovery Point Objective (RPO). This information, coupled with the costs

involved, is the basis used for developing a recovery strategy that meets the requirements of the client.

NC Replacement MMIS business assets can be classified into the following Business Continuity tiers, depending on the RTO.

- Continuous or immediate availability requiring recovery in less than 8 hours.
- High availability requiring recovery between 8 to 24 hours
- Medium availability requiring recovery between 24 to 48 hours
- Low availability allowing recovery beyond 48 hours

Team CSC's BCDR approach is based on an RTO of 48 hours for the core transaction processing systems, measured from the declaration of a disaster. Restoring primary production services within 48 hours is facilitated by leveraging processes proven annually by eMedNY and enhancements we will make to the baseline system, including the addition of advanced COTS technology. Our approach for the Replacement MMIS BCDR Plan includes telecomm connectivity, computing capacity, operating systems and applications software, databases, and IT and FA Operations restoration / services teams.

We will review our proposed BCDR solution with DHHS during the DDI Phase, and finalize the FA Operational BCDR Plan prior to the start of Transition. The objective of the review with the State is to ensure our approach is compatible with the latest NC State and DHHS Disaster Recovery requirements and performance standards.

Key elements of the BCDR approach include:

- Notification of designated DHHS stakeholders of significant service degradation or interruption incident, and restoration status, via email, landline, cell phone and / or NC Tracks web portal within one normal working hour of Team CSC identifying the incident
- Public notification of a significant service degradation or interruption, and restoration status via the NC Tracks portal within two normal working hours of Team CSC identifying the incident.
- Alerts issued to appropriate Team CSC staff, within time frames specified for the event (i.e., the Escalation and Notification Plan, which lays out potential events, actions, actions owners, and time frames).
- For a Declared Disaster, restoration of primary production capability at the Sunguard DR center in New Jersey, within 48 hours of the Declaration. A key enabler to quick restoration of key services is the continuous mirroring of data from the Albany, NY data center to the Sunguard DR center in New Jersey.
- Partnered annual BDCR tests, with test plans and participation / observation jointly developed by Team CSC and appropriate State personnel.
- When deemed necessary, Team CSC will provide recommendations for additional testing to the State Chair of the CCB whenever we determine that the scope or potential impact of a CSR warrant additional BCDR testing.

On the following pages is the Table of Contents for the BCDR plan currently in place, and tested for 100% viability, for the eMedNY system.

F.4.11 REPRESENTATIVE EMEDNY BCDR TABLE OF CONTENTS

To illustrate components of a BCDR plan similar to what CSC will create for the NC MMIS, **Exhibit F.4-3** presents a Table of Contents for the eMedNY operation.

Business Continuity / Disaster Recovery
Table of Contents

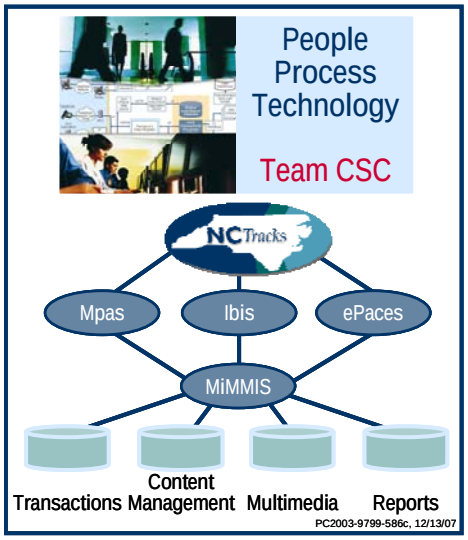
Exhibit F.4-3 Business Continuity / Disaster Recovery Plan Table of Contents. *Illustrates basis content of plan similar to the BCDR that CSC will develop for NC MMIS.*

F.4.12 SUMMARY

As demonstrated by our successes in executing our prepositioned plans and recovering from disasters at nuclear sites, 9/11, and a host of other examples; CSC has the necessary experience, processes, team members, and resources to successfully develop, implement, test, and execute an effective BCDR Plan for the Replacement MMIS in North Carolina.

F.5 – Ongoing Training

Ongoing Training for Operations is contained in Section D.4 (Training Approach) of this proposal.



Pages F.6-1 through F.6-5 contain confidential information.

F.6.2.1 Client Meetings (Formal/Informal)

Formal meetings are those scheduled by Contract Data Requirements List (CDRL) and require capture of the information discussed or presented. Team CSC management will assign an individual to capture the contents of the meeting, prepare a draft, present the draft to the designated NC DHHS individual for approval and publish the final on **NC***Tracks*. The archival storage for formal meetings is the section of the portal established for the retention of these meetings. Informal meetings are as important as formal meetings. Again, a scribe will be assigned and notes taken. It is important to capture all meeting information and assign action if required. Certain formal and informal meetings may result in issues that requires follow-up.

F.6.2.2 Written Reports

Written reports are those designated in the CDRL list. An example is the monthly report from the project manager to the NC DHHS staff. All assigned deliverables are also examples of written reports that require attention of upper management. Any correspondence that results as an outcome of the written report will become stored in the Archival vault with the original correspondence.

F.6.2.3 Informal Reports

An example of an informal report would be a call to a particular NC DHHS staff member on a system slowdown that has not affected the overall performance, but has the potential if immediate action is not taken. If the issue is resolved without an outage or a reportable slowdown, the information would be considered informal and so noted.

F.6.2.4 Senior Management Review

Senior management reviews, meetings of the Governance Council, Innovation Council, and the Team CSC Advisory Group are considered senior level reviews. Team CSC will record the minutes of these sessions and provide a transcript when required. Otherwise, the information presented will be captured, drafted, and forwarded to the appropriate NC DHHS for approval and then posted to **NC***Tracks*.

F.6.2.5 Internal Project Communications

Any scheduled or unscheduled meeting that is held for Team CSC personnel will be documented as stated above. Many times meetings are held in preparation for a formal meeting or a customer meeting. Information gathered during such meetings may or may not end up as a document requiring archival storage.

F.6.2.6 Meetings

Weekly meetings have proven especially effective in promoting clear direction, successful project management, and high team morale. Team CSC will assume responsibility for the meeting(s) and for documenting the results of these sessions. An agenda will be prepared and distributed prior to each meeting. A written report will be drafted and forwarded to the designated NC DHHS person for approval and placed in the appropriate place on the Replacement MMIS shared portal.

Daily, weekly, and some monthly scheduled meetings of team members will be the documented and kept in the team-only portion of the portal. If requested this information will be released to the appropriate customer organization.

F.6.2.7 Project Newsletters

When a project newsletter is prepared, it will be coordinated and approved prior to dissemination outside of the project. Once approved, the newsletter will be added to the appropriate community groups on the portal and be made available to the provider community as well as the various NC DHHS staffs.

F.6.2.8 Project Electronic Bulletin Boards

Community group areas of the Portal have been designed to place such information. It is designed to either post the information or for subscribers, pushed automatically.

F.6.2.9 Project Calendar

Team CSC will establish a Project Calendar which will identify major one-time and recurring project events. It may take several forms, such as a bulletin board, a project procedure manual, such that those who need to use it have adequate access to it. It also defines the procedures by which it is updated.

The Project Calendar will include such information as the frequency, date, time, normal agenda, and list of attendees for regular project status meetings; frequency and deadline for periodic time-and-expense reporting; and frequency of team operational performance reviews.

It will set specific times for reviews and reassessments of other important areas of the project, such as the Quality Plan, Communication Plan, and Risk Management Plan. The Project Calendar will also list other recurring or important project events, such as monthly information meetings, team-building activities, and training opportunities. It identifies major project events such as reviews, audits, requests for acceptance, and client presentations.

F.6.3 MEETING PROTOCOLS

For every formal meeting, an individual (by position) will be designated the Chair for the meeting. There will also be a secretary appointed for each formal meeting who will be responsible for obtaining the facility, sending out notice of the meeting (time and place), provide all required materials in sufficient time for review, and making all arrangement for electronic equipment, ample seating, etc. The secretary is also responsible to document the results of the session, prepare the draft and staff the draft for approval(s). Team CSC requires the following in order to conduct a successful meeting:

- Commitments/responsibilities expected from the State. Having the commitment from the State will facilitate meetings and ensure productivity.
- In the meeting agenda we will spell out what State approvals/requirements are expected before delivering a report/document.
- Meetings will have specific deliverable goals and will be measured by progress against those goals.

F.6.4 OPERATIONS COMMUNICATIONS PLAN

At a designated time during the DDI Phase, Team CSC will develop our Communications Plan for ongoing operations, following the requirements in the RFP and the specifications of the associated CDRL. Requirements will be specifically identified in the plan and appropriate communications activities identified. We will utilize the existing Communications Plan for DDI as a basis, with a view to continuing the processes and procedures that have proven most effective in managing communications during DDI. We will place strong emphasis on the continued use of the **NC***Tracks* capability and continuously seek to maximize its capabilities.

Team CSC managers will collaborate extensively with the State and our major constituencies and stakeholders to develop the detailed plan that will guide communications during Operations. The Communications Plan will include, at a minimum:

- Goals and objectives
- Roles and responsibilities
- Communications requirements
- Communication channels
- Entities with whom communications will be conducted
- Communications methods
- Types/frequency of communications
- Notification, documentation, archiving, and distribution policies and procedures
- Problem management and escalation procedures
- Portal content and management.

Team CSC will designate specific individuals who will be responsible for developing, maintaining, and executing the Operations Phase Communications Plan.

F.6.5 CONCLUSION

Our communications goal is an open environment in which we achieve total transparency of operations, fulfill or exceed communications, meeting, and reporting requirements and expectations, and implement sophisticated reporting capabilities, such as dashboards, that are readily accessible and contain up-to-the-minute status information. Team CSC is confident that we can satisfy the State's communications requirements as defined in this RFP and that we can continuously improve and refine our collaborative capabilities throughout the contract duration.

Pages G-1 through G-6 contain confidential information.

TITLE	Integrated Master Plan (IMP)	**CDRL NUMBER**	M0007
VENDOR	Computer Sciences Corporation		
TYPE OF DATA	Planning/Execution	**DATA RIGHTS**	State Material
FREQUENCY DUE	When Changed	**1ST SUBMISSION DATE**	With Proposal
METHOD OF DELIVERY	Electronic and paper with Proposal; electronic thereafter		
DESCRIPTION	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. • An event is a project assessment point that occurs at the culmination of significant project activities: accomplishments and criteria. • An accomplishment is the desired result(s) prior to or at completion of an event that indicates a level of the project's progress. • 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. 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 Team CSC 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. Changes to the IMP, other than minor clarifications, usually require a Contract change.		

TITLE	Integrated Master Schedule (IMS)	**CDRL NUMBER**	M0008
VENDOR	Computer Sciences Corporation		
TYPE OF DATA	Planning/Execution	**DATA RIGHTS**	State Material
FREQUENCY DUE	Monthly	**1ST SUBMISSION DATE**	With Proposal
METHOD OF DELIVERY	Electronic (MS Project)		
DESCRIPTION	The IMS describes a group of processes that focus on the scheduled day-to-day activities necessary to provide contractually required services. Processes include software testing and system engineering, monitoring the system, producing printed and electronic output, and performing daily activities related to database administration, backup and restoration, contingency and disaster recovery testing, training, and problem prevention. This document established dates and dependencies for item from the IMP, along with detailed tasks needed to complete DDI, Operations, and Turnover activities and milestones. The schedule will provide a minimum three-month projection for future DDI, Operations, and Turnover activities. Specific milestones are identified as those that: • Require NC DHHS acknowledgement or approval • Indicate completion of an activity that DHHS should know about or will enable DHHS to perform a related activity • Deliverables (CDRLs) to which DHHS must review or approve • Indicate start/end date of activities requiring DHHS performance		

TITLE	Project Management Plan (PMP)	**CDRL NUMBER**	M0009
VENDOR	Computer Sciences Corporation		
TYPE OF DATA	Planning/Execution	**DATA RIGHTS**	State Material
FREQUENCY DUE	When Changed	**1ST SUBMISSION DATE**	CA + 81 Days
METHOD OF DELIVERY	Electronic		
DESCRIPTION	The PMP defines how all project activities are executed, monitored, and controlled. It reflects 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 CSC-established policies, standards, guidelines, and procedures. Significant portions of the PMP 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 PMP references these documents rather than duplicating the information. EXECUTIVE SUMMARY 1. Project Management Plan Introduction 1.1 Purpose of the Project Management Plan 1.2 Document Organization 1.3 References and Relationships tom Other Documents 1.4 Project Management Plan Maintenance 1.5 Interrelationship of Project Plans 1.6 Integrated Project Management 2. Project Definition 2.1 Project Background 2.2 Project objectives 2.3 Project Scope 2.5 Key Project Requirements 2.6 Duration and Milestones 2.7 Budget and Funding Overview 2.8 Providing Resources 2.9 Deliverables (CDRL) and Work Products 2.10 Critical Success Factors and Associated Risks 2.11 Managing Risk 3. Roles and Responsibilities 3.1 Project Sponsor 3.2 Project Organization 3.3 CSC Oversight Organization 3.4 DHHS Organizational Responsibilities and Oversight 3.5 Other Stakeholders 3.6 Contractor Support 3.7 Organizational Environment for Integration 4. Project Management Approach 4.1 Facility and Resource Management 4.2 Administrative Controls and Standards		

	4.3 Tailoring Documents for Supporting Plans and Controls 4.4 Measurement and Analysis 4.5 Project/Milestone Reviews and Reporting 4.6 Productivity and Quality Management 4.7 Integrated Teeming 4.8 Project Estimation Overview 4.9 Decision Analysis & Resolution 4.10 Organizational Process Assets 5. Project Schedule and Resources 5.1 Summary of the Work Breakdown Structure (CDRL) 5.2 WBS Maintenance 6. Security and privacy Plan (CDRL) Attachment A - Acronym List Attachment B - CSC Team Charter Attachment C - CSC Team Staff Position Descriptions Attachment D - Stakeholder Involvement Matrix

TITLE	Risk and Issue Management Plan (RIMP)	**CDRL NUMBER**	M0010
VENDOR	Computer Sciences Corporation		
TYPE OF DATA	Planning/Execution	**DATA RIGHTS**	State Material
FREQUENCY DUE	When Changed	**1ST SUBMISSION DATE**	With Proposal
METHOD OF DELIVERY	Electronic and paper with proposal; electronic thereafter		
DESCRIPTION	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 will integrate management of risks and issues to allow the earliest practical identification and mitigation in order to minimize impacts. The plan also covers the application of the general process to this specific project in terms of major activities and roles and responsibilities. This plan includes 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.		

TITLE	Change Management Plan (CMP)	**CDRL NUMBER**	M0011
VENDOR	Computer Sciences Corporation		
TYPE OF DATA	Planning/Execution	**DATA RIGHTS**	State Material
FREQUENCY DUE	When Changed	**1ST SUBMISSION DATE**	CA + 81 Days
METHOD OF DELIVERY	Electronic		

DESCRIPTION

(Comment CSC618)

The CMP establishes the CM organization roles and responsibilities, policies, guidelines and procedures necessary for the Replacement MMIS System development, controlling and managing technical changes, and Fiscal Agent operations. The plan should describe the operation of the Change Control Board both during the DDI and Operations Phases. The guidance outlined in this plan will be incorporated into the engineering activities and management decision-making processes throughout the entire system life cycle from requirements identification to development to system operations and maintenance. The CMP will address the following:

1.0 CMP Introduction

A broad summary of the Plan's components and overall purpose

2.0 Objectives and Scope

A listing of the Plan's goals and the scope for which the Plan's change management action are formulated

3.0 Change Management Team

A description of the Team that will administer and implement the Plan, and how the Team will govern the Plan's execution. This section also reviews the relation of the Team to other Replacement MMIS project elements and to DHHS stakeholders.

