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

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Book 1 of 4
Sections A-D.1.13

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Table of Contents

BOOK 2

BOOK 3

BOOK 4

List of Exhibits

BOOK 1

BOOK 2

BOOK 3

Sec 50 Ref	Section 50 Requirement	Sec 60 Requirement	SOO Sec 10	Proposal Reference
50.2.2	**Proposal Submission Requirements Checklist** This section describes the information the Offeror shall include in Section B of the Proposal. Appendix 50, Attachment A of this RFP contains the Proposal Submission Requirements Checklist that each Offeror shall submit as part of the Technical Proposal. The completed Proposal Submission Requirements Checklist shall be included in this section of the Technical Proposal. Agreement or acknowledgement of a submission requirement shall be shown by writing "yes" or "no" next to the requirement	N/A (Pass/Fail)	N/A	B
50.2.3	**Executive Summary** The Executive Summary shall include a clear and concise summary of the Offeror's understanding of the project and the State's needs for a Replacement MMIS and Fiscal Agent services as defined in this RFP. This section shall also include a summary of the contents of the Technical Proposal. At a minimum, this shall include the Offeror's: • Understanding that this procurement is for the implementation of a multi-payer Replacement MMIS and that the Legacy MMIS+, as of the publication date of this RFP, is a multi-payer system for the NC DMA and DMH; • Understanding that the Offeror shall be required to expand the Replacement MMIS to include functionality and processing for additional NC DHHS divisions; • Understanding that the Offeror received Procurement Library information and is aware that updates will continue to be made available; • Commitments that are offered to the State in this Proposal; • Overall approach for this implementation (indicating whether it includes COTS, etc.) and the plans for the operation of the proposed system through the balance of the Contract; and • Proposed system's high-level functionality.	N/A (Pass/Fail)	10.1; 10.2 10.12	C
	High-Level System Functionality Matrix The Offeror shall complete the table in Appendix 50, Attachment B of this RFP. Based on the Offeror's review of the business areas addressed in Section 40 of this RFP, the Offeror shall provide high-level information relating its proposed system/product to each area's key functionality and the applicable requirement(s) met by the system/product. The Offeror shall enter the name of the product or system being proposed and list all systems/products related to the business area sequentially in alphabetical order. The Offeror shall enter a brief description of the functionality that the system or product addresses (e.g., enrollment, call tracking, etc.). If, in addition to meeting the State's requirements, this system/product offers additional benefit to the State, the Offeror may so designate in the Benefits column.	Included in the points allocated to 60.2 Technical and Operations Solution		
50.2.4	Proposed Solution Details	60.2 Technical and Operations Solution The extent to which the solution improves the State's current operations and has the capability to continue to foster future improvements in operations. The technical and operations solution includes the satisfaction of	10.2	D
50.2.4.1	Proposed System Solution and Solution for Design, Development, and Installation			D.1
50.2.4.1.1	Overview of System Solution and Solution for Design, Development, and Installation The Offeror shall describe the overall systems solution and design, development, and installation (DDI) strategy that includes: • A description of the baseline solution and how it addresses the system requirements; • A brief description of the approach for any customization/modifications required with the proposed approach;			D.1.2 D.1.3 D.1.4 D.1.4.1 D.1.4.2 D.1.4.3 D.1.4.4 D.1.4.5 D.1.4.6

Sec 50 Ref	Section 50 Requirement	Sec 60 Requirement	SOO Sec 10	Proposal Reference
	• A description of enhancements to the functional requirements stated herein that the proposed Replacement MMIS offers and why it is beneficial to the State; • A description of multi-payer issues that are critical to the success of the Replacement MMIS and how the Offeror shall manage such issues; • A description of all early implementations proposed and how they will be implemented to ensure continuity of current business operations; • A description of the work site(s) proposed to use for the work during the DDI Phase; • A description of the proposed technical architecture, including platforms and hardware, operating system(s), systems software, and development software, including the specifications that reflect alignment with the Statewide Technical Architecture (STA); • A description of any licensing and/or software/hardware support relationships with a third party and the general terms involved with any agreements, including limitations and constraints; and • A description of how the Offeror's solution minimizes the total cost of ownership for the proposed capability by explaining how the specific features of its approach will affect TCO. Offerors shall not provide specific estimates of TCO. The Vendor shall provide a warranty after final delivery of the system. The scope and duration of this warranty shall be identified in this Section of the Technical Proposal, and it shall include the repair of defects in system and non-system deliverables. A defect is defined as any aspect of deliverable's performance that does not meet its requirements.	requirements and goals, the system's architectural quality, and the Offeror's approach and staff skills in performing the needed Fiscal Agent operations in accordance with statutes as well as CMS and State regulations and policies.		D.1.4.7 D.1.4.8 D.1.4.9 D.1.4.10 D.1.4.11 D.1.4.12 D.1.4.13 D.1.4.14 D.1.5 D.1.6 D.1.7 D.1.8 D.1.9 D.1.10 D.1.11 D.1.12 D.1.13
50.2.4.1.2	Software Development and Systems Engineering Methodology The Offeror shall describe its software development and systems engineering methodology, including the State's role in its systems engineering processes. Reference the Software Development and Systems Engineering Methodology Contract Data Requirements List (CDRL) for additional information.		10.9	D.1.14
50.2.4.1.3	Data Conversion and Migration Approach The Offeror shall describe its Data Conversion and Migration Approach. While a Data Conversion and Migration Plan will contain details which may be unknown at the time of Proposal submission, the proposed Data Conversion and Migration Approach shall demonstrate that the Offeror's strategy will enable the fulfillment of all Business Data Conversion and Migration requirements and will be reflective of the content of the subsequent Data Conversion and Migration Plan to the extent practicable. Reference the Data Conversion and Migration Plan CDRL (Section 40.15 of this RFP) for additional information. The Offeror shall designate the proposed first submission date for the Business Data Conversion and Migration Plan.			D.1.15
50.2.4.1.4	Deployment/Rollout Approach The Offeror shall describe its Deployment/Rollout Approach. While a Deployment/Rollout Plan contains details which may be unknown at the time of Technical Proposal submission, the Deployment/Rollout Approach must demonstrate that the Offeror's Deployment/Rollout strategy will enable the fulfillment		10.6	D.1.16

Sec 50 Ref	Section 50 Requirement	Sec 60 Requirement	SOO Sec 10	Proposal Reference
	of all Deployment/Rollout requirements. The Offeror shall specify the proposed first submission date for the Deployment/Rollout Plan. Reference the Deployment/Rollout Plan CDRL (Section 40.15 of this RFP) for additional information.			

Sec 50 Ref	Section 50 Requirement	Sec 60 Requirement	SOO Sec 10	Proposal Reference
50.2.4.1.5	State Requirements Matrix Appendix 50, Attachment C, Exhibit I of this RFP contains all the requirements for the system's business areas as well as the operational requirements. The State us interested in knowing any requirements that are not in the baseline and requirements that exist in the baseline and require configuration and/or modification. The Offeror shall complete the table following the instructions below and submit the completed table in this section of its proposal. The Offeror shall identify in the columns provided each individual requirements that is not in the baseline or exists in the baseline and requires configuration and/or modification. The Offer shall complete Columns A-E for requirements that result in system capabilities (even if they are operational requirements). Valid values for columns A, B, C, and E are Y=Yes or N=No. Complete only Columns D and E for operational requirements for which there are no associated system capabilities. Note that a system capability that is in the Baseline System and does not require either manual configuration or software modification to meet the requirements would be marked with an "N" in Columns A, B, and C, and a "Y" in Column E. <u>Table Legend</u> (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.*			D.1.17
50.2.4.1.6	Adjusted Function Point Count Where a function point assessment can be made, the Offeror shall enter it in the table in Appendix 50, Attachment C, Part II of this RFP. This table must be filled out with the Offeror's estimated adjusted function point counts for the baseline system (application function point count), enhanced capabilities (enhancement function point count), and new capabilities (development function point count). For system requirements that do not translate well into function points (e.g., architectural standards, etc.) Offerors shall identify those requirements in the "Notes" field of the table. For third		10.5	D.1.18

Sec 50 Ref	Section 50 Requirement	Sec 60 Requirement	SOO Sec 10	Proposal Reference
	party COTS software Offerors do not need to count application adjusted function points but must be able to trace which requirements are satisfied by the COTS software.			
50.2.4.2	Operations			D.2
50.2.4.2.1	Proposed Solution for Operations The Offeror shall describe how it plans to meet the Operations Requirements outlined in Section 40 of this RFP. Information supplied in Section 50.2.6 of this RFP (Operations Management Approach) shall not be duplicated in this Section.	Included in the 20 points allocated to 60.2 Technical and Operations Solution	10.10	D.2.1 D.2.1.1 D.2.1.2 D.2.1.3 D.2.1.4 D.2.1.5 D.2.2
50.2.4.3	Statement of Work This section provides the format for and information required in the Offeror's SOW. The SOW shall cover all work required to satisfy the State's requirements throughout this RFP and external documents specifically referenced as requirements in this RFP. Offerors may propose work items that are not directly traceable to requirements in this RFP, and those shall be clearly marked as such. The SOW has no page limitation, but it shall not include information extraneous to the requirements for this Section. The SOW shall be all-inclusive of the work necessary to achieve the State's requirements. Other documents, particularly the Integrated Master Plan (IMP), also contain descriptions of the work being done; and the SOW may point to those documents, as appropriate, rather than duplicating information in multiple elements of the Technical Proposal. SOW sections associated with operations-based activities, (e.g., Operations, operations portions of Early Implementation, etc.) should be written as			D.3

Sec 50 Ref	Section 50 Requirement	Sec 60 Requirement	SOO Sec 10	Proposal Reference
	Performance Work Statements (PWS). The Offeror may divide the work in the SOW in any reasonable manner; however, work being done for DDI, Operations, Turnover, and Early Implementation Phases shall be separate. If the same type of work needs to be accomplished during each of these efforts, the Offeror shall list those work statements in each appropriate section.			
	Appendix 50, Attachment D of this RFP reflects the format for the SOW to be submitted in this Section of the Proposal.			
50.2.4.4	Training Approach The Offeror shall describe its Training Approach. While a Training Plan contains details which may be unknown at the time of Proposal submission, the Training Approach must demonstrate that the Vendor's training strategy will enable the fulfillment of all training requirements and reflect Training Plan contents to the extent possible. The Training Approach and subsequent Training Plan shall be inclusive of DDI and Operations for the Fiscal Agent, State, and Providers. The Offeror shall specify the first submission date for the Training Plan. Reference the Training Plan CDRL (Section 40.15 of this RFP) for additional instructions.		10.10	D.4
50.2.5	Project Management Plan Offerors shall describe how they perform planning and how they control execution via the use of cost, schedule, performance (scope and quality), staffing, risk, and issue metrics and reporting, as well as the methods they use to ensure the quality of these data. Offerors shall propose a plan for Project Management Reviews to include their planned content and frequency. Offerors shall identify those artifacts for which approval is important to the success of the project.		10.8	E.1
50.2.5.1	Integrated Master Plan The Offeror shall submit its IMP. Reference the IMP CDRL (Section 40.15 of this RFP) for additional information.	15 points 60.2 DDI Schedule The proposed schedule for Replacement Phase.		E.2
50.2.5.2	Integrated Master Schedule The Offeror shall submit its IMS. Reference the IMS CDRL (Section 40.15 of this RFP) for additional information.		10.5	E.3
50.2.5.3	Master Test Process and Quality Assurance Approach The Offeror shall describe its Master Test and Quality Assurance Approach. While a Master Test and Quality Assurance Plan (MTQAP) will contain details that may be unknown at the time of Proposal submission, the proposed Master Test and Quality Assurance Approach shall demonstrate that the Offeror's strategy will enable the fulfillment of all Master Test and Quality Assurance requirements. Reference the MTQAP CDRL (Section 40.15 of this RFP) for additional information.			E.4
50.2.5.4	Staffing Approach		10.10	E.5
50.2.5.4.1	Staffing Approach - DDI The Offeror shall provide its comprehensive Organizational Chart			

Sec 50 Ref	Section 50 Requirement	Sec 60 Requirement	SOO Sec 10	Proposal Reference
	for DDI and a description of its organization. The Offeror shall propose the positions and staff to be designated as key personnel for DDI. Offeror shall provide its Corporately Certified Position descriptions for the key personnel and résumé and references for any key personnel currently identified. The Offeror's Organization Chart for DDI is limited to two (2) pages. Position descriptions and résumés/references are limited as follows: one (1) page for each job description and three (3) pages for each résumé, including references for key personnel being identified. Appendix 50, Attachment I of this RFP is attached for information. With the exception of the positions the State has mandated as being key, these qualifications are being provided as guidelines.			
50.2.5.4.2	Staffing Approach—Operations The Offeror shall provide its proposed comprehensive Organization Chart for operations. The Offeror shall propose the positions to be designated as key personnel for operations and provide its Corporately Certified Position descriptions. The Operations Manager shall be identified in the proposal and his/her résumé and references submitted. For continuity, the State requires that the Operations Manager also serve in a key personnel position (to be proposed by the Offeror) upon the onset of DDI. The Offeror's Organization Chart for Operations is limited to two (2) pages. Job descriptions and résumés/references are limited as follows: one (1) page for each job description and three (3) pages for each resume, including references for key personnel being identified.	Included in the 20 points allocated to 60.2 Technical and Operations Solution		E.5
	Appendix 50, Attachment I of this RFP is attached for information. With the exception of the positions the State has mandated as being key, these qualifications are being provided as guidelines.	N/A		N/A
50.2.5.5	Communications Approach The Offeror shall describe its Communications Approach. While a Communications Plan will contain details which may be unknown at the time of Proposal submission, the proposed Communications Approach shall demonstrate that the Offeror's communications strategy will enable the fulfillment of all communications requirements and shall reflect its commitment to the development of a Joint Communications Plan (which involves the Vendor's preparation of a Communications Plan and then a collaboration with the State to prepare the Joint Communications Plan). Reference the Communications Plan CDRL (Section 40.15 of this RFP) for additional information. The Communications Plan shall cover only DDI.	Included in the points allocated to 60.2 Technical and Operations Solution		E.6
50.2.5.6	Risk and Issue Management Plan	60.2 Program Risk		E.7

Sec 50 Ref	Section 50 Requirement	Sec 60 Requirement	SOO Sec 10	Proposal Reference
	The Offeror shall submit its Risk and Issue Management Plan (RIMP). Reference the RIMP CDRL (Section 40.15 of this RFP) for additional information. The RIMP is also referenced on the Operations Management Section. Only one Plan, which encompasses DDI and operations, shall be submitted.	This includes risks affecting cost, schedule, and system and operational performance. Schedule realism will be evaluated as part of Program Risk.		
50.2.5.7	Initial Risk Assessment (Risk Profile) The Offeror shall submit an Initial Risk Assessment. This shall include risks identified by the Offeror affecting the Replacement, Operations, and Turnover Phases of the project. Reference the RIMP CDRL (Section 40.15 of this RFP) for additional information.			E.8
50.2.5.8	Change Management Approach The Offeror shall describe its Change Management Approach. While a Change Management Plan (CMP) will contain details which may be unknown at the time of proposal submission, the proposed Change Management Approach shall demonstrate that the Offeror's change management strategy will enable the fulfillment of all change management requirements and will be reflective of the content of any subsequent CMP to the extent practicable. Reference the CMP CDRL (Section 40.15 of this RFP) for additional information. Offerors shall propose a process that efficiently and effectively manages technical, programmatic, and operational changes within the overall program. The CMP is also referenced in Operations Management; however, only one CMP covering DDI and operations shall be submitted.	Included in the points allocated to 60.2 Technical and Operations Solution		E.9
50.2.6	Operations Management Approach The Offeror shall describe its Operations Management Approach and how it will succeed. While an Operations Management Plan will contain details which may be unknown at the time of Proposal submission, the proposed Operations Management Approach shall demonstrate that the Offeror's strategy will enable the fulfillment of all operations management requirements and will be reflective of the content of the subsequent Operations Management Plan to the extent practicable. The Offeror shall include a plan for operations management reviews, including frequency and general content. The Offeror shall designate the proposed first submission date for the Operations Management Plan. This Plan shall include the Communications Plan/Processes during operations. The Offeror shall describe how it will fulfill the primary requirements of Operations described in Section 40 of this RFP, including the provision of business continuity.	Included in the points allocated to 60.2 Technical and Operations Solution		F.1
50.2.6.1	Change and Configuration Management The Offeror shall describe its Change and Configuration Management Approach for Operations. This area in the Proposal shall not be duplicated. See Section 50.2.5.8 of this RFP.	N/A		F.2 E.9
50.2.6.2	Risk and Issue Management The Offeror's RIMP shall include operations as well as systems and DDI.	N/A		F.3 E.7
50.2.6.3	Business Continuity/Disaster Recovery Approach While a Business Continuity/Disaster Recovery Plan will contain details which may be unknown at the time of Proposal	Included in the points allocated to 60.2 Technical and Operations Solution		F.4

Sec 50 Ref	Section 50 Requirement	Sec 60 Requirement	SOO Sec 10	Proposal Reference
	submission, the proposed Business Continuity/Disaster Recovery Approach shall demonstrate that the Offeror's strategy will enable the fulfillment of all Business Continuity/Disaster Recovery requirements and will be reflective of the content of the subsequent Business Continuity/Disaster Recovery Plan to the extent practicable. Reference the CDRL and the Business Continuity/Disaster Recovery Plan CDRL (Section 40.15 of this RFP) for additional information.			
50.2.6.4	Ongoing Training The Offeror shall describe its approach to Ongoing Training in Section 50.2.5.5 of this RFP.	Included in the points allocated to 60.2 Technical and Operations Solution		F.5 D.4
50.2.6.5	Communications Process/Procedures The Offeror shall describe its Communications Approach for operations in Section 50.2.6 of this RFP. Reference the Communications Plan CDRL (Section 40.15 of this RFP) for additional information.	Included in the points allocated to 60.2 Technical and Operations Solution		F.6
50.2.7	Contract Data Requirements List The CDRL is a list of contract data requirements for the Replacement MMIS and is part of the contract. Reference the CDRL in Section 40.15 of this RFP. It contains specific requirements as identified by the State. The Offeror shall complete the CDRL with the additional data requirements it proposes. The State-identified CDRL referenced in other subsections within this Section 50 shall be addressed in their entirety within their respective Technical Proposal subsections. All other CDRLs identified by the State as well as those identified by the Offeror			G
50.2.8	Security Approach The Offeror shall describe its Security Approach. While the Offeror's Security Plan will contain details which may be unknown at the time of Proposal submission, the proposed Security Approach shall demonstrate that the Offeror's security strategy will enable the fulfillment of all security requirements and will be reflective of the content of the subsequent Security Plan. The Offeror shall designate the proposed first submission date for the Security Plan.	Included in the points allocated to 60.2 Technical and Operations Solution		H
50.2.9	Turnover Approach The Offeror shall describe the Turnover Approach. While the Turnover Plan may contain details that are unknown at the time of Technical Proposal submission, the Turnover Approach must demonstrate that the Offeror's Turnover strategy will enable the fulfillment of all turnover requirements and reflect the future Turnover Plan contents to the extent practicable. Reference the CDRL (Section 40.15 of this RFP) for the Turnover Plan. Offerers shall provide a warranty under which they will provide continuing system operational support to the incoming entity after expiration or termination of the Contract. Offerors shall propose the duration of this warranty, as well as terms that ensure that its expert staff will be on call for a sufficient amount of time to respond to questions or address any issues that arise during the warranty period. The successful Offeror will be	N/A		I

Sec 50 Ref	Section 50 Requirement	Sec 60 Requirement	SOO Sec 10	Proposal Reference
	responsible for communications to all stakeholders, interface agents, and the user community to present its plans to ensure the continuity of services.			
50.2.10	Corporate Capabilities	10 points 60.2 Corporate Capabilities and Financial Stability This includes an Offeror's strengths, capabilities, and overall experience, including corporate background and structure and financial soundness.		J
50.2.10.1	**Relevant Experience** The Offeror shall describe its overall corporate experience related to the objectives and requirements of this proposed Contract. This includes relevant MMIS experience; other health care claims processing experience; implementation and system maintenance of health care transaction replacement systems; Fiscal Agent operations experience; MMIS and other health care system experience; and multi-payer claims processing experience. Additionally, the Offeror shall specifically describe any other relevant projects that it believes establishes its ability to successfully complete the RFP requirements. Offerors shall specifically describe their experience with their replacement system; their experience, both implementation and operations, with the proposed replacement system and/or business areas; the success of the implementation and operations; and lessons learned from the experience.	15 points 60.2 Past Performance and Experience The Offeror's performance on previous projects of similar scope (e.g., health care and Medicaid-specific services).		J.1

Sec 50 Ref	Section 50 Requirement	Sec 60 Requirement	SOO Sec 10	Proposal Reference
50.2.10.2	**Summary Information Listing the Offeror's Corporate Relevant Experience** The Offeror shall provide a summary listing in a table format of all its contracts for MMIS and/or other health care claims processing for the last five (5) years. Appendix 50, Attachment E of this RFP contains the prescribed table format to use for Listing of Offeror's Corporate Relevant Experience.			J.2
50.2.10.3	**Financial Stability** The Offeror shall attach a copy of the entity's most recent two (2) years of independently audited financial reports and financial statements. The financial reports and financial statements pages from the auditing firm shall not be counted in the page limitation for this Section. The Offeror shall provide the name, address, and telephone number of a responsible representative of the Offeror's principal financial or banking organization. In addition, the Offeror shall include a disclosure of all judgments, pending or expected litigation, or other real or potential financial reversals that might materially affect the viability or stability of the proposing organization or any majority-owned subsidiary. Filings with the Securities Exchange Commission may be provided. If there are none, the Offeror shall represent that no such condition is known to exist.	Included in the 10 points allocated for 60.2 Corporate Capabilities and Financial Stability This includes an Offeror's strengths, capabilities, and overall experience, including corporate background and structure and financial soundness.		J.3
50.2.10.4	**Replacement MMIS Account's Place in the Corporate Structure** The Offeror shall describe how North Carolina's Replacement MMIS account shall fit into its business organizational structure during said account's DDI Phase and then during its Operations Phase. A business organizational chart(s) that details this shall be provided. The Offeror shall describe who in the organization has ownership and/or oversight of the performance criteria for the DDI Phase and how this oversight is managed and monitored.			J.4
50.2.10.5	**Damages and Penalties Accessed** The Offeror shall describe any damages, penalties or credits issued, individually in excess of one hundred thousand dollars ($100,000.00), that it or its majority-owned subsidiaries have paid, or which have been asserted against it or such subsidiaries, in the last five (5) years, including the date of each underlying claim and cross-referencing, as appropriate, to the contracts listed in response to Section 50.2.10.2 of this RFP. The Offer shall describe the circumstances of the claim and how it rectified the situation that caused the claim of the damages and/or penalties. When disclosing information pursuant to this Section 50.2.10.5, the Vendor may designate certain of its information as "Confidential" in accordance with Section 30.27.			J.5
50.2.11	Oral Presentations and Demonstrations The Offeror shall acknowledge in Section K of their Technical Proposal that they understand and agree to perform the requirements of the Oral Presentations and System Demonstrations as represented in this section.	N/A		A

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 Distribution
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

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
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 Voice Response Unit
BA	Business Analysis
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
CA	Control Accounts
CAFM	Computer-Aided Facilities Management
CAM	Control Account Managers
CAP	Competitive Acquisition Program
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	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	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 Amendment
CLIN	Contract Line Item Number
CM	Configuration Management
CMM	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
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	Certificate 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	Communication Plan

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
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
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 Ssytem
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 Administration
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
DSR	Daily Service Review
DSS	Division of Social Services (organization within NC DHHS)
DSS	Department of Social Services (as part of county government)
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 Fund Transfer
EHR	Electronic Health Record
EI	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
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 Aka 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 Detection System
FAQ	Frequently Asked Questions
FARO	Finance and Reimbursement Officer
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
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
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
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	Health Finance Management Association
HHA	Home Health Aid
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	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
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
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
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	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
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 Collabortaive
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
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 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
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	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

PMP	Project Management Professional
PMPM	Per Member Per Month
PMR	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)
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
PST	Production Simulation Testing
PV	Planned Value
PVCS	Polytron Version Control System
QA	Quality Assurance
QAP	Quality Assurance Plan
QASP	Quality Assurance Surveillance Plan
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
SCC	Security Control Center
SCHIP	State Children's Health Insurance Program
SD	System Development
SD	Software Development
SDB	Small Disadvantaged Business
SDEP	Service Delivery Excellence Program
SDLC	Software Development Life Cycle
SDM	Service Delivery Manager
SE	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
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	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
UI	User Interface
UPC	Universal Product Code
UPIN	Unique Provider Identification Number
UPS	Uninterruptible Power Supply
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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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.

11/5/08

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** DHHS 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	DATE: 5/23/08	E-MAIL: **dsagner@csc.com**	

CEII 11/5/08

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

May 2, 2008

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: 3

Questions and Answers on Updated Requirements

PURCHASER: Susan W. Lewis

USING AGENCY: NC DHHS

OPENING/TIME: N/A.

INSTRUCTIONS:

1. Two (2) properly executed copies of this Addendum shall be included with your Proposal.
2. This Addendum contains changes in specifications.
3. Acknowledgement of receipt of letter titled "North Carolina Replacement MMIS Updated Requirements," dated April 18, 2008 which shall be considered part of this Addendum DK (initials)
4. Acknowledgement of receipt of letter titled "North Carolina Replacement MMIS Updated Requirements," dated May 1, 2008 which shall be considered part of this Addendum DK (initials)
5. Execute Addendum:

Bidder: Computer Sciences Corporation

Authorized Signature: Dianne R. Sagner Date: 5/23/08

Name and Title (Typed or Printed): Dianne R. Sagner
Contracts Manager

11/5/08

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

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

...y/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
...ommission expires June 30, 2009

BID ADDENDUM

August 17, 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: 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

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 17, 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: 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

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

September 4, 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: 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

INSTRUCTIONS:

1. Two (2) properly executed copies of this Addendum shall 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 17th day of December, 2007
by Christina L McKenzie
Notary Public
CHRISTINA L. MCKENZIE
My commission expires June 30, 2009

BID ADDENDUM

September 4, 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: 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

INSTRUCTIONS:

1. Two (2) properly executed copies of this Addendum shall 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 14 day of December, 2007
by Christina L McKenzie
Notary Public
CHRISTINA L. MCKENZIE
My commission expires June 30, 2009

BID ADDENDUM

September 11, 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: 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

INSTRUCTIONS:

1. Two (2) properly executed copies of this Addendum shall be included with your Proposal.
2. This Addendum contains questions from potential Offerors and DHHS's responses and changes in specifications.
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

September 11, 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: 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

INSTRUCTIONS:

1. Two (2) properly executed copies of this Addendum shall be included with your Proposal.
2. This Addendum contains questions from potential Offerors and DHHS's responses and changes in specifications.
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

September 17, 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: 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

INSTRUCTIONS:

1. Two (2) properly executed copies of this Addendum shall 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

September 17, 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: 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

INSTRUCTIONS:

1. Two (2) properly executed copies of this Addendum shall 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

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

INSTRUCTIONS:

1. Two (2) properly executed copies of this Addendum shall be included with your Proposal.

2. This Addendum contains questions from potential Offerors and DHHS's responses and 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

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

INSTRUCTIONS:

1. Two (2) properly executed copies of this Addendum shall be included with your Proposal.
2. This Addendum contains questions from potential Offerors and DHHS's responses and changes in specifications.
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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

October 26, 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: 7

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

BID ADDENDUM

October 26, 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: 7

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 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: _____ 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 _____

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

BID ADDENDUM

October 26, 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: 8

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 _____

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

BID ADDENDUM

October 26, 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: 8

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 17th day of December, 2007
by Christina L. McKenzie
Notary Public

CHRISTINA L. MCKENZIE
My commission expires June 30, 2009

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
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

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: 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

November 28, 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: 10

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 _____
_____ 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

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: 10

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

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 _____
Notary Public

CHRISTINA L. MCKENZIE
My commission expires June 30, 2009

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 _____
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 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 20th 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: 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 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: 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

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.

Mark E. Johnson — 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 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 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.)

CONTRACT NO. (RFP 30-DHHS-1228-08-R)
COMPUTER SCIENCES CORPORATION

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.

Mark E. Anderson — Director of Contracts

Signature — Title

Computer Sciences Corporation — December 20, 2007

Agency/Organization — 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

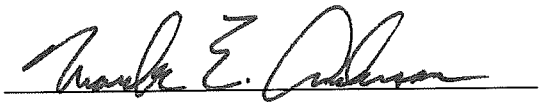
1. When an organization seeks reimbursement for indirect costs, total lobbying costs shall be separately identified in the indirect cost rate proposal and thereafter treated as other unallowable activity costs in accordance with the procedures of subparagraph B (3).
2. Organizations shall submit, as 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 20th 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
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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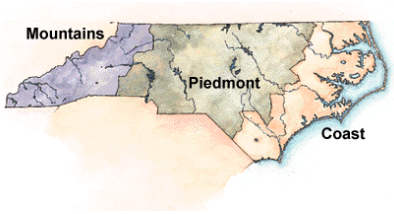
Team CSC has not included this section pending the request for Cost Proposal submission.

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.*

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.