4.0 Concepts

- Catalyst-driven change management concepts around which the Plan is developed
- Value systems that facilitate change
  - Resistance versus comfort with change
  - Incremental versus radical change

5.0 Functions/Roles

- Plan sponsorship
- Participants who contributed to development of the Plan, including any external stakeholders/organizations.
- Key change management roles and role descriptions
- Change initiator and receiver functions descriptions

6.0 Change Management Process

- Clarification of business goals with which the change management processes must align
- Assessment and analysis methods of:
  - Current state
  - Organizational redesign
  - Location
- Communication and education of change within Team, agency, and with stakeholders
- Methods for preparing change management team and relevant receivers for upcoming change

	7.0 Change Implementation • Managing the change as it is implemented: – Developing change-specific CMPs (actions, schedules, milestones, assessment, persons responsible, evaluation metrics for major changes) – Developing change-specific communication plan – Establishing sponsorship roadmap – Creating and assigning responsibility for change-specific coaching and training of change receivers (feeds into project Training Plan) ▪ Ensuring security risks of change are managed 8.0 Configuration Management • Identification of Configuration Classification and Taxonomy • Change Request Policy • Tracking Change Requests and related recommendations such a Recommended Improvement Opportunities • Requirements-Capabilities Traceability and Dependency Tracking • Configuration Review Board – Responsibilities and Decision Making Process • Configuration Change Dashboard and workflow for decision resolution and escalation • Change requests- responsibility, approvals, consultations, and informed reviews 9.0 Reinforcing the Change • Actions and schedules for assessing impacts of change • Other actions that reinforce change after implementation 10.0 Schedule • Summary of change-specific CMPs timetables and milestones 11. Metrics • Summary of change-specific metrics being collected, organized, and evaluated Feeding change-specific metrics into SLA performance data and evaluation

TITLE	Software Development and Systems Engineering Methodology	**CDRL NUMBER**	M0012
VENDOR	Computer Sciences Corporation		
TYPE OF DATA	Planning/Execution	**DATA RIGHTS**	State Material
FREQUENCY DUE	When Changed	**1ST SUBMISSION DATE**	CA + 81 Days
METHOD OF DELIVERY	Electronic		
DESCRIPTION	This document describes CSC's processes used for requirements analysis, design, construction, testing, deployment, documentation, quality assurance, and integration of software and hardware for the system. It also includes relationships of the methodology to risk and issue management as well as overall quality management. The document discusses development and deployment strategies as well as tools that are used for development or to improve efficiency and effectiveness. Software development and systems engineering planning and execution methods are discussed in this document, along with how technical and quality metrics are used to control and improve the process and products. The IMP identifies key events, accomplishments, and criteria for project-specific activities that are supported by this methodology.		

TITLE	Data Accession List (DAL)	**CDRL NUMBER**	M0013
VENDOR	Computer Sciences Corporation		
TYPE OF DATA	Planning/Execution	**DATA RIGHTS**	State Material
FREQUENCY DUE	When Changed	**1ST SUBMISSION DATE**	CA + 415 Days
METHOD OF DELIVERY	Electronic		
DESCRIPTION **(Comment CSC298)**	This document shall list all data (to include software) and documents that are not part of the critical design review that are created under this contract. The DAL shall include the data or document title, a description, the in-house release date, and the data rights associated with the item. The DAL is intended to identify data created in the performance of the Contract that are not considered deliverables. Software identified in the DAL may include one-time use test drivers not needed to maintain the final Replacement MMIS and other such software. *Note: Any data required for proper operation and maintenance of the system and for proper conduct of the Fiscal Agent operations will be identified in the CDRL rather than the DAL.*		

TITLE	Business Continuity/Disaster Recovery Plan (Final)	**CDRL NUMBER**	M0014
VENDOR	Computer Sciences Corporation		
TYPE OF DATA	Planning/Execution	**DATA RIGHTS**	State Material
FREQUENCY DUE	When Changed	**1ST SUBMISSION DATE**	CA + 172 Days
METHOD OF DELIVERY	Electronic		
DESCRIPTION	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 Fiscal Agent operations. Plan and processes documented in this plan shall be consistent with those identified in State requirements and referenced documents. Table of Contents SUMMARY 1.0 Plan Overview 2.0 Roles and Responsibilities 3.0 Notification and Communication 4.0 Preparation and Planning Processes 4.1 Contractor/State Partnership 4.2 Data Security and Privacy 4.3 Business Continuity Steps 5.0 Processes for Data Relocation and Recovery 5.1 Systems Management and Administration 5.2 System and Data Recovery 5.3 System and Data Restoration 6.0 Business Service and Process Relocation 6.1 Business Process Environment 6.2 Data Relocation 6.3 Relocation and Recovery Process 6.4 System and Data Restoration 7.0 Awareness and Recognition Training 8.0 Testing and Auditing Process 8.1 Types of Tests 9.0 Recovery Priority for Critical Resources 9.1 Recovery Time Objective (RTO) 9.2 Recovery Point Objective (RPO) 10. Response Plans for Epidemiological Disasters		

TITLE	Operations Management Plan (Final)	**CDRL NUMBER**	M0015
VENDOR	Computer Sciences Corporation		
TYPE OF DATA	Planning/Execution	**DATA RIGHTS**	State Material
FREQUENCY DUE	When Changed	**1ST SUBMISSION DATE**	March 16, 2011
METHOD OF DELIVERY	Electronic		
DESCRIPTION	The operations Management Plan strategically describes how the Fiscal Agent will successfully deliver and support all operational services. The plan clearly documents Team CSC's approach to operations and communicates and understanding of how it we will operate the Medicaid Fiscal Agent Contract. Roles and responsibilities of the Fiscal Agent and NC DHHS will be clearly delineated. The following areas will be included in the OMP, either by incorporating the topic in the document or referring to other stand-alone documents: • Strategic plan for operations • Process improvement • Quality management • Performance metrics • Operations management reviews • ITIL Alignment reviews • Change and configuration management • Risk and Issue Management Plan • Resource management • Security Plan • Disaster Recovery/Continuity of Operations Plan • Training Plan • Communications process/procedure (between Fiscal Agent and the State, providers, and citizens)		

TITLE	Program Performance Monitoring and Reporting	**CDRL NUMBER**	M0016
VENDOR	Computer Sciences Corporation		
TYPE OF DATA	Planning/Execution	**DATA RIGHTS**	State Material
FREQUENCY DUE	Monthly	**1ST SUBMISSION DATE**	CA + 933 Days
METHOD OF DELIVERY	Electronic		
DESCRIPTION **(Comment CSC720)**	The purpose of this report is to document the overall performance health of the NC Replacement MMIS program. The document outlines those performance areas that are monitored to pre-established standards. The aim of the document is to communicate project goals to all management levels and monitor program performance against those goals and alert management to approaching potential performance issues before they occur. Although performance will be monitored daily through using electronic tools and reported through the NC*Track* portal, summaries of project management scorecards and dashboards, and corrective actions taken in response to performance flagged as below standard during the month will be captured in this document. Specific topic monitored among others include: • Project technical metrics, analysis of trends, and corrective action plans • Significant technical progress/problems during the preceding period • Actual accomplishments in current reporting period • Planned accomplishments for the next reporting period • Issues requiring resolution • Status of all assigned action items • Current project risks and risk mitigation plans and activities • Contract status		

TITLE	Earned Value Management System Reports (DDI Phase)	**CDRL NUMBER**	M0017
VENDOR	Computer Sciences Corporation		
TYPE OF DATA	Planning/Execution	**DATA RIGHTS**	State Material
FREQUENCY DUE	Monthly	**1ST SUBMISSION DATE**	CA + 90 Days
METHOD OF DELIVERY	Electronic		
DESCRIPTION	This report shall describe the project status based on Team CSC's EVMS. At a minimum, this report provides earned value metrics with explanation of performance status, variances, corrective action plans, estimated cost to complete remaining work, and estimated cost at completion of work. Team CSC will use earned value management procedures in the performance of this contract that provide for: • Planning and control of cost and schedule performance • Measurement of performance (value for completed tasks) • Generation of timely and reliable information		

TITLE	Annual Survey Results Report	**CDRL NUMBER**	M0018
VENDOR	Computer Sciences Corporation		
TYPE OF DATA	Planning/Execution	**DATA RIGHTS**	State Material
FREQUENCY DUE	Annually	**1ST SUBMISSION DATE**	CA + 263 Days
METHOD OF DELIVERY	Electronic		
DESCRIPTION	Team CSC will conduct an annual customer service survey address aspects of Fiscal Agent 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 as specified by the State. Timing, content, scope and method of the survey will be directed by the State. Team CSC will document the survey findings including a summary and analysis and analysis of the data in the Annual Survey Results Report.		

Pages G-18 through G-32 contain confidential information.

TITLE	User Training Plan and Schedule	**CDRL NUMBER**	D0019
VENDOR	Computer Sciences Corporation		
TYPE OF DATA	Planning/Execution	**DATA RIGHTS**	State Material
FREQUENCY DUE	Annually or more frequently	**1ST SUBMISSION DATE**	CA + 689 Days
METHOD OF DELIVERY	Electronic		
DESCRIPTION	This document describes CSC's cohesive and responsive training program to ensure that all users can be efficient and effective while using the system, including CSC's staff, State staff, and external users – such as providers. The plan reflects 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 CSC will build and maintain the training environment. Additionally, it specifies the planned duration of implementation training rollout, including development of Desk Procedures (User Manual) for use in the Operations Phase. The plan specifies 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 describes the process used to identify and track training needs and to evaluate trainee feedback to improve course materials and methods. The Training Plan will be updated annually to address specific training activities for the upcoming year and shall be completed at least ninety days prior to the beginning of the Contract year.		

TITLE	Training Components (Media)	**CDRL NUMBER**	D0020
VENDOR	Computer Sciences Corporation		
TYPE OF DATA	Planning/Execution	**DATA RIGHTS**	State Material
FREQUENCY DUE	When Changed	**1ST SUBMISSION DATE**	CA + 841 Days
METHOD OF DELIVERY	Electronic		
DESCRIPTION	CSC will provide dedicated State/FA training specialists who will provide input to the development of Web Portal training materials such as CBT courses that will be available to these audiences in conjunction with instructor-led training courses in a location in accordance program requirements. 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. CSC will assess the training needs of State and FA users prior to implementation by meeting with subject matter experts for the different functions to be performed and will design training methods that will meet or exceed the established goals. The methods will include self-help tools such as CBT courses as well as instructor-led training courses to provide hands-on experience to users of the replacement system. The goal will be to insure efficient and effective use of the new system. FA staff will be tested for proficiency and the result reported to NC.		

TITLE	Training Evaluation Report	**CDRL NUMBER**	D0021
VENDOR	Computer Sciences Corporation		
TYPE OF DATA	Planning/Execution	**DATA RIGHTS**	State Material
FREQUENCY DUE	When Changed	**1ST SUBMISSION DATE**	CA + 659 Days
METHOD OF DELIVERY	Electronic		
DESCRIPTION	Team CSC will develop a 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. The training program will 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 Team CSC 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. Team CSC will conduct surveys and monitor training effectiveness among all user groups and prepare corrective action(s) for process improvement where indicated. All findings, corrective actions, and recommendations will be documented in the Training Evaluation report.		

TITLE	Fiscal Agent Desk Procedures Training Program	**CDRL NUMBER**	D0022
VENDOR	Computer Sciences Corporation		
TYPE OF DATA	Planning/Execution	**DATA RIGHTS**	State Material
FREQUENCY DUE	When Changed	**1ST SUBMISSION DATE**	CA + 841 Days
METHOD OF DELIVERY	Electronic		
DESCRIPTION	Team CSC will develop a Desk Procedures Training Program to ensure that all users can be efficient and effective while using the system, including the CSC staff, State staff, and external users– such as the providers. The training program will reflect the relative lead-time for the development of desk procedures 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 Team CSC will build and maintain the training environment. Additionally, it must specify the planned duration of the implementation training rollout during the Operations Phase. Team CSC will conduct surveys and monitor training effectiveness among all user groups and prepare corrective action(s) for process improvement where indicated. All findings, corrective actions, and recommendations will be documented in the Training Evaluation report.		

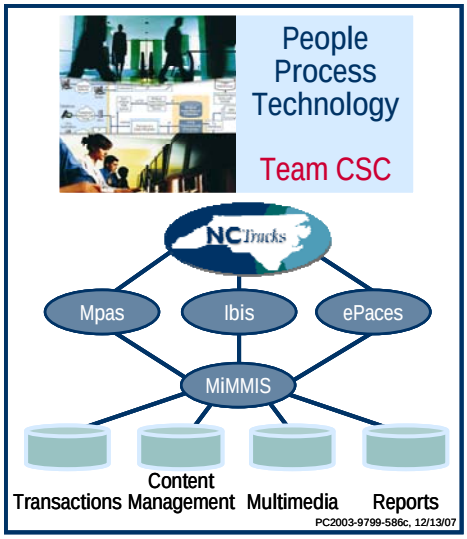
TITLE	Update System Documentation	**CDRL NUMBER**	D0023
VENDOR	Computer Sciences Corporation		
TYPE OF DATA	Planning/Execution	**DATA RIGHTS**	State Material
FREQUENCY DUE	When Changed	**1ST SUBMISSION DATE**	CA + 720 Days
METHOD OF DELIVERY	Electronic		
DESCRIPTION	This document lists the system documentation that is changed after a system update or release. It also details the significant changes by page so that the State can review just the changes. Changes in documentation will be attached to the change in requirement that necessitated the change. Some changes may require an entire revised document. All documents will be under configuration management control to ensure integrity.		

TITLE	Data Conversion and Migration Plan (Final)	**CDRL NUMBER**	D0024
VENDOR	Computer Sciences Corporation		
TYPE OF DATA	Planning/Execution	**DATA RIGHTS**	State Material
FREQUENCY DUE	When Changed	**1ST SUBMISSION DATE**	CA + 233 Days
METHOD OF DELIVERY	Electronic		
DESCRIPTION	The plan describes the processes that will be used to develop, execute, and maintain the Data Conversion and Migration Plan. The plan describes a comprehensive plan to convert and migrate all required data from the Legacy MMIS+ to the Replacement MMIS. It includes strategies and activities required to support development, testing, certification, and long-term operations. The IMP will identify key events, accomplishments, and data criteria. The plan will 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. The plan will 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 describes the roles and responsibilities of the parties involved in these activities.		

Pages G-36 through G-45 contain confidential information.

H — Security Approach

Team CSC's comprehensive solution to information security for the Replacement MMIS combines centralized security and project management, proactive risk governance, requirements traceability, and security administration (plans, policies, procedures, audit, accountability, training and awareness, etc.) at all levels of the systems infrastructure. This approach ensures a Replacement MMIS that is available, reliable and accomplishes its stated mission.



Team CSC will meet or exceed all of the security requirements of the RFP by working within the framework of the security methodology specified by NC State and Federal security mandates. Our work with State and Federal mandates for HIPAA compliance has made us an industry-leading Information Assurance (IA) provider. Team CSC will draw upon this experience in the Federal and State Health communities to develop specific security policies and procedures that limit risk for the Replacement MMIS. **Our security services will be customized to address your need for data privacy, data integrity, system confidentiality and availability, integrity, and an audit process and reporting mechanism that captures the information necessary for full accountability. We will work closely with you as we develop and implement our security solution. It is only through an open and honest partnership between Team CSC and DHHS representatives that we will ensure consistent approaches to security and privacy across all elements of the Replacement MMIS.**

Our Baseline System Security

In addition to 24x7 availability and robust processing capabilities, eMedNY has been designed with compliance of all HIPAA standards in mind: Transaction and Code Sets, Security and Privacy compliance, as well as the necessary preparation for future HIPAA requirements, such as unique identifiers for employers, providers and health plans.

CSC will leverage our corporate Global Security Services (GSS) capabilities and certified operations and facilities to meet or exceed the rigorous requirements defined by the State of NC for the Replacement MMIS. Our approach will establish an enterprise-wide, full life-cycle, federally compliant approach to information security. Team CSC will provide a constant and consistent level of information protection in proper balance with the Replacement MMIS operating environment, including NC*Tracks*.

Upon award and in partnership with DHHS, Team CSC will conduct an independent information security risk assessment and will implement a comprehensive security initiative to ensure that the Replacement MMIS is fully documented. We will also implement security initiatives that provide best practice processes for the protection of all data and information contained in the Replacement MMIS. These processes will ensure a consistent physical, logical and technical security barrier to protect the confidentiality of the Replacement MMIS sensitive data and provide data delivery

and performance commensurate with the DHHS mission. Team CSC will strictly monitor and control access to the CSC controlled Replacement MMIS facilities, data and systems. (**SOO 10.12.1-12)**

(10.12.1-12)

H.1 USE OF CURRENT INDUSTRY, STATE AND FEDERAL HIPAA SECURITY AND PRIVACY MANDATES

(40.1.2.12, 40.1.1.87, 40.14.2.28)

(40.1.2.12, 40.1.1.87, 40.14.2.28) During the DDI and operation phase, the Replacement MMIS system and associated facilities, hosted servers and applications will require well-defined security controls. We will implement these controls through the robust IT security infrastructure that incorporates compliance with the appropriate State and Federal regulations, statutes, and policies concerning the protection of personally identifiable health information and/or financial information. The compliance techniques, processes, and procedures identified throughout the security approach address the methodology that team CSC will utilize to satisfy the requirements specified by the many NC State and Federal Standards.

The State's business needs for security will be integrated into the Replacement MMIS system design through our requirements tracking application. This approach allows the introduction, tracking and final disposition of all system requirements, including security requirements, into a total system requirements database. **The processes for tracking, security risk mitigation, and enforcement the security requirements will be examined in their ability to support the confidentiality, integrity, authorization and availability objectives defined by the State of North Carolina Statewide Information Security Manual, the appropriate National Institute of Standards and Technology (NIST) and Federal Information Processing Standards (FIPS) including NIST 800-37, 800-53 as well as FIPS 140-2 for encryption, the North Carolina HIPAA Strategic Plan as it pertains to individually-identifiable health information (IIHI) and protected health information (PHI), DHHS OSP 2005, DHHS Application Security Policy, NC OSCIO 2004, Application Security Policy with Guidelines, and the DHHS Privacy and Security policies**. Security considerations and recommended control measures will be documented in the project management plan and specifications for implementation must be approved by DHHS. **(SOO 10.9-14)**

(10.9-14)

Team CSC recognizes that maintaining the confidentiality and integrity of recipient eligibility data (e.g., PHI/IIHI) is a high priority and will use an arsenal of state-of-the-art technical, physical and logical security measures, as well as processes and procedures to afford the best protection based on the sensitivity level of the information. These measures will conform to North Carolina State and Federal confidentiality laws and North Carolina data security standards. Our security approach will, at a minimum, meet all of the State and Federal standards cited in the RFP, without exception.

The Replacement MMIS will provide the 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. **(40.1.1.87)**

(40.1.1.87)

Team CSC will leverage the Federal Information Security Management Act (FISMA) compliant solution sets produced in accordance with NIST standards,

(10.9-14) **where applicable, and/or best practice procedures to enforce all DHHS security policies, standards, and guidelines for the Replacement MMIS. (SOO 10.9-14)**

H.1.1 SECURITY FEATURES INHERENT IN THE SYSTEM DESIGN AND OPERATION

(40.1.1.172) **(40.1.1.172)**

CSC considers Replacement MMIS data and facilities to be valuable assets integral to the performance of Replacement MMIS tasks. This consideration is the main impetus for setting security objectives. Anything that jeopardizes the security and availability of these assets, regardless of whether this means physical or logical denial, jeopardizes the ability to conduct business in a timely and efficient manner. The security features inherent in system design and operations will meet NC DHHS requirements and will:

- Ensure the integrity and accuracy of data.
- Provide for the privacy of proprietary, trade secret, personal, privileged, or otherwise sensitive data.
- Protect and preserve Replacement MMIS physical and logical assets from misappropriation, misapplication, conversion and vandalism.
- Protect employees and others from suspicion in the event that another individual defaults on his responsibilities.
- Segregate access to software resources, facility resources, computer functions, information resources (i.e. files), and physical resources (i.e. computer hardware).
- Protect production, development, and operating system resources against unauthorized disclosure, modification, or destruction.
- Provide a unique identification for each individual user of the system.
- Provide a means of identifying a specific user and of verifying that identification prior to granting that user access to any system data.
- (40.1.1.172) Provide capability to populate user / security profile related data for Web portal access prior to implementation **(40.1.1.172)**
- Provide a means of logging and reporting all unauthorized access attempts.
- Provide a means of logging all transactions that occur within the system in order to assign individual accountability for those transactions.
- Provide an audit trail within physical and data security controls.
- Support the efforts of internal and external auditors.
- Provide for a specific procedure for the investigation of all unauthorized access attempts.
- Provide a means of auditing management authorizations.
- Minimize interference with the day-to-day operations of the system.

To achieve the above objectives and protect Replacement MMIS assets a threat avoidance approach will be taken. Threats to Replacement MMIS can fall into three categories: data, physical and personnel. Below we discuss how our solution mitigates each threat. Sub-sequent sections of this document will provide more detail.

The security approach is also discussed in Section D.1.10 "Proposed Technical Architecture."

H.1.1.1 Mitigations to Threats

H.1.1.1.1 Threats to Data Assets

Virus Contamination
CSC will deploy virus protection software from a leading vendor. The software is deployed to all workstations and servers.

All entry points to the LAN will be firewalled and have an intrusion detection sensors. All email will be scanned for viruses inbound and outbound.

Impersonation
For all internal Replacement MMIS systems, all users will be issued a unique logon id and password. Passwords will be are required to be changed on initial logon. Passwords will have a maximum lifespan of 60 days and a history of the previous ten passwords is maintained so that they cannot be reused. At a minimum, passwords must be formatted to meet the C2 security level. Passwords will be encrypted in storage on the system and during the authentication procedure. Users are required to keep passwords confidential. Password policies and security awareness training keep users informed of their responsibilities. Security Awareness training includes training in Social Engineering techniques.

Network Tapping
Controls to mitigate network tapping include encryption of sensitive data that is transmitted, controlling physical access to the system, and utilizing network-monitoring tools.

CSC security services will regularly evaluate network security focusing on the defensive perimeter of the network, and the devices (firewalls, routers, etc.) that protect the network from attacks launched from outside the enterprise.

CSC will employ Intrusion Detection System (IDS) at all network gateways.

H.1.1.1.2 Threats to Physical Assets

Break In
Building access is controlled through use of an electronic card-key system. There are multiple access control points throughout the facility. Individuals assigned to the project are permitted access authorization commensurate with their position responsibility. Security personnel will be on site.

Fire
Facilities meet local fire code guidelines. Data center is steel construction. No flammable chemicals or materials will be stored within the buildings, and smoking will not be permitted in buildings. The emergency power generating system and its diesel fuel are external to the building and are located a safe distance from the general public

Power Outages
Outages mitigated through the use of onsite diesel generators.

Disaster (Natural or man-made)
Disaster recovery plan will be developed.

FM -200 Extinguishing Agent in Data Center
CSC has equipped the Albany Data Center with an FM 200 extinguishing system which causes no damage to equipment. It leaves no residue after discharge and therefore requires no cleanup.

H.1.1.1.3 Threats of Personnel

Employee Theft
Within any organization the possibility of employees stealing resources exists. Within the CSC facilities, employee theft could include physical property and/or confidential Medicaid data. These acts could be of malicious or criminal intent.

To mitigate, access to data will be restricted to those employees and third parties who have a need for that access. Access is further restricted to a level of access necessary for the user to complete their job function. All users will be required to sign a covenant against disclosure of sensitive data. Physical security measures will be in place, which limit the access users have to those parts of the facility that they require access to. Any equipment that a user is required to take off-site must be signed out with security administration.

Sabotage
The deliberate or accidental destruction of property is a high risk for today's businesses. Sabotage can take many forms including destruction of property, deletion of computer data, and introduction of computer viruses. Physical access to servers is restricted; access to all Replacement MMIS systems is limited to authorized users. A least privilege strategy will be enforced such that users have the minimum authorization to resources as appropriate for their job; no one user has access to all systems; all systems are backed up daily; backup tapes stored off-site.

H.1.1.2 Operations Environment

(40.1.2.3, 40.1.2.5, 40.1.2.10, 10.12.1-12)

(40.1.2.3, 40.1.2.5, 40.1.2.10) (SOO 10.12.1-12)
Team CSC will perform all operations, system maintenance and modification or other work under this contract at State-approved locations. Our facilities and sites, including our data center and any subcontractor locations, will comply with appropriate State and Federal privacy and physical safeguards. Proposed CSC operations facilities are discussed in Section D.2.2.

Our Raleigh office will be located within 15 miles of DHHS. The Raleigh facility will include secure, private office space for three NC State employees and shall include, without limitation, the office furniture and equipment specified in the RFP. Laptops and cell phones will be provided to traveling Fiscal Agent representatives that meet the security requirements of the Replacement MMIS System Security Plan (SSP).

The Data Center function conducted by CSC's NY organization is being performed in their current capacity as a Medicaid carrier and has been subject to the security requirements specified in their state of origin as well as other HIPAA requirements.

As such, this operation has complied with the requirements for certification, security plans, and disaster recovery plans and has participated in a number of audits by State and/or Federal agencies or their approved designee. The Raleigh, NC office space site will be configured to comply with DHHS specifications upon award of the contract.

H.1.1.3 Systems Environment Interconnection/Information Sharing

(40.1.2.92) **(40.1.2.92)**

The CSC facility in Raleigh NC will connect to the CSC Data Center in Albany NY via redundant point-to-point circuits provisioned through multiple carriers. This will ensure privacy, security and fault tolerance. Likewise, connections between the Disaster Recovery facility and the CSC Raleigh site as well as the CSC Albany site will be through redundant point-to-point circuits. All end-points will be firewalled and be monitored by intrusion detection/intrusion protection systems. Users at remote sites can connect to the infrastructure through an IPsec VPN. The infrastructure also includes a secure, fire-walled, intrusion detection/intrusion protected system protected gateway to the Internet.

The systems environment is described in detail in Section D.1.10 “Proposed Technical Architecture.”

H.1.1.4 Identification and Authentication

The Replacement MMIS will integrate with NCID identity management service. The user ID and Password scheme will be compliant with State policies. Likewise user ID and password management schemes will be compliant with State policy. Replacement MMIS user interfaces are presented in a thin client, Web browser. All interfaces which require a user login will be on Secure Socket Layer (SSL) encrypted connections only. No user ID or passwords will be conveyed in clear text on the network.

Any remote access to Replacement MMIS systems by authorized Team CSC staff will require two factor authentications over an IPSec VPN.

All secured Web sites security certificates will be obtained from industry accepted Certificate Authorities.

H.1.1.5 Authorization and Access Control

With the exception of public content available on the **NC***Tracks* portal, access to all Replacement MMIS systems is limited to authorized users. A least privilege strategy will be enforced such users have the minimum authorization to resources as appropriate for their role. Rights-trimming is practiced so that users only see functions they are authorized to use. No ‘greying’ out is needed.

As discussed above, Web based access to systems which require authorization will be on SSL encrypted connections. Messaging between Replacement MMIS servers will be encrypted using standard cryptography algorithms.

H.1.1.6 Administration

Extensive planning is exercised in developing the application and network architecture. The IT Security group is the sole organization chartered with security administration including user provisioning, patch management, intrusion detection,

Anti-Virus, log management, etc. Security administration will be logically segmented by roles such that no single user will have access to all Replacement MMIS systems.

NCID will be the single authority for provisioning and authentication of **NC***Tracks* users. To manage the granular role definition, a federated directory service will be implemented that will allow Team CSC to manage access roles using local directory services.

H.1.1.7 Audit

All Replacement MMIS servers and applications will be configured to generate audit logs. Audit logs will be monitored and reviewed on a daily basis. In addition to automated monitoring of audit logs, applications will be instrumented to generate alerts to the CSC Federal Management Center, described in Section D.2.1.5 "IT Services Delivery," when a significant security event is detected.

Network and host based intrusion detection and intrusion prevention systems will be deployed. Alerts are generated to the CSC Federal Management Center and appropriate action will be taken. Network operations and security operations functions, are segregated, such that security alerts will only be handled by security staff.

H.1.1.8 Security Zoning

A zone architecture is proposed. All communications between zones will be, by default, denied unless an explicit access is permitted. All public facing servers will be placed in a DMZ and all zones will be logically portioned by firewalls.

H.1.2 ENTITY-WIDE SECURITY PROGRAM PLANNING AND MANAGEMENT

(40.1.1.17, 40.1.1.18, 40.1.2.26, 40.1.2.35, 40.1.2.36, 40.1.2.42, 40.1.2.81, 40.1.2.84)

(40.1.1.17, 40.1.1.18, 40.1.2.26, 40.1.2.35, 40.1.2.36, 40.1.2.42, 40.1.2.81, 40.1.2.84) Team CSC understands the DHHS requirements for securing the Replacement MMIS systems and data. Team CSC, in partnership with DHHS, will provide a capability to implement the security standards of the Replacement MMIS operating environment. Information resources stored, transmitted and processed in the shared or dedicated operating environment will be protected in accordance with DHHS and Federal standards. Team CSC will implement appropriate security controls across the system environment in accordance with state, federal and industry standards and will maintain the Replacement MMIS environment with appropriate management and accountability. The Replacement MMIS will provide the capability for initial batch loading of security records and profiles prior to implementation.

As a primary requirement to meeting the management control requirements of the Replacement MMIS, Team CSC will centralize Replacement MMIS physical, personnel and cyber security services under the control of a single Security Manager. This Security Manager will report directly to the Replacement MMIS Program Manager.

In addition, during the predevelopment phase and prior to the DDI phase of the Replacement MMIS system, an overall requirements analysis will be conducted by the CSC NC MMIS Executive Account Director, the IT Technical Director, the IT

Services Delivery Manager, the Program Analyst, the Systems Security Manager, and other lead individuals as necessary. As part of this requirements analysis, the Replacement MMIS project management team will endeavor to incorporate security requirements, system integrity, confidentiality, and reliability requirements throughout every phase of the Replacement MMIS systems development life cycle (SDLC).

Specific areas that security requirements will be integrated into include:

- Facility security requirements
- Secure desktop and network operating systems
- Secure networks
- Virus Protection
- Risk Assessments and Risk Management
- Fault tolerance systems
- Tape backup systems and procedures
- Uninterruptible power supplies (UPS)
- Data Protection assurance
- Handling, marking and disposition of Sensitive and/or IIHI/PHI data
- Secured storage of sensitive data/information
- User access requirements
- Computer room security requirements

H.1.2.1 DDI Phase

During the development phase, the following tasks will be undertaken:

- Conceive and design system architectural plans
- Formulate plans for acquisition of systems
- Conduct Certification and Accreditation (C&A)
- Draft and finalize documentation for System Security Plans (SSPs), Disaster Recovery Plans (DRPs), Business Continuity Plans (BDPs), Security Risk Assessments (RAs), Standard Operating Procedures (SOPs), and other plans, policies, etc.
- Complete memorandums of agreement and understanding, etc.
- Plan for ongoing security related to full operations

H.1.2.2 Operations Phase

Security operations and administration of facilities and systems will be audited/monitored via the use of logging sheets and automated system audit logs. These log sheets and audit logs, at a minimum, will include:

- **Front door Sign in Sheet.** All visitors to the Replacement MMIS facilities, entering or leaving the operations area, will be required to sign in and out.
- **Server Room Sign in Sheet.** Everyone that is not previously authorized, entering the server room will be required to sign in and out

- **Server Activity Log.** Any and all activity performed on the Replacement MMIS servers will be logged.
- **System Logs.** Default logs will be monitored, saved and maintained on-line. Logs that will be included are:
  - Application Log
  - Security Log
  - System Log
  - Directory Service Log
  - Domain Name Server Log
  - File Replication Service Log
- **Backup Logs.** Backup activity for the Replacement MMIS will be maintained in a log separate from the application catalog.
- **System Messages.** System messages will be monitored, saved, and maintained on-line.

A key element of the CSC Team's security management solution will be a cohesive communication flow to and from the DHHS Secure One Communications Center (SOCC) which will be used to ensure that information about a critical situation is provided to the right personnel in the DHHS in a timely manner.