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 faced enormous challenges in fulfilling its

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

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.

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 Agent account management and operations experience. Her diverse hands-on approach gives NC DHHS a leader with the attention to

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.*

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 3 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.**

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**.

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.

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 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.

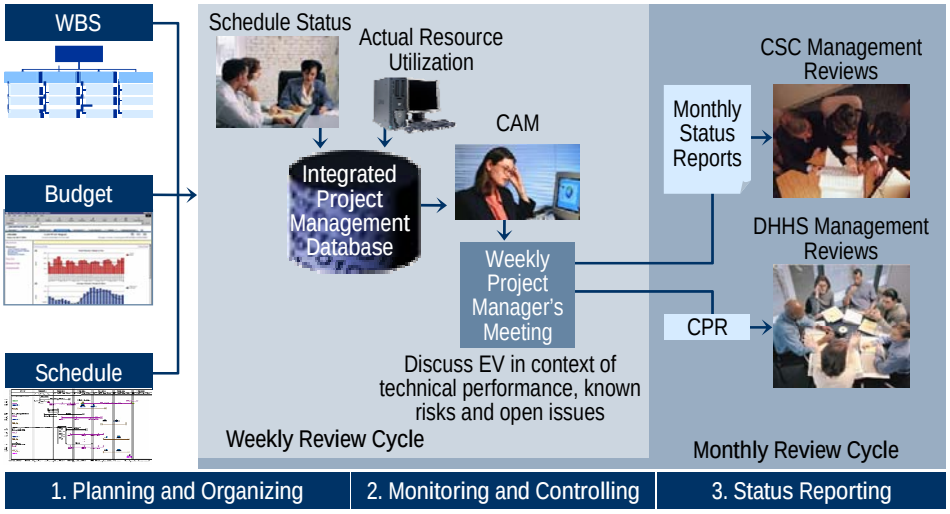


Exhibit C.1-4. CSC's Comprehensive EVMS Workflow

- 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

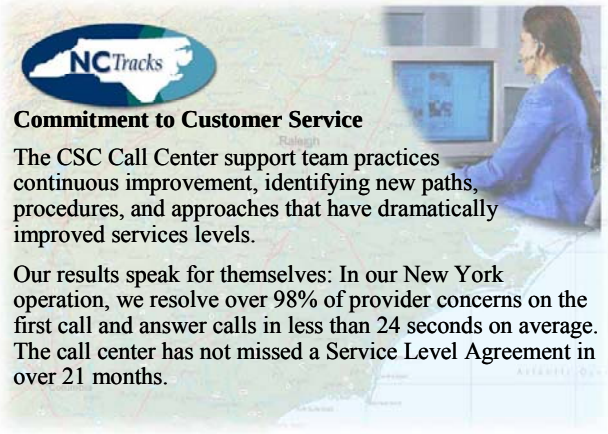
Establishing solid operational metrics with appropriate thresholds allows NC DHHS and Team CSC to proactively monitor the status of all operational units via meaningful thresholds and color-coded performance indicators.

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:

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.

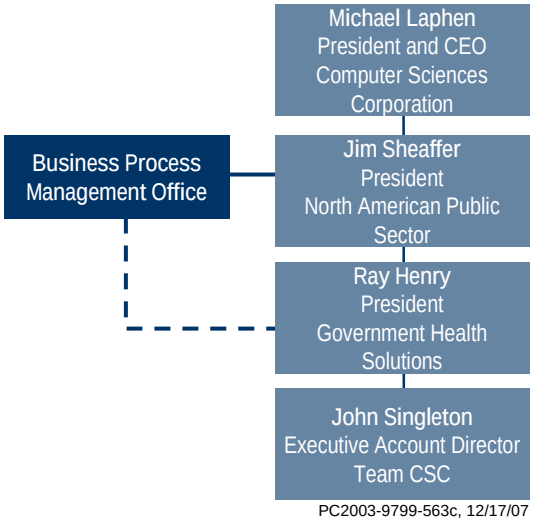


Exhibit C.1-5. MMIS Placement in CSC's Corporate Structure. *The North Carolina Replacement MMIS project is a corporate priority.*

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.

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.

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

Exhibit C.1-6 on the following page 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

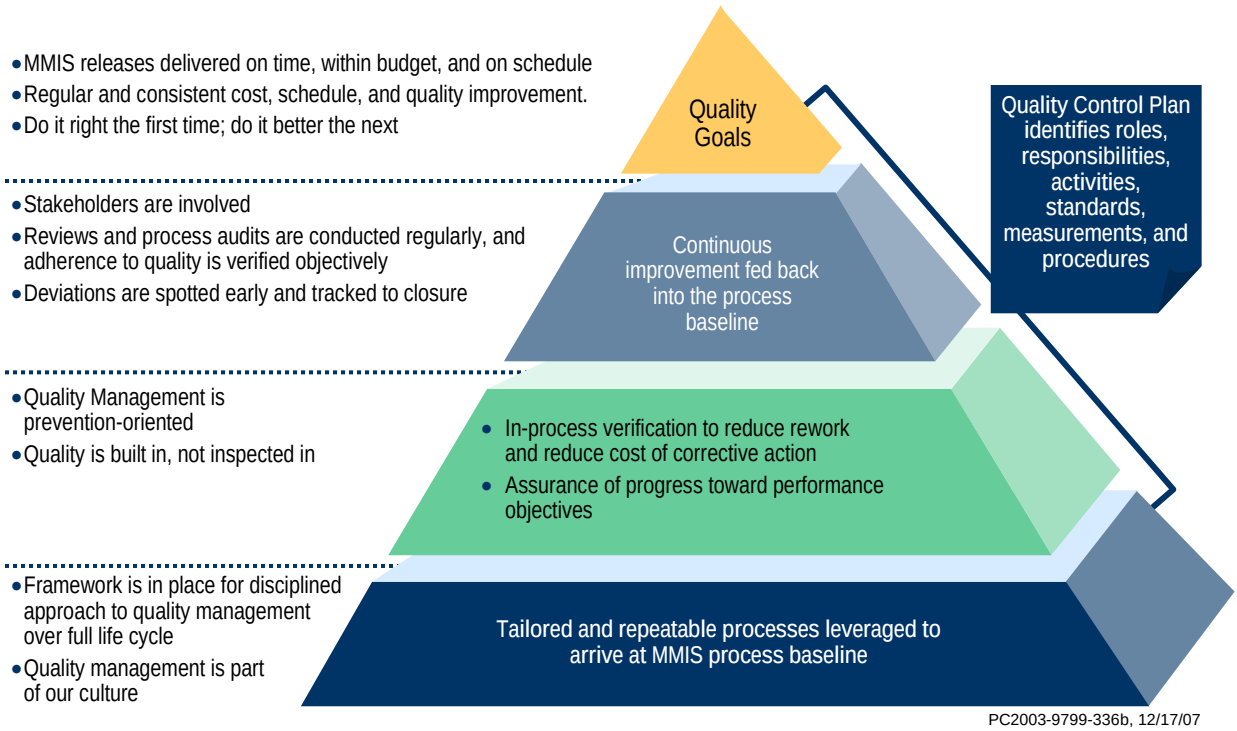


Exhibit C.1-6. Dimensions of Quality

a changing business environment. Our change 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.

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** on the following page 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.

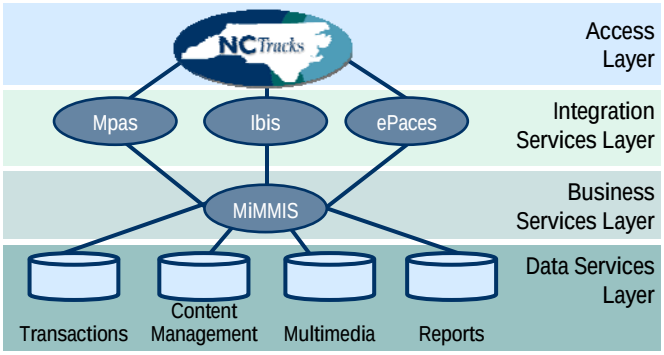


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Exhibit C.1-7. Replacement MMIS Overview

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.

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.

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 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.

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,

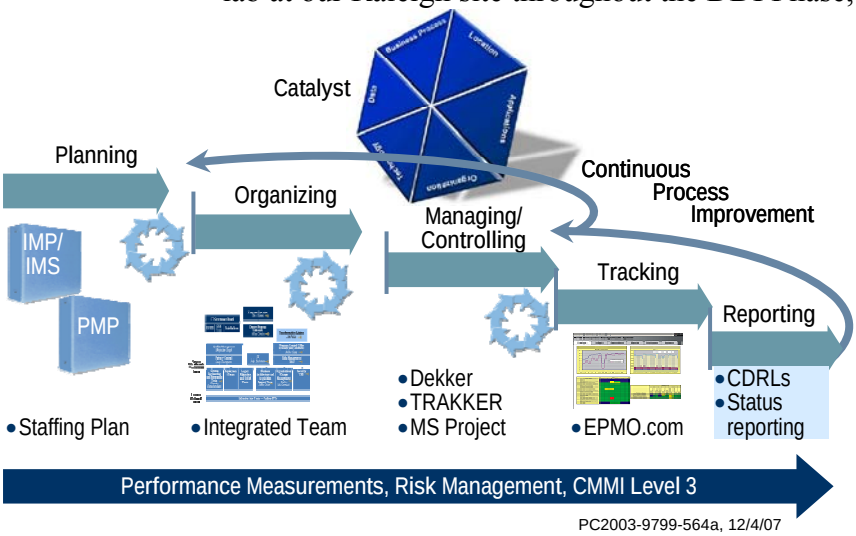

Exhibit C.1-8. CSC's Catalyst Methodology Reduces Risk

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 27-month DDI Phase.

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

The Borland suite provides

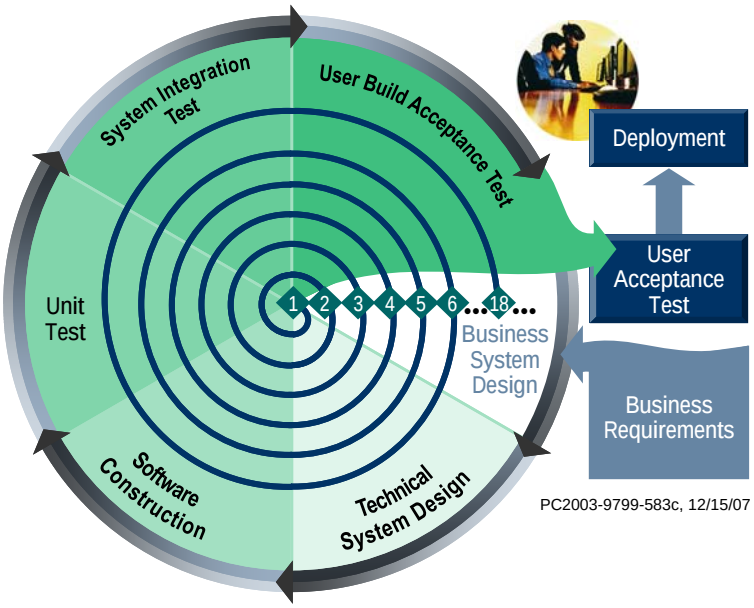

Exhibit C.1-9. Iterative Build Approach Delivers High Quality Software – The First Time!

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.

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

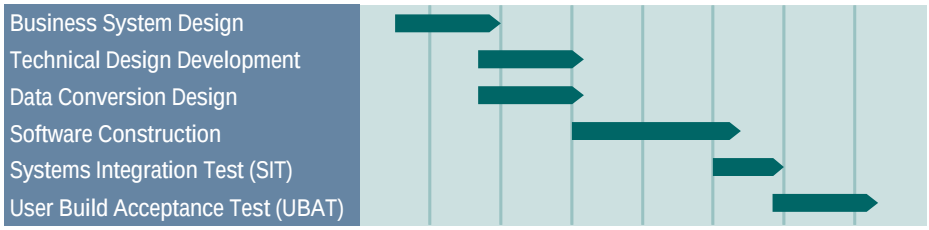

Exhibit C.1-10. Components of a Build

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 — Proposed Solution Details

After reviewing the State's detailed requirements we conducted an exhaustive gap analysis to determine how well our baseline system met the Replacement MMIS specifications. We found our system to be an excellent fit and in this Section we detail how we will tailor our baseline to meet your DDI and Operational needs.

In Section D of our proposal, Proposed Solution Details, we discuss our baseline system and the modifications we will make to deliver a Replacement MMIS that is tailored to your needs. In D.1 we present our proposed system solution and solution for DDI. We begin with a discussion of your environment and how your requirements and needs shaped our design decisions (D.1.1). We then provide you with an overview of our proposed solution and the way that solution will meet your needs today and tomorrow (D.1.2). We end our introductory material with an overview of eMedNY, our baseline system currently deployed in New York and the key system features that are important to the State (D.1.3).

Features of the Baseline System

- Unsurpassed reliability – less than 15 minutes of downtime in the last 3 years while operating 24/7
- Never missed a payment cycle
- More than 220 SLAs met since December, 2006
- First State to implement the full compliment of HIPAA transactions
- Average of less than .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 Medical History pilot
- Award-winning data warehouse

Our proposal next looks at your Replacement MMIS requirements (D.1.4) and how we will modify our baseline. This section is organized in the same manner as the RFP beginning with General System Requirements (D.1.4.1) and continuing through Financial Management and Accounting (D.1.4.14). In addition to meeting your specific requirements Section D.1 contains:

- Our approach for customization and modifications (D.1.5)
- Enhancements to the Replacement MMIS functional requirements (D.1.6)
- Our understanding of your multi-payer environment and the various stakeholder communities (D.1.7)
- Our recommendations for early implementation (D.1.8)
- Our DDI work site locations (D.1.9)
- A detailed discussion of our technical architecture (D.1.10)
- Licensing and hardware/software relationships (D.1.11)
- How our solution will minimize your total cost of ownership (D.1.12)
- Our post-delivery warranty (D.1.13)
- Details of our software development and systems engineering methodology (D.1.14)
- How we will convert and migrate data from the incumbent contractor (D.1.15)
- Our approach for deployment/rollout (D.1.16)
- The State Requirements Matrix (D.1.17)
- The adjusted function point count (D.1.18)

In D.2 we present our Operations approach. We have organized this part of our discussion functionally based on how we will perform the work. Activities are tied to the structure of our

organization. Details are in our Staffing Approach (E.5). Our Operations section is divided into several areas:

- Overview of our solution for operations (D.2.1)
- Claims management (D.2.1.1)
- Financial management (D.2.1.2)
- Client services (D.2.1.3)
- Health program services (D.2.1.4)
- IT services (D.2.1.5)
- Operations facilities (D.2.2)

The remainder of Section D includes our Statement of Work (D.3) and our training approach for DDI and Operations (D.4)

Throughout our proposal you will see information presented in the left-hand margin. Where our proposal text addresses a specific RFP requirement the requirement number appears in the margin opposite the text. You will also see a number of icons that appear when we discuss key features of our approach. **Exhibit D-1** is a list of these icons and what they signify. Bolded text next to the icon provides supporting information.

Icon	What it Means	Icon	What it Means
	How we will work collaboratively with the State		Step in our process or a function that enforces security or regulatory compliance
	How our processes and information are fully open to the State		A point in our process or an activity that provides quantifiable information about our performance
	A system feature or process that promotes quality		Our past performance or information relevant to our ability to successfully deliver the Replacement MMIS
	A feature or activity that reduces risk to the State		A way that we will reduce the State's total cost of MMIS ownership
	A new idea we have developed or will bring to the Replacement MMIS		An approach we will take to reduce cost to the State
	A way that we have or will improve MMIS operations		

Exhibit D-1. List of Icons and What They Signify. Bolded Text Next to the Icon Provides Supporting Information.

D.1 Proposed System Solution and Solution for DDI

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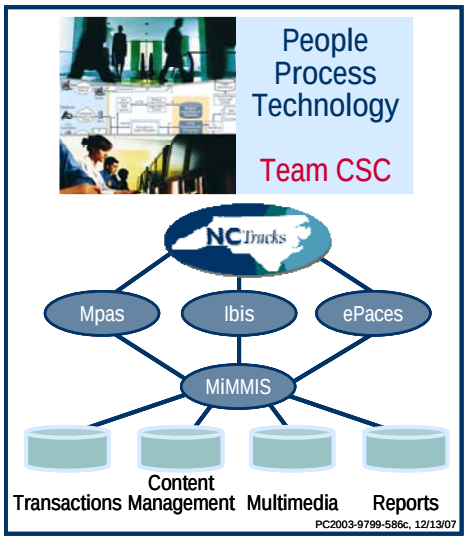
D.1.1 FULFILLING NORTH CAROLINA'S OBJECTIVES (50.4.2.1, 10.2)

50.4.2.1, 10.2

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 operating 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.

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.

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. Building on baseline capability, Team CSC commits to a flexible, table-driven multi-payer system that will incorporate the current Medicaid, Public Health, Mental Health, Rural Health programs and be easily extended to any future programs.

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 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.

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. 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.**

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 provides providers access via the Automated Voice Response System (AVRS) to DHSR information such as the Health Care Personnel Registry.

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

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 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

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

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.

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.**

"We have leveraged of 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.

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 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

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

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.

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.

"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 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 engine capabilities of the application. **Faster, more efficient processing due to lack of paper, e.g. faxing or mailing of documents, enables the Prior Authorization Representative to evaluate and process the approval returning the authorization via an electronic path to the provider.**

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

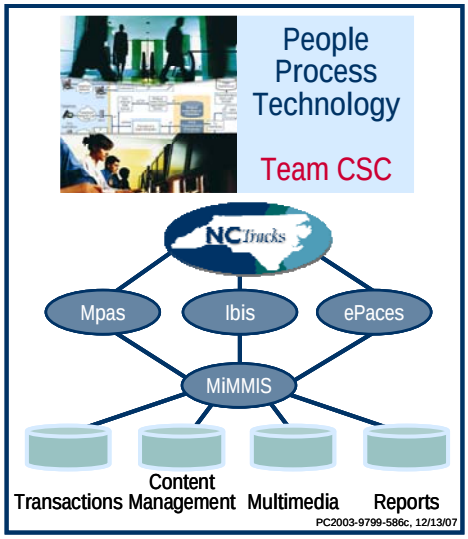
Pages D.1.1-6 through D.1.1-7 contain confidential information.

D.1.2 OVERVIEW OF SYSTEM SOLUTION AND SOLUTION FOR DDI

The Team CSC multi-payer Replacement MMIS Solution 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 complete their certification work in 60 days, to meet the NC Statement of Objectives and related goals in other relevant documents such as the DHHS Business Plan.

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 (SOO) 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, 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.

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.

Pages D.1.2-2 through D.1.2-9 contain confidential information.

D.1.3 BASELINE SYSTEM FUNCTIONALIY

Team CSC's proven Baseline MMIS system is grounded in sound architectural principles and enhanced through innovative approaches to produce a superior solution which will exceed client requirements.

Team CSC's Baseline System for the North Carolina Replacement MMIS is our CMS-certified Medicaid Management Information System (MMIS) that currently supports the State of New York, eMedNY. Our baseline system also includes the supporting imaging, document, and reporting management systems, as well as the eMedNY.org interactive Web portal. CSC developed and has maintained and operated this system for the State of New York, Department of Health since March 2005. In addition, CSC has served continuously as the Fiscal Agent for the State since 1986. The system currently processes 450-million claim and 140-million non-claim transactions per year, supporting more than 110,000 enrolled and 50,000 active providers serving more than four million active recipients. However, he most impresive and important fact is that we have never missed a payment cycle, making all provider payments on schedule while dispersing in excess of $40 billion annually.

From the initial design of eMedNY through today when we update the system while it continues to operate, every design decision is made with protection of availability in mind. Noteworthy is the fact that CSC's eMedNY platform has experienced only 7 minutes of downtime in the last 3 years, a feat achieved by professionally managing an optimal combination of people, processes, and technology. The Service Level Agreement required for the operating environment is 100% availability 24x7x365 and that is what we deliver every day.

The baseline systems operating environment consists of a multi-tier architecture including a browser-based presentation layer, a data translation layer, and an IBM Enterprise class server.

The fundamental component of the system is our integrated operational data store. This is built using a DB2 relational database and IBM's CICS Transaction Server for z/OS which can easily process thousands of transactions per second making it a mainstay of enterprise computing. This architecture provides the highest levels of reliability, availability, scalability, and performance. Our baseline system supports 13 terabytes of primary data storage and an additional 6 terabytes of online storage, mirrored for disaster recovery. **Production data is forwarded to the SunGard recovery site in real time at a rate of ~300mb/sec compressed over dual OC3 leased data lines.**

Providers access the system through the eMedNY.org portal using the ePACES to access the MMIS functionality. The communications infrastructure includes toll-free dial-up access for point-of-service (POS), personal computer (PC), and automated voice response (AVR) support. The State and counties use Web-based access via the Internet, while large volume users have point-to-point access. CSC also maintains external feeds for inbound and outbound transactions such as electronic funds transfer (EFT). The data warehouse systems environment operates on a NCR teradata platform that houses 63 months of data comprising 18 terabytes of raw data.

Pages D.1.3-2 through D.1.3-19 contain confidential information.

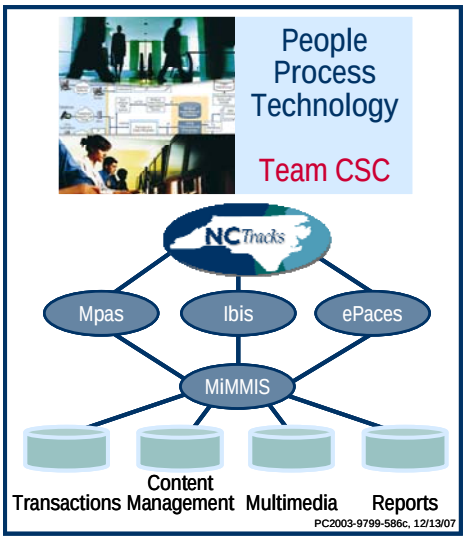
D.1.4 Replacement MMIS Requirements

D.1.4 intentionally left blank

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 COTS products and open standards.



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.

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

Major Features	Major Benefits to NC DHHS
Shared Infrastructure	• 7x24x365 infrastructure including high-bandwidth networking ensures a solution that will meet North Carolina's immediate and long-term needs.
High performance, highly reliable baseline system	• Will meet the performance expectations for current loads and for the increases expected with the addition of new payers • All checkwrites met with no delays • Minimal recoupment activity because of accuracy of processing

Pages D.1.4.1-2 through D.1.4.1-46 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 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 stakeholder, external systems, and other subsystems interaction.

(40.1.1.3)

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.** (**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 Recipient database also stores the original ID that represents the earliest Medicaid ID assigned to a recipient to facilitate continuous 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)**

(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 comprising 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 State administrators to perform 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. (**40.2.1.40 – 40.2.1.42**)

(40.2.1.40 – 40.2.1.42)

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 multiple IDs. (**40.2.1.8**)

(40.2.1.8)

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 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**)

Mass Adjustments Processing for Recipient Updates
The Replacement MMIS allows users to view the impact of mass adjustments before the adjustment actually occurs.

(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 are scanned by DPH, 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**)

(40.2.1.88 – 40.2.1.92, 40.2.1.106 - 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 parameters for date-span and applicant/recipient characteristics. (**40.2.1.100 – 40.2.1.102, 40.2.1.104, 40.2.1.110**)

(40.2.1.100 – 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 may also be initiated by State administrators 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

(40.2.1.95, 40.2.1.111) **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)**

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

(40.2.1.94, 40.2.1.96 – 98, 40.2.1.103, 40.2.1.105)
- 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**)

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)**

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**)

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)**

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

(40.2.1.34 – 35, 40.2.1.43 – 46) before the Claims Subsystem processes these transactions to effect payment. (**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 Medicare 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)

Exhibit D.1.4.2.6-2 shows the Medicare Part D page which provides access to drug coverage information.

Page D.1.4.2-16 contains confidential information.

D.1.4.2.7 Recipient Cost Sharing and Premium Processing

Team CSC will leverage the Baseline System's Scope of Benefits construct to store cost-sharing and premium payment information tied to a recipient's benefit program. These fields, together with other Recipient information such as eligibility entitlements and family case information, will be used to compute a recipient's cost-sharing factor, subject to a maximum threshold for the family, and premium payment due to the State.

Team CSC will work with State to design and implement premium management activities including:

- Generation of correspondence including Explanations of Benefits (EOB), in a recipient's preferred language, involving invoices for billing premiums due, notices of non-payment, cancellation notices, receipts, refunds, and Explanations of Benefits
- Collect premium payments or process refunds
- Process financial records for premium payments and refunds
- Generate premium payment and cost-sharing applied report
- Compute a recipient's cost-sharing factor subject to a maximum threshold for the family and premium payment due to the State. (**40.2.1.50 – 40.2.1.59)**

(40.2.1.50 – 40.2.1.59)

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 low income subsidy. 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**)

(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. State 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 – 80)**

(40.2.1.73, 40.2.1.75 – 80)

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 Transport 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:

- Provide Web Service to support online access to Medicare coverage data from EIS for Parts A, B, C, and D for Medicaid recipients

- 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, 40.2.1.82, 40.2.1.85, 40.2.1.87**)

(40.2.1.79, 40.2.1.82, 40.2.1.85, 40.2.1.87)

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 loci-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**)

(40.2.1.4, 40.2.1.108 - 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.

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Page D.1.4.3-1 contains confidential information.

CSC has extensive prior experience delivering excellent eligibility verification services. As an example, in addition to supporting New York Medicaid providers, **CSC has conducted the Medicare eligibility Common Working File (CWF) National Maintenance Contract for the past 10 years. This system supports the entire network of CWF Host Sites and Medicare contractors and serves as the basis for Medicare eligibility checking for the program nationwide, serving 36 million Medicare beneficiaries. CSC has demonstrated responsible system administration and excellence in the quality of our CWF releases and support services, including the processing of over 1.1 billion claims per year. CSC maintains 1.3 million lines of code which holds the 1,200 separate validation edits to which each claim is subjected, as well as edits across provider types. The CWF contract has maintained both a level 3 software Capability Maturity Model Integration rating and ISO 9001/2000 certification.** We will apply our demonstrated capabilities and existing baseline system eligibility verification functionality to meeting the State of North Carolina's business needs and enhancing our baseline system as described below.

The following subsections describe the proposed Eligibility Verification functionality in the areas of:

- Eligibility Verification Subsystem Overview
- Sources/Formats of Transactions
- Access Authorization and Protection of Data Confidentiality
- Audit Trail, Tracking, and Reporting.

Each subsection responds to the associated requirements from RFP Section 40.3.1. Requirements have been grouped by subject matter.

D.1.4.3.1 Eligibility Verification Subsystem Overview

The Electronic Commerce (eCommerce) subsystem is the first point of contact for providers and other external system users. The eCommerce subsystem supports real-time and batch submissions of transactions and files for eligibility checking. It is the front-end to all Replacement MMIS Online Transaction Processing (OLTP) engines.

eCommerce supports the conversion and subsequent "driving" of batch files into the system as individual transactions. The eCommerce subsystem utilizes the Pervasive COSMOS translation engine to translate inbound ASC X12N datastreams required for HIPAA into internal formats that are acceptable to supporting subsystems, and translates internal data back to the required format for outbound responses resulting in improved efficiency.

The Eligibility Verification functionality of the Replacement MMIS supports processing, interaction, and collaboration among diverse stakeholders including State agencies, providers, Team CSC and other authorized entities. **Exhibit D.1.4.3.1-1** illustrates the primary Replacement MMIS interactions.

Page D.1.4.3-3 contains 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.

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 contains 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 inbound requests and outbound responses for audit trail purposes on the EVS Transaction Log database and assigns an Audit Number. This number identifies specific transactions on the log. **This log will maintain a permanent record of provider, recipient, and other inquiries/responses to support the need for proof of eligibility and to provide an audit trail and security.** Thus, EVS will maintain records of all inquiries and verification responses made, as well as records of information requesters, information conveyed, and rejected transaction results, as applicable. The audit number will be transmitted back to the provider for use as a reference number. We will modify existing eCommerce application code and associated X12N 271 mapping to pass the Audit Number back to the submitter. **(40.3.1.5, 40.3.1.7, 40.3.1.8)**

(40.3.1.5, 40.3.1.7, 40.3.1.8)

The Replacement MMIS eCommerce subsystem currently supports online inquiry to 24 months of provider 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. 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)**

(40.3.1.6)

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 contains 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.

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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. In New York, the eMedNY AVRS is available 24 hours per day, 7 days per week, 365 days per year, except for agree-upon scheduled downtime.

(40.4.1.1) Team CSC will collaborate with the State regarding the need for scheduled downtime for the proposed Replacement MMIS configuration. **(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.

(40.4.1.9) 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)**

(40.4.1.15) 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) **(40.4.1.10)**

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 processing queue. **(40.4.1.16)**

(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 for problem resolution. (**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 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 inquires for dates of service greater than the current date are not currently supported. **(40.4.1.5)**

(40.4.1.4)

(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 enhanced as well. **(40.4.1.6)**

(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 Audit 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 Audit Number information for all requests, including eligibility verification inquiry and response, to the requester for reference. Modifications to the eCommerce interface with the AVRS and Web-site will be necessary. (40.4.1.25) (40.4.1.26) **(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
- 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
- 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)**

(40.4.1.22)

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 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 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)**

(40.4.1.24)

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.

Proposed Replacement MMIS Web-based applications will utilize XML as the transaction format, rather than X12. Web and application servers will be housed and maintained in the Team CSC data center and, as such, will not be required to format transactions that utilize public networks. If the State determines 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)

The eCommerce Subsystem assigns a unique Audit 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 Audit Number to the provider for DMS/Medicaid eligibility verification inquiries, and other inquiries as needed. **(40.4.1.29)**

(40.4.1.35,
(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 maintains the currency of this information. **(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. (40.4.1.32) 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, 40.4.1.33)** (40.4.1.32, 40.4.1.31, 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.

Page D.1.4.5-1 contains confidential information.

- 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.

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-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.

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)**

(40.5.1.35)

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 date 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)**

(40.5.1.104)

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)**

(40.5.1.7, 40.5.1.12)

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 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)**

(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, 40.5.2.18, 40.5.1.20)**

(40.5.1.6, 40.5.1.7, 40.5.1.12, 40.5.2.18, 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)**

(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)

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 contains confidential information.

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
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 Part A enrollment indicator Part B enrollment indicator Effective dates Carrier name • Carrier Detail Information Carrier code

Enrollment Tracking System Tab	Data Maintained on the Database
	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. 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)**

(40.5.1.9)

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 will be constructed to include the implementation of the NPI and multiple associated taxonomies. 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 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 implement the affect of merged or decoupled identification numbers on the production of 1099s for reported earnings. All prior numbers will remain on the system indefinitely and the NPI submitted by a provider on a claim transaction can be validated against the database as required. **(40.1.1.26, 40.5.1.36, 40.5.1.37)**

(40.1.1.26, 40.5.1.36, 40.5.1.37)

Operational Provider Record Flags. The Provider Subsystem will allow "flagging" of data based on State-approved rules. We will work with the State to establish the rules for any data to be flagged. These rules will be defined to support all divisions

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

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) **(40.5.1.47)**

- 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).

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)**

(40.5.1.49, 40.5.1.52)

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)

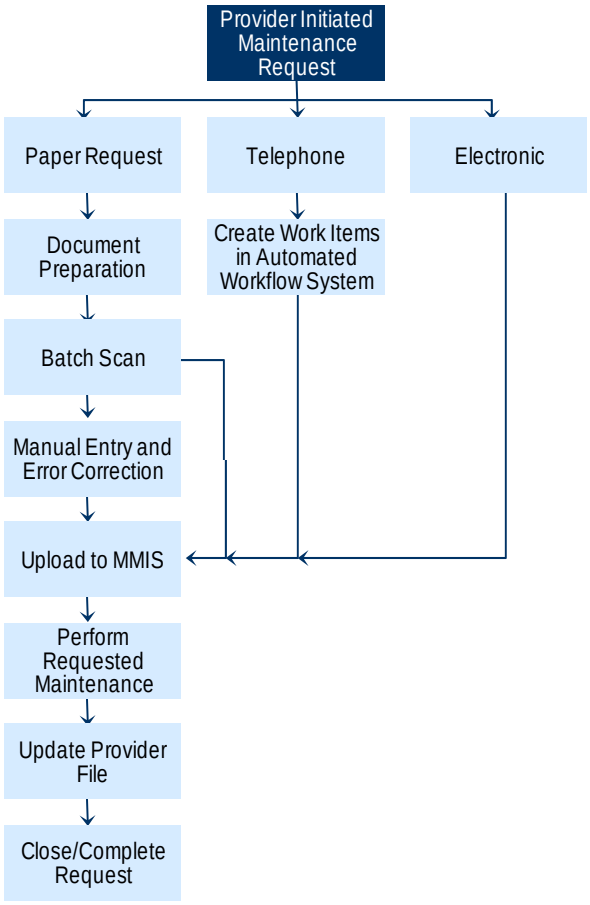
Adverse reporting of provider data results may result in additional letters being generated from the system that explain the reason for participation denial and the appeals process. These letters are retained in the electronic provider file. All electronic and paper correspondence are imaged and maintained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

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.



PC2003-9799-560b, 12/11/07

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.*

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)

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 as directed by the State. 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 initiates the provider update requests on approved intervals, such as 90 days prior to expiration, then 45 days, then 15 days. If the information has not been returned, Team CSC contacts the provider to see if any assistance is required. All actions are maintained within the Provider Enrollment Activity Log for each provider supporting an audit trail in the event there are questions as to the status of the provider's response. **(40.5.1.55, 40.5.1.56, 40.5.1.62, 40.5.1.74)**

(40.5.1.55, 40.5.1.56, 40.5.1.62, 40.5.1.74)

When providers fail to submit updated information or if it has been determined by our trained Provider Credentialing staff that a provider does not meet current participation criteria, the provider is suspended from further participation. In addition, the system generates a letter with State-approved language to advise the provider of his or her

loss of program participation status. Recognizing that there may be justifiable reasons for delays and that some providers may have an unusual issue under review, Team CSC will report all unusual issues to the appropriate Division and provide access to a work queue and supporting documents for authorized State users to support the business decision process. Of course, the online data is accessible for all State-authorized users to view by line of business and act on as appropriate. This will include the ability for State-authorized users to view and update information on sanctioned providers by line of business via the **NC***Tracks* Web portal. **(40.5.1.63, 40.5.1.76, 40.5.1.80)**

(40.5.1.63, 40.5.1.76, 40.5.1.80)

The Replacement MMIS may encounter claims from out-of-state providers who have not received program participation approval. The Claims Processing Subsystem can apply an edit for such claims so the claims deny and report when the out-of-state provider is not enrolled. Another approach would be to have these claims suspend in a designated work queue. A suspense report would identify the claims and allow our 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)**

(40.5.1.77)

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,

(40.5.1.65, 40.5.1.86) 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)**

- 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.1.4.5.6.7 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. The user enters new or changed data using the **NC***Tracks* Web portal provider pages. 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)** (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.

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)**

(40.5.1.87, 40.5.1.88, 40.5.1.96)

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)**

(40.5.1.91 - 93)

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:_____

PC2003-9799-580b, 12/17/07

Exhibit D.1.4.5-1. 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.1.4.5-2. 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

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.

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.

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.

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 contains confidential information.

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.

(40.6.1.53, 40.6.1.74, 40.6.1.75)

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**)

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. 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**)

(40.6.1.2 - 3)

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)

The Reference Subsystem accommodates procedure 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**)

(40.6.1.8, 40.6.1.25, 40.6.1.38, 40.6.1.43)

CSC has developed two innovative software tools during the development and implementation of the Baseline System. Team CSC will use these two tools for rapid and productive development and customization of the Baseline System to meet the State's specific requirements. We will use the CSC Rules Builder tool to

help ease the process of edit rule construction. The Rules Builder provides a graphical user interface for users to interactively construct edit rules that are subsequently passed to a rule generator to create the edit programs for computer execution. We will also use the CSC Code Generator tool to expedite the creation and customization of online facilities for maintaining the data elements in the Reference database. We are confident that these two innovative tools will provide a more rapid and accurate implementation of the Reference Subsystem for the State.

D.1.4.6.2 Edit and Audit Controls

Team CSC's proposed solution supports the edit and audit functions in the claims adjudication process through three principal mechanisms:

- A visual rules-builder software that allows users to construct edit rules that are then used to generate edit programs for use by the claims adjudication process
- A set of Claim Edit tables that provide a user-configurable, table-driven approach for the dispositions of edits, routing of suspended claims, edit exception processing, and resolution support related to each edit
- A set of Utilization Control tables that provide a user-controlled method of implementing and maintaining auditing criteria to maintain service frequency limitations, quantity limitations, and service conflicts for procedure codes, rate codes, revenue codes, and diagnosis.

The CSC Rules Builder is a tool to help ease the process of edit rule construction. The Rules Builder provides a graphical user interface (GUI) by which users can interactively construct edit rules using graphical elements to represent the decision and action events required to express a business rule. Once an edit rule has been completed, it can be saved and passed to a rule generator that creates an edit program to be used by the claims adjudication process.

(40.6.1.71)

Team CSC is confident that the graphical rule representation will provide a more accurate approach for implementing edits from the State's policy specifications. Moreover, the Rules Builder and the collection of graphical rules will provide a more convenient and simple approach for State users to maintain the edit criteria for claims adjudication. Exhibit D.1.4.6.2-1 shows a typical edit specification and the graphical rule representation constructed from it. (**40.6.1.71**)

Pages D.1.4.6-7 through D.1.4.6-9 contains confidential information.

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**)

(40.6.1.13)

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 Subsystem. 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

(40.6.1.22, 40.6.1.93) Pricing and Revenue Code tables. The RBRVS enables calculation of physician fee schedule records for claims payment. (**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, 40.6.1.45 – 46, 40.6.1.48**)

(40.6.1.23, 40.6.1.45 – 40.6.1.46, 40.6.1.48)

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
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 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. 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**)

(40.6.1.7, 40.6.1.32, 40.6.1.37, 40.6.1.39, 40.6.1.58 - 59)

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
- 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
- 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**)

(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.

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. The update process will allow for State-customized updates, non-overriding of designated State values and generates control reports to identify the updates received, updates that were bypassed and the existing data on the Drug tables. It will also provides 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**)

(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. 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.1.4.6-15 through D.1.4.6-18 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.

(4.6.1.89 – 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. (**4.6.1.89 – 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)**

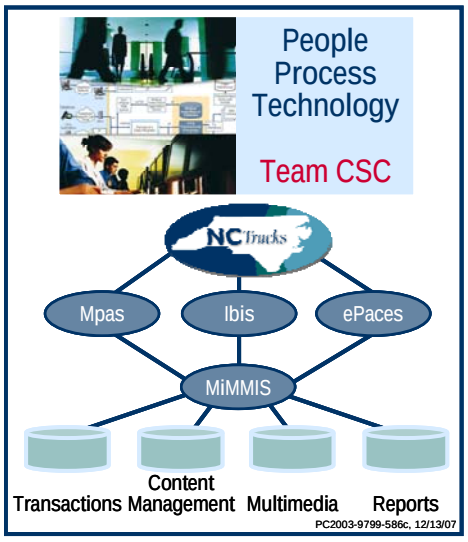
(40.6.1.61 – 65, 40.6.1.70)

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.

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, and streamlines processing for more effective and cost-efficient operations.

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.1.4.7-11 contain 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.1.4.7-13 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.1.4.7-15 through D.1.4.7-17 contains 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 (in the "PA Edits" area on the page above). The PA Edit Disposition Table in the Reference Subsystem, discussed above, 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.

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)**

(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)

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.1.4.7-22 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

(40.7.1.38) 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)**

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 (40.7.1.42) Prior Approval Search pages. **(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 (40.7.1.51) negotiated with the State. **(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 (40.7.1.53) Rosters for both the referred-to and referring providers to meet this requirement. **(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)**

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.

(40.7.1.21)

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)** 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)**

(40.7.1.31)

(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.1.4.7-29 contains confidential information.

(40.7.1.59) 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)**

(40.7.1.37)

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 and processes 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.

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, 40.7.1.62)**

(40.7.1.61 - 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.1.4.7-32 through D.1.4.7-33 contains confidential information.

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.

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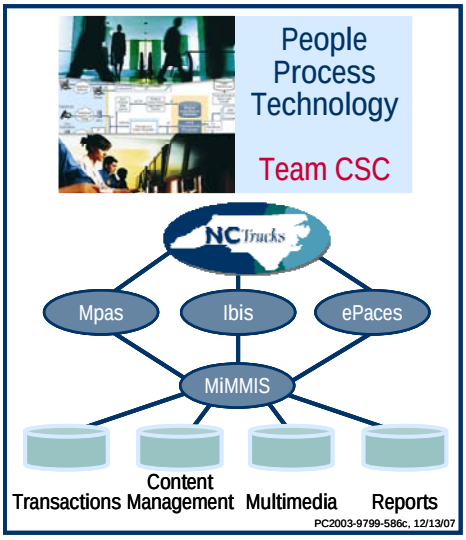
D.1.4.8 Claims Processing Subsystem

CSC is a leader in delivery of innovative healthcare IT solutions and will implement an online, real-time, and bulk 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.

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.

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 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 by Population Group, below. **(40.1.1.1)**

(40.1.1.1)

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 assistance 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** using Optical Character Recognition (OCR) technology to capture the data from all claim forms including CMS-1500, CMS-1450 (UB-04), ADA dental, and pharmacy universal 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 business rules established by the various divisions within DHHS. Authorized users are able to view claims history, resolve suspended claims, check on the status of

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 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 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 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

9799-999

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**.

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.

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)**

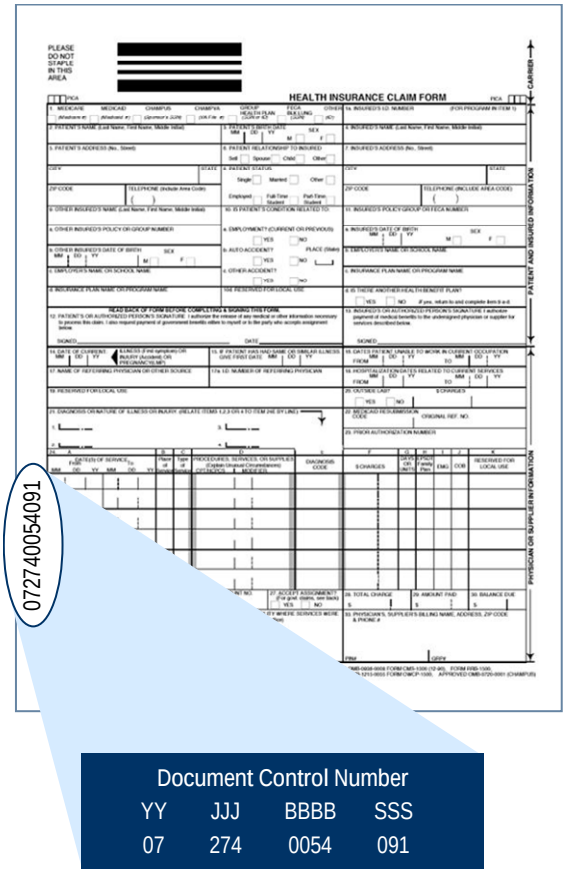
(40.8.1.101)

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.

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)



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.*

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)

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

(40.8.1.11)

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)**

(40.8.1.16, 40.8.1.20, 40.8.1.213, 40.8.1.295)

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 "paid" or "denied" and allows the claim 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)**

(40.8.1.47, 40.8.1.137, 40.8.1.139, 40.8.1.214, 40.8.1.219)

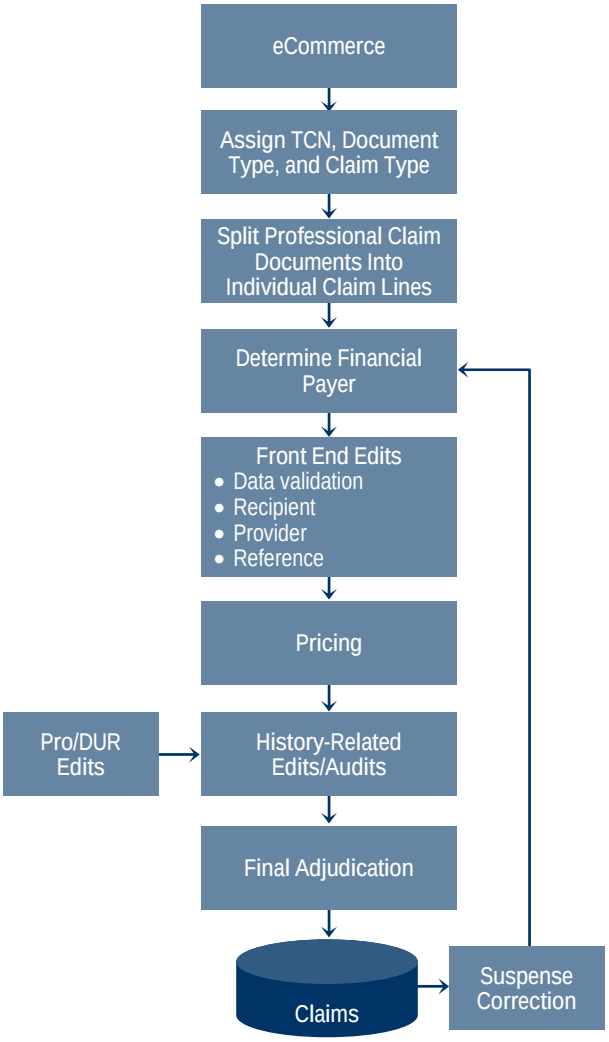


Exhibit D.1.4.8.5-1. Claims Adjudication Process. *The claims process provides thorough adjudication to report all errors and determine final claims status as quickly as possible.*

D.1.4.8.5.1 Determination of Financially Responsible Payer by Population Group

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. 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
- 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.

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)**

(40.1.1.9)

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 to identify 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 link the benefits plans with the population groups the payer is responsible to cover. During the Design Phase, **we will work with the 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, we will develop a matrix similar to the table 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 define the scope of benefits, eligibility criteria, and pricing methods applicable within a specific health benefit program for a population group as defined by the payer associated with the benefit plan. The Replacement MMIS will be able to edit claims billed under one of the benefit plans and ensure that the policy of the payer is applied and that procedures or rates are paid according to the business rules established by the payer. 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 benefit plans as identified in the table above,

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 population groups that are covered by financial payers such as DMA, DMH, DPH, and ORHCC.

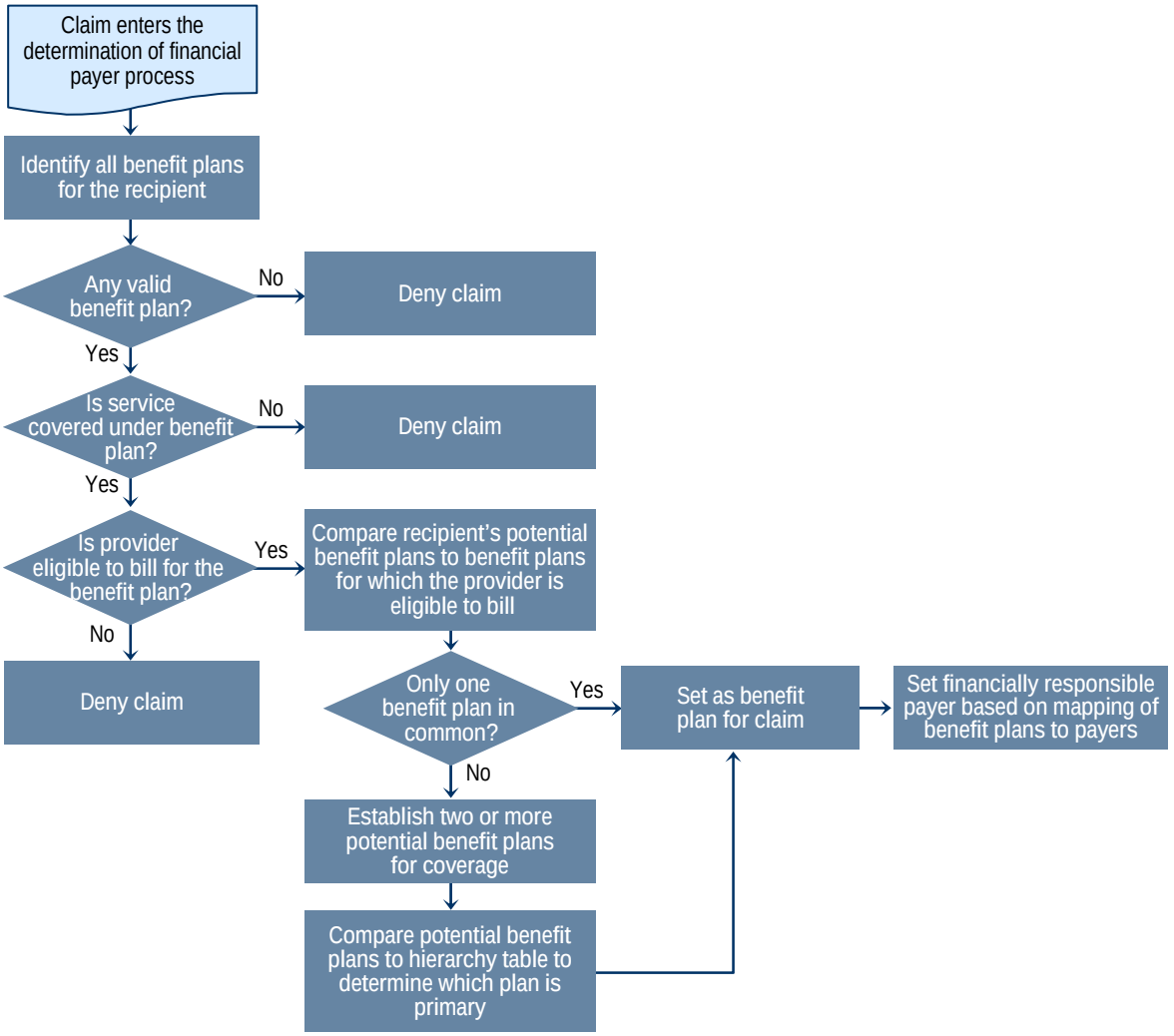
In the Replacement MMIS, the financial payers will provide eligibility data for all recipients, allowing us to identify the enrollment of recipients in one or more benefit plans. Our Recipient Subsystem is capable of maintaining multiple date-sensitive eligibility segments for each recipient and these segments will be associated with a benefit plan. The benefit plan will define the covered services, pricing methodologies, 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 a provider type and one or more provider specialties for which they are credentialed. We will modify the provider database to include an association or link between the provider and specific benefit plans for each financially responsible payer. The link will be based upon enrollment information including the provider type and provider specialty. **(40.8.1.85)**

(40.8.1.85)

As illustrated in **Exhibit D.1.4.8.5.1-2**, Multi-Payer Determination Process, we will implement an approach for the identification and assignment of the financially responsible payer and benefit plan applicable to each service on the claim that considers information applicable to both 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 rules associated with the financially responsible payer. The Replacement MMIS will consider any retro-eligibility determinations and funding availability during the financial payment cycle and recycle claims through the financial payer determination process if there are changes to a recipient's eligibility or if sufficient funds are not available for the primary financially responsible payer. **(40.1.1.6, 40.8.1.87)**

(40.1.1.6, 40.8.1.87)



PC2003-9799-320b, 10/23/07

Exhibit D.1.4.8.5.1-2, Multi-Payer Determination Process. *The Team CSC approach allows the capability to establish a benefit plan and a financially responsible payer early in the claims adjudication process.*

The Team CSC multi-payer solution will allow all claims to process through the system according to specific policies and procedures defined by 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

(40.8.1.86, 40.8.1.92 – 94)

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 – 94)**

As claims/claim lines enter the adjudication process, the transactions will be subject to logic that determines the financially responsible payer. 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. 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 on the claim record. If there are no valid benefit plans for the recipient, we will deny the claim, otherwise we will determine if the benefit plans associated with the recipient cover the service billed on the claim. If none of the valid recipient benefit plans covers the billed service, we will deny the claim.

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.

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 record. 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.

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 and ultimately set the financially responsible payer for the claim based on a table of benefit plans associated with payers. If more than one benefit plan covers the service, a pre-determined financial payer and benefit plan hierarchy will be used to assign a benefit plan. If no matching benefit plan exists, the claim will be denied.

Once the benefit plan has been assigned and the financially responsible payer has been determined, the system will be able to retrieve the benefit package and apply benefit coverage rules for the billed service. The claim will then flow through the remainder of the adjudication process which is subject to edits, audits, and pricing logic that are specific to the financially responsible payer.

We will add two new fields to the claim record to indicate the primary benefit plan that covers the service and whether a secondary benefit plan covers the service, when needed. This approach will allow us to reprocess the claim automatically, if the Financial Subsystem determines that the primary payer does not have sufficient funds to pay for the service. This financial payer determination logic will be performed each time claims are reprocessed to ensure that any data corrections made subsequent to the initial payer determination are incorporated and to ensure the services for which

(40.1.1.7, 40.8.1.88 – 90, 40.8.1.106)

payment is requested are covered by the appropriate State Medical Assistance program. **(40.1.1.1, 40.1.1.7, 40.8.1.88 – 90, 40.8.1.106)**

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.

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 bypass additional recipient-related edits. When an edit posts to the claim, the adjudication module searches for the edit number on the Claim Edit Dependencies Table. If the edit is on the table, the corresponding edits in the table are bypassed for

Pages D.1.4.8-29 through D.1.4.8-33 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.1.4.8-35 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.1.4.8-37 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.1.4.8-39 through D.1.4.8-40 contains confidential information.

(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

(40.8.1.97, 40.8.1.112, 40.8.1.114)

service performed, the Claims Processing Subsystem posts an edit to the claim. **(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)

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

Page D.1.4.8-43 contains confidential information.

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.

D.1.4.8.5.4.3 Provider Edits

The Claims Processing Subsystem performs provider edits to validate that the provider is enrolled and is authorized to perform the billed services for the dates of service for the program on the claim, including checking the billing, attending, referring, or prescribing provider. During the adjudication process, the system compares both header and line level provider information on the claim against corresponding provider information maintained by the Provider Subsystem. When the Claims Processing Subsystem identifies inconsistencies, the system posts edit codes to the header or line item that fails a provider edit. **(40.8.1.116, 40.8.1.152)**

(40.8.1.116, 40.8.1.152)

The Claims Processing Subsystem ensures that all provider identification numbers and names on the claim match the corresponding provider numbers and names maintained by the Provider Subsystem. The solution is capable of accepting National Provider Identification (NPI) numbers and cross-references the NPI to the internal provider ID during claims adjudication processing.

The provider editing process verifies that the billing provider has an active enrollment status, the rendering provider is a member of the group billing the service, and the provider is authorized to perform the service billed. Provider type, provider specialty, category of service, and participation indicators are evaluated to ensure the provider is allowed to perform the services on the claim. **(40.8.1.117)**

(40.8.1.117)

The Claims Processing Subsystem **ensures that the provider and provider location are appropriately licensed and certified for the billed service, including CLIA 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)**

(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 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)**

(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. 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. 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. **(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)

D.1.4.8.5.5 Pricing

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)**

(40.8.1.340)

- Manual pricing.

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)

Currently, the Claims Processing Subsystem is able to price procedure codes automatically with up to two pricing-related modifiers, and suspends claims that require pricing of procedure codes with three or four 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)**

(40.8.1.49)

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. **(40.8.1.355, 40.8.1.366)**

(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)

D.1.4.8.5.5.1 Pharmacy Pricing

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)**

(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)**

(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.

Page D.1.4.8-48 contains confidential information.

multiple NDCs, rebateable legend drugs, and selected over-the-counter products. Pricing information for NDCs is stored in the drug pricing tables. This enhancement will include modification of the receipt, response, and adjudication/pricing logic, and enhancement of pharmacy claims history. Team CSC will work closely with the State to ensure our approach and solution fully meet the multiple-NDC requirement.

(40.8.1.67) **(40.8.1.67)** Team CSC will also implement new functionality to enable the Replacement MMIS to apply edits for coverage of non-legend drugs within compound drugs. We will develop new edits to disallow supply items included within 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

(40.8.1.60) CNS and the State to ensure that we develop an appropriate interface. **(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

(40.8.1.341) pricing process. **(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

(40.8.1.167) allow the user to enter edit criteria for encounters. **(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.

(40.8.1.291, 40.8.1.354) 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)**

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. For claims billed using State-specific services, we are able to carry pricing segments in the Reference database or prices can be established through allowed amounts on the Prior Approval (PA) record. Such services 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)**

(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 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)**

(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.

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)**

(40.8.1.38, 40.8.1.103)

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)**

(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 deduct either 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 DPH 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 DPH 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)**

(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

(40.8.1.31, 40.8.1.134 – 136)

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)**

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

(40.8.1.64, 40.8.1.84)

- Edit pharmacy claims against DME, physician, or Competitive Acquisition Program (CAP) claims. **(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)**

(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.

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 continue to receive 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 for the Replacement MMIS and ensure that all appropriate edits are created using the Baseline System**. During the DDI Phase, Team CSC will collaborate with NC DHHS in considering and evaluating the use of a third-party product, such as a solution from Bloodhound Technologies, to implement CCI edits. 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)**

(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. 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 service or date of claim receipt and the action to be taken on claims that meet the

Page D.1.4.8-58 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

a "to be paid" or "to be denied" status. The Financial system updates these documents with a status of "paid" and "denied" once the documents have been processed through the weekly financial cycle. **(40.8.1.45)**

(40.8.1.45)

The final reimbursement amount is calculated during the final adjudication process. For documents with a "to be paid" status, the final reimbursement amount is the summation of all claim lines that have a "pay and report" or "pay and void" status. The reimbursement amount is stored on the Claims Header table and utilized by the Financial Subsystem during check and remittance production.

D.1.4.8.5.7.5 Store Claim Data.

The last step within final adjudication is the storing of claim data on the Claims Header and Line tables. Using the internal claim record, the system automatically places claim data in the appropriate DB2 tables.

D.1.4.8.5.7.6 Claims Inquiry

User-friendly Replacement MMIS pages enable authorized users to efficiently search for all claims, including pharmacy, using a variety of date elements:

- Recipient ID
- Provider ID
- Transaction Control Number (internal control number)
- Prescription number
- Drug code — NDC.