Team CSC's Replacement MMIS Security Manager will interface with DHHS security staff, the DHHS SOCC, and the Security Control Center (SCC) currently in place at the CSC Data Center. **The CSC SCC currently is manned 24 hours a day, seven days a week, and provides protection and surveillance for the CSC Data Center.**

Team CSC understands the importance of having effective, informed leadership available in emergency situations. In the event of any emergency or disaster, Team CSC's Replacement MMIS security personnel will be notified immediately of the need for their presence by the Security Control Center personnel. Team CSC's Replacement MMIS security personnel will be on call 24 hours a day in case of emergency. The CSC Data Center's SCC will maintain an up-to-date phone listing of all Team CSC and NC State Replacement MMIS employees.

Personnel Security Management

To protect Replacement MMIS data against potential threats relating to personnel security, Team CSC will implement and enforce a rigorous personnel security program. This security program will establish appropriate site-wide standards and guidelines (policies, plans, practices, procedures and training) for:

24x7x365 Coverage
• Security Control Center is currently manned 24x7x365 to provide continuous protection and surveillance of the CSC Data Center operations

- Ensuring the safety of all NC MMIS employees
- Performing security checks and background investigations
- Ensuring all employees are aware of Replacement MMIS security measures and the implications of security violations

- Developing a standard set of Rules of Behavior for ensuring that all employees are aware of their responsibilities under HIPAA
- Ensuring all employees are aware of the enforcement of DHHS policies regarding handling of sensitive information and PHI
- Performing appropriate follow-through in employee discipline matters when employee's actions have breached DHHS security policy/procedures
- Ensuring employee terminations result in access revocation

Security Training Management

Upon award of contract and assignment to the DHHS contract, Team CSC will indoctrinate and thoroughly brief all personnel on security requirements imposed by this contract. Employees will be reminded that security management for this contract rests with CSC. Team CSC will ensure that all contractor employees using DHHS automated systems or processing Replacement MMIS sensitive data receive the required annual Security Awareness Training. Contractors will also receive periodic training in security awareness, accepted security practices, and system rules of behavior. Security training will also include HIPAA Privacy Compliance training. Employees will not have exposure to PHI prior to receiving HIPAA Privacy Compliance training.

Team CSC's Security Manager will be responsible for notifying all team members immediately if there are any changes in the DHHS security policies, procedures, and directives. Changes will be reviewed by the NC MMIS security staff and disseminated to all Replacement MMIS personnel during mandatory, periodic, or security awareness briefings. Replacement MMIS employees will be provided an annual re-briefing on their security and privacy responsibilities. The Replacement MMIS Security Manager will ensure that all Replacement MMIS employees' complete company provided Security Awareness Training annually. An automated audit/reporting mechanism will be implemented to assist security personnel in the tracking of the security training requirement.

The CSC Team's Replacement MMIS security approach solution will adhere to all state, Federal and DHHS security policies and standards. Team CSC will make all information related to the Replacement MMIS, that is collected from any of the managed Replacement MMIS devices, available electronically or in hard copy to the DHHS SOCC or as requested. **Exhibit H.1.2** provides a summary overview of the Team CSC's security management approach to security and the resultant benefits to DHHS.

Security Approach	DHHS Benefits and Key Outcomes
• Provide 24x7x365 security monitoring • Leverage common Replacement MMIS shared security services and processes (DHHS SOCC) • Create a single CSC POC for information security issues and policy. Security Manager has full authority and responsibility for security related issues. • Support Replacement MMIS C&A activities, DR Plans, business continuity plans, and schedule tests as directed	• Reduces costs by reducing the resources spent reacting to cyber attacks. • Reduces cost by integration with the current DHHS SOCC, US-Cert and Patch and Alert Service • Single point of contact for security initiatives provides close collaboration with Replacement MMIS Security Management, system and security teams • Centralized Security Management resources for periodically scheduled requirements and tests
• Design and ensure the integrated set of targeted security	• Leverages FISMA-compliant solution sets in accordance with NIST

Security Approach	DHHS Benefits and Key Outcomes
services provides protection consistent with state, federal and organizational security policy	standards • Enforces all state, federal and DHHS security policies and standards including HIPAA • Provide policies, plans, practices, and procedures for NC MMIS personnel to follow
• Provide experienced, certified security specialists with skills in various disciplines to provide services that will configure, administrate, and monitor the security tools	• Centralizes patch notifications, updates, and reporting • Operates and manages security components • Documents, configures, and standardizes accredited security devices • Updates software, configuration files, signatures, hot fixes and patches • Life cycles new security components as required
• Leverage the CSC Security Centers of Excellence, and commercial security practices • Track emerging security technologies, products and their impacts to the target security architecture	• Reduces cost, training, and schedule by leveraging emerging technologies in support of the compliant target security architecture • Produces evaluation reports that provide security designs documents against data, network, and computing protection targets

9799-999

Exhibit H.1.2. Team CSC's Management Approach to Security. *We have the experience and commitment to protect sensitive recipient, provider and State information*

H.1.2.1 Security Risk Management

(40.1.2.26, 40.1.2.27, 40.1.2.29, 40.1.2.30, 40.1.2.37, 10.9-14)

(40.1.2.26, 40.1.2.27, 40.1.2.29, 40.1.2.30, 40.1.2.37) (SOO 10.9-14)

The focus of Team CSC's security risk management effort will be the annual security assessment, under the direction of the Security Manager, of those security threats and vulnerabilities that may jeopardize NC State assets and the vital Replacement MMIS functions or services. Team CSC will use those tools provided by NC State and the Federal Government to model and identify security threats, vulnerabilities, and risks as well as their impact to the Replacement MMIS system. This information will be used to develop mitigation strategies and justify the resources required to provide the appropriate level of response and prevention. The result of every risk assessment will be a report that will be used as a proactive management tool to direct and provide resources for the prevention testing and final protection strategy of critical Replacement MMIS assets and services.

(Risk Management Approach
• Team CSC's Security Risk Management approach will be an ongoing, periodic, iterative, and active process throughout the system life cycle

Our risk management process will adhere to the concept of proactive risk monitoring to assure continual system confidentiality, availability, and integrity. It will identify threats, define risks and implement strategies to mitigate the most critical risks. CSC's security risk management process includes the following steps:

- **Identify:** Threats and vulnerabilities
- **Analyze:** Analyze the risks to verify their validity and provide information about possible impact
- **Response Planning:** Determine how to react to or mitigate the risk
- **Monitor and Control:** Monitor risks and response actions through the use of automated tracking tools for verification of process

Security risk management policy and procedures will be developed per NIST SP800-30 and specifically tailored for the Replacement MMIS. The Replacement MMIS Security Manager will be responsible for the conduction of risk assessments within the DHHS-defined assessment periods. Subsequent risk assessments will be conducted with each Replacement MMIS release that may impact the security status or accreditation of the system. Risk assessments will identify vulnerabilities, threats, and residual risk to the mitigation strategies applied to the Replacement MMIS system per NIST SP800-30 guidance. Vulnerability scanning will be conducted on an DHHS-defined frequency, or when significant security advisories warrant (in accordance with NIST SP800-42). All vulnerability information will be shared with DHHS and prioritized and remediated per DHHS policy and NIST SP800-40. Identified risks will be analyzed for impact and consideration for remediation. Technical risks related to system defects (e.g., mis-configurations and patches) will be submitted for correction. Security risk and mitigation planning will meet DHHS and FISMA reporting requirements, to include the use of plan of action and milestones (POA&M) templates for remediation.

Exhibit H.1.2.1-1 depicts the initial and periodic, iterative process that will be used as the proactive security risk management process throughout the Replacement MMIS SDLC. Every, identified, vulnerability can have one or more identified areas of impact. For example, a single vulnerability can have a low impact on operations but a high impact on data integrity. These impacts are combined with the probability of occurrence to calculate the overall severity of the risk.

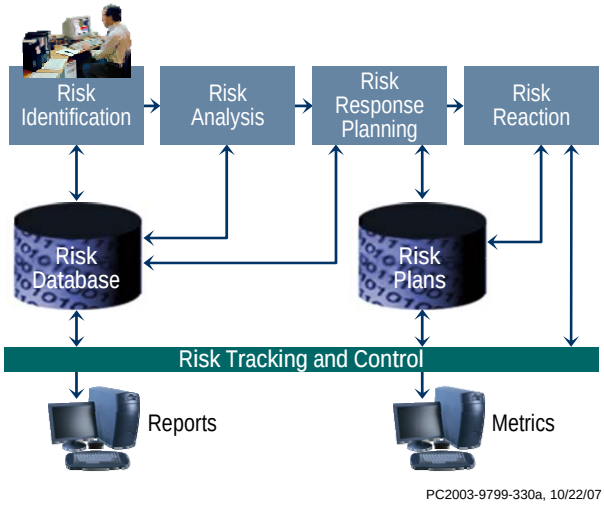


Exhibit H.1.2.1-1. Security Risk Management Process

Additional information about our risk approach is contained in our Risk and Issue Management Plan (RIMP) in Section E.7 of this proposal.

H.1.2.2 Data Protection Assurance

(40.1.1.17, 40.1.1.90, 40.1.2.28, 40.1.2.31, 40.1.2.32, 40.1.2.33, 40.1.2.34, 40.1.2.39, 40.1.2.49, 40.1.2.60, 40.1.2.61, 40.1.2.108)

(40.1.1.17, 40.1.1.90, 40.1.2.28, 40.1.2.31, 40.1.2.32, 40.1.2.33, 40.1.2.34, 40.1.2.39, 40.1.2.49, 40.1.2.60, 40.1.2.61, 40.1.2.108)

Team CSC recognizes that the Replacement MMIS information and data assets are highly confidential. These assets are the basis for our security services, and we are committed to assuring confidentiality and maintaining the highest level of integrity over those assets. By implementing encryption of all data in transit, we provide confidentiality for the data. By implementing and enforcing physical, logical and technical processes and procedures that provide highly restricted access and an audit trail of who has "touched" the data and what the final disposition of that information was, we enforce the integrity of the data. Our data integrity process will provide a capability for each record or file to be saved as created, not be overwritten by updates

or changes, in order that an historical review can be performed on each individually dated version. In addition, all data will be backed up on a periodic basis, to be determined by DHHS and Team CSC, in accordance with State and/or Federal standards. Data will be stored at a remote location, sufficiently distant from the production servers to prevent a simultaneous loss of both environments.

Team CSC will test the approach that will protect IIHI and PHI data, during both the DDI and Operations Phase of testing and conversion of legacy files. All information created, analyzed and otherwise handled by Team CSC employees and other Replacement MMIS personnel will be treated as an asset, and will be protected in accordance with its value. As always, Team CSC documents the processes and procedures in order to ensure a consistent treatment of the security requirement.

Data Security and Safeguarding

Team CSC will implement and administer information and data access controls, policies, procedures, and standards for the Replacement MMIS. Additionally, Team CSC also will implement a data security program that a will assist management in the physical protection of data and media, documents, files, tapes, disks, diskettes, and other materials from loss, destruction, or erasure during performance of their contractual obligations. Team CSC will use best practice technical mechanisms to protect computer resources and associated data against accidental or unauthorized modification, destruction, or disclosure. This security approach will use NC State requirements to establish appropriate site-wide standards and guidelines for data security safeguards pertaining to the Replacement MMIS. It will include:

- Coordinating the implementation and maintenance of data software and hardware
- Encryption of data transmissions that may contain IIHI or PHI; encryption of traveling laptops; there is also a capability to encrypt data that is stored or at rest
- Monitoring, detecting, reporting, and investigating breaches in computer security
- Providing consultation for technical and application development efforts involving computer data security and integrity issues
- Maintaining and updating a computer security manual specifically for use by those responsible for the security of their IIHI or PHI resources.
- Maintaining a working relationship with external auditors and assisting management when responding to matters involving security and control of IIHI or PHI information.
- Maintaining an awareness of existing and proposed legislation and regulatory laws pertaining to information system security and privacy
- Providing security awareness training, as needed, directed at the protection of information
- Implementing a User-Id and password administration that incorporates NC State current access system (NSID V6) requirements and provides translation to the mainframe that allows for granularity of access to information based on the individual employees role and ensuring that it is enforced across all platforms

- The Replacement MMIS provides on-line access to reports (based on role-based security), enabling downloads for export / import into multiple software formats and availability for use in multiple media
- Assignment of user/group access to Replacement MMIS resources including but not limited to applications, files, and data fields. (Users will have a role based access interface that only permits them to see the minimum amount of information necessary to do their jobs)
  - Each user will have a unique user ID profile combined with a 'strong' (specific schema and length) password
  - User IDs will be frozen if the correct login information is not entered within a set number of access attempts
  - Each user's password will expire after a set number of days based on a staggered schedule
  - Each user will have a profile within the security subsystem that controls or restricts access to specified applications and specified functions (inquiry or update) within each application.
  - Access controls will be developed that will prevent users from unauthorized access, copying, storing or otherwise manipulating data to which they have no rights.
  - Individual workstation security will be configured to ensure users' workstations are locked if the workstation is left unattended for a specified length of time.

Data Audit

Audit and accountability policy and procedures will be developed specifically for the Replacement MMIS using NIST SP800-61 guidance. Auditable events and content of audit records will be determined by interaction with NC State Replacement MMIS personnel. Performance issues will be considered during the process, but system and application level auditing must be sufficient to support after-the-fact investigations of security incidents. Any special circumstances warranting a temporary alteration of auditable events will also be documented. Audit storage capacity requirements will be determined by technical requirements resulting from these policy decisions.

The Replacement MMIS audit and accountability policy and procedures will describe what actions to take in what situations. NIST provides operating system- and application-specific checklists and implementation guides to assist with the initial implementation of the Replacement MMIS audit policy. **Auditing guidance from these checklists and implementation guides will be used as references, but DHHS-specific policies and operational needs will ultimately dictate implementation. Team CSC will monitor and review Replacement MMIS system and application audit records for indications of inappropriate or unusual activity. Investigation of suspicious activity or suspected violations will result in reports of the findings to appropriate officials, and the taking of necessary actions.**

At a minimum, security logs will be protected using write-once media, or role-based access controls and stored separately from system logs. Minimum audit retention periods will be determined by DHHS and NIST SP800-61 guidance. Retention periods will be sufficient to perform after-action investigations and collect forensic evidence as necessary.

Replacement MMIS systems and networks will generate audit logs that show addition, modification, and/or deletion of information. Audit logs will be protected from unauthorized modification, access, or destruction and will be recorded, retained, and regularly analyzed to identify unauthorized activity.

(10.12.1-26) CSC will cooperate with the State in respect to internal audits of operations and systems at any time deemed necessary by the State. **(SOO 10.12.1-26)**

H.1.2.3 Security Staff Organization

(40.1.3.1) **(40.1.3.1)**

The Replacement MMIS information security organization will be independent from IT operations and will be structured to integrate the Replacement MMIS security program across the organization. Team CSC will provide highly qualified staff who hold systems and security certifications such as Certified Information Systems Security Professionals (CISSPs), Security Institute (SANS) or Global Information Assurance Certification (GIAC) certified experts, and other systems (SysAdmin, Audit, Network specific), or product-certified engineers targeted to maximize DHHS investment in security technologies. These professionals will have broad experience in applying State and Federal Government specified requirements and industry best practices in real-world environments to safeguard the Replacement MMIS information confidentiality, integrity, and availability in a cost-effective manner. Team CSC will maintain documentation regarding the current license and certification status of individuals who are required to be licensed or certified throughout the life cycle of the contract.

To comply with DHHS information security standards, Team CSC will develop and implement an information security program for the Replacement MMIS program. Eddie Green, our dedicated Systems Security Manager will oversee all information security certification and accreditation activities and administer the information security program. This program will ensure that all security compliance requirements are evaluated against the Replacement MMIS Security Plan, State and Federal core security requirements, and IT controls. It also will ensure that they provide measurable reporting and tracking processes to reduce the risk of noncompliance. It will implement the conducting of a quarterly configuration (including patch management) audit of all Replacement MMIS hardware, software, and network security settings.

We will encourage all security staff to obtain appropriate security accreditations, obtain regular and systematic security training and knowledge, and participation in State, Federal and industry-wide security conferences and seminars.