Team CSC will enhance existing functionality to include pharmacy claims search criteria to include:

- Pharmacy Number
- Therapeutic class
- Drug code — GCN
- Drug code — GCN-sequence. **(40.8.1.204)**

(40.8.1.204)

Exhibit D.1.4.8.5.7.6-1 shows the Claim Search page.

Page D.1.4.8-61 contains 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

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.1.4.8-65 contains confidential information.

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)

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.

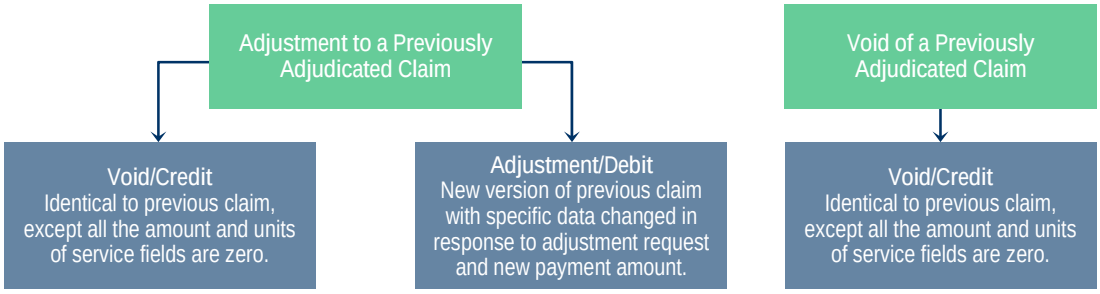


Exhibit D.1.4.8.8.1-1. Claim Adjustment and Void Records. *The Replacement MMIS automatically creates the required credit or debit claims when performing an adjustment or void.*

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

(40.8.1.218)

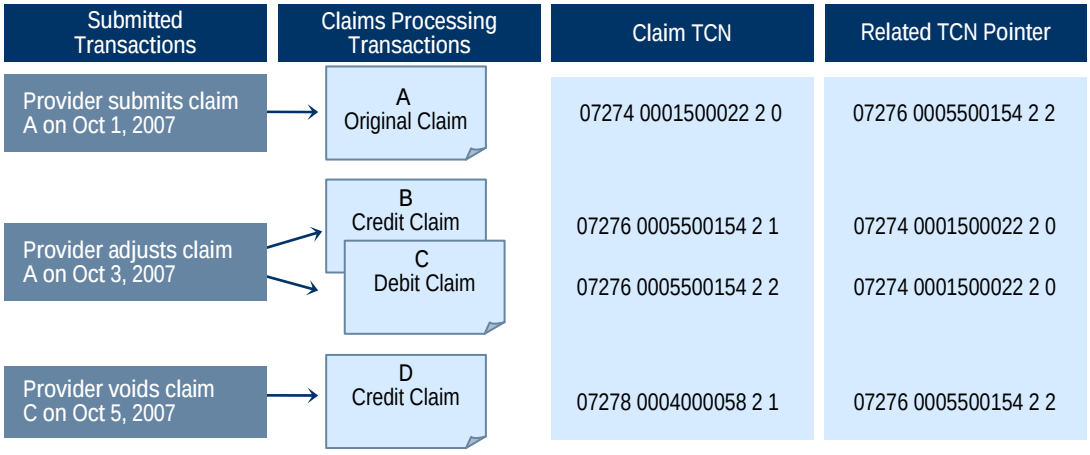
The Claims Processing Subsystem has no limit to the number of times a claim can be adjusted, and keeps a complete and accurate audit trail of each adjustment or void. The system allows the user to view the complete history of a voided or adjusted claim in chronological order including all associated transactions. **(40.8.1.218)**

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:

(40.8.1.207)

- Retroactive changes to rates or pricing **(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.

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.

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.

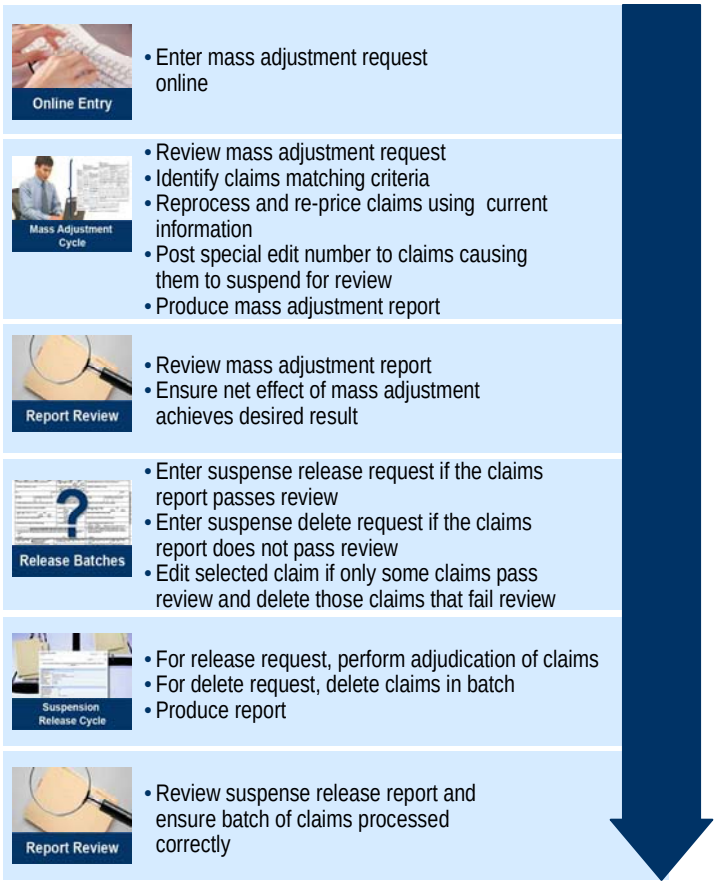


Exhibit D.1.4.8.8.2-1. Mass Adjustment Request Processing. *The Team CSC approach for Mass Adjustments allows authorized users to review the results of the potential adjustments prior to final processing.*

When the Replacement MMIS processes the mass adjustment requests, it selects the appropriate previously adjudicated claims based on the selection criteria. The Baseline System does not currently allow for mass adjustments to suspended claims, but we will modify the system to accommodate the adjustment of suspended claims, as defined by NC DHHS. 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. **(40.8.1.180)**

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

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.*

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.

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 includes editing and auditing for recipient eligibility, drug coverage and benefit limitations, pharmacy network enrollment, third party liability, 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)**

(40.8.1.61)

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

(40.8.1.77, 40.7.1.10)

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)**

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. 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:

- 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 denies claims for DESI drugs and does not allow the denial to be overridden.

(40.8.1.73) **(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.1.4.8-78 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.1.4.8-80 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.1.4.8-82 through D.1.4.8-83 contains confidential information.

- Drug-Disease Contraindications
- Drug-Pregnancy Alerts
- Pediatric Precautions
- Lactation Precautions
- Geriatric Precautions
- High Dose/Low Dose warnings.

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)**

(40.8.1.39 – 42)

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 contains 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.

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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)

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)**

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. **(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 more Benefit Plans from which the user may make a selection to review the detailed data associated with the selected Benefit Plan. The Add MC Benefit Plan section of this page is used to add a new Managed Care Benefit Plan.

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 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)**

(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.1.4.10.1-2** shows the primary interactions and operating environment of the Health Check Subsystem.

Page D.1.4.10-3 contains confidential information.

navigational capabilities so that users may access other parts of the system as needed (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.1.4.10.1-4** 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.1.4.10.1-4. 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 - 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 standard and updatable notification templates determined by the reason for the notification. 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)

(40.10.1.8)

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)**

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. (**4.10.1.9)**

(4.10.1.9)

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.

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.

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 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. (**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), 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. The EPSDT report will be produced no later than the fifth day of the month.

(40.10.1.14, 40.10.1.17, 40.1.19 - 21)

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**)

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.1.2.10.8 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.

Pages D.1.4.11-1 through D.1.4.11-2 contains confidential information.

The TPL Subsystem collects and maintains third-party resource information, such as insurance policies for other financially-responsible parties, to support coordination of benefits and cost-avoidance during claims adjudication. The TPL Subsystem also supports full recovery of previously paid claims that should be reimbursed by other responsible parties. Team CSC will work with the State to implement the following TPL Subsystem functions for cost-control and recovery, applicable across both medical and pharmacy claims processing, for Medicaid or non-Medicaid recipients as appropriate and directed by the State:

- Provide Web-based administrative functions to research and maintain recipients' TPL resource data and third-party insurance company information
- **Provide TPL cost-avoidance criteria data for the Claims Subsystem to identify and process cost-avoidance and pay-and-chase claims**

- **Collect previously paid claims related to pay-and-chase, casualty, estate recovery and retro-insurance coverage to support cost-recovery analysis and recoupment effort**
- **Provide workflow support for managing cost-recovery actions including case creation, bill generation, payment collection tracking, and other recoupment activities**

- **Support Health Insurance Premium Payment System alternatives for qualified recipients and generate HIPP payment transactions for the Claims Subsystem to effect payment to insurance carriers**.

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 inquiry, add, update, and search capabilities to access and maintain the TPL database using the familiar Web browser.

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.

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, and address. **(40.11.1.21, 40.11.1.51)**

(40.11.1.21, 40.11.1.51)

Pages D.1.4.11-5 through D.1.4.11-8 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 an 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 where 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

(40.11.1.6, 40.11.1.8 – 40.11.1.9)

- Court-ordered information
- Begin/end dates for validity of policy. **(40.11.1.6, 40.11.1.8 – 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)

- Defense Department's Defense Enrollment Eligibility Reporting System. **(40.11.1.28)**

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. **(40.11.1.23)**

(40.11.1.23)

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 involving Non-Custodial Parent (NCP) policy holder will generate a trigger to the Recipient Subsystem to flag this TPL resource association with the recipient
- TPL resource updates from CSE that are identified as new cases are pended until approved by the State
- 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 notice of the recipient's special condition. **(40.11.1.56-40.11.1.58)**

(40.11.1.56-40.11.1.58)

D.1.4.11.4 Health Insurance Premium Payments (HIPP) Process

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 HIPP data 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. Finally, the system generates and routes the financial transactions to the Claims Subsystem which processes the actual payment to the insurance carriers. **(40.11.1.36)**

(40.11.1.36)

D.1.4.11.5 Cost Avoidance and Pay-and-Chase Processing

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. The claims adjudication process will deny cost-avoided claims, identify for DHHS the dollar amounts associated with these cost-avoided claims, as well as create an extract file of the pay-and-chase claims, including billing information. 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)**

(40.11.1.10 - 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)**

(40.11.1.2)

- Cost-avoid claims for inpatient hospital stays for pregnant women **(40.11.1.3)**

(40.11.1.3)

- 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)**

(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 annual or lifetime benefits are exhausted. **(40.11.1.55)**

(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. **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)**

(40.11.1.39, 40.11.1.29)

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 - 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**)

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. 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. 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)**

(40.11.1.14 - 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 with rules-based workflow technology to support the 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
- Automatic or manual creation of invoices with supporting claim information to bill for recoverable drug claims from insurance carriers

(40.11.1.26, 40.11.1.31, 40.11.1.47)

- Automatic or manual creation of invoices with supporting claim information to bill for Estate recovery. **(40.11.1.26, 40.11.1.31, 40.11.1.47)**

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. State users can approve or cancel trauma questionnaires. State users can perform online tracking of open cases, type of case, case status, lien amount, and amount of recoveries. Online pages will allow review of invoices 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, provider name or ID, attorney name, and accident number. 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, 40.11.1.37, 40.11.1.38, 40.9.1.40 – 43, 40.11.1.49)**

(40.11.1.17, 40.11.1.22, 40.11.1.34 - 35, 40.11.1.37 - 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 – 40.11.1.46, 40.9.1.48, 40.11.1.50)

- Recall claim information involved in a recovery case for email or postal dispatch
- Flag recipients who have reached a defined threshold. **(40.11.1.44 – 40.11.1.46, 40.9.1.48, 40.11.1.50)**

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
- 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 ACTS, CSDW, and EIS
- Provide an extract of TPL recipient resource updates related to Child Support to ACTS. **(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 – 40.11.1.65)

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 count 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 – 40.11.1.61)**

(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. **(40.10.1.19)**

(40.10.1.19)

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.

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Pages D.1.4.12-1 through D.1.4.12-2 contains 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

9799-999

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

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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. (40.12.1.13)

(40.12.1.13)

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)
- 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)**

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)**

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. T**he 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 and does not total rebates at the UPC level. 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. In addition, we will modify existing processing to include UPC level summarization capability. We will collaborate with the State to ensure we identify all transactions to be included and the appropriate selection parameters and to verify that our approach will meet all of the State's requirements. **(40.12.1.5)**

(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 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:

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.

- 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 a capability easily 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)**

(40.12.1.38)

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)**

(40.12.1.26), (40.12.1.6, 40.12.1.8)

D.1.4.12.4.7 Generate Letters

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)**

(40.12.1.10 - 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.

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)**

(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)

D.1.4.12.5.2 Entry and Processing of Remittance Advices

Drug Rebate staff enters the Drug Rebate remittance statements into the system using several pages available in the Replacement MMIS:

- Remittance Advice Selection page
- Remittance Advice Summary page
- Remittance Advice ROSI Detail page
- Remittance Advice PQAS Detail page.

The ROSI and PQAS pages are designed to follow the CMS mandated Reconciliation of State Invoice (ROSI) and Prior Quarter Adjustment Statement (PQAS) forms in providing invoice and post-payment detail information. The Replacement MMIS pre-populates certain fields on these pages to reduce the data entry time required if the drug manufacturer has paid what was invoiced with no adjustments or disputes.

The Remittance Advice Search page, shown in **Exhibit D.1.4.12. 5.2-1**, is used to select a specific remittance advice for data entry or for inquiry. A user can access the Remittance Advice Summary page by selecting a Labeler Code. **(40.12.1.9)**

(40.12.1.9)

Remittance Advice rows are pre-populated during the Drug Rebate invoicing process so that data entry need only update those line items that the manufacturer adjusts or disputes. Remittance Advice rows can also be entered directly through the data entry process when a manufacturer remits money or information as a result of changes in the rebate-per-unit amounts or resolved disputes. **(40.8.1.210)**

(40.8.1.210)

Pages D.1.4.12-16 through D.1.4.12-17 contains confidential information.

the State to confirm that our proposed approach meets the State's intent. (40.12.1.24 - 25) **(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.
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.

Req. #		Team CSC Response/Approach
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.
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.

Req. #		Team CSC Response/Approach
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.
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.
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.

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 Reporting Capabilities

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. **(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 addition 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 - 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 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. **(40.1.3.1.8)**

(40.131.8)

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 - 5)**

(40.13.1.4 - 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. The federal reporting module generates the following standard federal reports and extracts: **(40.13.1.14)**

(40.13.1.14)

- MSIS Extract Files
- 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 reports relevant to the North Carolina healthcare population, and transmit that information to Team CSC and the State.

Team CSC, SAS, and The Sheps Center leverage advances in reporting and analytics tools to provide broad business intelligence capability using pre-

Pages D.1.4.13-11 through D.1.4.13-13 contains 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.

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. Multi-payer features of our solution include:

- Check write schedule flexibility to 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 DMH/DD/SAS 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 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.

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 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 financially suspend claims in accordance with DHHS specifications in order to be certain that adequate funding is available before checks are written and funding source contributions are demanded.

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 to be used in the future.

In cases where there are multiple funding sources, 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 by tertiary payers in the order of the payment hierarchy to the extent that state or other coverage funds are still available.

Multiple funding sources may be used to determine the percentage contribution required from each to cover the claims service. When multiple budgets may cover a service, and the primary budget does not have enough funds, the system will allow additional budgets to be used to cover the balance of the claims paid amount.

Based on configurable rules as set by DHHS, if a claim is paid and the paid amount has been cut-back by the initial payer for any reason, the system will have the ability to refile the claim to the next payer for additional adjudication of funds. The rules for resubmission to the next payer can be configurable by payer and each payer will be able to establish a hierarchy within the financial payers the system manages.

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 State Controller's office. Having reports available immediately will allow State staff to understand the total value of claims processed, as well as total funding required by each funding entity, within each benefit program, whether State, the federal government, individual counties or other funding sources.

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 for claims pending or denying.

The Baseline System will be compliant with National Provider Identification (NPI) requirements when DDI 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 long 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 data field. 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 jobstreams, 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 paper claims 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

(40.8.1.282, 40.1.1.11)

(40.8.1.282, 40.1.1.11) 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.

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 services, and reducing administrative costs. **(40.14.1.7)**

(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 your ongoing processing needs and represents the best solution available for a full-featured, flexible, and compliant system. In order to convey more fully 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

(40.14.1.11, 40.14.1.62)

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 their respective financial coding appropriate to specific program funds.

(40.14.1.11, 40.14.1.62) 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.

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 contains confidential information.

system has the capability to pay claims according to an established budget hierarchy, accessing funds from the first benefit plan where funds are available, and service is covered.

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 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 program 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. All claims that are fiscally pended at the end of a financial cycle are documented on Provider Remittance Statements.**

Federal False Claims Act

(40.14.1.69)

(40.14.1.69) Our baseline system also provides the capability to suspend all of a provider's approved claims from payment, because of licensure problems, suspicion of abusive billings, or in cases where an action has been brought under the False Claims Act. In these cases, there may have been fraudulent billing activity, and Team CSC will work closely with DHHS to develop procedures for assigning a universal General Ledger Pend status for these cases.

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 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

(40.1.1.1, 40.1.1.6, 40.1.1.7, 40.1.1.9, 40.1.1.10, 40.8.1.30, 40.8.1.295 40.8.1.313, 40.8.1.273)

(40.1.1.1, 40.1.1.6, 40.1.1.7, 40.1.1.9, 40.1.1.10, 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
- 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.

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) 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) 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 "to be paid" 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 produces balancing reports at detail and summary levels aligned to program budgeted dollars including budget data received directly from DMH.

Accumulation of Paid Claims

(40.8.1.220)

(40.8.1.220) Claims adjudicated in a "paid" 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.

Adjustments to Initial Payment Balances

(40.8.1.235, 40.8.1.243, 40.8.1.277, 40.8.1.279, 40.8.1.297, 40.8.1.312, 40.8.1.316. 40.14.1.6)

(40.8.1.235, 40.8.1.243, 40.8.1.277, 40.8.1.279, 40.8.1.297, 40.8.1.312, 40.8.1.316. 40.14.1.6) 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 is paid to the provider in the form of a paper check or an Electronic Funds Transfer (EFT).

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.

Cash Advance

(40.8.1.330, 40.8.1.269, 40.14.1.2)

(40.8.1.330, 40.8.1.269, 40.14.1.2) 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 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 already was.

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

(40.14.1.30)

(40.14.1.30) 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.

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, 40.8.1.236)

(40.8.1.222, 40.8.1.223, 40.8.1.230, 40.8.1.240, 40.8.1.236) The Replacement MMIS will produce system-generated checks, remittance advices, voucher statements, and other documentation for each DHHS LOB. 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 per payment cycle.

After all approved claims and other financial transactions have been summarized; the system calculates a total payment amount for each provider. This payment amount will be entered to either a payment check or to an EFT file to be transferred to our disbursement bank.

Check Processing

(40.14.1.06)

(40.14.1.06) 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 that is used to print the checks. Entry of pre-printed check numbers to the system is done by inputting 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 Program, Check Amount, and Issue/Mail Date. Users may also enter notes pertaining to the manual check.

Early Release of Checks

In some instances, consistent with DHHS policies, providers may request an early release of their check. All such requests are made through DHHS LOBs. Upon direction from the DHHS, we will manually pull the check designated for early release and immediately mail it to the provider. Our Financial Transaction Processing staff will access a screen that updates the Check Issue Date to the date it was mailed.

Page D.1.4.14-13 contains confidential information.

notifying us. Under these circumstances, a scheduled EFT transaction cannot be posted to the closed 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)

(40.8.1.262, 40.8.1.302, 40.8.1.307, 40.8.1.236) 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. 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.

Provider Earnings File

(40.8.1.215, 40.8.1.221, 40.8.1.298, 40.8.1.236)

(40.8.1.215, 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 updating of 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 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 LOB 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

In certain circumstances, the need may arise to stop, hold or void a disbursement transaction. The Baseline System offers the ability to easily 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

Support for Positive Pay

(40.8.1.261) **(40.8.1.261)** The North Carolina Department of State Treasurer (NCDST) sponsors a "Positive Pay" program which provides for the detection of counterfeit State warrants (checks) that may be presented against an agency's account. It also allows for an upfront reconciliation of presented warrants to be performed by the NCDST, minimizing the after-the-fact reconciliation process for the agency. Another benefit of the program is that it accommodates the prevention of warrants that have been escheated or are stale dated, from being paid. The "Stale Date Policy for State Warrants" issued September 2, 2003 requires all accounts, unless exempted by the State Controller, to participate in the positive pay program.

At the conclusion of cycle financial processing, we will submit to NCDST a check-issuance file containing the warrant data for all warrants being issued. This file will include data elements such as account number, warrant number, amount, and issue date, and payee name. Using this file, NCDST performs an upfront matching of warrants presented through the Federal Reserve Bank, allowing for detection any counterfeits presented.

The program adds another layer of control, supplementing similar controls established by our disbursement bank, helping ensure that only valid warrants for the correct amounts and correct warrant numbers are paid. Positive Pay also has a stale date feature, allowing warrants presented more than a specified number of days after the issued date to be dishonored.

During DDI we will work closely with the State to develop file layouts and transfer procedures designed to ensure that Positive Pay is well coordinated with our selected Bank.

Financial Cycle Reports

All reports are available online and provide information about any claim payments posted to up to the day of review. This reporting will include all claims suspended due to insufficient funding. The weekly report can be compared to weekly budget allocations prior to the execution of the checkwrite for DHHS expenditure allocation and control.

(40.14.1.319, 40.8.1.334) **(40.14.1.319, 40.8.1.334)** At the end of the checkwrite cycle, a payment report is system-generated and includes the identification of actual costs to budgeted program dollars for each DHHS LOB. This report will include payment information that indicates whether payments calculated do not exceed the budgeted amount and provides budget variances by LOB program and other DHHS approved criteria.

(40.14.1.93) **(40.14.1.93)** Additional reporting will be made available online that identifies any financial exception reporting related to un-reconciled balances or undefined chart of accounts. We will work with DHHS to define the required specifications during DDI.

Cycle Reprocessing

(40.8.1.239) **(40.8.1.239) 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, if selected as the next fiscal agent. 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.**

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)**

(40.8.1.234)

Remittance Advices

(40.8.1.318, 40.8.1.225, 40.8.1.320) **(40.8.1.318, 40.8.1.225, 40.8.1.32**0) Checkwrite reporting and remittance advices are produced at the end of the payment cycle by LOB. 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.

(40.8.1.270, 40.8.299) **(40.8.1.270, 40.8.299)** 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. Each Remittance Advice detail line provides the claim control number, recipient name and identification number, provider patient account number, service codes, as well as billed, allowed and paid amounts associated with the claim. DHHS-LOB approved explanation codes are applied based on claim adjudication, e.g., cutback, denied due to TPL coverage, adjustment/recoupment reason codes, etc.

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.

(40.8.1.233) **(40.8.1.233)** The Remittance Payment Control Process enables authorized users to customize a provider's remittance by appropriately setting various indicators and codes related to remittance processing. Users may specify the remittance media, remittance

sequence, maximum lines per remittance and whether or not to suppress pends on remittances.

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.

Remittance Suppression

(40.8.1.301; 40.8.1.305)

(40.8.1.301; 40.8.1.305) Our Financial Management and Accounting Subsystem will provide the capability to suppress generation of remittances in certain circumstances.

- The system can suppress the generation of zero-pay cycles for any provider or provider type.
- The system also 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 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.1.4.14-18 through D.1.4.14-19 contains confidential information.

(40.14.1.88, 40.14.1.89, 40.14.1.90) 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 **(40.14.1.88, 40.14.1.89, 40.14.1.90)**

When a check is received and cannot be associated with a specific receivable the transaction will be processed by a receipts dispositioning unit. 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. The system captures the user, date and time of each transaction. Please refer to our discussion below under the heading for Funds Received 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.

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 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 day, 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 retro 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. Recoupment Accounts Receivables are used to track and collect these types of balances. Recoupment accounts receivable balances are not system generated, they are created by online or batch entered Recoupment or Cash Advance 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.

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 weekly and provide 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)** Existing monthly reporting will provide notification to DHHS when an account receivable has reached one year from the date it as created. 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 system enables us to "zero-out" an existing receivable and enter a new program recoupment, ensuring that recoveries do not have adverse affect on the provider's ability to continue services to program recipients.

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 that are received in subsystem and can support any other program management or external entity interface that enables online interactive data entered and processed in accordance with 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 base 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 can only be entered online via the Funds Received Detail Page as shown in **Exhibit D.1.4.14-6**.

The Financial Receipt Disposition Page, as illustrated in **Exhibit D.1.4.14-7**, is 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.

Pages D.1.4.14-25 through D.1.4.14-26 contains confidential information.

(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, 40.14.1.64)

Fiscal transactions are used, but not limited to, the controlling of refunds, recoupments, liens/levies, withholds, advance payments, 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. **(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, 40.14.1.73,40.14.1.64)**

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)

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. The recouped dollars are credited to the appropriate LOB budget prior to the processing of new day claims. **(40.8.1.258)**

(40.8.1.258)

(40.8.1.210, 40.8.1.215, 40.8.1.255, 40.8.1.257, 40.8.1.256, 40.8.1.265, 40.8.1.272, 40.8.1.321, 40.8.1.322, 40.8.1.323, 40.8.1.323, 40.8.1.324, 40.8.1.325, 40.14.1.2, 40.14.1.5, 40.14.1.7, 40.14.1.10, 40.14.1.43, 40.14.1.38, 40.14.1.40, 40.4.14.44, 40.14.1.45, 40.14.1.46, 40.14.1.48, 40.14.1.51)

Every recoupment transaction is identified by a Financial Reason Code, which indicates the type of transaction 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. **(40.8.1.210, 40.8.1.215, 40.8.1.255, 40.8.1.257, 40.8.1.256, 40.8.1.265, 40.8.1.272, 40.8.1.321, 40.8.1.322, 40.8.1.323, 40.8.1.323, 40.8.1.324, 40.8.1.325, 40.14.1.2, 40.14.1.5, 40.14.1.7, 40.14.1.10, 40.14.1.43, 40.14.1.38, 40.14.1.40, 40.4.14.44, 40.14.1.45, 40.14.1.46, 40.14.1.48, 40.14.1.51)**

The Financial Management and Accounting Subsystem will provide the capability to set up multiple open accounts receivable items for recoupment against provider claims payable in the financial system, subject to a hierarchy table. 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.

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)** Often, it is necessary to prevent claim payments to providers under varying conditions. Some of these payments need to be withheld in full while others are only partially withheld. In all cases, payments can beheld for a period of time to be specified by DHHS. In these situations, a Financial Reason Code with a Special Processing Code setting of "Automatic" will be used. 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 payment disbursement upon request, recoupment of receivable dollars, depositing cash receipts. We will establish appropriate payable/receivable financial transactions as discussed in the related sections of this document. All DHHS LOB and DMA Audit Section required reporting will be defined and developed during DDI.

D.1.4.14.2.12 Recipient Functionality

(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, 40.1.14.1.55, 40.14.1.56, 40.14.1.57)

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, 40.1.14.1.55, 40.14.1.56, 40.14.1.57) Our Baseline System will be enhanced to support recipient premium invoicing and collections, as well as recipient premium 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.

(40.14.1.57, 40.14.1.58, 40.14.1.59)

Cost Sharing

(40.14.1.57, 40.14.1.58, 40.14.1.59) 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 baseline system incorporates full capabilities for generating Explanation of Medical Benefits (EOB's). 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)

(40.8.1.231, 40.8.1.232, 40.8.1.381, 40.14.1.60)

(40.8.1.231, 40.8.1.232, 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.

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**.

Page D.1.4.14-30 contains confidential information.

identification number and/or associated tax names on file, and the number they have on file, the automated letter function will issue immediate notification to the provider requesting updated W-9 information. The provider will have already received a "B-Notice" from the IRS, and is subject to immediate penalty if they do not respond within the designated period.

If penalties are incurred, the transaction follows regular Accounts Receivable procedures as described earlier. Ongoing status reporting is provided in accordance with State and Federal 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)** 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. Requirements relating to data exchanges in both directions, including detail specifications, will be finalized during the DDI.

DMH Client Data Warehouse Extract

(40.14.1.18) **(40.14.1.18)** We will establish 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

(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 month-end reporting. The financial reporting is produced in accordance with each DHHS LOB policy, procedures, frequency, and media following the checkwrite.

D.1.4.14.2.1 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 the most efficient support for all the Financial Management activities required by DHHS. The following section describes these additional functionalities that our system will provide:

External Authorized DHHS System Data for Accounting and Record Keeping

(40.14.1.74) **(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.

Retroactive Financial Transactions

(40.14.1.4) **(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.**

Fund Years/Sources

(40.14.1.63) **(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.

Change Transactions

(40.8.1.327) **(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

(40.8.1.281, 40.14.1.15) 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)** The system supports ad hoc querying tools that can be used to extract data from online screens to produce statistical samples that may be required by respective LOB auditors. 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) (40.8.1.15) **(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 base Replacement MMIS Our Replacement MMIS System 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.