Personnel responsibilities will vary by role for the Replacement MMIS system. Briefly outlined below are the duties and responsibilities for the proposed security personnel positions necessary to accomplish the security approach:

Security Personnel

CSC will provide properly cleared, certified security personnel targeted to maximize DHHS investment in security technologies

- **Security Manager.** The Replacement MMIS Security Manager will serve as the Replacement MMIS Senior System Security Officer. His/her duties have been previously identified, above.
- **Sr. Security Engineer.** The Sr. Security Engineer shall perform network vulnerability analysis and reporting. Perform network security monitoring and analysis, identify suspicious and malicious activities, identify and tracks malicious code (including worms, viruses, Trojan Horses, etc), enter and track events and incidents. In addition, he/she will review current Information Assurance (IA) policy, doctrine and regulations provide recommendations for consolidating or developing IA policy and procedures and apply knowledge of current IA policy to the State information security structure as related to the Replacement MMIS. The Sr. Security Engineer will be responsible for the testing and operation of firewalls, intrusion detection systems, enterprise anti-virus systems and software deployment tools. He/she will review and recommend the installation, modification or replacement of hardware or software components and any configuration change(s) that affects security. He/she will maintain data and communicate to management the impact caused by theft, destruction, alteration or denial of access to information.
- **Jr. Security Engineer.** The Jr. Security Engineer will have working knowledge of LANs, VPNs, Routers, firewalls and Intrusion Detection and Prevention Systems, as well as patch management and will be responsible for performing vulnerability scans using vendor utility tools. He/She will be responsible for monitoring user access processes and procedures to ensure operational integrity of the system. He/she will implement the information security configuration and maintain the system access processes for issuing, protecting, changing and revoking passwords. He/she will implement, enforce, and communicate security policies and/or plans for data, software applications, hardware and telecommunications; test and operate firewalls, intrusion detection systems, enterprise anti-virus systems and software deployment tools. He/she will also provide enforcement of security directives, orders, standards, plans and procedures at server sites as well as maintain data and communicate to management the impact caused by theft, destruction, alteration or denial of access to information on Replacement MMIS business and/or customers.
- **System Security Officer(s).** The Replacement MMIS SSOs will provide information assurance (IA) policy, procedures, and documentation support for the tasks associated with the Certification and Accreditation of the Replacement MMIS. They will provide support for tasks associated with the development of IA integrated technical solutions and operational support to current security programs as needed. Their expertise will focus on development and analysis of IA policy, plans and procedures. Additional expertise is required in the analysis and application of technical, management, and operational security controls.Functions

will also include gathering evidence on systems, analysis, and evaluation of threats and vulnerabilities. The providing of technical guidance and support for "best practice" approaches towards threat and vulnerability mitigation. They will provide functional support for the creation and maintenance of associated security documentation packages and bring operational policy and information assurance requirements into effective and logical solutions.

H.1.2.4 Performance Assessment and Audit

(40.1.2.30, 40.1.2.40, 40.1.2.41, 40.1.2.94 40.1.2.95)

(40.1.2.30, 40.1.2.40, 40.1.2.41, 40.1.2.94, 40.1.2.95)

Upon award, CSC, in coordination with DHHS staff will support the NC MMIS Certification and Accreditation (C&A) process for the NS Replacement MMIS. Team CSC will also assist in or perform an annual security assessment of the system as required by NS DHHS regulations and Team CSC's security personnel will support any additional ad hoc assessments deemed necessary by the DHHS.

Team CSC will provide the required security C&A proofs and support documentation for the Replacement MMIS infrastructure. We will support the Replacement MMIS C&A activities to adjudicate the certification and accreditation of the system.

As part of the C&A Process, Team CSC, in coordination with the DHHS, or its authorized representative, will analyze all Replacement MMIS related system activities to identify the hardware and software components to be evaluated, and generally support the scope of the required system certification and accreditation process.

Certification & Accreditation
C&A process will support the State with its annual Security Audit in accordance with Government Audit Standards and Information Systems Audit Standards.

The Replacement MMIS C&A documentation phase will focus on developing supporting documentation: a System Security Plan (SSP), a validated Security Requirements Traceability Matrix (SRTM), contingency plans, configuration management plans, incident response plan, security awareness and training plans, physical, cyber and personnel plans, etc. Team CSC will ensure that documentation complies with NS State, Federal and industry standards.

The documentation of the Replacement MMIS will establish the general support system baseline and be the basis of Team CSC's assessment process management. Documentation includes, at a minimum, the following:

- Develop, review policy and procedures, and document as necessary, in accordance with the DHHS Information Security Manual.
- Create and track Plans of Action and Milestones (POA&Ms), in accordance with regulations.
- (10.9-14) Document security testing and assessments, in accordance with DHHS Information security Manual. **(SOO 10.9-14)**
- Support the DHHS C&A and assessment process in accordance with appropriate regulations.
- Perform and document risk assessments.
- Provide documentation of management, operational, and technical controls IAW DHHS and NIST 800-53 requirements.

- Document security awareness training to all Replacement MMIS personnel.
- Document reports of audit of the Fiscal Agent performance, compliance, and system reviews.
- Contract with an independent qualified audit firm to perform a SAS 70 Audit and produce a SAS 70 Type 2 report. The audit and report will include the operations of the Fiscal Agent site as well as any other sites used by the Fiscal Agent for Replacement MMIS processing or related activities.

The C&A and assessment processes implemented for the Replacement MMIS will allow DHHS managers will assist the State in the annual Replacement MMIS security audits. The process will establish a baseline and permit a consistent, comparable, and repeatable assessment process for evaluation of security controls. It will promote a better understanding of the mission risks resulting from the operation and will assure the system's security controls are implemented correctly, operating as intended, and are producing the desired results. It will assess the magnitude of harm that could result from unauthorized access, use, disclosure, disruption, modification, or destruction of information. Finally, it will enable DHHS to comply with NIST 800-37 and NIST SP 800-53 requirements as well as support NC State auditors, or their authorized representatives, with the annual security audit.

H.1.2.5 Reporting

(40.1.2.43)

(40.1.2.43)

Replacement MMIS security reviews, assessments, audit information, etc. and their associated reports will be used to provide documentation of the project status as well as current and potential issues. They will allow tracking of requirements and mitigation strategies. These reports and associated documentation will be made available to CSC Replacement MMIS management and DHHS personnel. Team CSC will use the Replacement MMIS security reviews as well as the other reports to promote rapid identification and timely action for accomplishing DHHS technical and scheduled objectives. A primary tenet of our security management approach is to provide DHHS with visibility and input throughout the lifecycle of the contract. All Replacement MMIS security operations, management, and DHHS-specific security event information will be available to DHHS at all times. Our review and reporting structure supports this goal by integrating internal Team CSC with DHHS reviews.

H.1.3 ACCESS CONTROLS FOR THE SYSTEM AND FACILITY

(40.1.2.44, 40.1.2.45, 40.1.2.46, 40.1.2.47, 40.1.2.48, 40.1.2.49, 40.1.2.50, 40.1.2.52, 10.12.1-26)

(40.1.2.44, 40.1.2.45, 40.1.2.46, 40.1.2.47, 40.1.2.48, 40.1.2.49, 40.1.2.50, 40.1.2.52) (SOO 10.12.1-26)

The Replacement MMIS Security Manager will be responsible for ensuring the implementation the security guidelines established by industry, State and Federal standards to provide for the security of the Replacement MMIS. Access controls for the Replacement MMIS will include:

H.1.3.1 Physical Control of Replacement MMIS Facilities

Physical security is a key component of our approach to controlling access to the Replacement MMIS system and facilities. Our goal is to provide protection against a

well defined set of physical threats by providing security best practices that will resistance the would-be intruder's attack.

Upon contract award and prior to Replacement MMIS DDI and operations, an initial physical security survey will be conducted of the selected facility or facilities to determine what needs to be accomplished to bring it to the standards specified by the DHHS Security Requirements to protect Replacement MMIS personnel and assets. Team CSC will conduct a follow-up physical security survey before acceptance of the property or occupancy to ensure the completion of required modifications and security upgrades. In addition, periodic reassessments will be conducted to ascertain whether the security program continues to meet the minimum security safeguards required to protect Replacement MMIS data and assets, and to ensure the facilities are in compliance with DHHS fire and safety regulations.

Facility Security

The Replacement MMIS facilities will be configured as secured, trusted user/trusted sites and will have the following security controls to protect and safeguard Replacement MMIS sensitive information, assets and activities conducted at these facilities:

- Where possible, facility entrances will be locked and secure at all times. Entrances to Replacement MMIS operations areas will be configured with swipe card readers that record the time, date, user ID, before entrance into the facility is permitted.
- Facilities will be configured with an after hours physical intrusion detection system (burglar alarm system) consisting of electronic or magnetic door locks, motion detectors, glass break sensors. Where possible, security cameras will be used to augment the security parameter.
- Facility perimeter walls will be slab-to-slab walls.
- All facilities and security rooms will be prominently posted as restricted areas and will be separated from non-restricted areas by physical barriers that require additional controlled access.
- All security rooms will be limited to those individuals who routinely need access through the use of guards, ID badges, and/or entry devices such as key cards.
- All facilities will have procedures for verifying access authorizations before granting physical access (formal, documented policies, procedures, and instructions for validating the access privileges of an individual before granting those privileges). The appropriate management level will authorize (by signature) physical access to a facility or security room.
- A Site Security Administrator or Systems Security Officer will maintain the access authorization forms for each authorized individual and review the access authorization list with the appropriate managers monthly. These monthly reviews are to be documented in an Access Authorization Review Log and signed by the reviewing manager.
- All authorized staff will display ID badges at all times while in a secure facility or security room.

- Unauthorized personnel will be denied access to areas containing Replacement MMIS sensitive information via the use of restricted areas, security rooms, and locked doors.
- Tailgating – the act of following another authorized person entering a facility or security room will be prohibited.
- Non-authorized employees, visitors, delivery service, maintenance personnel will be required to sign a register or visitor sign-in log and will be escorted or monitored by authorized staff while in the facility or security room.
- All facilities and security rooms maintain will maintain a register or Visitor Sign-In Log that is used to record:
  - The visitor's name
  - Date
  - Time of entry
  - Time of departures
  - Purpose of visit
  - Person visited
- Visitor logs will also be used to record access for authorized staff that have lost or forgotten their access card, keys, or any other security identification mechanism.
- A Site Security Administrator or Systems Security Officer will close out the visitor sign-in logs at the end of each month and review them with the appropriate site manager monthly. These monthly reviews are to be documented in a Visitor Log Review Log and signed by the reviewing manager.
- All visitors will display a visitor or guest badge at all times while in a facility or security room.
- All facilities will be cleaned during working hours in the presence of a regularly assigned employee or staff person.
- For a restricted area, the identities of visitors will be verified, and a new authorized access list will be issued monthly.
- Managers will designate selected individuals who will be given the activation and deactivation codes for the security alarm system, as appropriate.
- The Site Security Administrator or Systems Security Officer will maintain a list of individuals who have the security system activation/deactivation codes and review and update the list monthly or more frequently as necessary.
- A Site Security Administrator or Systems Security Officer will ensure that the security system activation/deactivation codes are changed quarterly and each time an individual who has been given the activation/deactivation codes is terminated or transferred.
- All authorized staff that possesses a facility access card will be required to sign nondisclosure agreement regarding the material to which they have access.

- All authorized staff that possesses a facility access card must report a missing or stolen card immediately to the Site Security Administrator or System Security Officer.

- Where possible, facility access control systems will be automated and used to manage and authorize access to the facility. They will be used to provide weekly and/or monthly Facility Access Reports and maintain security audit logs.
- A Site Security Administrator or the Systems Security Officer will review the facility access reports at least once a month to determine whether suspicious or unusual activities have occurred. The Site Security Administrator or the Systems Security Officer will document the monthly review of the facility access reports in a Facility Access Review Log as well as document and report any unusual or suspicious activity to the appropriate managers.
- Emergency exit and re-entry procedures will exist for each facility to ensure that only authorized personnel are allowed to reenter restricted and/or other Replacement MMIS security areas after fire drills or other evacuation procedures.

Electrical Power Protection and Conditioning

Each Replacement MMIS server in the computer room at all Replacement MMIS facilities will be protected against power outages, brownouts, power spikes, and power surges with an uninterruptible power supply (UPS). UPS will be used to provide an orderly and systematic shutdown of the Replacement MMIS servers. The UPS will be configured to issue shutdown commands to the servers after a designated period following a power outage.

The proposed Replacement MMIS Data Center in New York is equipped with two one-megawatt diesel generators, which provide emergency backup power to our data center, and several other building areas including Com rooms 1, 2, & 3, Systems Development, the Executive Department, the Security Office, and Provider Services. The diesels are equipped with 2,000-gallon fuel tanks and are capable of running approximately 30 hours under the current load. CSC currently has a preventative maintenance contract with a local vendor. The diesels are maintained and serviced on a quarterly basis. The vendor also provides emergency back up service upon demand in the unlikely case it is needed. The diesels are tested and exercised automatically, on a periodic, scheduled basis.

Redundant Cooling System

Redundant air conditioning units will protect all Replacement MMIS Computer Rooms from cooling failure. These units will run independent of the office space air conditioning system.

Fire Safety

Team CSC will comply with all State and local laws with regard to fire protection and fire emergency procedures. Fire retardant capabilities, smoke detectors and electrical interruption/detection devices will be implemented to confirm to the NC State building requirements at all Replacement MMIS facilities. Fire Drills will be conducted, as required by Law, on a semi-annual basis. Fire emergency evacuation teams will be organized and trained in safe methods of evacuation. Fire extinguishers will be conveniently placed and identified in all Replacement MMIS facilities.

H.1.3.2 System Authorization Access Controls

(40.1.1.19, 40.1.1.20, 40.1.2.49, 40.1.2.50 40.1.2.51)

(40.1.1.19, 40.1.1.20, 40.1.2.49, 40.1.2.50, 40.1.2.51)

The Replacement MMIS is enterprise-ready. During the DDI phase, integrating the NCID Enterprise Service (version 7 (or later), Model 2) is easily facilitated by its service-oriented N-tier architecture that separates the user interface and access from business logic. Since the Replacement MMIS already employs role-based user access controls, it can be aligned with DHHS security access policies by reconciling State policies with CSC policies and adopting the more stringent requirements where they diverge. The role-based access control limits users to authorized functionality through the use of 'rights-trimming' (i.e., not displaying any functions not authorized to the user).

All authorized users of the Replacement MMIS solution will use the same browser-based interface to access all functionality and data of the Replacement MMIS. Since the access is browser-based it can be extended to any business community authorized by the State without additional programming beyond what is necessary for their particular purpose. The role-based security includes securing information or data down to the data element level.

During the operations phase, Team CSC will implement a Pega workflow process for user account provisioning. **As another example of our integrated solution, the workflow will reduce 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.**

H.1.4 MANAGEMENT OF APPLICATION DEVELOPMENT AND CHANGE CONTROLS

(40.1.2.51, 40.1.2.52, 40.1.2.53)

(40.1.2.51, 40.1.2.52, 40.1.2.53)

The essence of change control and management of application development is Configuration Management (CM). CM requires controlling data items through change management processes and configuration control functions as well as auditing to confirm that the control processes are working effectively. CM documents the behavior of it authorized users, their type of access (read, write, etc.).

Configuration management policies and procedures will be developed specifically for the Replacement MMIS to support its unique environment, criticality, and sensitive data. The Replacement MMIS Security Manager will provide system-level security oversight service for all CM activities to ensure that the CM will maintain a protected software library for baseline applications and configurations. Access to Replacement MMIS CM will be limited and changes monitored using access controls and auditing.

CSC will implement software security features that are commensurate with the CM control mechanisms to ensure the confidentiality of the sensitivity level of the Replacement MMIS data. The security controls selected will protect information resources from unauthorized access or modification.

Team CSC will ensure all Replacement MMIS application development software is tested, documented, and approved prior to promotion to production. Only specified

CM personnel will be permitted to effect the movement of application development software on the Replacement MMIS.