(40.8.1.30, 40.8.1.259, 40.8.1.260, 40.8.1.283, 40.8.1.294)

(40.8.1.30, 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 calculate 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.

(40.8.1.266) ***Provider Incentives***

(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.

(40.8.1.286, 40.8.1.291, 40.8.1.292) ***Encounter Processing***

(40.8.1.286, 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 masterfile 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) Timely filing edits will be applied in accordance with DHHS policy as it relates to the State's fiscal year. The reports will be generated in accordance with DHHS specifications.

(40.8.1.293) ***Pharmacist Professional Fee***

(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.

(40.8.1.274) ***Retroactive Changes to Deductibles***

(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.

(40.8.1.199, 40.8.1.211, 40.8.1.268) ***Drug Rebate Procedures***

(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.

(40.14.1.70) ***Team CSC Administrative Billing***

(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.

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.

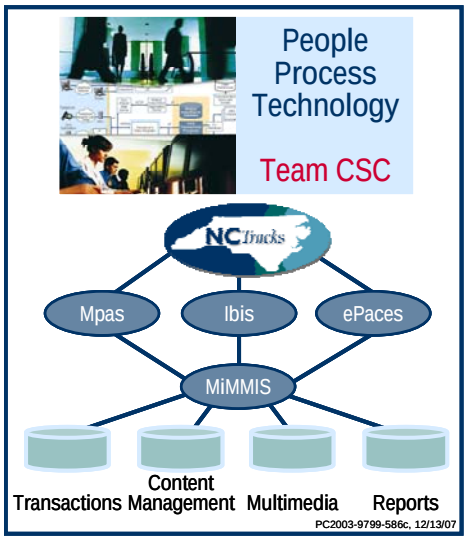
Pages D.1.7-1 through D.1.7-6 contain confidential information.

Pages D.1.8-1 through D.1.8-12 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 our current Raleigh facility located at Suite 220, 2803 Slater Road, Morrisville, NC. This existing CSC office is within the required 15 miles radius of the Dorothea Dix Campus facilities placing the center of operations in a highly cost effective area. Immediately after contract award, the CSC Team will select our permanent location, build out the facility, and relocate to that larger facility where we will remain for the duration of the contract.

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, (40.1.2.4)

- Fiscal Agent local facility (DDI and Operations phases) **(40.1.2.3)**
- Fiscal Agent Key Personnel (DDI and Operations phases) **(40.1.2.4)**
- Fiscal Agent Business Units (DDI and Operations phases) **(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)
- Network Operations Center for the Replacement MMIS (DDI and Operations phases)

- Data and Imaging Center (DDI and Operations phases)
- Storage of physical Medicaid files (DDI and Operations phases)

Some limited activities will be conducted at other locations:

- Pharmacy Prior Approval: A "per use" service from Member Health Cleveland processing center, which will be the least expensive, as required by contract
- 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

In addition to the current CSC office, 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.

Exhibit D.1.9-1 provides a more detailed listing of where our functions supporting the Replacement MMIS will be located.

D.1.9.1 CSC Team North Carolina Facility

Team CSC's Raleigh, North Carolina facility has ample room for DDI activities, work space for the State and meeting facilities. Additional space is available in the building if required.

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 Operation Center	Raleigh
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

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Exhibit D.1.9-1 Team CSC Support Locations. *Team CSC's support to Replacement MMIS is centered in North Carolina.*

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 and the Web Portal. 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. 40.1.2.5** We will include space identified above in the planning for the size and location of the initial DDI Phase Facility

40.1.2.5

Our current North Carolina facility complies with the facility requirements for State employees stated in the RFP **40.1.2.5** 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. **40.1.2.6** 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 **40.1.2.7-8**. We will also provide copier, scanner, and fax services to State employees operating at our location **40.1.2.9**.

Exhibit D.1.9.1-1. Team CSC's Raleigh Offices. *Locating near Dorothea Dix Campus Promotes Partnership.*

40.1.2.6, 40.1.2.7-8, 40.1.2.9)

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**

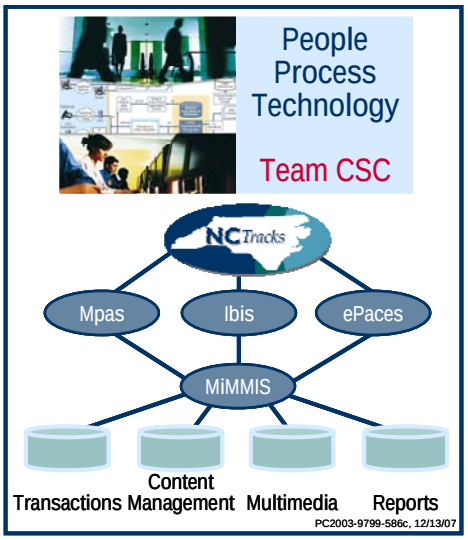
DHHS requirements. We realize that DHHS may also perform onsite inspections to monitor renovation, expansion, or construction progress. **Team CSC will consult DHHS if there are any changes in regard to the facilities approach or plans during the implementation.** In addition, **we will ensure that the 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.**

Pages D.1.10-1 through D.1.10-21 contain confidential information.

D.1.11 LICENSING AND SOFTWARE/HARDWARE SUPPORT RELATIONSHIPS

Team CSC will deliver an effective Health Check solution that avoids costly health care services through early detection and treatment using more timely and accurate information.

This section provides a description of all licensing and/or software/hardware support relationships with a third party and the general terms involved with any agreements, including limitations and constraints per RFP requirement 50.2.4.1.1 bullet 7.



CSC will negotiate with all software/hardware vendors licensing terms that are consistent with the terms of RFP Section 30; specifically "30.13 OWNERSHIP, PATENT, COPYRIGHT, AND TRADE SECRET PROTECTION". For each licensable product, CSC will obtain a perpetual, irrevocable license that will grant both CSC and the State the right to use the software on the Replacement MMIS and successor systems.

Per our standard practice, Team CSC will obtain support agreements from all software/hardware vendors for the duration of the contract that provide:

- Access to new software/firmware versions and releases as they become available;
- Remote problem analysis and assistance;
- Telephone and electronic access to support services;
- Priority response for mission critical incidents; problems that may or have caused an SLA breach or have a financial impact;
- Replacement of defective hardware

License and support agreements have a significant impact on cost and commitment period from each vendor. The license and support terms for each product will be included as terms and conditions with each price quote submitted by a vendor to CSC. CSC will negotiate license and support agreements with each vendor when Replacement MMIS pricing is developed.

CSC has corporate agreements with vendors of key products of our solution. The corporate agreements provide CSC with deeply discounted pricing and preferential support per license constraints. These licensing constraints place conditions on usage of the product. The general constraint is that the product may be installed in a CSC facility on behalf of a specific client or at a client site where the product is administered by CSC. The constraints do not restrict our ability to obtain perpetual, irrevocable and transferable licenses. They do, however, impact the cost of licenses that allow transfer of licenses to a successor contractor or to the state.

Page D.1.11-2 contains 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

20 December 2007
Volume I — Technical Proposal

Book 2 of 4
Sections D.1.14-D.4

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Table of Contents

BOOK 2

BOOK 3

BOOK 4

List of Exhibits

BOOK 1

BOOK 2

BOOK 3

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 Distribution
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

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
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 Voice Response Unit
BA	Business Analysis
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
CA	Control Accounts
CAFM	Computer-Aided Facilities Management
CAM	Control Account Managers
CAP	Competitive Acquisition Program
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	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	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 Amendment
CLIN	Contract Line Item Number
CM	Configuration Management
CMM	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
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	Certificate 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	Communication Plan

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
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
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 Ssytem
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 Administration
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
DSR	Daily Service Review
DSS	Division of Social Services (organization within NC DHHS)
DSS	Department of Social Services (as part of county government)
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 Fund Transfer
EHR	Electronic Health Record
EI	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
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 Aka 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 Detection System
FAQ	Frequently Asked Questions
FARO	Finance and Reimbursement Officer
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
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
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
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	Health Finance Management Association
HHA	Home Health Aid
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	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
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
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
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	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
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 Collabortaive
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
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 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
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	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

PMP	Project Management Professional
PMPM	Per Member Per Month
PMR	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)
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
PST	Production Simulation Testing
PV	Planned Value
PVCS	Polytron Version Control System
QA	Quality Assurance
QAP	Quality Assurance Plan
QASP	Quality Assurance Surveillance Plan
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
SCC	Security Control Center
SCHIP	State Children's Health Insurance Program
SD	System Development
SD	Software Development
SDB	Small Disadvantaged Business
SDEP	Service Delivery Excellence Program
SDLC	Software Development Life Cycle
SDM	Service Delivery Manager
SE	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
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	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
UI	User Interface
UPC	Universal Product Code
UPIN	Unique Provider Identification Number
UPS	Uninterruptible Power Supply
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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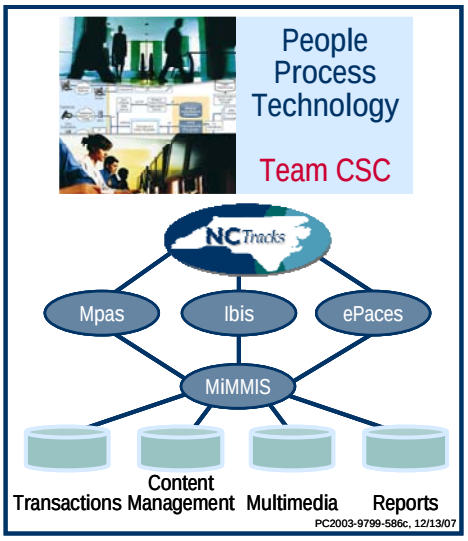
Pages D.1.14-1 through D.1.14-47 contain confidential information.

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.

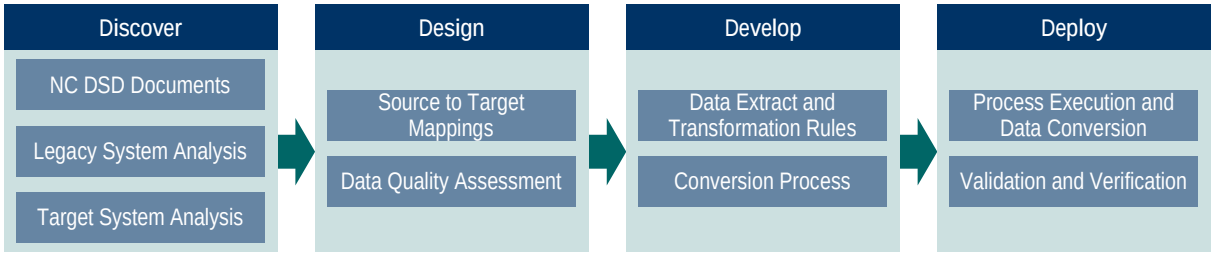

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Exhibit D.1.15.1.1-1. Team CSC Catalyst 4D Methodology for Data Conversion and Migration. *Our migration model is provable and ensures successful conversion.*

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 Mappings block identifies the business solution and the services required to implement that solution. This level of detail:

- 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.

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.

40.1.2.20 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)**

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 Legacy 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 a team with 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

40.1.2.18 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)**

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

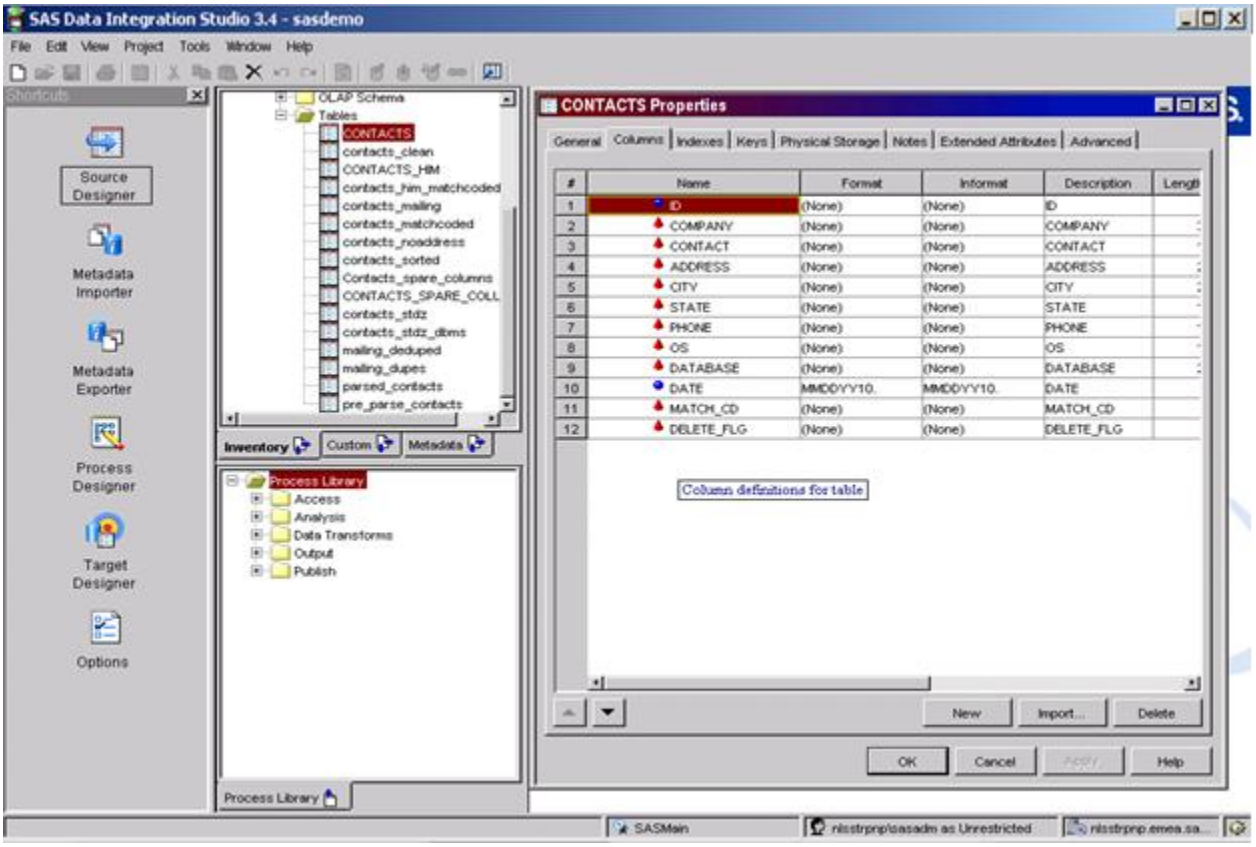
The Team CSC solution provides a robust, flexible, and extensible MMIS data model. The model has been successfully deployed in a functional MMIS application and is extensively documented. As such, most of the work for Target System Analysis is already complete.

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 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.

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:



9799-999

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 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.

D.1.15.3.1 High Level Source to Target 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™.

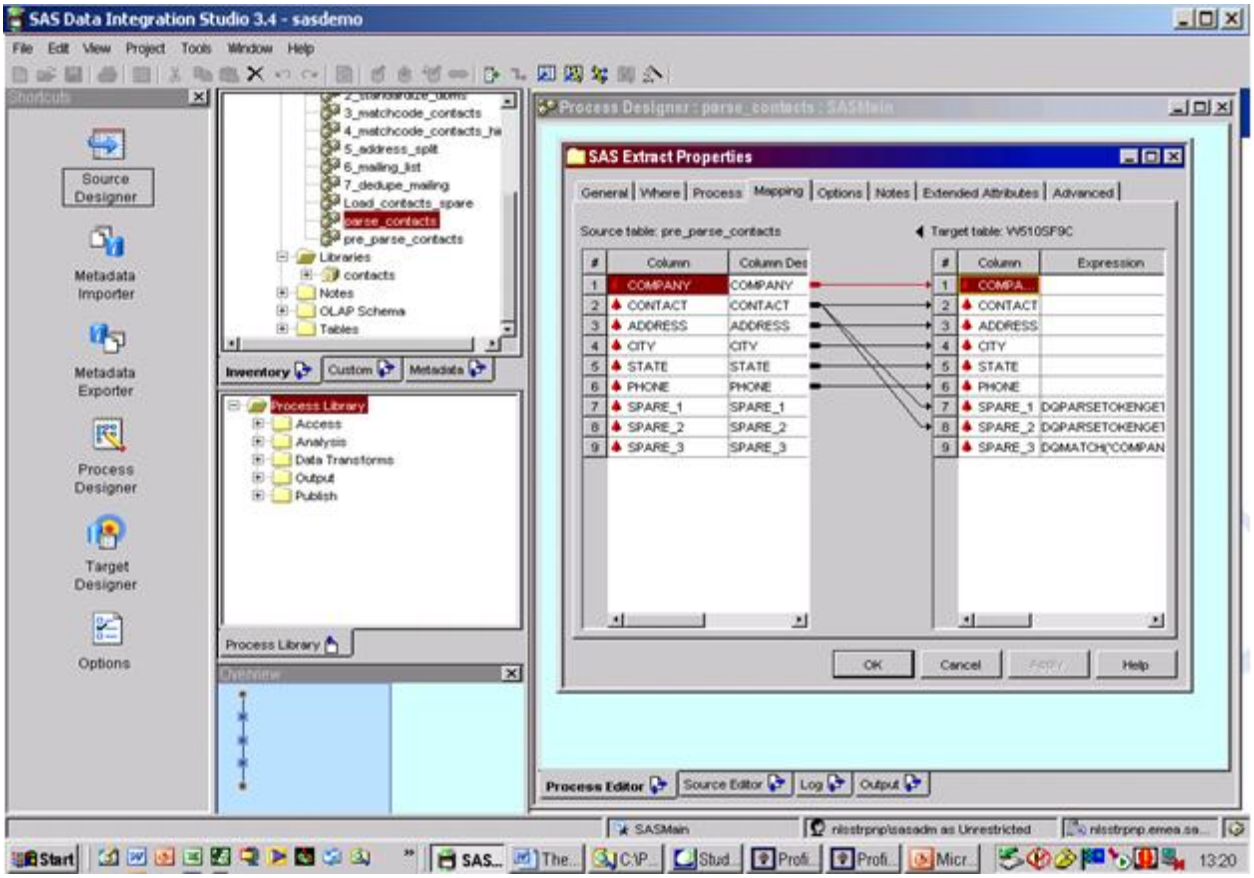


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Exhibit D.1.15.3-1. Source to Target Mapping via SAS Data Integration tools. *Data can be quickly and easily mapped from source to target via the SAS tools.*

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 High Level Mapping Document
- Extracted Business Rules and Data Files, and
- Non-Matched Mappings Document.

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 user community and other stakeholders.

Thus, the 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.

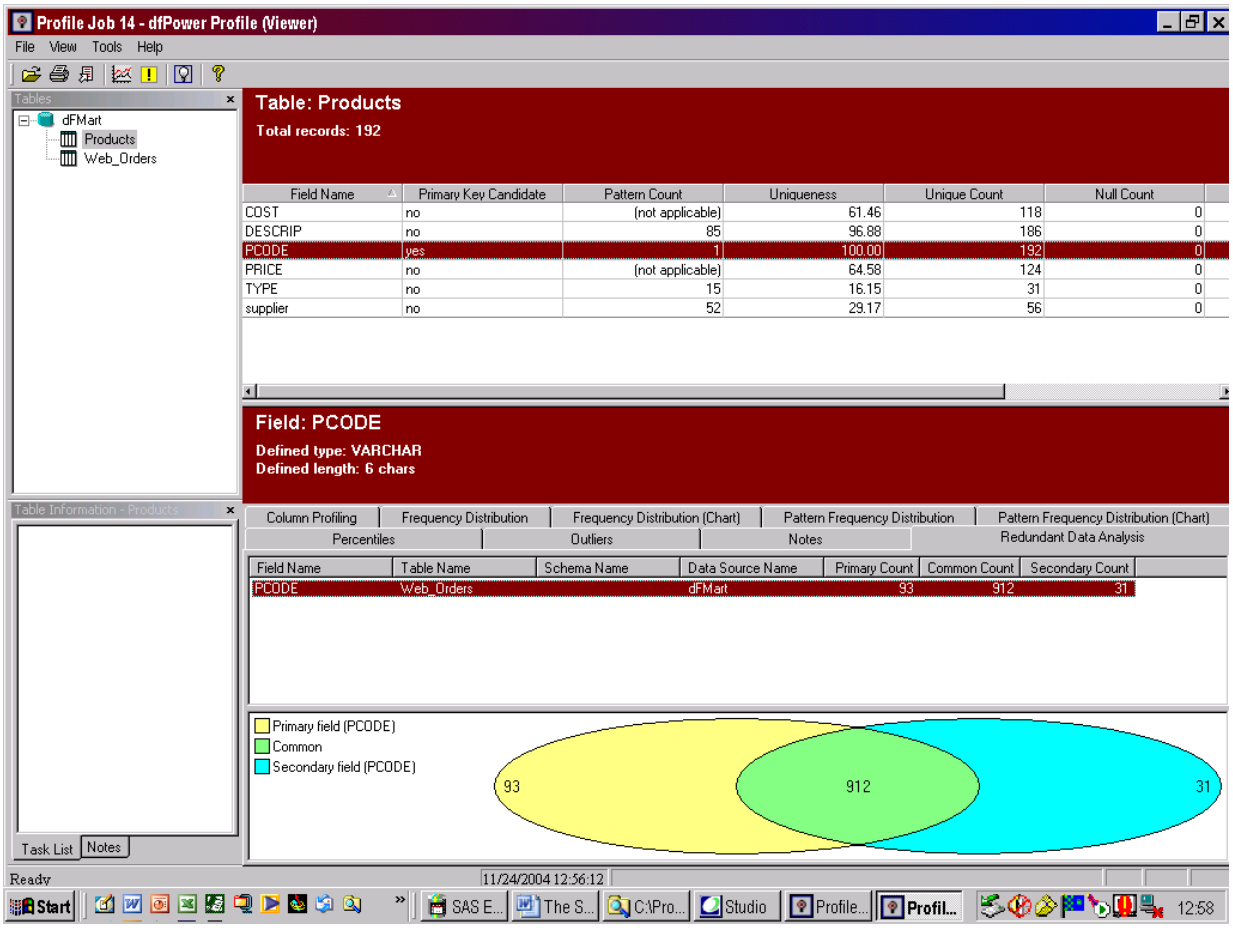

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Exhibit D.1.15.3.2-1. Data Profiling via the SAS Data Integration tools. *SAS tools data profiling capabilities make it easy to check for data consistency across different sources.*

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.

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 (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 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.

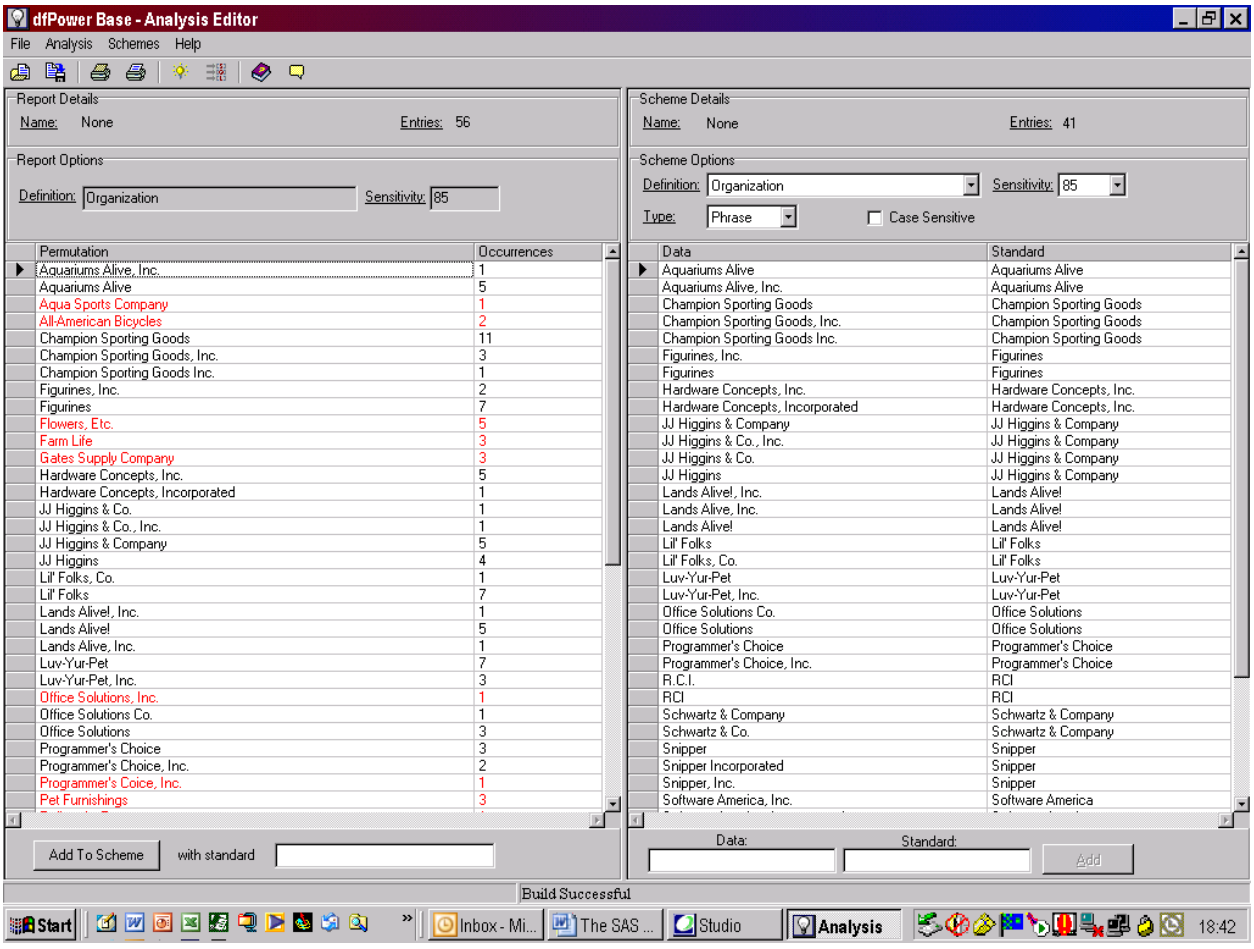

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Exhibit D.1.15.4.1-1. Data Standardization via the SAS Data Integration tools. *Data Standardization tools facilitate data mapping for applications.*

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. 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)**

The output from this process will be the Completed Data Conversion and Migration Routines.

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.

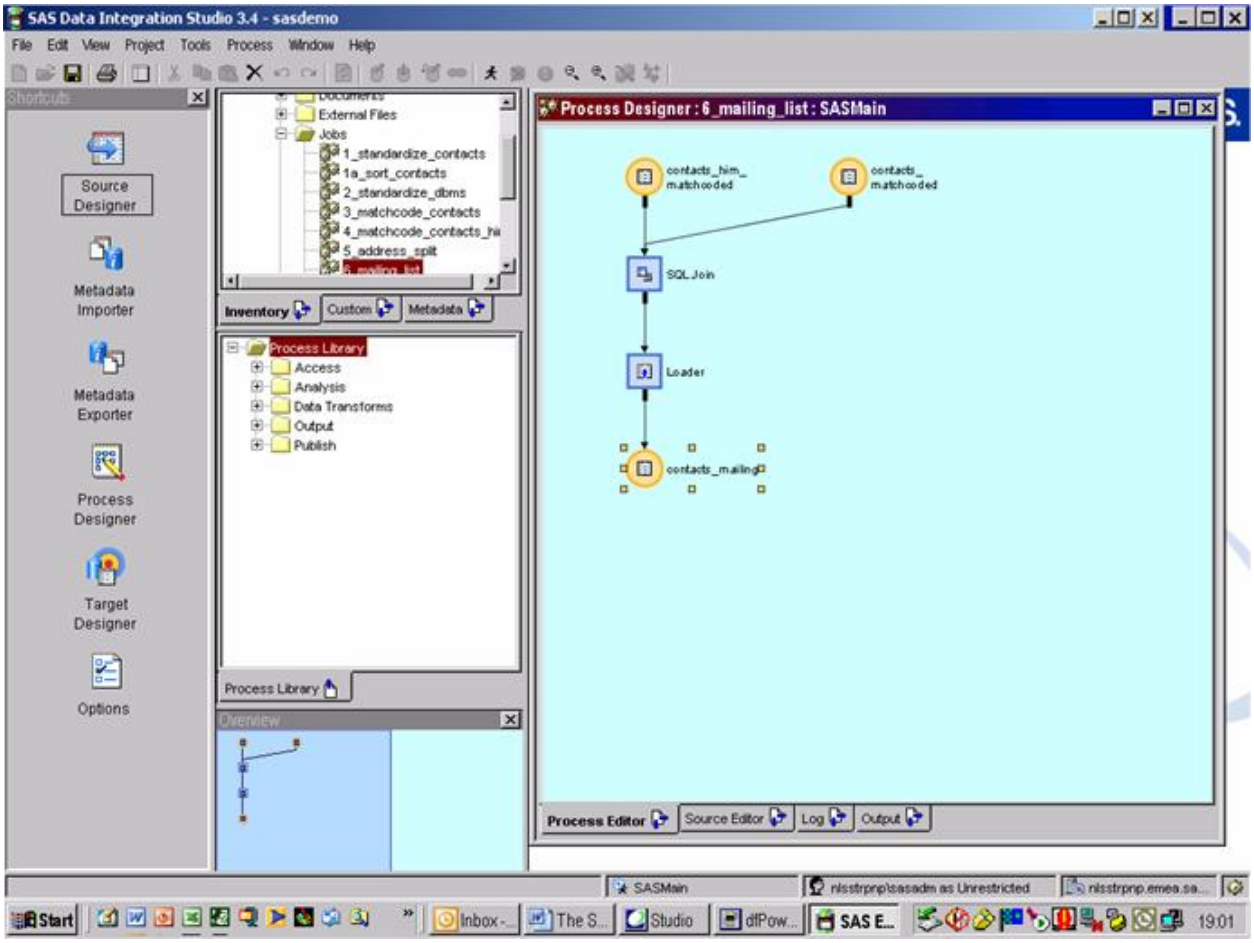

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Exhibit D.1.15.4.2-1. Construction of a Conversion Process via SAS Data Integration tools.
SAS provides an easy to use graphics interface to build data conversion processes rapidly.