H.1.5 CONTROLS FOR PROTECTING, MANAGING AND MONITORING THE TECHNICAL ENVIRONMENT

(40.1.2.40, 40.1.2.54, 40.1.2.55)

(40.1.2.40, 40.1.2.54, 40.1.2.55)

Team CSC's proposed solution for protecting, managing, and monitoring the technical environment is a combination of audit, risk identification and assessment, risk management, and security administration encompassing the entire enterprise. Security administration is the implementation and refers to protecting diverse assets, such as information, technical resources, buildings, and personnel. The risk to any of these assets being compromised is what drives the security line of business.

H.1.5.1 Security Administration (Management)

Security Administration (Management) involves a model for delivering security services focused on performing daily activities to protect the critical assets identified above, detecting the related events, responding to and remediation of the problems.

Team CSC will use its information security framework described in the security approach to implement operational practices that will prevent any single individual from establishing control over the privacy, security, and processing of Replacement MMIS critical information and/or resources. Additionally, Team CSC specifically will provide DHHS with the following solutions for managing and monitoring the Replacement MMIS technical environment:

H.1.5.2 Auditing and Logging

Audit and accountability policy and procedures will be developed specifically for the Replacement MMIS using NIST SP800-61 guidance on computer security incident handling and audit log retention. Auditable events and content of audit records will be determined by risk assessments. Performance issues will be considered during the risk assessment process, but system- and application-level auditing must be sufficient to support after-the-fact investigations of security incidents. Any special circumstances warranting a temporary alteration of auditable events will also be documented (e.g., following a network attack). Audit storage capacity requirements will be determined by technical requirements resulting from these policy decisions.

Audit processing requires that the Replacement MMIS notify operators of audit failures and audit logs reaching capacity. The Replacement MMIS audit and accountability policy and procedures will describe what actions to take in these situations. NIST provides operating system- and application-specific checklists and implementation guides from various sponsors to assist with the implementation of the Replacement MMIS audit policy. Auditing guidance from these checklists and implementation guides will be used as references, but DHHS-specific policies and operational needs will ultimately dictate implementation. The CSC Team will monitor and periodically review Replacement MMIS system and application audit records for indications of inappropriate or unusual activity, investigation of

suspicious activity or suspected violations, reports of findings to appropriate officials, and the taking of necessary actions.

At a minimum, security logs will be protected using write-once media, or role-based access controls and stored separately from system logs. Minimum audit retention periods will be determined by DHHS and NIST SP800-61 guidance. Retention periods will be sufficient to perform after-action investigations and collect forensic evidence as necessary.

Replacement MMIS generates audit logs that show addition, modification, and/or deletion of information. Audit logs will be protected from unauthorized modification, access, or destruction and will be recorded, retained, and regularly analyzed to identify unauthorized activity. Unauthorized activities noted in any of the resources will be reported to the security manager for investigation and final disposition in accordance with the service level agreements established with DHHS for the Replacement MMIS.

Team CSC will implement and deploy the tools, toolsets, and staff to support, operate, maintain, and report the results of audit trail information obtained from critical Replacement MMIS resources.

H.1.5.3 Resource Management

Team CSC will implement and deploy the tools, toolsets, and staff to support, operate, and maintain resource management to include Firewall Management, Vulnerability Assessment, Patch Management, Anti-virus Service, Intrusion Detection/Prevention and Wireless Detection in accordance with State and DHHS standards. Team CSC will provide maintenance of necessary hardware/software upgrades and updates, and necessary replacements. We will test and deploy the latest patches and bug fixes as they become available and are approved by DHHS to ensure optimal performance of the hardware and software supported in accordance with Replacement MMIS mission.

Firewall management service will include firewall security scans capable of detecting open port vulnerabilities in order to ensure that the firewall is secure. These services will support complexity with respect to the Replacement MMIS LAN/WAN size, bandwidth, and speeds. It will provide Domain Name Server (DNS) and Simple Mail Transfer Protocol (SMTP) configuration support to ensure that the Replacement MMIS firewall is appropriately set up to handle DNS queries and mail traffic, as required. Team CSC will implement firewall policies in accordance with DHHS access requirements and include weekly and monthly trending reports and statistics.

H.1.5.4 Vulnerability Assessments

Team CSC will conduct vulnerability assessment services for the Replacement MMIS that will include network-based technical vulnerability assessments and penetration testing, Team CSC will use the industry-leading **Foundstone™** scanning tool for vulnerability assessments and security patch management for Windows/Unix systems.

H.1.5.5 Patch Management

CSC will develop procedures to ensure the timely and consistent use of security patches. Software patches addressing significant security vulnerabilities will be prioritized, evaluated, tested, documented, approved and applied promptly to minimize the exposure of un-patched resources.

H.1.5.6 Anti-Virus Service

Team CSC will provide anti-virus services to stop malicious code from entering the Replacement MMIS network. This service will include traffic scanning, anti-virus software/hardware, monitoring of anti-virus advisories, management, and maintenance.

H.1.5.7 Intrusion Detection

An Intrusion Detection System (IDS) will be deployed across the Replacement MMIS infrastructure that will consist of sensors on host and network devices. The IDS sensors will analyze the system for irregularities and for real-time monitoring of the system. It will be used to provide system administrators with a list of the different levels of risk activity monitored.

H.1.5.8 Wireless Detection System

Team CSC will deploy, operate, and maintain a wireless detection system within the proposed Replacement MMIS Data Center to enforce DHHS wireless security policies and regulations. It will support the critical security infrastructure of the Replacement MMIS for the protection of information assets from the myriad of threats enabled by the proliferation of wireless (IEEE 802.1.x) technologies. Team CSC uses the industry-leading **Air Defense™** tool for wireless security and operational support solutions.

The CSC Security Team will interface with the DHHS SOCC and service desk for security notifications (Information Security Vulnerability Management [ISVM]), incident response reporting, and remediation. Team CSC will provide DHHS with vulnerability information, scan summaries, device/host reports, and trend analyses.

H.1.6 CONTROLS FOR CONTINUING SERVICES AND ACCESS TO INFORMATION DURING AND AFTER MINOR TO DISASTROUS INTERRUPTIONS (SEE ALSO THE BUSINESS CONTINUITY/DISASTER RECOVERY PLAN)

(40.1.2.26, 40.1.2.38, 40.1.2.42)

(40.1.2.26, 40.1.2.38, 40.1.2.42)

The CSC Replacement MMIS Team will support Replacement MMIS disaster recovery plans, business continuity plans, and annual testing, as required. Our solution will implement security standards established by DHHS for its operational entities in addition to baseline NIST and HIPAA standards to meet the goals of preventing unauthorized access to and unauthorized alteration of Replacement MMIS data and information in the event of a disaster. Team CSC will test backup and recovery plans annually through simulated disasters and lower-level failures. We will also provide awareness training on recovery plans to fiscal agent personnel and DHHS staff.

Team CSC's security approach for continuing services and access to information during and after minor to disastrous interruptions is covered in detailed in *Section F.4., Business Continuity/Disaster Recovery Approach*

H.1.7 RESPONSES TO ATTACKS ON SECURITY AND ACTUAL BREACHES OF SECURITY

(40.1.2.29, 40.1.2.56, 40.1.2.57, 40.1.2.58, 40.1.2.59)

(40.1.2.29, 40.1.2.56, 40.1.2.57, 40.1.2.58, 40.1.2.59)

Team CSC will provide effective computer incident response support on a 24x7x365 basis. Initially, the CSC Computer Security Incident Response Team (CSIRT) will review the State's security infrastructure and develop the appropriate strategic plans in collaboration with DHHS. Team CSC will provide the people process, and technology to support a centralized, standardized, focused incident handling service for the Replacement MMIS.

The key element of Team CSC's solution is the CISCO MARS Security Information Management Systems (SIMS). Team CSC will integrate the SIMS tool with external and internal intrusion detection sensors, firewalls, and application logs. Depending on the security devices capability, Team CSC will use a reporting architecture that will "push" security information data via a combination of agents that are stored directly on the SIMS.

CSC understands that the State's workforce has the responsibility to report security incidents to agency management in accordance with statewide and agency standards, policies, and procedures. Agency management has the responsibility to report security incidents to the ITS Information Security Office, acting on behalf of the State Chief Information Officer, as required by N.C.G.S. §147-33.113 and in accordance with Standard 130101, Reporting Information Security Incidents, and Standard 130102, Reporting Information Security Incidents to Outside Authorities.

Team CSC's incident response capability for the Replacement MMIS will include identification, containment, eradication, recovery, and follow-up capabilities to ensure effective recovery from incidents. Incident response policies and procedures will be developed specifically for the Replacement MMIS to support its unique environment, criticality, and sensitive data in accordance with. NIST SP 800-61. Incident Response Training and Testing will be conducted and documented on an DHHS-defined frequency (at least annually) to ensure designated personnel are cognizant of their roles and responsibilities, and to verify the Replacement MMIS system's incident response capabilities perform effectively.

Lessons learned from ongoing incident handling activities will be incorporated into incident handling procedures. Incident reporting will be conducted in accordance with DHHS policy.

Incident Response will include the use of phones and pagers to contact the Replacement MMIS Security Manager, the DHHS SOCC, and other DHHS offices as required. Incident response and handling will be directed by the Replacement MMIS security manager; evidence gathering will be conducted at the direction of the DHHS.

environment, criticality, and sensitive data in accordance with. NIST SP 800-61. Incident Response Training and Testing will be conducted and documented on an DHHS-defined frequency (at least annually) to ensure designated personnel are cognizant of their roles and responsibilities, and to verify the Replacement MMIS system's incident response capabilities perform effectively.

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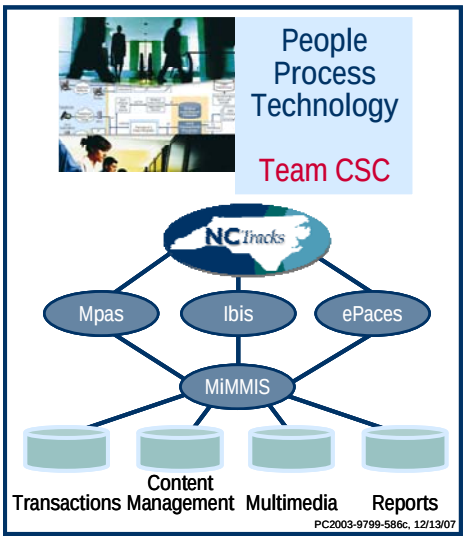
I — Turnover

Team CSC's turnover approach will ensure an uninterrupted and transparent turnover of the Replacement MMIS and Fiscal Agent operations to the successor Fiscal Agent. This will be accomplished through comprehensive advanced planning, extensive coordination with the State, and our expert staff dedicated to meeting our contractual obligations.



The completion of our contract for any reason would trigger several important events. The CSC Team understands that it is critical to the State of North Carolina that the providers and recipients of the Medicaid and other medical assistance programs continue to receive the services that they need to continue uninterrupted. In the event that DHHS notifies us that our contract will come to completion and that it will become necessary to turnover the Replacement MMIS system, the CSC Team will immediately mobilize the resources required to implement the draft Turnover Plan. We will make every effort to ensure that this impending turnover of responsibilities progresses without interruption of services and is conducted as transparently as possible to all parties concerned. **(SOO 10.12.2-1, SOO 10.12.2-3, SOO 10.12.2-4)**

(SOO 10.12.2-1, SOO 10.12.2-3, SOO 10.12.2-4)

The CSC Team will continue to actively demonstrate our professionalism and expertise during the Turnover Phase and fulfill our turnover responsibilities. As the incumbent Fiscal Agent, Team CSC remains committed to meeting all contractual obligations and to maintaining a strong working relationship with the North Carolina Department of Health and Human Services (DHHS). **(SOO 10.12.2-2, 50.2.9, 40.15)**

(10.12.2-2, 10.12.2-1, 40.15)

The Turnover Phase of the Replacement MMIS Contract is the final phase of our customer-focused service to the State and its stakeholders. During this period, the Replacement MMIS system and all technical and operational support activities will be relinquished to the successor Fiscal Agent. The successful completion of the Turnover Phase is just as critical as the Design, Development, and Implementation Phase and the Operations Phase to the CSC Team. During this stage, we take the necessary actions to professionally support a turnover that minimizes disruption to all North Carolina Medicaid stakeholders and program operations.

To achieve this end, Team CSC will pursue the following objectives for the Turnover Phase:

- Support a structured, controlled turnover to the successor Fiscal Agent by fully defining Team CSC roles, responsibilities, activities, and schedules
- Help prevent service disruptions for all NC stakeholders, including State agencies, interface agencies, providers, recipients, and system users

Pages I-2 through I-13 contain confidential information.

North Carolina Replacement Medicaid Management Information System (MMIS)

RFP Number: 30-DHHS-1228-08

Prepared for:
North Carolina Department of Health and Human Services

Office of Medicaid Management Information System Services

Prepared by:
Computer Sciences Corporation

30 May 2008
Volume I — Technical Proposal

Book 4 of 4
Sections J-K

Best and Final Offer

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BOOK 3

BOOK 4

List of Exhibits

List of Abbreviations

AARP	American Association of Retired Persons
ABEND	Abnormal Ending
ABTC	Asia Pacific Economic Council Business Travel Card
ACCP	American College of Clinical Pharmacy
ACD	Automatic Call DistributionDistributor
ACH	Automated Clearing House
ACII	Allergy and Clinical Immunology International
ACTS	Automated Collection and Tracking System
ACWP	Actual Cost of Work Performed
ADA	American Dental Association, American Diabetes Association, Americans with Disabilities Act of 1990 (US), American Dietetic Association
ADAO	Adult Developmental Disability Assessment and Outreach
ADC	Application Development Completion
ADCEP	Adult Developmental Disability Community Enhancement Program
ADD	Application Detailed Design
ADP	Application Design and Prototyping
AEDC	After Effective Date of Contract
AFTP	Anonymous File Transfer Protocol
AHF	American Hospital Formulary
AHFS	American Hospital Formulary Service
AHIC	American Health Information Community
AHIMA	American Health Information Management Association
AHIP	America's Health Insurance Plan
AIAN	American Indian Alaskan Native
AIDS	Acquired Immune Deficiency Syndrome
AIM	Application Implementation
AINS	Automated Information Notification System
ALM	Application Life-Cycle Management
AMCP	Academy of Managed Care Pharmacy
ANSI	American National Standards Institute
AP	Area Program, Accounts Payable

AP	Accounts Payable
APC	Application Preliminary Design
APEC	Asia-Pacific Economic Cooperation
API	Application Program Interface
AQT	Application Qualification Testing
AR	Accounts Receivable
ARA	Application Requirements Analysis
ASAO	Adult Substance Abuse Assertive Outreach and Screening
ASC	Accredited Standards Committee, Ambulatory Surgery Center
ASCDR	Adult Substance Abuse IV Drug User/Communicable Disease
ASCP	American Society of Consultant Pharmacists
ASHP	American Society of Health Systems Pharmacists
ASP	Automated Support Package
AV	Actual Value
AVRS	Automated Voice Response System
AVRU	Automatic Automated Voice Response Unit
AWP	Average Wholesale Price
BA	Business Analysis, Business Analyst
BAC	Budget at Completion
BCBS	Blue Cross Blue Shield
BCCM	Breast and Cervical Cancer Medicaid
BCP	Business Continuity Plan
BCWP	Budgeted Cost of Work Performed
BCWS	Budgeted Cost of Work Scheduled
BENDEX	Beneficiary Data Exchange
BI	Business Intelligence
BIA	Business Impact Analysis
BPEL	Business Process Execution Language
BPM	Business Process Management
BPMO	Business Process Management Office
BPMS	Behavioral Pharmacy Management System
BPO	Business Process Outsourcing

BRIDG	Biomedical Research Integrated Domain Group
BSD	Business System Design
BV	Budget Variance
C&A	Certification and Accreditation
C&KM	Collaborative and Knowledge Management
C&SI	Consulting and System Integration
CA	Computer Associates, Control Accounts
CA	Control Accounts
CAFM	Computer-Aided Facilities Management
CAM	Control Account Managers
CAP	Community Alternatives Program, Competitive Acquisition Program, Corrective Action Plan
CAP	Community Alternatives Program
CASE	Computer-Aided Software Engineering
CAT	Contingency Assessment Team
CBT	Computer-Based Training
CCAS	Certified Clinical Addiction Specialist
CCS	Certified Clinical Supervisor
CCB	Change Control Board , Configuration Control Board
CCB	Change Control Board
CCI	Correct Coding Initiative
CCM	Child Case Management
CCNC	Community Care of North Carolina
CCSP	Claims Customer Service Program
CDAO	Child Developmental Disability Assessment and Outreach
CDHP	Consumer Driven Healthcare Plan
CDHS	California Department of Health Services
CDISC	Clinical Data Interchange Standards Consortium
CDR	Critical Design Review
CDRL	Contract Data Requirements List
CDS	Controlled Dangerous Substance
CDSA	Children's Developmental Services Agencies

CDW	Client Data Warehouse
CEO	Chief Executive Officer
CERT	Comprehensive Error Rate Testing, Computer Emergency Readiness Team
CERT	Computer Emergency Readiness Team
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CHECK	NC State Departments of Health and Office of State Controller
CI	Configuration Item
CICS	Customer Information Control System (IBM)
CIO	Chief Information Officer
CISSP	Certified Information Systems Security Professional
CLIA	Clinical Laboratory Improvement Amendments, Clinical Laboratory Improvement Act
CLIN	Contract Line Item Number
CM	Configuration Management
CMM	Capability Maturity Model , Center for Medicare Management
CMM	Capability Maturity Model
CMMI	Capability Maturity Model Integration
CMOS	Configuration Memory Operating System
CMP	Change Management Plan
CMS	Call Management System, Centers for Medicare and Medicaid Services
CMS	Centers for Medicare and Medicaid Services
CNDS	Common Name Data System or Service
CNS	Comprehensive Neuroscience
CO	Contracting Officer
COB	Coordination of Benefit
COCC	Certificates of Creditable Coverage
COCR	County Options Change Request
COE	Center of Excellence
COOP	Continuity of Operations
COR	Contracting Officer's Representative
CORI	Criminal Offender Record Information

COS	Category of Service
COTR	Contracting Officer's Technical Representative
COTS	Commercial Off-the-Shelf
CP	Claims Processor, Communication Plan
CPA	Certified Public Accountant
CP	Claims Processor
CPAF	Cost Plus Award Fee
CPAR	Customer Performance Assessment Review
CPAS	Claims Processing Assessment System
CPE	Current Production Environment
CPFF	Cost Plus Fixed Fee
CPI	Cost Performance Index
CPM	Critical Path Methodology
CPR	Contract Performance Reporting, Cost Performance Report
CPR	Cost Performance Report
CPSW	Claims Processor Switch
CPT	Current Procedural Terminology
CPU	Central Processing Unit
CR	Change Request
CRIS	Clinical Research Information System
CRM	Customer Relationship Management
CRNA	Certified Registered Nurse Anesthetist
CROWD	Center for Research on Women with Disabilities
C-RUP	Catalyst Extended RUP
CRP	Conference Room Pilot
CS	Commercial Service
CSC	Computer Sciences Corporation
CSDW	Client Services Data Warehouse
CSE	Child Support Enforcement
CSIRT	Computer Security Incident Response Team
CSR	Customer Service Representative, Customer Service Request
CSSC	Customer Support and Service Center

CSV	Comma Separated Value
CTI	Computer Telephony Integration
CV	Cost Variance
CWBS	Contract Work Breakdown Structure
CWF	Common Working File
DA	Delivery Assurance
DAL	Data Accession List
DASD	Direct Access Storage Device
DAW	Dispense As Written
DB2	IBM Relational Database Management SsytemSystem
DBA	Database Administrator
DBAR	Disaster Backup and Recovery
DBMS	Database Management System
DCEU	Data Cleansing and Entry Utility
DCMWC	Division of Coal Mine Workers' Compensation
DCN	Document Control Number
DD	Developmental Disabilities
DDC	Drug Discount Card
DDI	Design, Development, and Implementation
DEA	Drug Enforcement AdministrationAgency
DEC	Developmental Evaluation Centers
DED	Data Element Dictionary
DEERS	Defense Enrollment Eligibility Reporting System
DEP	Release Deployment
DERP	Drug Effectiveness Review Project
DESI	Drug Efficacy Study Implementation
DHH	Department of Health and Hospitals
DHHS	Department of Health and Human Services
DHMH	Department of Health and Mental Hygiene
DHSR	Division of Health Service and Regulation
DIACAP	DOD Information Assurance Certification and Accreditation Process
DIRM	Division of Information Resource Management

DLP	Derived Logical Process
DMA	Division of Medical Assistance
DME	Durable Medical Equipment
DMECS	Durable Medical Equipment Coding System
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
DMERC	Durable Medical Equipment Regional Carrier
DMH	Division of Mental Health
DMH/DD/SAS	Division of Mental Health, Developmental Disabilities, and Substance Abuse Services – May be referred to as DMH
DMZ	Demilitarized Zone
DNS	Domain Name Server
DOB	Date of Birth
DoD	Department of Defense
DOH	Department of Health
DOJ	Department of Justice
DOL	Department of Labor
DOORS	Data Object Oriented Repository System
DOR	Department of Revenue
DPH	Division of Public Health
DPM	Deputy Program Manager
DR	Disaster Recovery
DRG	Diagnosis-Related Group
DSD	Detailed System Design
DSH	Disproportionate Share Hospital
DSR	Daily Service Review
DSS	Division of Social Services (organization within NC DHHS)
DSS	Decision Support System, Department of Social Services (as part of county government), Division of Social Services (organization within NC DHHS)
DSS	Decision Support System
DUR	Drug Utilization Review
EA	Enterprise Architecture
EAC	Estimate at Completion
EBM	Evidence-Based Medicine

EBP	Elementary Business Process
ECS	Electronic Claims Submission
EDB	Enrollment Database
EDI	Electronic Data Interchange
EDITPS	Electronic Data Interchange Transaction Processing System
EDMS	Electronic Document Management System
EDP	Electronic Data Processing
EDS	Electronic Data Systems
EEOICP	Energy Employees Occupational Illness Compensation Program
EFT	Electronic Funds Transfer
EHR	Electronic Health Record
EI	External Input , External Inquiry
EI	External Input
EIA	Electronic Industries Alliance
EIN	Employer Identification Number
EIS	Eligibility Information System
ELA	Enterprise License Agreement
EMC	Electronic Media Claim
eMedNY	New York MMIS
EMEVS	Electronic Medicaid Eligibility Verification System
EMR	Electronic Medical Record
ENM	Enterprise Network Management
ENV	Environment
EO	External Output
EOB	Explanation of Benefits
EOMB	Explanation of Medicaid(Medicare)(Medical) Benefits
EPA	Environmental Protection Agency
ePACES	Electronic Provider Automated Claims Entry System
EPAL	Enterprise Privacy Assertion Language
EPC	Evidence-based Practice Center
EPMO	Enterprise Program Management Office
EPMR	Executive Level Project Management Review

EPS	Energy Processing System
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment (Aaka Health Check)
EQ	External Query
ER	Emergency Room
ERA	Electronic Remittance Advisory
ERE	Estate Recovery Evaluation
ESRD	End Stage Renal Disease
ETC	Estimate to Completion
ETIN	Electronic Transmitter Identification Number
ETL	Extract, Transform, Load
ETN	Enrollment Tracking Number
EV	Earned Value
EVMS	Earned Value Management System
EVS	Eligibility Verification System
FA	Fiscal Agent
FADS	Fraud and Abuse Detection System
FAO	Fiscal Agent Operations
FAQ	Frequently Asked Questions
FARO	Finance and Reimbursement OfficerOrganization
FAS	Fiscal Agent Staff
FBI	Federal Bureau of Investigation
FBLP	Federal Black Lung Program
FCA	Functional Configuration Audit
FCAPS	Fault Management, Configuration, Accounting, Performance, and Security Management
FCN	Financial Control Number
FDA	Food and Drug Administration
FDB	First DataBank
FDDI	Fiber Distributed Data Interface
FedEx	Federal Express
FFP	Federal Financial Participation, Firm Fixed Price

FFP	Firm Fixed Price
FFS	Fee-For-Service
FFY	Federal Fiscal Year
FIFO	First-In/First-Out
FIPS	Federal Information Processing Standards
FISMA	Federal Information Security Management Act of 2002
FMAP	Federal Medical Assistance Percentage
FMC	Federal Management Center
FP	Function Point
FTE	Full-Time Equivalent
FTP	File Transfer Protocol
FUL	Federal Upper Limit
FYE	Fiscal Year Ended
GAAP	Generally Accepted Accounting Principles
GAO	General Accounting Office
GC3	Generic Classification Code
GCN	Generic Code Number
GEMNAC	Graduate Medical Education National Advisory Committee
GHS	Government Health Services
GIAC	Global Information Assurance Certification
GIS	Global Infrastructure Services
GUI	Graphical User Interface
GL	General Ledger
GMC	Global Management Center
GME	Graduate Medical Education
GMENAC	Graduate Medical Education National Advisory Committee
GMP	General Management Process
GNN	Generic Name
GSS	Global Security Solutions
GTEDS	GTE Data Services
H.E.A.T.	Hydra Expert Assessment Technology
HCC	Health Check Coordinator

HCCR	Health Check Coordinator Reporting
HCCS	Health Check Coordinator System
HCFA	Health Care Financing Administration (predecessor to CMS)
HCPCS	Healthcare Common Procedure Coding System
HCPR	Health Care Personnel Registry
HCSC	Health Care Service Corporation
HETS	HIPAA Eligibility Transaction System
HFMA	Healthcare Finance Financial Management Association
HHA	Home Health Aide
HIC	Health Insurance Claim
HICL	Health Insurance Contract Language
HIE	Health Information Exchange
HIGLAS	Health Integrated General Ledger and Accounting System
HIM	Health Information Management
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIPDB	Healthcare Integrity and Protection Data Bank
HIPP	Health Insurance Premium Payment
HIS	Health Information System
HIT	Healthcare Information Technology
HIV	Human Immunodeficiency Virus
HL7	Health Level 7 (Format and protocol standard)
HMA	Health Management Academy
HMO	Health Maintenance Organization
HP	Hewlett Packard
HPII	High Performance Image Import
HRSA	Health Resources and Services Administration
HSIS	Health Services Information System
HUB	Historical Underutilized Business
HW	Hardware
I/O	Input/Output
IA	Information Assurance
IAD	Incremental Application Development

IAVA	Information Assurance Vulnerability Alert
IAW	In Accordance With
Ibis	Integrated Business Information System
IBR	Initial Baseline Review
IBS	Integrated Business Solution
ICD	International Classification of Diseases , Iterative Custom Development
ICD	International Classification of Diseases
ICF-MR	Intermediate Care Facilities for the Mentally Retarded
ICR	Intelligent Character Recognition
ID	Identification
IDS	Intrusion Detection System
IEEE	Institute of Electrical and Electronics Engineers
IFPUG	International Function Point Users Group
IGN	Integrated Global Network
IIHI	Individually Identifiable Health Information
ILM	Information Life-Cycle Management
IM	Information Management
IMP	Integrated Master Plan
IMS	Integrated Master Schedule
Ind HC	Independent Health Care
IOM	Institute of Medicine
IP	Internet Protocol
IPGW	Internet Protocol Gateway
IPL	Initial Program Load
IPMD	Integrated Program Management Database
IPR	In-Progress Review
IPRS	Integrated Payment and Reporting System
IPT	Integrated Product Team
IRS	Internal Revenue Service
ISO	International Standards Organization
ISPTA	International Security, Trust and Privacy Alliance
ISVM	Information Security Vulnerability Management

IT	Information Technology
ITIS	Integrated Taxonomic Information System
ITF	Integrated Test Facility
ITIL	Information Technology Infrastructure Library
ITIS	Integrated Taxonomic Information System
ITS	Information Technology Solutions
IV&V	Independent Verification and Validation
IVR	Interactive Voice Response
JAD	Joint Application Development
JCL	Job Control Language
KE	Knowledge Engineer
KFI	Key From Imaging
KM	Knowledge Management
KPI	Key Performance Indicator
KPP	Key Performance Parameter
LAN	Local Area Network
LDAP	Lightweight Directory Access Protocol
LDSS	Local Department of Social Services
LEP	Limited English Proficiency
LHD	Local Health Department
LME	Local Managing Entity
LMFT	Licensed Marriage and Family Therapist
LOB	Line of Business
LOE	Level of Effort
LPA	Licensed Psychological Associates
LPC	Licensed Professional Counselors
LMFT	Licensed Marriage and Family Therapists
LPN	Licensed Practical Nurse
LST	Legacy Systems Transformation
LTC	Long-Term Care
MA	Medicare Advantage
MAAR	Monthly Accounting of Activities Report

MAC	Maximum Allowable Cost
MAR	Management and Administrative Reporting
MARS	Management and Administrative Reporting Subsystem
MARx	Medicare Advantage Prescription Drug Program
MAS	Medicaid Accounting System
MA-SHARE	Massachusetts — Simplifying Healthcare Among Regional Entities
MCE	Medicare Code Editor
MCHP	Maryland Children's Health Program
MCO	Managed Care Organization
MDCN	Medicare Data Communications Network
MDME	Medicare Durable Medical Equipment
MEQC	Medicaid Eligibility Quality Control
MES	Managed Encryption Service
MEVS	Medicaid Eligibility Verification System
MIME	Multipurpose Internet Mail Extensions
MiMMIS	Multi-Payer Medicaid Management Information System
MIP	Medicare Integrity Program
MIS	Management Information System
MITA	Medicaid Information Technology Architecture
MM	Meeting Minutes
MMA	Medicare Modernization Act
MMCS	Medicare Managed Care System
MMIS	Medicaid Management Information System
MOAS	Medicaid Override Application System
MOF	Meta Object Facility
MPAP	Maryland Pharmacy Assistance Programs , Medical Procedure Audit Policy
MPAP	Maryland Pharmacy Assistance Programs
Mpas	Multi-Payer Administrator System
MPLS	Multi-Protocol Label Switching
MPP	Media Processing Platform
MPW	Medicaid for Pregnant Women

MS	Microsoft
MSIS	Medicaid Statistical Information System
MSMA	Monthly Status Meeting Agenda
MSP	Medicare Secondary Payer
MSR	Monthly Status Report
MT	Management Team
MTBF	Mean Time Between Failures
MTF	Medical Treatment Facility
MTQAP	Master Test and Quality Assurance Plan
MTS	Medicare Transaction System
NAHIT	National Association for Health Information Technology
NAS	Network Authentication Server
NASMD	National Association of State Medicaid Directors
NAT	Network Address Translation
NATRA	Nurse Aide Training and Registry
NC	North Carolina
NCAMES	North Carolina Association for Medical Equipment Services
NCAS	North Carolina Accounting System
NCHA	North Carolina Hospital Association
NCHC	North Carolina Health Choice for Children
NCHCFA	North Carolina Health Care Facilities Association
NCID	North Carolina Identity Service
NCMGMA	North Carolina Medical Group Manager's Association
NCMMIS+	North Carolina Medicaid Management Information System (Legacy system)
NCP	Non-Custodial Parent
NCPDP	National Council for Prescription Drug Programs
NCQA	National Committee on Quality Assurance
NCSC	North Carolina Senior Care
NCSTA	North Carolina Statewide Technical Architecture
NC*Tracks*	North Carolina Transparent Reporting, Accounting, Collaboration, and Knowledge Management System
NDC	National Drug Code