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.

40.1.2.14 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)**

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.

40.1.2.15 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)**

The output from this phase will be an approved Validation Report.

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) • Tailored highly qualified workforce to support operations (SOO 10.10)
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) • Sustained life-cycle support (SOO 10.09) • Adhered to IFPUG software size functionality where applicable (SOO 10.5)
SEC ISS	• Stringent adherence to set deadlines • Ability to respond to disaster recovery	• Executed quick deployment of replacement strategies (SOO 10.6) • Managed the master plan to achieve a successful project (SOO 10.8))
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 10.2) • Ensured that the EPA received a reasonable return on all performance standards by meeting/exceeding service level agreements (SOO 10.2)

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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.

(50.2.4.1.5)

D.1.17 State Requirements Matrix (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 Matrix Development Approach

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.

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	Y
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.1.4.1-5 **D.1.4.8.5.1;** D.1.4.8-25	Y

Requirement #	Requirement Description	A	B	C	D	E
40.1.1.3	Provides capability to allow recipients and providers to enroll in one (1) or more benefits plans	N	Y	N	**D.1.4.1.2;** D.1.4.1-6 **D.1.4.2.1;** 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
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.1.4.8-25	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.1.4.8-28	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.1.4.8-46	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.1.4.8.5.1;** D.1.4.8-24	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.1.4.8-85	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.2.1.1.3.4 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.2.1.1.3.4 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.1.4.8.2 D.1.4.8-16	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
	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.1-7	Y

Requirement #	Requirement Description	A	B	C	D	E
40.1.1.18	Provides capability for initial batch loading of security records and profiles prior to implementation	N	N	N	**D.1.4.1.5;** D.1.4.1-11	Y
	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.1.3.1;** H.1-21	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.1.3.1;** H.1-21	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: ▪ Adaptable ▪ Available ▪ Extensible ▪ Interoperable ▪ Manageable ▪ Redundant ▪ Resilient ▪ Scalable ▪ Securable	N	N	N	D.1.10 D.1.10-1	Y
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

Requirement #	Requirement Description	A	B	C	D	E
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	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	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.1.4.2-11 **D.1.4.5.2.4;** D.1.4.5-17	Y
	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

Requirement #	Requirement Description	A	B	C	D	E
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 MMIS	N	N	N	**D.1.4.1.7;** D.1.4.1-13	Y
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

Requirement #	Requirement Description	A	B	C	D	E
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.1.4.1-13	Y
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.1.4.1-13	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.1.4.1-13	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

Requirement #	Requirement Description	A	B	C	D	E
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 access while allowing authorized copies to be used for further processing	N	N	N	**D.1.4.1.7;** D.1.4.1-13	Y
	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

Requirement #	Requirement Description	A	B	C	D	E
40.1.1.58	Provides capability for online help for all features, functions, and data element fields as well as descriptions and resolutions for error messages, using help features, including indexing, searching, tool tips, mouse-over, field value options, hypertext links to files, reports, and context-sensitive help topics	N	Y	N	**D.1.4.1.6;** D.1.4.1-12 **D.1.4.1.9;** D.1.4.1-14	Y
40.1.1.59	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.1.4.1-14	Y
	Search and Query					Y
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
	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	N	N	N	**D.1.4.1.11;** D.1.4.1-15	Y

Requirement #	Requirement Description	A	B	C	D	E
	produced					
40.1.1.68	Provides capability to produce updatable, form-based, version-controlled, customized templates for letter generation with capability for free-form text as specified in business 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.1.4.1-15	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.1.4.1-15	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 correspondence communication and allow for the identification of the best selection for combination of address(es), USPS, fax, e-mail	N	Y	N	**D.1.4.1.11;** D.1.4.1-16	Y
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.1.4.1-15	Y

Requirement #	Requirement Description	A	B	C	D	E
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.1.4.1-15	Y
40.1.1.83	Provides capability to create and distribute documents to multiple addresses	N	N	N	**D.1.4.1.11;** D.1.4.1-15	Y
40.1.1.84	Provides capability to redistribute static letters	N	N	N	**D.1.4.1.11;** D.1.4.1-15	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.1.4.1-15	Y
40.1.1.87	Provides capability to enforce security rules to control who issues each type of letter and to designate and enforce a chain of review for certain letters	N	N	N	**D.1.4.1.11;** D.1.4.1-16	Y
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	N	N	N	**D.1.4.1.12;** D.1.4.1-17	Y

Requirement #	Requirement Description	A	B	C	D	E
	▪ Cost allocation ▪ Contract invoicing ▪ Standard pre-formatted reports with parameters selection criteria					
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.1.4.1-16	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 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	N	N	N	**D.1.4.1.13;** D.1.4.1-18 **D.1.4.1.13;** D.1.4.1-19 **D.1.4.1.13;** D.1.4.1-21	Y
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.1.4.1-20	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.1.4.1-21	Y

Requirement #	Requirement Description	A	B	C	D	E
40.1.1.95	Provides capability to allow the assignment or routing of tasks by the user	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.1.4.1-20	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
40.1.1.100	Provides capability for automated work load balancing	N	N	N	**D.1.4.1.13;** D.1.4.1-20	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.1.4.1-21 **D.1.4.1.18;** D.1.4.1-37	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.1.4.1-21	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.1.4.1-22	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.1.4.1-22	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.1.4.1-22	Y

Requirement #	Requirement Description	A	B	C	D	E
	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	N	N	N	**D.1.4.1.14;** D.1.4.1-22 **D.1.4.1.14;** D.1.4.1-23	Y
40.1.1.108	Provides capability to modify rules, allowing the application to be adaptable with the dynamic rules	N	N	N	**D.1.4.1.14;** D.1.4.1-23 **D.1.4.1.14;** D.1.4.1-24 **D.1.4.1.18;** D.1.4.1-46	Y
40.1.1.109	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.1.4.1-24 **D.1.4.1.14;** D.1.4.1-28	Y
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	N	N	N	**D.1.4.1.14;** D.1.4.1-24	Y
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	N	N	N	**D.1.4.1.14;** D.1.4.1-26	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.1.4.1-23	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	N	N	N	**D.1.4.1.14;** D.1.4.1-23	Y
40.1.1.114	Provides capability to track and report rules usage	N	N	N	**D.1.4.1.14;** D.1.4.1-28	Y
40.1.1.115	Provides capability to produce and maintain documentation regarding all business rules	N	N	N	**D.1.4.1.14;** D.1.4.1-23	Y
40.1.1.116	Provides capability for integration with a workflow management process	N	N	N	**D.1.4.1.14;** D.1.4.1-23	Y

Requirement #	Requirement Description	A	B	C	D	E
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.1.4.1-23	Y
40.1.1.118	Provides capability to reuse business rules across processes	N	N	N	**D.1.4.1.14;** D.1.4.1-25	Y
40.1.1.119	Provides capability to change business rules independent of process	N	N	N	**D.1.4.1.14;** D.1.4.1-24 **D.1.4.1.14;** D.1.4.1-26	Y
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	N	Y	N	**D.1.4.1.14;** D.1.4.1-29	Y
	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.1.4.1-29	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.1.4.1-29	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.1.4.1-29	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.1.4.1-30	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.1.4.1-29	Y
40.1.1.126	Provides capability for State access to all test system files	N	N	N	**D.1.4.1.15;** D.1.4.1-29	Y
40.1.1.127	Provides capability for version control in the ITF	N	N	N	**D.1.4.1.15;** D.1.4.1-30	Y

Requirement #	Requirement Description	A	B	C	D	E
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.1.4.1-30 **D.4.4.2;** D.4-11 **D.4.6.3;** D.4-15	Y
	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.4.6.1;** D.4-15	Y
40.1.1.131	Provides capability for proficiency testing, quality reviews, and retraining, as needed, for Fiscal Agent staff				**D.4.5.1;** D.4-13	Y
40.1.1.132	Provides capability to deliver provider training through Web-based services and electronic media	Y	N	N	**D.4.5;** D.4-12	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.4.6.3;** D.4-15	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.4.6.8;** D.4-18	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.4-18	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.1.4.1-30	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.1.4.1-32	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.1.4.1-32	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.1.4.1-32	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.1.4.1-30	Y
40.1.1.142	Provides capability for call monitoring by supervisors and State monitors	N	N	N	D.1.4.1.17 D.1.4.1-35	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.1.4.1-32	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.1.4.1-32	Y
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.1.4.1-31	Y

Requirement #	Requirement Description	A	B	C	D	E
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.1.4.1-31	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.1.4.1-32	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.1.4.1-31	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.1.4.1-32	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.1.4.1.18;** D.1.4.1-40	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.1.4.1.18;** D.1.4.1-40	Y
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.1.4.1.18;** D.1.4.1-40	Y

Requirement #	Requirement Description	A	B	C	D	E
	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	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	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	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	Y
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	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	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.1.4.1-36	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.1.4.1-36	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.1.4.1-36	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.1.4.1-37	Y

Requirement #	Requirement Description	A	B	C	D	E
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.1.4.1-37	Y
40.1.1.164	Provides capability to access, complete, and submit online surveys	N	N	N	**D.1.4.1.18;** D.1.4.1-37	Y
40.1.1.165	Provides capability to link to CBT course presentations	N	N	N	**D.1.4.1.18;** D.1.4.1-37	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.1.4.1-37	Y
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.1.4.1-37 **D.1.4.1.18;** D.1.4.1-39	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.1.4.1-37	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.1.4.1-37	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.1.4.1-37	Y
40.1.1.171	Provides capability to link to stakeholder Web sites	N	N	N	**D.1.4.1.18;** D.1.4.1-37	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.1.4.1-39	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.1.4.1.18;** D.1.4.1-45 **H.1.2.2;** H.1-12	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.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.1.1.1;** H.1-5	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 ▪ 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				**D.1.9;** D.1.9-3 **D.2.2;** D.2.2-3 **H.1.1.1;** H.1-5	Y

Requirement #	Requirement Description	A	B	C	D	E
	▪ 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;** 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;** D.1.9-3 **D.2.1.5.1.6;** D.2.1.5-7 **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;** D.1.9-3 **D.2.1.5.1.4;** D.2.1.5-5 **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;** D.1.9-3 **D.2.2;** D.2.2-3	Y
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.1.1.1;** 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

Requirement #	Requirement Description	A	B	C	D	E
					E.1.2.14 E.1-31	
	Regulatory Compliance					
40.1.2.12	Fiscal Agent (DDI and Operations Phases) shall ensure that the Replacement MMIS incorporates compliance with appropriate Federal and State regulations, statutes, and policies concerning the protection of 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 ▪ 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)	N	N	N	**D.1.4.1.1;** D.1.4.1-2 **H.1;** H.1-2	Y

Requirement #	Requirement Description	A	B	C	D	E
	▪ 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 ▪ 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

Requirement #	Requirement Description	A	B	C	D	E
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.1.15-14	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.1.15-14	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 contractor.	N	N	N	**D.1.4.1.3;** D.1.4.1-9 **D.1.15.4.2;** D.1.15-12	Y
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.1.15-12	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	Y

Requirement #	Requirement Description	A	B	C	D	E
					D.1.15.4.1; D.1.15-10	
	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 **D.2.1.5.3;** D.2.1.5-11	Y
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.2.1.5-11	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.2.1.5-11	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.1.4.1.3;** D.1.4.1-10 **D.2.1.5.3;** D.2.1.5-11	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.4.1.7;** F.4-7 **H.1.2;** H.1-9 **H.1.2.1;** H.1-11 **H.1.6;**	Y

Requirement #	Requirement Description	A	B	C	D	E
					H.1-26	
40.1.2.27	Fiscal Agent (DDI Phase) shall assess and document the security threats and vulnerabilities for the proposed Replacement MMIS and shall implement the recommended controls and countermeasures to eliminate or reduce the associated risks.				**H.1.2.1;** H.1-11	Y
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.1-14	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.1-11 **H.1.7;** H.1-26	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.1-11 **H.1.2.4;** H.1-16	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.1-12	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.1-12	Y
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.1-12	Y

Requirement #	Requirement Description	A	B	C	D	E
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.1-12	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.1-7	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.1-11	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.1-11	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.4.1.3;** F.4-3 **H.1.6;** H.1-25	Y
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.1-12	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.1-16 **H.1.4;**	Y

Requirement #	Requirement Description	A	B	C	D	E
					H.1-23	
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.1-16	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.4.1.7;** F.4-6 **H.1.2;** H.1-7 **H.1.6;** H.1-25	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.1-18	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.				**H.1.3;** H.1-18	Y
40.1.2.45	Fiscal Agent (DDI and Operations Phases) shall provide accountability control to record facility access.				**H.1.3;** H.1-18	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.				**H.1.3;** H.1-18	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.				**H.1.3;** H.1-18	Y

Requirement #	Requirement Description	A	B	C	D	E
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.				**H.1.3;** H.1-18	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.1-12 **H.1.3;** H.1-18 **H.1.3.1;** H.1-21	Y
	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.1-18 **H.1.3.1;** H.1-21	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.1.3.1;** H.1-21 **H.1.4;** H.1-22	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.1-18 **H.1.4;** H.1-22	Y

Requirement #	Requirement Description	A	B	C	D	E
.	**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 in isolation.				**H.1.4;** H.1-22	Y
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.1-23	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.1-23	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.1-26	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.1-26	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.1-26	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.1-26	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.1-12	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.1.4.1.18;** D.1.4.1-40 **H.1.2.2;** H.1-12	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.1.4.1.18;** D.1.4.1-40 **D.2.1.5.3;** D.2.1.5-11	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.1.4.1.18;** D.1.4.1-45 **D.2.1.5.3;** D.2.1.5-11	Y
	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.2.1.5-11	Y
40.1.2.65	Fiscal Agent (DDI and Operations Phases) shall standardize all views, windows, and reports, including:				**D.1.4.1.6;** D.1.4.1-12	Y

Requirement #	Requirement Description	A	B	C	D	E
	▪ 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.2.1.5.3;** D.2.1.5-12	
	Workflow Management					
40.1.2.66	Fiscal Agent (Operations Phase) shall perform manual workload balancing.				**D.1.4.1.13;** D.1.4.1-20 **D.2.1.5.3;** D.2.1.5-11	Y
40.1.2.67	Fiscal Agent (Operations Phase) shall perform work item reassignments.				**D.1.4.1.13;** D.1.4.1-20 **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.1.4.1-23 **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.1.4.1-23 **D.2.1.5.3;**	Y

Requirement #	Requirement Description	A	B	C	D	E
					D.2.1.5-11	
40.1.2.70	Fiscal Agent (Operations Phase) shall perform business rule changes on a release basis.				**D.1.4.1.14;** D.1.4.1-23 **D.2.1.5.3;** D.2.1.5-11	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.1.4.1-29 **D.2.1.5.3;** D.2.1.5-12	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.1.4.1-29	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 State applications throughout the life of the Contract.				**D.1.4.1.15;** D.1.4.1-29 **D.2.1.5.3;** D.2.1.5-12	Y
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.1.4.1-29 **D.2.1.5.3;** D.2.1.5-12	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.1.4.1-29 **D.2.1.5.3;** D.2.1.5-12	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.1.4.1-29 **D.2.1.5.3;** D.2.1.5-12 **D.4.4.2;** D.4-10	Y

Requirement #	Requirement Description	A	B	C	D	E
					D.4.5; D.4-12	
	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.2.1.3-22 **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.2.1.3-22 **D.4.;** D.4-3 **D.4.6;** D.4-13	Y
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.4-14	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.4.4.1;** D.4-8	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.4.4.1;** D.4-9 **H.1.2;** H.1-7	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.2.1.3-30 **D.4.4.1;** D.4-8	Y

Requirement #	Requirement Description	A	B	C	D	E
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.4-9	Y
40.1.2.84	Fiscal Agent (Operations Phase) shall report to the State monthly on Fiscal Agent staff training and proficiencies.				**D.4.4.2;** D.4-9 **D.4.5.1;** D.4-13 **H.1.2;** H.1-7	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.2.1.3-22 **D.4.6;** D.4-14	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.2.1.3-22 **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.2.1.3-23 **D.4.6;** D.4-14	Y
40.1.2.88	Fiscal Agent (Operations Phase) shall plan, organize, and conduct the annual Medicaid Fair.				**D.2.1.3.4;** D.2.1.3-28 **D.4.6.3;** D.4-16	Y
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.2.1.3-16	Y

Requirement #	Requirement Description	A	B	C	D	E
	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.1.4.1-30 **D.2.1.3.2;** D.2.1.3-16	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.1.4.1-30 **D.2.1.3.2;** D.2.1.3-16	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.1.4.1-32 **H.1.1.3;** H.1-6	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 reviewing entity identified by the State, with resources, data, and reports in the audit of Fiscal Agent performance, compliance, and system reviews.				**H.1.2.4;** H.1-16	Y
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.1-16	Y

Requirement #	Requirement Description	A	B	C	D	E
	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.1.4.1.18;** D.1.4.1-47 **D.2.1.5.3;** D.2.1.5-12 **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.1.4.1.18;** D.1.4.1-47 **D.2.1.5.3;** D.2.1.5-12	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.1.4.1.18;** D.1.4.1-47 **D.2.1.5.3;** D.2.1.5-13	Y
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				**D.1.4.1.18;** D.1.4.1-47 **D.2.1.5.3;** D.2.1.5-13	Y

Requirement #	Requirement Description	A	B	C	D	E
	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 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.1.4.1.18;** D.1.4.1-46	Y

Requirement #	Requirement Description	A	B	C	D	E
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.1.4.1.18;** 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.1.4.1.18;** D.1.4.1-47	Y
40.1.2.103	Fiscal Agent (Operations Phase) shall allocate system modification tasks against productive hours.				**D.1.4.1.18;** D.1.4.1-47	Y
40.1.2.104	Fiscal Agent (DDI and Operations Phases) shall manage system modification activities using the change management process.				**D.1.4.1.18;** 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.1.4.1.18;** 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.1.4.1.18;** 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.1.4.1.18;** 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				**H.1.2.2;** H.1-12	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.1-15	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
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

Requirement #	Requirement Description	A	B	C	D	E
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.1.4.2.5 D.1.4.2-13	Y
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	N	Y	N	**D.1.4.2.4;** D.1.4.2-10	Y

Requirement #	Requirement Description	A	B	C	D	E
	received through the EIS interface are processed or are listed on error reports					
40.2.1.17**	Provides capability to reconcile DMH Accredited Standard Committee (ASC) X12N 834 transactions eligibility data with the Replacement MMIS each State business day in order to verify that all records and segments received via the 834 transaction are processed or are listed on error reports	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
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 **D.1.4.2.5;** D.1.4.2-11	Y
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.1.4.2-11	Y
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	N	Y	N	**D.1.4.2.4;** D.1.4.2-10	Y

Requirement #	Requirement Description	A	B	C	D	E
	eligibility update					
40.2.1.27	Provides capability to receive and process deductible information from the recipient eligibility record and make it available for claims processing	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.)	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.1.4.2-7	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
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	N	N	N	**D.1.4.2.6;** D.1.4.2-15	Y

Requirement #	Requirement Description	A	B	C	D	E
	accordance with CMS Redesign practices					
40.2.1.37	Provides capability to produce reports after each buy-in update to identify all transactions received, all transactions that processed successfully, and all transactions that had errors, invalid data, and/or could not be matched to a recipient in accordance with CMS Redesign practices	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.1.4.2-13	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 enrollment/disenrollment occurs	N	N	N	**D.1.4.2.4;** D.1.4.2-11	Y
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

Requirement #	Requirement Description	A	B	C	D	E
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 using information on the recipient's eligibility record	N	N	Y	**D.1.4.2.7;** D.1.4.2-17	Y
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	N	N	Y	**D.1.4.2.9;** D.1.4.2-18	Y

Requirement #	Requirement Description	A	B	C	D	E
	recipient deleted/terminated from specified Medicaid coverage					
40.2.1.61	Provides capability to produce a COCC for a specific period if requested by the recipient/client or by the State	N	N	Y	**D.1.4.2.9;** D.1.4.2-18	Y
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.1.4.2-18	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.1.4.2-18	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.1.4.2-18	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.1.4.2-18	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.1.4.2-17	Y
40.2.1.70	Provides capability to include data in the MMA Enrollment File necessary to count the	N	Y	N	**D.1.4.2.8;** D.1.4.2-17	Y

Requirement #	Requirement Description	A	B	C	D	E
	number of enrollees for the phased-down State contribution payment					
40.2.1.71	Provides capability to include records in the MMA Enrollment File for those individuals for whom the State has made an enrollment determination for the Part D low income subsidy	N	N	N	**D.1.4.2.8;** D.1.4.2-17	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.1.4.2-17	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.1.4.2-17	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.1.4.2-17	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.1.4.2-17	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.1.4.2-17	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.1.4.2-17	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.1.4.2-17	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	N	N	N	**D.1.4.2.8;** D.1.4.2-17 **D.1.4.2.11;** D.1.4.2-19	Y
40.2.1.80	Provides capability to accept and process Medicaid/Medicare coverage data from EIS and make it available for claims processing	N	N	N	**D.1.4.2.8;** D.1.4.2-17	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

Requirement #	Requirement Description	A	B	C	D	E
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.1.4.2-7	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	Y
	DPH Online Enrollment					Y
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 by selected enrollment options	N	N	N	**D.1.4.2.5;** D.1.4.2-12	Y
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

Requirement #	Requirement Description	A	B	C	D	E
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
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.1.4.2-12	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.1.4.2-12	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.1.4.2-12	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	N	Y	N	**D.1.4.2.5;** D.1.4.2-12	Y

Requirement #	Requirement Description	A	B	C	D	E
	demand with date span parameters based on application and/or recipient characteristics					
40.2.1.105**	Provides capability for inquiry selection for one (1) or more applications/records that meet specified criteria, by any of the following: ▪ 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
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.1.4.2-19	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.1.4.2-19	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.1.4.2-12	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.1.4.2-13	Y
40.2.1.113	Provides capability for recipient lock-in/lock-out to a specific pharmacy and/or primary	Y	Y	N	**D.1.4.2.5;** D.1.4.2-14	Y

Requirement #	Requirement Description	A	B	C	D	E
	care provider and/or prescriber					
40.2.1.114	Provides capability for recipient lock-in/lock-out from a specific pharmacy and/or primary care provider and/or prescriber	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
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.1.4.2-19	Y
40.2.1.121	Provides capability for online inquiry into audit trail	N	N	N	**D.1.4.2.12;** D.1.4.2-19	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.1.4.2-13	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.2.1.3-40	Y
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.2.1.3-40	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.2.1.3-40	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.2.1.3-41	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.2.1.2-14	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.2.1.3-23	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.2.1.3-39	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.2.1.3-40	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.2.1.3-40	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.2.1.3-40	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.2.1.3-40	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.2.1.3-39	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
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	N	N	N	**D.1.4.3.3;** D.1.4.3-7	Y

Requirement #	Requirement Description	A	B	C	D	E
	▪ Protecting the confidentiality of all recipient information					
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.2.1.3-38	Y
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.2.1.3-38	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.2.1.3-39	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.2.1.3-53	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.2.1.3-38 **D.2.1.3.10;** D.2.1.3-48	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.2.1.3-53	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

Requirement #	Requirement Description	A	B	C	D	E
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
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.1.4.4-8	Y

Requirement #	Requirement Description	A	B	C	D	E
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
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.1.4.4-10	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	N	N	Y	**D.1.4.4.4;** D.1.4.4-8	Y

Requirement #	Requirement Description	A	B	C	D	E
	▪ 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 ▪ 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	N	N	Y	**D.1.4.4.6;** D.1.4.4-12	Y

Requirement #	Requirement Description	A	B	C	D	E
	that will be synchronized with application system updates					
	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
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	N	Y	N	**D.1.4.4.3;** D.1.4.4-7	Y

Requirement #	Requirement Description	A	B	C	D	E
	status, etc.), and inquiry source (AVRS, Web, EVS, etc.)					
40.4.1.35	Provides capability to uniquely identify and track each online recipient eligibility verification and nurse aide verification inquiry and response	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.2.1.3-16	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.2.1.3-16	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.2.1.3-16	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) days a week, three hundred sixty-five (365) days a year, with the exception of State-approved scheduled maintenance.	N	N	N	**D.2.1.3.4;** D.2.1.3-27	Y

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.2.1.3-53	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.2.1.3-53	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.2.1.3-53	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.2.1.3-53	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

Requirement #	Requirement Description	A	B	C	D	E
40.5.1.4	Provides capability for secure log-on that allows providers to retrieve and update incomplete application or check status of a submitted application	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.1.4.5-7	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;** D.1.4.5-8 **D.1.4.5.2.3;** D.1.4.5-10	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
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.1.4.5-162	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.1.4.5.2.4;** 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

Requirement #	Requirement Description	A	B	C	D	E
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.1.4.5-8	Y
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.1.4.5-18	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.1.4.5-21 **D.1.4.5.3;** D.1.4.5-20	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	N	N	Y	**D.1.4.5.2;** D.1.4.5-8	Y

Requirement #	Requirement Description	A	B	C	D	E
	provider enrollment form requests				**D.1.4.5.2.4;** D.1.4.5-18	
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.1.4.5-21	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.1.4.5-20	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
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

Requirement #	Requirement Description	A	B	C	D	E
40.5.1.36	Provides capability to accommodate NPI and multiple associated taxonomies	N	N	N	**D.1.4.5.2.4;** D.1.4.5-17	Y
40.5.1.37	Provides capability to validate all NPIs	N	N	N	**D.1.4.5.2.4;** D.1.4.5-17	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.1.4.5-19	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.1.4.5-19	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
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	N	N	N	**D.1.4.5.3;** D.1.4.5-20	Y

Requirement #	Requirement Description	A	B	C	D	E
	credentialing data verifications					
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.1.4.5-19	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
	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.1.4.5-24	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.1.4.5-24	Y
40.5.1.57	Provides capability to make State-approved forms available online	N	N	N	**D.1.4.5.4.5;** D.1.4.5-25	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.1.4.5-25	Y
40.5.1.59	Provides capability to accept and process online requests for additions and changes to	Y	N	N	**D.1.4.5.4.7;** D.1.4.5-26	Y

Requirement #	Requirement Description	A	B	C	D	E
	the provider data					
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.1.4.5-24	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.1.4.5-25	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.1.4.5-23	Y
40.5.1.65	Provides capability for online access of providers to training materials, training registrations, and tracking, including audit history of all provider trainings	N	N	N	**D.1.4.5.4.5;** D.1.4.5-26	Y
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.1.4.5-26	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.1.4.5-23	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.1.4.5-23	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.1.4.5-23	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	N	N	N	**D.1.4.5.4.3;** D.1.4.5-25	Y

Requirement #	Requirement Description	A	B	C	D	E
	non-enrollment					
40.5.1.72	Provides capability to maintain 1099 and associated payment summary data	N	N	N	**D.1.4.5.4.1;** D.1.4.5-23	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.1.4.5-24	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
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.1.4.5-24	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.1.4.5-25	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	N	N	N	**D.1.4.5.4.1;** D.1.4.5-23	Y
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

Requirement #	Requirement Description	A	B	C	D	E
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.1.4.5-25	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.1.4.5-25	Y
	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.1.4.5.1;** D.1.4.5-6 **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.1.4.5-29	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.1.4.5-29	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.1.4.5-29 **D.1.4.5.5.4;** D.1.4.5-28	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.1.4.5-27	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.1.4.5-27	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.1.4.5-29	Y

Requirement #	Requirement Description	A	B	C	D	E
40.5.1.95	Provides capability to maintain and submit to the State provider training sessions participants	N	N	N	**D.1.4.5.5.4;** D.1.4.5-29	Y
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.1.4.5-29	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.1.4.5-29	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.1.4.5-29	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.1.4.5-30	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.1.4.5-30	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.1.4.5-30	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.1.4.5-30	Y
40.5.1.103	Provides capability for individual access to query tools	N	N	N	**D.1.4.5.5.5;** D.1.4.5-30	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.2.1.3-17	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.2.1.3-17	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.2.1.1.4.4;** D.2.1.1-13 **D.2.1.3.4;** D.2.1.3-30	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.2.1.3-9 **D.2.1.3.4;** D.2.1.3-30	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.2.1.3-10	Y
40.5.2.8**	Fiscal Agent shall accept, process, and maintain DMH attending-only provider records entered by the LME				**D.2.1.3.1.5;** D.2.1.3-10	Y
	Provider Enrollment, Credentialing, and Verification					
40.5.2.9	Fiscal Agent shall implement at the direction of the State suspension or termination				**D.2.1.3.1.2.1;** D.2.1.3-8	Y