NDM	Network Data Mover
NEDSS	National Electronic Disease Surveillance System
NEHEN	New England Healthcare EDI Network
NGD	Next Generation Desktop
NHA	North Carolina Hospital Association
NHIN	National Health Information Network
NHSCHP	National Health Service Connecting for Health Program
NIACAP	National Information Assurance Certification and Accreditation Process
NIH	National Institutes of Health
NIST	National Institute of Standards and Technology
NNRP	Non-Network Retail Pharmacy
NOC	Network Operations Center
NPDB	National Practitioner Data Bank
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
NPS	North American Public Sector
NSC	National Supplier Clearinghouse
NYeC	New York eHealth CollabortaiveCollaborative
NYS	New York State
O&M	Operations and Maintenance
O&P	Orthotics and Prosthetics
OAC	Office of Actuary
OBRA-90	Omnibus Budget Reconciliation Act of 1990
OBS	Organizational Breakdown Structure
OCI	Organizational Conflict of Interest, Organizational Change Implementation
OCR	Optical Character Recognition
OCSQ	Office of Clinical Standards and Quality
ODS	Operational Data Store
OIG	Office of the Inspector General
OLAP	Online Analytical Processing
OLTP	Online Transaction Processing
OMB	Office of Management and Budget

OMMISS	Office of MMIS Services
ONC	Office of the National Coordinator
ONCHIT	Office of the National Coordinator for Health Information Technology
OP	Operations Management Plan
OPA	Ohio Pharmacists Association
ORDI	Office of Research and Development
ORHCC	Office of Rural Health and Community Care
OS	Operating System
OSC	Office of the State Comptroller
OSCAR	Online, Survey, Certification, and Reporting
OTC	Over the Counter
OWCP	Office of Workers' Compensation Programs
P&L	Profit and Loss
PA	Prior Approval
PAC	Pricing Action Code
PAL	Prescription Advantage List
PASARR	Pre-Admission Screening and Annual Resident Review
PBAC	Policy-Based Access Control
PBC	Performance-Based Contract, Package Design and Prototyping
PBD	Package-Based Development
PBM	Pharmacy Benefits Management
PBX	Private Branch Exchange
PC	Personal Computer
PCA	Physical Configuration Audit
PCCM	Primary Care Case Management
PCP	Primary Care Physician , Primary Care Provider
PCP	Primary Care Physician
PCS	Personal Care Service
PDA	Personal Digital Assistant
PDC	Package Development Completion
PDF	Portable Document Format
PDP	Prescription Drug Plans

PDTS	Pharmacy Data Transaction System or Service
PDTS	Pharmacy Data Transaction Service
PEND	Slang for suspend
PERM	Payment Error Rate Measurement
PES	Package Evaluation and Selection
PHI	Protected Health Information
PHSS	Population Health Summary System
PIHP	Pre-Paid Inpatient Mental Health Plan
PIM	Personal Information Management
PIR	Problem Investigation Review , Process Improvement Request
PIR	Problem Investigation Review
PMB	Performance Measurement Baseline
PMBOK	Project Management Body of Knowledge
PMI	Project Management Institute
PML	Patient Monthly Liability
PMO	Project Management Office
PMP	Project Management Plan, Project Management Professional
PMP	Project Management Professional
PMPM	Per Member Per Month
PMR	Performance Metrics Report, Program Management Review, Project Management Review
PMR	Program Management Review
PMR	Performance Metrics Report
POA&M	Plan of Action and Milestones
POMCS	Purchase of Medical Care Services
POP	Point of Presence
POS	Point of Sale (Pharmacy), Point of Service
POS	Point of Service
PPA	Prior Period Adjustment
PQAS	Prior Quarter Adjustment Statement
PRE	Release Preparation
PreDR	Preliminary Design Review

PREMO	Process Engineering and Management Office
PRIME	Prime Systems Integration Services
PrISMS	Program Information Systems Mission Services
ProDR	Production Readiness Review
ProDUR	Prospective Drug Utilization Review
PRPC	Pega Rules Process Commander
PSC	Program Safeguard Contractor
PSD	Package System Design
PST	Production Simulation Test or Testing
PST	Production Simulation Testing
PV	Planned Value
PVCS	Polytron Version Control System
QA	Quality Assurance
QAP	Quality Assurance Plan
QASP	Quality Assurance Surveillance Plan
QC	Quality Control
QCP	Quality Control Plan
QIC	Qualified Independent Contractor
QMB	Qualified Medicare Beneficiary
QMO	Quality Management Organization
QMP	Quality Management Plan
QMS	Quality Management System
R&A	Reporting and Analytics
RA	Remittance Advice
RACI	Responsibility, Accountability, Coordination, and Informing Requirements
RADD	Rapid Application Development and Deployment
RAID	Redundant Array of Inexpensive Disks
RAM	Responsibility Assignment Matrix
RAS	Remote Access Server
RBM	Release-Based Maintenance
RBRVS	Resource-Based Relative Value Scale
RCA	Root Cause Analysis

RDBMS	Relational Database Management System
REMIS	Renal Management Information System
REOMB	Recipient Explanation of Medicaid Benefits
Retro-DUR	Retroactive Drug Utilization Review
RFI	Request For Information
RFP	Request for Proposals
RHH&H	Regional Home Health and Hospice
RHHI	Regional Home Health and Hospice Intermediaries
RHIO	Regional Health Information Organization
RIA	Rich Internet Application
RICE	Reports, Interfaces, Conversions, and Extensions
RIMP	Risk and Issue Management Plan
RM	Risk Manager
RMP	Risk Management Plan
RN	Registered Nurse
ROI	Return on Investment
ROSI	Reconciliation of State Invoice
RPN	Retail Pharmacy Network
RPO	Recovery Point Objective
RRB	Railroad Retirement Board
RSS	Really Simple Syndication
RTM	Requirements Traceability Matrix
RTO	Recovery Time Objectives
RTP	Return to Provider
SA	System Architect
SADMERC	Statistical Analysis Durable Medical Equipment Carrier
SAN	Storage Area Network
SANS	System Administration, Networking and Security Institute
SAP	Systems Acceptance Plan
SAS	Statement on Auditing Standards, Statistical Analysis Software
SCC	Security Control Center
SCHIP	State Children's Health Insurance Program

SD	Software Development, System Development
SD	Software Development
SDB	Small Disadvantaged Business
SDEP	Service Delivery Excellence Program
SDLC	Software Development Life Cycle
SDM	Service Delivery Manager
SE	Software Engineering, System Engineering
SE	Software Engineering
SEC	IT Security
SEI	Software Engineering Institute
SEPG	Software Engineering Process Group
SFY	State Fiscal Year
SIMS	Security Information Management Systems
SIT	Systems Integration Testing
SIU	Special Investigations Unit
SLA	Service Level Agreement
SMAC	State Maximum Allowable Charge
SME	Subject Matter Expert
SMR	Senior Management Reviews
SMTP	Simple Mail Transfer Protocol
SNIP	Strategic National Implementation Process
SOA	Service-Oriented Architecture
SOAP	Simple Object Access Protocol
SOB	Scope of Benefit
SOC	Security Operations Center
SOCC	Secure One Communications Center
SOO	Statement of Objectives
SP	Security Plan
SPAP	State Pharmacy Assistance Plan
SPI	Schedule Performance Index
SPOE	Service Point of Entry
SRR	System Readiness Review

SRT	Service Restoration Team
SRTM	Security Requirements Traceability Matrix
S*S	Sure*Start
SSA	Social Security Administration
SSL	Secure Socket Layer
SSN	Social Security Number
SSO	System Security Officer
SSP	System Security Plan
STD	Standard
STA	Statewide Technical Architecture
STD	Standard
STest	String Test
STP	Staffing Plan
SURS	Surveillance and Utilization Review Subsystem
SV	Schedule Variance
SW	Software
T&M	Time and Materials
TBD	To Be Determined
TCE	Training Center of Excellence
TCN	Transaction Control Number
TCO	Total Cost of Ownership
TCP	Transmission Control Protocol
TDD	Technical Design Document, Telecommunication Device for the Deaf
TDD	Technical Design Document
TED	TRICARE Encounter Data
TES	Time Entry System
TIA	Technical Infrastructure Acquisition
TMA	TRICARE Management Activity
TMOP	TRICARE Mail Order Pharmacy
TOA	Threshold Override Applications
TP	Turnover Plan
TPA	Third Party Administrator

TPAR	Transactional Performance Assessment Review
TPCI	To Complete Performance Index
TPL	Third-Party Liability
TRR	Test Readiness Review
TRRx	TRICARE Retail Pharmacy
TRScan	Transform Remote Scan
TSN	Transmission Supplier Number
TTY	Text Telephone
TxCL	Therapeutic Class Code
UAT	User Acceptance Test
UBAT	User Build Acceptance Test
UDDI	Universal, Description, Discovery, and Integration
UI	User Interface
UPC	Universal Product Code
UPIN	Unique Provider Identification Number
UPS	Uninterruptible Power Supply, United Parcel Service
UPS	United Parcel Service
UR	Utilization Review
URA	Unit Rebate Amount
USB	Universal Serial Bus
US-CERT	United States Computer Emergency Readiness Team
USD	Unicenter Service Desk
USI	User-System Interface
USPS	United States Postal Service
UT	User Testing
V&V	Verification and Validation
VAC	Variance at Completion
VAF	Value Adjustment Factor
VAN	Value Added Network
VAR	Variance Analysis Report
VAT	Vulnerability Assessment Tools
VoIP	Voice Over Internet Protocol

VP	Vice President
VPMS	Voice Portal Management System
VPN	Virtual Private Network
VSAM	Virtual Storage Access Method
WAN	Wide Area Network
WBS	Work Breakdown Structure
WEDI	Workgroup for Electronic Data Interchange
WFM	Workflow Management
WSDL	Web Services Description Language
WSMF	Web Services Management Framework
XAD	Accelerated Application Development
XAP	Accelerated Application Prototyping
XBD	Accelerated Business Process Design
XML	Extensible Markup Language
XPDL	XML Process Definition Language
XTC	Accelerated Timebox Completion

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Pages J.1-1 through J.1-34 contain confidential information.

Pages J.2-1 through J.2-85 contain confidential information.

J.3 FINANCIAL STABILITY

To support CSC's representations about its financial stability, we provide financial statements, annual reports and related information. CSC's two most recent Annual Reports containing the financial information requested by the RFP are included herein. However, given our size there is no single banking official who is responsible for CSC's affairs. As such, we are providing the name of CSC's Vice President and Treasurer, Mr. Thomas R. Irvin. His office is located at 2100 E. Grand Avenue El Segundo, CA., 90245. His phone number is 310.615.1745, fax number is 310.322.9398 and email address is trvin@csc.com.

CSC has not had any citations, fines or penalties, nor have there been any significant warnings by any governmental authority in the past ten years.

(Please see separate pdf files for CSC Annual Reports 2007 and 2006.)

J.4 REPLACEMENT MMIS ACCOUNT'S PLACE IN THE CORPORATE STRUCTURE

Just as the Replacement MMIS effort is vital to the State and to North Carolina's 1.7 million Medicaid recipients, it is a key undertaking for CSC. We look forward to building on our successful baseline system (eMedNY) and delivering excellence to the State. One illustration of our commitment to excellent performance is the prominent place the Replacement MMIS program will have in CSC's corporate hierarchy. As **Exhibit J.4-1** indicates, the North Carolina Replacement MMIS project has a prominent position within the CSC overall corporate structure. As a corporate organization with CMMI Level 3 certification, and ISO 9001 registered programs, CSC understands the criticality of placing large development, implementation and operations programs properly within the organization structure to ensure clear lines of authority and sufficient levels of direct and indirect oversight to ensure performance. Because CSC sees the North Carolina Replacement MMIS project as an enterprise-level program evolving to meet both planned and unplanned needs of the State, CSC maintains a constant organizational reporting structure within the corporation, regardless of the phase.

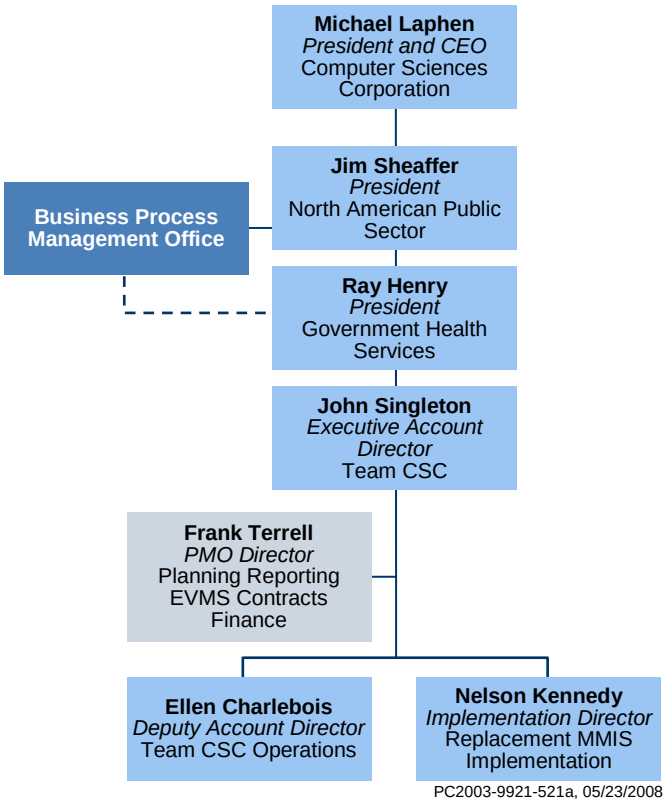

Exhibit J.4-1. MMIS Placement in CSC Corporate Structure. *The North Carolina Replacement MMIS project represents a strategically important opportunity to CSC. Its high placement within CSC's organization ensures appropriate support and oversight throughout the project's term.*

The North Carolina Replacement MMIS project is placed in the North American Public Sector (NPS) organization under Jim Sheaffer. Mr. Sheaffer reports directly to the CEO of CSC, Mr. Mike Laphen. Mr. Sheaffer will provide monthly, quarterly and annual formal reviews of both the DDI and Operations Phases of the Replacement MMIS project as a standard part of CSC

ongoing business practices. The day-to-day overall management and operations for the entire Replacement MMIS project will be provided by Mr. John Singleton, Vice President and Executive Account Director. Mr. Singleton reports directly to the President of the Government Health Services (GHS) Division, Mr. Ray Henry. Mr. Henry will provide daily and weekly ad-hoc oversight and formal monthly performance and financial reviews of all aspects of the Replacement MMIS DDI and Operational phases. Reporting directly to John Singleton are three two directors. Nelson Kennedy, Implementation Director, will lead the new Replacement MMIS Implementation tasks and activities. Ellen Charlebois, Deputy Account Director, leads the Fiscal Agent Operations supporting the DDI Phase and the Operations Phases. Mr. Frank Terrell serves as the Project Management Office (PMO) Director for all phases of the North Carolina Replacement MMIS project and provides an ongoing independent project monitoring function. **(SOO 10.12.1-5)**

Corporate-level and independent quality oversight will be provided by CSC's Business Process Management Organization (BPMO). CSC NPS understands that a strong business process engine, fueled by best practices and a continuous improvement mechanism, will drive increasingly improved business performance and provide maximum value and quality for our clients. Our approach is to achieve the highest possible performance through appropriate examination, diagnosis, and investment in our underlying business processes, in addition to traditional corrective actions. CSC NPS's Business Process Management Office (BPMO) was created specifically to focus on ensuring the excellent performance of our business processes. This commitment is built directly upon CSC's first management principle: "We commit to client satisfaction as our most important business objective".

The BPMO supports four operating directorates:

- Quality Management (QMO): QMO is the independent process execution review and compliance organization.
- Delivery Assurance (DA): DA provides an independent look at priority programs within NPS using the Delivery Assurance Review process.
- Sure*Start (S*S) / Process Deployment : Sure*Start is an integrated methodology service line which helps NPS programs get off to a successful start by coordinating the initial program transition to operations.
- Process Engineering and Management Office (PREMO): PREMO is responsible for the NPS process baseline, including management of the 1300 series ofrelated policies, as well as coordinating all NPS benchmarking activities, and providing business process consulting within the NPS operations.

The four BPMO organizations work together collaboratively and provideing an integrated set of products and services supporting the Replacement MMIS program operations throughout the lifecycle. The North Carolina PMO provides reports via the **NC***Tracks* web portal supporting the State's objectives reporting schedule, risk, project financial performance, EVMS, and issues to include information developed through the PMO and BPMO analysis. **(SOO 10.8-10)**

Page J.5-1 contains confidential information.

Pages K-1 through K-2 contain confidential information.