Requirement #	Requirement Description	A	B	C	D	E
	action for providers whose licenses have been revoked or suspended by State licensing or accrediting bodies.					
40.5.2.10	Fiscal Agent shall conduct activities to suspend, terminate, or withhold payments, percentages, and incentives from providers under investigation by State or Federal agencies at the sole discretion of the State.				**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
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				**D.2.1.3.1.2;** D.2.1.3-5	Y

Requirement #	Requirement Description	A	B	C	D	E
	signature, and required participation criteria.					
40.5.2.21	Fiscal Agent shall update provider data based on information received during the credentialing, re-credentialing, and subsequent enrollment of the provider.				**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.2.1.3-12	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.2.1.3-13	Y
40.5.2.26	Fiscal Agent shall send a system-generated letter to the provider advising disposition of the case and appeal process procedures.	Y	N	N	**D.2.1.3.1.10;** D.2.1.3-13	Y
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.2.1.3-13	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.2.1.3-14	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.2.1.3.1.2;** D.2.1.3-5 **D.2.1.3.1.11;** D.2.1.3-14	Y
40.5.2.30	Fiscal Agent shall ensure the Review/Appeals Coordinator obtains any additional				**D.2.1.3.1.11;** D.2.1.3-14	Y

Requirement #	Requirement Description	A	B	C	D	E
	information to provide to the State Review Committee to support an informed decision.					
40.5.2.31	Fiscal Agent shall route appeals and all supporting documentation to the State Review Committee Work Queue for disposition.	N	Y	N	**D.2.1.3.1.11;** D.2.1.3-14	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.2.1.3-14	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.2.1.3-16	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 (2) business days.				**D.2.1.3.2;** D.2.1.3-17	Y
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.2.1.3-17	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.2.1.3-20	Y
40.5.2.37	Fiscal Agent shall refer questions regarding eligibility and program benefits to the State.				**D.2.1.3.2;** D.2.1.3-19	Y
40.5.2.38	Fiscal Agent shall refer questions regarding rates and budgets to the State.				**D.2.1.3.2;** D.2.1.3-19	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.2.1.3-15 **D.2.1.3.2;** D.2.1.3-19	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.2.1.3-20	Y

Requirement #	Requirement Description	A	B	C	D	E
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.2.1.3-31	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.2.1.3-28	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.2.1.3-28	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.2.1.3-28	Y
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.2.1.3-29	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.2.1.3-25	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.2.1.3-25	Y
40.5.2.48	Fiscal Agent shall track and report on provider requested visits.	Y	N	N	**D.2.1.3.4;** D.2.1.3-27	Y
40.5.2.49	Fiscal Agent shall implement annual marketing plans for electronic commerce options.				**D.2.1.3.3;** D.2.1.3-22	Y
40.5.2.50	Fiscal Agent shall conduct provider workshops at State-approved locations.				**D.2.1.3.4;** D.2.1.3-25 **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.2.1.3-26	Y
40.5.2.52	Fiscal Agent shall assist the State with quarterly training conferences.				**D.2.1.3.4;** D.2.1.3-26	Y

Requirement #	Requirement Description	A	B	C	D	E
40.5.2.53	Fiscal Agent shall distribute on-site training evaluation questionnaires for providers to complete.				**D.2.1.3.4;** D.2.1.3-26	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.2.1.3-26 **D.4.6.8;** D.4-18	Y
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.2.1.3-26 **D.4.6.8;** D.4-18	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.2.1.3-27	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.2.1.3-28	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.2.1.3-28	Y
40.5.2.59	Fiscal Agent shall maintain State-approved instructional materials for viewing and retrieval.				**D.2.1.3.4;** D.2.1.3-30	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.2.1.3-30	Y
	Imaging Provider Communications					
40.5.2.61	Fiscal Agent shall image all provider written communications.				**D.2.1.1.4.4;** D.2.1.1-13 **D.2.1.3.4;** D.2.1.3-30	Y

Requirement #	Requirement Description	A	B	C	D	E
	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 applicable to a provider site visit, linking to the provider identification number for complete profile data retrieval.				**D.2.1.1.4.4;** D.2.1.1-13 **D.2.1.3.4;** D.2.1.3-30	Y
	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.2.1.1.4.4;** D.2.1.1-13 **D.2.1.3.4;** D.2.1.3-30	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.2.1.3-30	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.2.1.3-20	Y
40.5.2.66	Fiscal Agent shall maintain up-to-date complete system and user documentation.				**D.2.1.3.4;** D.2.1.3-29	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.2.1.3.2;** D.2.1.3-19	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.2.1.3-22 **D.2.1.3.4;** D.2.1.3-28	Y
	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	N	N	N	**D.2.1.3.2;** D.2.1.3-17	Y

Requirement #	Requirement Description	A	B	C	D	E
	Sunday.					
40.5.2.70	Fiscal Agent shall perform daily system checks to ensure that the recording/tracking business area is functioning as designed and provides system logging of check date, time, operator, comments, and reporting as directed by the State.	N	N	N	**D.2.1.3.2;** D.2.1.3-17	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.2.1.3-30	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.2.1.3-17	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.2.1.1-18 **D.2.1.3.10;** D.2.1.3-48	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.2.1.3-48	Y
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.2.1.3-7 **D.2.1.3.10;** D.2.1.3-48	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.2.1.3-48	Y
40.5.3.5	Fiscal Agent shall send denial letters and other State-required information within one				**D.2.1.3.1.2.1;** D.2.1.3-9	Y

Requirement #	Requirement Description	A	B	C	D	E
	(1) State business day of provider participation denial.				**D.2.1.3.10;** D.2.1.3-48	
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.2.1.3-49	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.2.1.3-14 **D.2.1.3.10;** D.2.1.3-49	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.2.1.3-14 **D.2.1.3.10;** D.2.1.3-49	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.2.1.3-49	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. 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.	N	N	N	**D.2.1.3.10;** D.2.1.3-49	Y
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.2.1.3-49	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.2.1.3-50	Y
40.5.3.13	Fiscal Agent shall provide online real-time access to Provider data for State-	N	N	N	**D.2.1.3.10;** D.2.1.3-50	Y

Requirement #	Requirement Description	A	B	C	D	E
	designated staff using API and SOA concepts between EIS and the Replacement MMIS.					
40.5.3.14	Fiscal Agent shall provide initial and ongoing updated e-mail listservs based on initial and ongoing provider enrollments, disenrollments, and change requests the same day the transaction occurs ninety-nine and nine tenths (99.9) percent of the time.	N	N	N	**D.2.1.3.10;** D.2.1.3-50	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.2.1.3-50	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.2.1.3-50	Y
40.5.3.17	Fiscal Agent shall produce State-approved initial and ongoing updates to training materials and secure, browser-based, Web-enabled tutorials in the content, frequency, format, and all media as directed by the State.				**D.2.1.3.4;** D.2.1.3-28 **D.2.1.3.10;** D.2.1.3-50	Y

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.1.4.6-5	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.1.4.6-5	Y

Requirement #	Requirement Description	A	B	C	D	E
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.1.4.6-10	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.1.4.6-10	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.1.4.6-10	Y
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.1.4.6-12	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.1.4.6-5	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.1.4.6-20	Y
40.6.1.10	Provides capability for parameter-driven, ad hoc activity logging reports	N	N	N	**D.1.4.6.9;** D.1.4.6-20	Y
40.6.1.11	Provides capability to ensure appropriate tracking, controls, and audit logs are	N	Y	N	**D.1.4.6.9;** D.1.4.6-20	Y

Requirement #	Requirement Description	A	B	C	D	E
	associated with all file updates					
40.6.1.12	Provides capability to link Reference File updates to applicable edits/audits	N	N	N	**D.1.4.6.9;** D.1.4.6-20	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 ▪ 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	N	Y	N	**D.1.4.6.3;** D.1.4.6-10	Y
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	N	Y	N	**D.1.4.6.2;** D.1.4.6-9	Y

Requirement #	Requirement Description	A	B	C	D	E
	program, per provider ▪ Cross-referencing edits/audits ▪ Information line					
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.1.4.6-12	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.1.4.6-9	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 or specified range	N	N	N	**D.1.4.6.2;** D.1.4.6-9	Y
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.1.4.6-9	Y
40.6.1.19	Provides capability to categorize edits/audits	N	N	N	**D.1.4.6.2;** D.1.4.6-9	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.1.4.6-9	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.1.4.6-9	Y

Requirement #	Requirement Description	A	B	C	D	E
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.1.4.6-11	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 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	N	Y	N	**D.1.4.6.4;** D.1.4.6-11	Y

Requirement #	Requirement Description	A	B	C	D	E
	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 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					

Requirement #	Requirement Description	A	B	C	D	E
	▪ 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 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.	N	Y	N	**D.1.4.6.6;** D.1.4.6-14	Y

Requirement #	Requirement Description	A	B	C	D	E
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.1.4.6-5	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 each year and report all errors that occur in processing of the annual DRG code update	N	Y	N	**D.1.4.6.5;** D.1.4.6-12	Y
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.1.4.6-13	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.1.4.6-13	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.1.4.6-13	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.1.4.6-13	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.1.4.6-12	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.1.4.6-12	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.1.4.6-9	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.1.4.6-7	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.1.4.6-8	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.1.4.6-20	Y
40.6.1.37	Provides capability to electronically store accommodation rate data	N	N	N	**D.1.4.6.4;** D.1.4.6-12	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.1.4.6-5	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.1.4.6-12	Y
40.6.1.40	Provides capability to produce electronic copies of Reference Files	N	N	N	**D.1.4.6.8;** D.1.4.6-19	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.1.4.6-5	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.1.4.6-12	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 ▪ Edits ▪ Rate methodology and calculations ▪ Professional services fees	N	Y	N	**D.1.4.6.1;** D.1.4.6-5	Y

Requirement #	Requirement Description	A	B	C	D	E
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.1.4.6-10	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	N	Y	N	**D.1.4.6.4;** D.1.4.6-11	Y
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 ▪ 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	N	Y	N	**D.1.4.6.4;** D.1.4.6-11	Y

Requirement #	Requirement Description	A	B	C	D	E
	▪ 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.1.4.6-12	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.1.4.6-11	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 ▪ 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	N	Y	N	**D.1.4.6.6;** D.1.4.6-14	Y

Requirement #	Requirement Description	A	B	C	D	E
	▪ 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.1.4.6-14	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.1.4.6-14	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.1.4.6-14	Y
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.1.4.6-5	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.1.4.6-12	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.1.4.6-12	Y
40.6.1.56	Provides capability to identify Drug Efficacy Study Implementation (DESI) drugs	N	N	N	**D.1.4.6.6;** D.1.4.6-14	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.1.4.6-12	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.1.4.6-12	Y
40.6.1.59	Provides capability to electronically store laboratory maximum reimbursement rates for	N	N	N	**D.1.4.6.4;** D.1.4.6-12	Y

Requirement #	Requirement Description	A	B	C	D	E
	individual and “panel” laboratory procedures					
40.6.1.60	Provides capability to maintain an online audit trail of all updates to Reference data, including PRO-DUR data, identifying source of the change, CSR number, memo number, before and after images, and change dates to assure State and Federal auditing requirements are met	N	Y	N	**D.1.4.6.9;** D.1.4.6-20	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.1.4.6-20	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.1.4.6-20	Y
40.6.1.63	Provides capability to generate an online status report of State Memos	N	N	N	**D.1.4.6.9;** D.1.4.6-20	Y
40.6.1.64	Provides capability for note entry	N	N	N	**D.1.4.6.9;** D.1.4.6-20	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	N	N	N	**D.1.4.6.9;** D.1.4.6-20	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.1.4.6-20	Y
40.6.1.67**	Provides capability to maintain budget criteria information	N	Y	N	**D.1.4.6.4;** D.1.4.6-12	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.1.4.6-12	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.1.4.6-19	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.1.4.6-20	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.1.4.6-6	Y

Requirement #	Requirement Description	A	B	C	D	E
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.1.4.6-12	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.1.4.6-16	Y
40.6.1.74	Provides capability to maintain and electronically store pharmacy pricing methodologies to appropriately price claims according to the appropriate financial payer or population according to State policy and business rules	N	N	Y	**D.1.4.6.1;** D.1.4.6-5	Y
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.1.4.6-5	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.1.4.6-14	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.1.4.6-14	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.1.4.6-14	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.1.4.6-14	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.1.4.6-13	Y

Requirement #	Requirement Description	A	B	C	D	E
40.6.1.81	Provides capability to restrict pharmacy services according to State policy and business rules	N	N	N	**D.1.4.6.6;** D.1.4.6-16	Y
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.1.4.6-16	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.1.4.6-13	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.1.4.6-13	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.1.4.6-17	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.1.4.6-17	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.1.4.6-7	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.1.4.6-19	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 ▪ Children's Developmental Service Agencies ▪ Licensed Clinical Social Worker and Licensed Professional Counselor and	N	Y	N	**D.1.4.6.7;** D.1.4.6-19	Y

Requirement #	Requirement Description	A	B	C	D	E
	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 ▪ Home Infusion Therapy ▪ Hospice ▪ Local Education Agency Practitioners ▪ Local Health Department ▪ Multi-specialty Independent Practitioner					

Requirement #	Requirement Description	A	B	C	D	E
	▪ 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.1.4.6-19	Y
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.1.4.6-19	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.1.4.6-19	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.1.4.6-11	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.				**D.2.1.5.3;** D.2.1.5-12	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.				D.2.1.5.3 D.2.1.5-13	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.				**D.2.1.5.3;** D.2.1.5-13	Y
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.				**D.2.1.5.3;** D.2.1.5-13	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.	N	N	N	D.2.1.5.3 D.2.1.5-13	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.				**D.2.1.5.3;** D.2.1.5-14	Y

Requirement #	Requirement Description	A	B	C	D	E
40.6.2.9	Fiscal Agent shall provide PAL tiers information for provider inquiries.				**D.2.1.4.1.1;** D.2.1.4-4 **D.2.1.4.3;** D.2.1.4-13	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.2.1.4-26 **D.2.1.5.3;** D.2.1.5-13	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.2.1.5.3;** D.2.1.5-13	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.2.1.4-26	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.2.1.5.3;** D.2.1.5-13	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.2.1.4-23	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.1.4.7-8	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.1.4.7-8	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.1.4.7-23	Y
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.1.4.7-23 **D.1.4.8.9;** D.1.4.8-75	Y

Requirement #	Requirement Description	A	B	C	D	E
40.7.1.11	Provides capability for entry, inquiry, updates, and reporting for prior approvals, overrides, and referrals	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.1.4.7-17	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.1.4.7-17	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.1.4.7-17	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.1.4.7-12	Y
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.1.4.7-7	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.1.4.7-24	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.1.4.7-25	Y

Requirement #	Requirement Description	A	B	C	D	E
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.1.4.7-26	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.1.4.7-25	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.1.4.7-14	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.1.4.7-25	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.1.4.7-26	Y
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.1.4.7-28	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.1.4.7-28	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.1.4.7-27	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	N	N	N	**D.1.4.7.6;** D.1.4.7-27	Y

Requirement #	Requirement Description	A	B	C	D	E
	or zero units remaining within approved timeframe in which time closure of prior approval should occur					
40.7.1.33	Provides capability to generate letters of notification for approved, denied, reduced, or pended prior approval requests	N	N	N	**D.1.4.7.7;** D.1.4.7-28	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.1.4.7-18	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.1.4.7-27	Y
40.7.1.36	Provides capability to apply Prior Approval logic by LOB, benefit, and recipient eligibility category	N	Y	Y	**D.1.4.7.3.4;** D.1.4.7-20	Y
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.1.4.7-30	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.1.4.7-24	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.1.4.7-34	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.1.4.7-23	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	N	N	Y	**D.1.4.7.4;** D.1.4.7-20	Y

Requirement #	Requirement Description	A	B	C	D	E
	combinations thereof					
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.1.4.7-24	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.1.4.7-34	Y
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.1.4.7-34	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.1.4.8-45	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.1.4.7-17	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.1.4.7-19	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.1.4.7-17	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.1.4.7-24	Y

Requirement #	Requirement Description	A	B	C	D	E
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.1.4.7-24	Y
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.1.4.7-24	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.1.4.7-27	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.1.4.7-27	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.1.4.7-25	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.1.4.7-30	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.1.4.7-30	Y
40.7.1.60	Provides capability to identify and capture recipient drug information where aberrant drug patterns have been identified	N	N	N	**D.1.4.7.8.2;** D.1.4.7-34	Y

Requirement #	Requirement Description	A	B	C	D	E
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.1.4.7-30	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.1.4.7-30	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.1.4.7-31	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.1.4.7-34	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.2.1.4-10	Y
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.2.1.4-8	Y

Requirement #	Requirement Description	A	B	C	D	E
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.2.1.4-8	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.2.1.4-9	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.2.1.4-9	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.2.1.4-9	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 retrospective and therapeutic days.				**D.2.1.4.2.3;** D.2.1.4-9	Y
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.2.1.4-6	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.2.1.4-9	Y
40.7.2.12	Fiscal Agent shall perform long-term care facility on-site visits with or without State				**D.2.1.4.2.5;** D.2.1.4-10	Y

Requirement #	Requirement Description	A	B	C	D	E
	staff as requested for specific provider problems.					
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 ▪ 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				**D.2.1.4.2.2;** D.2.1.4-6	Y
40.7.2.14	Fiscal Agent shall present prior approval, referral, and override information and provide				**D.2.1.4.2.5;** D.2.1.4-10	Y

Requirement #	Requirement Description	A	B	C	D	E
	education at provider workshops.					
40.7.2.15	Fiscal Agent shall respond to and resolve all phone inquiries/questions from recipients, providers, Office of Citizen Services, and manufacturers pertaining to pharmacy drug-related issues and concerns.				**D.2.1.4.3;** D.2.1.4-10	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.2.1.4-10	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.2.1.4-5	Y
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.2.1.4-10	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.2.1.4-5	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.2.1.4-8	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.2.1.4-7	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	N	N	N	**D.2.1.4.2.2;** D.2.1.4-6	Y

Requirement #	Requirement Description	A	B	C	D	E
	conducted to determine prior approval authorization.					
40.7.2.24	Fiscal Agent shall provide for toll-free telephone and fax number access for providers to request prior approvals, referrals, and overrides				**D.2.1.4.2.1;** D.2.1.4-5	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.2.1.4-11	Y
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.2.1.4-11	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.2.1.4-12	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.2.1.4-12	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.2.1.4-14	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.2.1.4-11	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

Requirement #	Requirement Description	A	B	C	D	E
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.2.1.4-14	Y
40.7.2.34	Fiscal Agent shall develop criteria-driven recommendations for each new drug within an existing Prior Approval therapeutic class category.				**D.2.1.4.3;** D.2.1.4-14	Y
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.2.1.4-13	Y
40.7.2.37	Fiscal Agent shall adjudicate provider appeals.				**D.2.1.4.3;** D.2.1.4-14	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.2.1.4-12	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.	N	N	N	**D.2.1.4.3;** D.2.1.4-14	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.2.1.4-13	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.2.1.4-14	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.2.1.4-14	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.2.1.4-26	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.2.1.4-26	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.2.1.4-26	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.2.1.4-26	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.2.1.4-26	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 Monday through Friday 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
40.7.3.7	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	N	N	N	D.2.1.4.5 D.2.1.4-27	Y

Requirement #	Requirement Description	A	B	C	D	E
	time.					
40.7.3.8	Fiscal Agent shall produce system-generated letters to recipients and providers of the status of prior approval requests within twenty-four (24) hours from the time of receipt.	N	N	N	**D.2.1.4.5;** D.2.1.4-27	Y
40.7.3.9	Fiscal Agent shall produce weekly Pharmacy Alerts.	N	N	N	**D.2.1.4.5;** D.2.1.4-27	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.2.1.4-27	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.2.1.4-27	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.2.1.4-27	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.2.1.4-27	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

Requirement #	Requirement Description	A	B	C	D	E
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
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.1.4.8-44 **D.1.4.8.5.4.4;** D.1.4.8-45	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.1.4.8-45	Y

Requirement #	Requirement Description	A	B	C	D	E
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 Files or business area/interfaces	N	N	N	**D.1.4.8.5;** D.1.4.8-22	Y
40.8.1.21	Provides capability to support the Medicare Correct Coding Initiative (CCI)	Y	Y	N	**D.1.4.8.5.6;** D.1.4.8-55	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.1.4.8-45	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.1.4.8-34	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.1.4.8-34	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.1.4.8-64	Y

Requirement #	Requirement Description	A	B	C	D	E
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.1.4.8-68	Y
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.1.4.8-54	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.1.4.8-52	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.1.4.8-35 D.1.4.8-45	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.1.4.8-42	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.1.4.8-85	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.1.4.8-64	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.1.4.8-51	Y
40.8.1.39**	Provides capability to define parameters and create a file for the negative and positive	N	N	N	**D.1.4.8.11;** D.1.4.8-86	Y

Requirement #	Requirement Description	A	B	C	D	E
	eligibility quality control sampling for DMH					
40.8.1.40**	Provides capability to produce reports regarding the results of the DMH negative and positive sampling	N	N	N	**D.1.4.8.11;** D.1.4.8-86	Y
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.1.4.8-86	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.1.4.8-86	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.1.4.8-85	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.1.4.8-85	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.1.4.8-60	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.1.4.8-53 **D.1.4.8.10;** D.1.4.8-85	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.1.4.8-68	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.1.4.8-46	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.1.4.8-45	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.1.4.14-10	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.1.4.8-74	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.1.4.8-83	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.1.4.8-83	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.1.4.8-61	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.1.4.8-57	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.1.4.8-47	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.1.4.8-74	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.1.4.8-47	Y
40.8.1.60	Provides capability to interface with Comprehensive Neuroscience (CNS) Program-Behavioral Pharmacy Management System (BPMS); provides capability to interface with BPMS quality indicator algorithms developed by an outside vendor (CNS)	Y	Y	N	**D.1.4.8.5.5.1;** D.1.4.8-49	Y
40.8.1.61	Provides capability for PRO-DUR and Retroactive DUR	Y	Y	N	**D.1.4.8.9;** D.1.4.8-74	Y

Requirement #	Requirement Description	A	B	C	D	E
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.1.4.8-76	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.1.4.8-59	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.1.4.8-54	Y
40.8.1.65	Provides capability for an online audit trail of all POS/PRO-DUR transactions	N	N	N	**D.1.4.8.6;** D.1.4.8-75	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.1.4.8-76	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.1.4.8-49	Y
40.8.1.68	Provides capability for flexible State-determined dispensing fees	N	N	N	**D.1.4.8.5.5.1;** D.1.4.8-48	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.1.4.8-59	Y
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.1.4.8-79	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.1.4.8.6;** D.1.4.8-62	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.1.4.8-83	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.1.4.8-76-7	Y

Requirement #	Requirement Description	A	B	C	D	E
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.1.4.8-59	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.1.4.8-43	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.1.4.8-48	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.1.4.8-74	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.1.4.8-47	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.1.4.8-83	Y
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.1.4.8-75	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.1.4.8-49	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.1.4.8-47	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.1.4.8-42	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.1.4.8-54	Y

Requirement #	Requirement Description	A	B	C	D	E
	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.1.4.8-25	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.1.4.8-28	Y
40.8.1.89	Provides capability to determine financial payer hierarchy	N	N	N	**D.1.4.8.5.1;** D.1.4.8-28	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.1.4.8-28	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.1.4.8-85	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.1.4.8-45	Y

Requirement #	Requirement Description	A	B	C	D	E
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.1.4.8-42	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.1.4.8-31	Y
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.1.4.8-32	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.1.4.8-64	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.1.4.8-51	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.1.4.8-51	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.1.4.8-51	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.1.4.8-58	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.1.4.8-28	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.1.4.8-64	Y

Requirement #	Requirement Description	A	B	C	D	E
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.1.4.8-52	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.1.4.8-64	Y
40.8.1.110	Provides capability to process all claims against the edit criteria	N	N	N	**D.1.4.8.5.4;** D.1.4.8-41	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.1.4.8-51	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.1.4.8-41	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.1.4.8-41	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.1.4.8-41	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.1.4.8-42	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.1.4.8-44	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.1.4.8-44	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.1.4.8-42	Y
40.8.1.119	Provides capability to edit for prior approval and ensure an active prior approval number is on file	N	N	N	**D.1.4.8.5.4.4;** D.1.4.8-45	Y
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.1.4.8-56	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.1.4.8-81	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.1.4.8-83	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.1.4.8-56	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.1.4.8-56	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.1.4.8-53	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.1.4.8-53	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.1.4.8-55	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.1.4.8-55	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.1.4.8-56	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.1.4.8-46	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.1.4.8-85	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.1.4.8-29	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.1.4.8-45	Y
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.1.4.8-54	Y
40.8.1.135	Provides capability to identify potential and/or exact duplicate claims in the MMIS and	N	N	N	**D.1.4.8.5.6;** D.1.4.8-54	Y

Requirement #	Requirement Description	A	B	C	D	E
	POS within and across financial payers					
40.8.1.136	Provides capability to edit using duplicate audit and suspect-duplicate criteria to validate against history, suspended claims, and same-cycle claims	N	N	N	**D.1.4.8.5.6;** D.1.4.8-54	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	N	N	N	**D.1.4.8.5.3.2;** D.1.4.8-31	Y
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.1.4.8-65	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.1.4.8-66	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.1.4.8-34	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.1.4.8-34	Y
40.8.1.144	Provides capability to maintain a record of service codes required for audit processing where the audit criteria covers a period longer than five (5) years (such as once-in-a-lifetime procedures)	N	N	N	**D.1.4.8.5.6;** D.1.4.8-53	Y
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	N	N	N	**D.1.4.8.5.3.2;** D.1.4.8-32	Y

Requirement #	Requirement Description	A	B	C	D	E
	▪ Pay					
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.1.4.8-34 **D.1.4.8.5.3.3;** D.1.4.8-38 **D.1.4.8.5.3.3;** D.1.4.8-38-39	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.1.4.8-38	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.1.4.8-57	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.1.4.8-79	Y
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.1.4.8-43	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.1.4.8-46	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.1.4.8-44	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.1.4.8-44 **D.1.4.8.5.4.4;** D.1.4.8-45	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.1.4.8-39	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.1.4.8-39	Y

Requirement #	Requirement Description	A	B	C	D	E
40.8.1.156	Provides capability to edit for service limitations	N	N	N	**D.1.4.8.5.3;** D.1.4.8-30 **D.1.4.8.5.3.3;** D.1.4.8-39	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.1.4.8-39	Y
40.8.1.158	Provides capability to track service limitations online	N	N	N	**D.1.4.8.5.3.3;** D.1.4.8-39	Y
40.8.1.159	Provides capability to edit and suspend with procedure codes set to manually price unless there is a prior approval for the procedure code for the recipient with the servicing provider	N	N	N	**D.1.4.8.5.5.5;** D.1.4.8-50	Y
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.1.4.8-41	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.1.4.8-56	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.1.4.8-50	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.1.4.8.5.6;** D.1.4.8-53 **D.1.4.8.5.6;** D.1.4.8-54	Y
40.8.1.165	Provides capability to edit for disproportionate share hospitals	Y	Y	N	**D.1.4.8.5.6;** D.1.4.8-55	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.1.4.8-29	Y
40.8.1.167	Provides capability for encounter-specific editing and auditing	N	N	N	**D.1.4.8.5.5.2;** D.1.4.8-49	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.1.4.8-46	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.1.4.8-63	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.1.4.8-63	Y
40.8.1.171	Provides capability to process Medicare cost-sharing charges	N	N	N	**D.1.4.8.5.5.4;** D.1.4.8-50	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.1.4.8-50	Y
40.8.1.173	Provides capability to subject all pharmacy claims to the automated POS PRO-DUR consistently	N	N	N	**D.1.4.8.9.1;** D.1.4.8-77	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.1.4.8-59	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.1.4.8-63	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.1.4.8-66	Y
40.8.1.177	Provides capability for claims correction process that allows inquiry and update by transaction control number, provider ID, recipient ID, location code, adjustment initiator ID, clerk ID, claim type, date of service, ranges of dates, and prior approval number	N	N	N	**D.1.4.8.7;** D.1.4.8-63	Y
40.8.1.178	Provides capability to sort suspended claims into applicable work queues	N	N	N	**D.1.4.8.7;** D.1.4.8-63	Y
40.8.1.179	Provides capability to forward suspended claims to multiple locations	N	N	N	**D.1.4.8.7.2;** D.1.4.8-67	Y

Requirement #	Requirement Description	A	B	C	D	E
40.8.1.180	Provides capability to accept mass adjustments to suspended claims	N	Y	N	**D.1.4.8.8.2;** D.1.4.8-72	Y
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.1.4.8-64	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.1.4.8-63	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.1.4.8-69	Y
40.8.1.184	Provides capability to adjust Claims History only	N	N	N	**D.1.4.8.8;** D.1.4.8-68	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.1.4.8-68	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.1.4.8-68	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.1.4.8-68	Y
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.1.4.8-68	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.1.4.8-65	Y

Requirement #	Requirement Description	A	B	C	D	E
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.1.4.8-66	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.1.4.8-66	Y
40.8.1.193	Provides capability to assign a unique status to corrected claims	N	Y	N	**D.1.4.8.7;** D.1.4.8-66	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.1.4.8-66	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.1.4.8-67	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.1.4.8-67	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
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	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.1.4.8-85	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.1.4.8-85	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.1.4.8-85	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.1.4.8-85	Y

Requirement #	Requirement Description	A	B	C	D	E
	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 ▪ Drug codes ▪ GCN ▪ GCN-Sequence ▪ NDC	N	Y	N	**D.1.4.8.5.7.6;** D.1.4.8-60	Y
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.1.4.14-27	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.1.4.8-70	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.1.4.8-71	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.1.4.8-68	Y
40.8.1.209	Provides capability to process unit dose credits	Y	Y	N	**D.1.4.8.5.7.4;** D.1.4.8-59	Y
40.8.1.210	Provides capability to input transactions to Drug Rebate and TPL of all collected dollars	Y	Y	N	**D.1.4.12.5.2;** D.1.4.12-15	Y

Requirement #	Requirement Description	A	B	C	D	E
40.8.1.211	Provides capability to capture pharmacy/drug rebates on professional and institutional claims	N	N	N	D.1.4.14.2.15 D.1.4.14-35	Y
40.8.1.212	Provides capability to capture and electronically store the clerk ID of the individual who initially entered the adjustment and the clerk ID who worked the suspended adjustment	N	Y	N	**D.1.4.8.7;** D.1.4.8-65	Y
	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.1.4.14.2.3 D.1.4.14-14	Y
40.8.1.216	Provides capability to generate Health Insurance Premium Payments (HIPP)	N	N	Y	D.1.4.14.2.15 D.1.4.14-34	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.1.4.8-56	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.1.4.8-69	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 appropriate financial processing tasks	N	N	N	**D.1.4.8.5;** D.1.4.8-23	Y
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	N	N	N	D.1.4.14.2.2 D.1.4.14-10	Y

Requirement #	Requirement Description	A	B	C	D	E
	financial transactions					
40.8.1.221	Provides capability to apply payments to open accounts receivables when the provider has a positive balance, apply third party collections, create Adjudication Claims File for checkwrite period, and update Provider Earnings file	N	N	N	D.1.4.14.2.3 D.1.4.14-14	Y
40.8.1.222	Provides capability to produce system-generated check registers, provider checks, and RAs and update control totals by LOB	N	N	N	D.1.4.14.2.3 D.1.4.14-12	Y
40.8.1.223	Provides capability to print provider voucher statements and checks by LOB	N	N	N	D.1.4.14.2.3 D.1.4.14-12	Y
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.1.4.14-10	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.1.4.14.2.3 D.1.4.14-16	Y
40.8.1.226	Provides capability to track the status of all financial transactions by payer source	N	N	N	D.1.4.14.2.15 D.1.4.14-34	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.1.4.14-10	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.1.4.14-10	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.1.4.14-10	Y
40.8.1.230	Provides capability to create a single check or EFT per payment cycle for each provider by LOB	N	N	N	D.1.4.14.2.3 D.1.4.14-12	Y
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.1.4.14-29	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.1.4.14-29	Y

Requirement #	Requirement Description	A	B	C	D	E
40.8.1.233	Provides capability to produce and distribute paper RAs formatted separately for individual provider types	N	N	N	D.1.4.14.2.3 D.1.4.14-16	Y
40.8.1.234	Provides capability to produce ANSI 835 and 820 transactions	N	N	N	D.1.4.14.2.4 D.1.4.14-16	Y
40.8.1.235	Provides capability for EFT by LOB	N	N	N	D.1.4.14.2.3 D.1.4.14-11	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.1.4.14-12	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.1.4.14-18	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 D.1.4.14-33	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.1.4.14.2.4 D.1.4.14-16	Y
40.8.1.240	Provides capability to produce EFT register and ANSI 835	N	N	N	D.1.4.14.2.4 D.1.4.14-12	Y
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.1.4.14-32	Y
40.8.1.242	Provides capability to modify payment cycle schedule	N	N	N	D.1.4.14.2.3 D.1.4.14-10	Y
40.8.1.243	Provides capabilities to provide independent and separate banking	N	N	N	D.1.4.14.2.3 D.1.4.14-11	Y
40.8.1.244	Provides capability to combine claims from MMIS and POS for payment processing	N	N	N	D.1.4.14.2.15 D.1.4.14-34	Y
40.8.1.245	Provides capability to withhold adjudicated claims from the payment cycle by payer source	N	N	N	D.1.4.14.2.15 D.1.4.14-34	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.1.4.14-31	Y

Requirement #	Requirement Description	A	B	C	D	E
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.1.4.14-10	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.1.4.14-10	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.1.4.14-8	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.1.4.14-8	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.1.4.14-28	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.1.4.14-10	Y
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.1.4.14-10	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.1.4.8-68	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.1.4.14-27	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.1.4.14-27	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.1.4.14.2.11 D.1.4.14-27	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.1.4.14-27	Y
40.8.1.259	Provides capability to apply Patient Monthly Liability (PML) to specific types of claims	Y	Y	N	**D.1.4.8.5.5.7;** D.1.4.8-52	Y

Requirement #	Requirement Description	A	B	C	D	E
	and post liability amounts used					
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.1.4.8-52	Y
40.8.1.261	Provides the capability for positive pay processing	N	N	N	D.1.4.14.2.3 D.1.4.14-15	Y
40.8.1.262	Provides the capability for provider payment data	N	N	N	D.1.4.14.2.3 D.1.4.14-14	Y
40.8.1.263	Provides capability to apply withholds to capitation payments	N	N	N	D.1.4.14.2 D.1.4.14-34	Y
40.8.1.264	Provides capability to release withholds to capitation payments	N	N	N	D.1.4.14.2 D.1.4.14-34	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.1.4.14-27	Y
40.8.1.266	Provides capability to apply provider incentives to management fee claims	N	N	N	D.1.4.14.2 D.1.4.14-35	Y
40.8.1.267	Provides all payments, adjustments, and other financial transactions to enrolled providers for approved services	N	N	N	D.1.4.14.2.10 D.1.4.14-26	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 D.1.4.14-35	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.1.4.14.2.3 D.1.4.14-11	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	N	N	N	D.1.4.14.2.4 D.1.4.14-16	Y
40.8.1.271	Provides capability to create financial transactions	N	N	N	D.1.4.14.2.10 D.1.4.14-26	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.1.4.14-26	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.1.4.14-9	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 D.1.4.14-35	Y
40.8.1.275	Provides capability to create transactions for corrections to receivables entered into the Replacement MMIS	N	N	N	D.1.4.14.2.11 D.1.4.14-27	Y
40.8.1.276	Provides capability to create transactions for manual checks	N	N	N	D.1.4.14.2.3 D.1.4.14-12	Y
40.8.1.277	Provides capability to create transactions for paper checks	N	N	N	D.1.4.14.2.3 D.1.4.14-11	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.1.4.14-13	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.1.4.14-11	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.1.4.14-23	Y
40.8.1.281	Provides capability for notes tracking to accommodate tracking of calls	N	N	N	D.1.4.14.2 D.1.4.14-33	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.1.4.14.2.1 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 D.1.4.14-34	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 D.1.4.14-34	Y
40.8.1.285	Provides capability to process capitation payments	N	N	N	**D.1.4.8.6;** D.1.4.8-63	Y
40.8.1.286	Provides capability to withhold a percentage of capitation payments	N	N	N	**D.1.4.8.6;** D.1.4.8-63	Y
40.8.1.287	Provides capability to process Managed Care management fees	N	N	Y	**D.1.4.8.6;** D.1.4.8-63 **D.1.4.8.6;** D.1.4.8-63	Y

Requirement #	Requirement Description	A	B	C	D	E
40.8.1.288	Provides capability to process management fees for Health Check	N	N	Y	**D.1.4.8.6;** D.1.4.8-63	Y
40.8.1.289	Provides capability to process capitation and/or management fee adjustments	N	N	Y	**D.1.4.8.6;** D.1.4.8-63	Y
40.8.1.290	Provides capability to process management fees for APs/LMEs	N	N	Y	**D.1.4.8.6;** D.1.4.8-63	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.1.4.8-49	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 D.1.4.14-35	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 D.1.4.14-35	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 D.1.4.14-34	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	Y
40.8.1.296	Provides capability to carry the provider’s selection of receiving checks or EFT form of payment	N	N	N	D.1.4.14.2.4 D.1.4.14-13	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.1.4.14.2.3 D.1.4.14-11	Y
40.8.1.298	Provides capability to accept pended and adjudicated claims against Provider Earnings file	N	N	N	D.1.4.14.3 D.1.4.14-14	Y
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	N	Y	N	D.1.4.14.2.4 D.1.4.14-16	Y

Requirement #	Requirement Description	A	B	C	D	E
	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 ▪ 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.1.4.14-18	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.1.4.14-17	Y
40.8.1.302	Provides capability to update provider payment data	N	N	N	D.1.4.14.2 D.1.4.14-14	Y
40.8.1.303	Provides capability to maintain a process of fiscal pends	N	N	N	D.1.4.14.2.2 D.1.4.14-8	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.1.4.14.2.2 D.1.4.14-10	Y

Requirement #	Requirement Description	A	B	C	D	E
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.1.4.14-17	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.1.4.8-85	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.1.4.14.2.2 D.1.4.14-14	Y
40.8.1.308	Provides capability for summary-level provider accounts receivable and payable data and pending recoupment amounts that are automatically updated after each claims processing payment cycle	N	N	N	D.1.4.14.2 D.1.4.14-27	Y
40.8.1.309	Provides capability to adjust claim money fields to net out	N	N	N	D.1.4.14.2.10 D.1.4.14-27	Y
40.8.1.310	Provides capability to automatically establish new accounts receivables	N	N	N	D.1.4.14.2.10 D.1.4.14-26	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.1.4.14-20	Y
40.8.1.312	Provides capability for the issuance of provider checks and/or EFTs for all claims in the current checkwrite cycle	N	N	N	D.1.4.14.2.3 D.1.4.14-11	Y
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.1.4.14.2.2 D.1.4.14-9	Y
40.8.1.314	Provides capability to process transactions for manually written checks generating a Claims History record	N	N	N	D.1.4.14.2.2 D.1.4.14-12	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.1.4.14-13	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.1.4.14-1	Y

Requirement #	Requirement Description	A	B	C	D	E
40.8.1.317	Provides capability to process check voucher information from the State Controller's Office	N	N	N	D.1.4.14.2.6 D.1.4.14-23	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.1.4.14.2.1 D.1.4.14-1	Y
40.8.1.319	Provides capability to ensure that the weekly budget reporting is consistent with the costs allocated during the checkwrite by LOB	N	N	N	D.1.4.14.2.3 D.1.4.14-8	Y
40.8.1.320	Provides capability to produce reports and RAs within the financial processing function of the checkwrite cycle by LOB	N	N	N	D.1.4.14.2.3 D.1.4.14-10	Y
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.1.4.14.2.7 D.1.4.14-21	Y
40.8.1.322	Provides capability to use a hierarchy table when a provider has multiple recoupment accounts	N	N	N	D.1.4.14.2.10 D.1.4.14-27	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.1.4.14-27	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.1.4.14-27	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.1.4.14-27	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.1.4.14-30	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 D.1.4.14-32	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 D.1.4.14-32	Y

Requirement #	Requirement Description	A	B	C	D	E
40.8.1.329	Provides capability to generate weekly, monthly, quarterly, and annual financial reports after checkwrites	N	N	N	D.1.4.14.2.14 D.1.4.14-32	Y
40.8.1.330	Provides capability for Advance Provider payments by LOB	N	N	N	D.1.4.14.2.2 D.1.4.14-11	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 D.1.4.14-33	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 D.1.4.14-33	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.1.4.14-10	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.1.4.14-108	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.1.4.8-46	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.1.4.8-46	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.1.4.8-50	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.1.4.8-46	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.1.4.8-50	Y
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.1.4.8-46	Y

Requirement #	Requirement Description	A	B	C	D	E
40.8.1.341	Provides capability to determine calculations for the PAL tiers	Y	Y	N	**D.1.4.8.5.5.1;** D.1.4.8-49	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.1.4.8-48	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.1.4.8-47	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.1.4.8-50	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.1.4.8-52	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.1.4.8-50	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.1.4.8-52	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.1.4.8-52	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.1.4.8-52	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.1.4.8-51	Y
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.1.4.8-51	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.1.4.8-50	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.1.4.8-56	Y
40.8.1.354	Provides capability to price encounter claims at equivalent fee for service payment less	N	Y	N	**D.1.4.8.5.5.2;** D.1.4.8-49	Y

Requirement #	Requirement Description	A	B	C	D	E
	deductions, such as TPL or co-payments					
40.8.1.355	Provides capability to maintain multiple date-specific prices for each applicable provider, procedure code, revenue code, and DRG	N	N	N	**D.1.4.8.5.5;** D.1.4.8-47	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.1.4.8-50	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.1.4.8-51	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.1.4.8-51	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.1.4.8-50	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.1.4.8-42	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.1.4.8-47	Y
40.8.1.362	Provides capability to apply Graduate Medical Education (GME), both direct and indirect, to inpatient claims	N	N	N	**D.1.4.8.5.5;** D.1.4.8-47	Y
40.8.1.363	Provides capability to price NDC codes	N	N	N	**D.1.4.8.5.5.1;** D.1.4.8-47	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.1.4.8-50	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.1.4.8-46	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.1.4.8-47	Y
40.8.1.367	Provides capability to apply variable recipient co-pay percentages to a claim from a	N	Y	N	**D.1.4.8.5.5.7;** D.1.4.8-53	Y

Requirement #	Requirement Description	A	B	C	D	E
	prior approval					
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.1.4.8-47	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.1.4.8-46	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.1.4.8-47	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.1.4.8-50 **D.1.4.8.5.5.8;** D.1.4.8-53	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 data submission requirements.	N	N	Y	**D.1.4.8.11;** D.1.4.8-87	Y
40.8.1.373	Provides capability to process HIPP payments	N	Y	N	D.1.4.14.2.12 D.1.4.14-28	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.1.4.14-28	Y
40.8.1.375	Provides capability to collect recipient premium payments	N	N	N	D.1.4.14.2.12 D.1.4.14-28	Y
40.8.1.376	Provides capability to produce refunds of recipient premiums	N	N	N	D.1.4.14.2.12 D.1.4.14-28	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.1.4.14-28	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.1.4.14-28	Y

Requirement #	Requirement Description	A	B	C	D	E
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.1.4.8-52	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.1.4.8-52	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.1.4.14-29	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				**D.2.1.1.2;** D.2.1.1-5	Y

Requirement #	Requirement Description	A	B	C	D	E
	▪ Claims pricing ▪ Adjudication processing ▪ Adjustment processing ▪ Payment processing ▪ Financial processing ▪ Encounter processing					
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.	N	N	N		Y
	Mailroom					
40.8.2.4	Fiscal Agent shall prepare and process all incoming and outgoing mail.				**D.2.1.1.3.1;** D.2.1.1-6	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.				**D.2.1.1.3.3;** D.2.1.1-7	Y
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.2.1.1.3.1;** D.2.1.1-6	Y
40.8.2.9	Fiscal Agent shall maintain system logging for packages/envelopes mailed via USPS or any other mailing service.				**D.2.1.1.3.4;** D.2.1.1-7	Y
40.8.2.10	Fiscal Agent shall prepare RTP letters, REOMBs, notice of service approval or denial,				**D.2.1.1.3.5;** D.2.1.1-7	Y

Requirement #	Requirement Description	A	B	C	D	E
	and appeal rights TPL letters, drug recovery invoices, estate letters, COCC, and small packages for First Class Mail delivery.					
40.8.2.11	Fiscal Agent shall print and mail/deliver electronically Replacement MMIS State-approved forms.				**D.2.1.1.3.5;** D.2.1.1-7	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.2.1.1.3.5;** D.2.1.1-7 **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.2.1.1.3.5;** D.2.1.1-7 **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;** 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;** D.2.1.1-11	Y
	Adjustments					
40.8.2.16	Fiscal Agent shall sort, log, and batch adjustment requests and supporting documentation.				**D.2.1.1.4.1;** D.2.1.1-11	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.2.1.1.4.1;** D.2.1.1-11	Y
40.8.2.18	Fiscal Agent shall return adjustment requests with RTP letter to provider, indicating missing or other required information needs.				**D.2.1.1.4.1;** D.2.1.1-11	Y
40.8.2.19	Fiscal Agent shall scan adjustments and supporting documentation.				**D.2.1.1.4.1;** D.2.1.1-11	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.2.1.1.4.1;** D.2.1.1-11	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.2.1.1.4.1;** D.2.1.1-11	Y
	Claims Entry					
40.8.2.22	Fiscal Agent shall perform data entry of all hard copy claims.				**D.2.1.1.4.2;** 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.2.1.1.4.4;** D.2.1.1-13	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.2.1.1-16	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.2.1.3-34	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.2.1.3-36	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” claim data.				**D.2.1.3.6;** D.2.1.3-36	Y
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.2.1.3-33	Y

Requirement #	Requirement Description	A	B	C	D	E
40.8.2.30	Fiscal Agent shall accept tape-to-tape billing from defined sources.	N	N	Y	**D.2.1.3.6;** D.2.1.3-33	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.2.1.3-33	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.2.1.3-37	Y
40.8.2.33	Fiscal Agent shall perform provider ECS/EDI acceptance testing.				**D.2.1.3.6;** D.2.1.3-38	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.2.1.3-38	Y
40.8.2.35	Fiscal Agent shall log tapes and diskettes upon receipt and assigns batch number.				**D.2.1.3.6;** D.2.1.3-39	Y
40.8.2.36	Fiscal Agent shall perform acceptance testing of VANs for Pharmacy POS claim submission.				**D.2.1.3.6;** D.2.1.3-39	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.2.1.3-39	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.2.1.1-13	Y
	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.2.1.4-11	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

Requirement #	Requirement Description	A	B	C	D	E
	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.2.1.4-4	
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.2.1.4-4	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.2.1.4-4	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
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

Requirement #	Requirement Description	A	B	C	D	E
	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
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.2.1.2-7	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.2.1.1-18	Y
40.8.3.2	Fiscal Agent shall print and mail Replacement MMIS State-approved forms to				**D.2.1.1.6;** D.2.1.1-18	Y

Requirement #	Requirement Description	A	B	C	D	E
	providers within two (2) business days of receipt of the provider request (at no cost to the provider).					
40.8.3.3	Fiscal Agent shall provide ECS/EDI Help Desk staff from 8:00 A.M. to 5:00 P.M. Eastern Time on State business days.				**D.2.1.3.6;** D.2.1.3-37 **D.2.1.3.10;** D.2.1.3-45	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.2.1.3-45	Y
40.8.3.5	Fiscal Agent shall assign an ICN to every claim, attachment, and adjustment within twenty-four (24) hours of receipt.				**D.2.1.1.6;** D.2.1.1-18	Y
40.8.3.6	Fiscal Agent shall maintain data entry-field accuracy rates above ninety-eight (98) percent.				**D.2.1.1.6;** D.2.1.1-18	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.2.1.1-18	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.2.1.1-18	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.	N	N	N	**D.2.1.1.6;** D.2.1.1-18	Y

Requirement #	Requirement Description	A	B	C	D	E
40.8.3.11	Fiscal Agent shall provide correct claims disposition and post to the appropriate account or when appropriate, request additional information within one (1) State business day of receipt.	N	N	N	**D.2.1.1.6;** D.2.1.1-19	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 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.				**D.2.1.2.5;** D.2.1.2-21	Y
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.2.1.4-27	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.	N	N	N	**D.2.1.1.6;** D.2.1.1-19	Y
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.2.1.1-19	Y

Requirement #	Requirement Description	A	B	C	D	E
40.8.3.19	Fiscal Agent shall successfully complete each checkwrite by the date on the State-approved Checkwrite Schedule.				**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	N	N	Y	**D.1.4.9.1;** D.1.4.9-4	Y

Requirement #	Requirement Description	A	B	C	D	E
	achieved					
40.9.1.8	Provides capability to auto-assign recipients into a Managed Care program(s) See Auto Assignment Business Rules in the Managed Care DSD Exhibits in the Procurement Library.	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: ▪ State History File ▪ Finalized Claim Activity File	N	N	N	**D.1.4.9.1;** D.1.4.9-5	Y

Requirement #	Requirement Description	A	B	C	D	E
	▪ 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 combinations thereof	N	Y	N	**D.1.4.9.2;** D.1.4.9-6	Y
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	N	N	Y	**D.1.4.9.1;** D.1.4.9-3	Y

Requirement #	Requirement Description	A	B	C	D	E
	enhanced/reduced fees for all individual providers or administrative entities					
40.9.1.28	Provides capability to create notification letters to the provider/administrative entity regarding the adjustment to management fee rates and the reason for the adjustment	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, disease management and system of care groupings, drug utilization, and other group comparisons, as well as the current peer group comparisons	N	N	N	**D.1.4.9.5;** D.1.4.9-13	Y
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.2.1.3-47	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.2.1.3-47	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.2.1.3-48	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.2.1.3-48	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 override, and enter the override approval into the system.				**D.2.1.3.9;** D.2.1.3-47	Y
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.2.1.3-17	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.2.1.3-17	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.2.1.3-51	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.2.1.3-52	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.2.1.3-52	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.2.1.3-52	Y
40.9.3.5	Fiscal Agent shall respond to a requesting provider within one (1) hour for a telephone request for an emergency override.				**D.2.1.3.10;** D.2.1.3-52	Y
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.2.1.3-52	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.2.1.3-52	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.2.1.3-52	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.2.1.3-52	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.2.1.3-52	Y

Requirement #	Requirement Description	A	B	C	D	E
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.2.1.3-52	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.1.4.10-8	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

Requirement #	Requirement Description	A	B	C	D	E
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
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	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	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	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	Y
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

Requirement #	Requirement Description	A	B	C	D	E
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	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.2.1.3-43	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.2.1.3-42	Y
40.10.2.3	Fiscal Agent shall participate in Health Check Coordinator Training Sessions in Raleigh, NC.				**D.2.1.3.8;** D.2.1.3-44	Y
40.10.2.4	Fiscal Agent shall update Health Check Billing Guide.				**D.2.1.3.8;** D.2.1.3-43	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.2.1.3-44	Y
40.10.2.6	Fiscal Agent shall conduct annual regional Health Check workshops for participating				**D.2.1.3.8;** D.2.1.3-44	Y

Requirement #	Requirement Description	A	B	C	D	E
	providers in six (6) separate sites throughout the State.					
40.10.2.7	Fiscal Agent shall monitor the Denied Claims Report for Health Check denials and contact providers by telephone to educate and schedule provider visits if denial rate is above ten (10) percent.				**D.2.1.3.8;** D.2.1.3-45	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.2.1.3-45	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.2.1.3-45	Y
40.10.2.10	Fiscal Agent shall submit the monthly FTE Report to the State for approval.				**D.2.1.3.8;** D.2.1.3-45	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.2.1.3-43	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.2.1.3-43 **D.2.1.3.8;** D.2.1.3-44	Y
40.10.2.13	Fiscal Agent shall coordinate rewrite of the Health Check Billing Guide.				**D.2.1.3.8;** D.2.1.3-43	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.2.1.3-51	Y

Requirement #	Requirement Description	A	B	C	D	E
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.2.1.3-51	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.2.1.3-51	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.2.1.3-51	Y
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.2.1.3-51	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.2.1.3-51	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.2.1.3-51	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.2.1.3-51	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.1.4.11-7	Y

Requirement #	Requirement Description	A	B	C	D	E
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.1.4.11-11	Y
40.11.1.3	Provides capability to ensure that claims for inpatient hospital stays for pregnant women are cost avoided	N	N	N	**D.1.4.11.5;** D.1.4.11-11	Y
40.11.1.4	Provides capability for updating of insurance carrier information	N	N	N	**D.1.4.11.2;** D.1.4.11-5	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.1.4.11-7	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.1.4.11-9	Y
Requirement Deleted 40.11.1.7	~~Provides capability to electronically store multiple, date-specific TPL resources for each Medicare recipient~~					
40.11.1.8	Provides capability to electronically store all third party resource information by	N	N	N	**D.1.4.11.3;** D.1.4.11-9	Y

Requirement #	Requirement Description	A	B	C	D	E
	recipient					
40.11.1.9	Provides capability to electronically store third party carrier information	N	N	N	**D.1.4.11.3;** D.1.4.11-9	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.1.4.11-11	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.1.4.11-11	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.1.4.11-12	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.1.4.11-12	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.1.4.11-12	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.1.4.11-12	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.1.4.11-12	Y
40.11.1.17	Provides capability to approve or cancel trauma questionnaires	N	N	Y	**D.1.4.11.6;** D.1.4.11-13	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.1.4.11-12	Y
40.11.1.19	Provides capability to maintain an online audit trail of all updates to TPL data	N	N	N	**D.1.4.11.9;** D.1.4.11-14	Y
40.11.1.20	Provides capability to generate carrier update transactions to the State	N	N	N	**D.1.4.11.7;** D.1.4.11-14	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.1.4.11-4	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.1.4.11-13	Y
40.11.1.23	Provides capability to ensure that if the recipient has a pharmacy policy on the date of	N	N	N	**D.1.4.11.3;** D.1.4.11-9	Y

Requirement #	Requirement Description	A	B	C	D	E
	service that the pharmacy policy is billed or displayed at point of sale rather than any medical policy					
40.11.1.24	Provides capability to identify previously paid claims from the past three (3) years of claims history when TPL resources are identified or verified retroactively	N	N	N	**D.1.4.11.6;** D.1.4.11-12	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.1.4.11-12	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.1.4.11-13	Y
40.11.1.27	Provides capability to produce accident inquiry letters for identified recipients	N	N	Y	**D.1.4.11.6;** D.1.4.11-12	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.1.4.11-9	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.1.4.11-11	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.1.4.11-12	Y
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.1.4.11-13	Y
40.11.1.32	Provides capability to track and report on invoices	N	N	Y	**D.1.4.11.6;** D.1.4.11-12	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.1.4.11-11	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.1.4.11-13	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.1.4.11-13	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.1.4.11-10	Y

Requirement #	Requirement Description	A	B	C	D	E
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.1.4.11-13	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.1.4.11-13	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.1.4.11-11	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.1.4.11-13	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.1.4.11-13	Y
40.11.1.42	Provides capability to add and update the TPL threshold amount online	N	N	Y	**D.1.4.11.6;** D.1.4.11-13	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.1.4.11-13	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.1.4.11-13	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.1.4.11-13	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.1.4.11-13	Y
40.11.1.47	Provides capability to generate unique Case Identification Numbers	N	N	Y	**D.1.4.11.6;** D.1.4.11-13	Y
40.11.1.48	Provides capability to close a case without full recovery	N	N	Y	**D.1.4.11.6;** D.1.4.11-13	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.1.4.11-13	Y
40.11.1.50	Provides the capability to flag claims for recipients who have reached a defined	N	Y	N	**D.1.4.11.6;** D.1.4.11-13	Y

Requirement #	Requirement Description	A	B	C	D	E
	threshold					
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.1.4.11-4	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.1.4.11-14	Y
40.11.1.53	Provides capability for daily (next business day) transmission logs showing successful transmission of TPL data to DIRM for CSDW, ACTS, and EIS	N	N	N	**D.1.4.11.7;** D.1.4.11-14	Y
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.1.4.11-11	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.1.4.11-11	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.1.4.11-9	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.1.4.11-9	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.1.4.11-9	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.1.4.11-14	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.1.4.11-14	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.1.4.11-14	Y

Requirement #	Requirement Description	A	B	C	D	E
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.1.4.11-14	Y
40.11.1.63	Provides capability to produce a daily extract of TPL carrier and recipient resource data for ACTS, CSDW, and EIS	N	N	N	**D.1.4.11.7;** D.1.4.11-14	Y
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.1.4.11-14	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.1.4.11-14	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.1.4.11-14	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.2.1.2-15	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.2.1.2-15	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.2.1.2-16	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.2.1.2-16	Y
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

Requirement #	Requirement Description	A	B	C	D	E
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.2.1.2-17	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.2.1.2-17	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.2.1.2-17	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.2.1.2-17	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	N	N	N	**D.1.4.12.4.1;** D.1.4.12-8	Y

Requirement #	Requirement Description	A	B	C	D	E
	▪ Manufacturer (labeler) enrollment, termination and reinstatement dates ▪ Manufacturer Unit Rebate Amount (URA) ▪ Manufacturer units of measure					
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	N	Y	N	**D.1.4.12.4.4;** D.1.4.12-10	Y
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

Requirement #	Requirement Description	A	B	C	D	E
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.1.4.12-5	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
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.1.4.12-18	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.1.4.12-18	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	N	N	N	**D.1.4.12.3.1;** D.1.4.12-68	Y

Requirement #	Requirement Description	A	B	C	D	E
	level					
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 ▪ Interest only at the drug detail level	N	Y	N	**D.1.4.12.3.2;** D.1.4.12-7	Y
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.1.4.12-18	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.1.4.12-18	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.1.4.12-18	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.1.4.12-15	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.1.4.12-19	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

Requirement #	Requirement Description	A	B	C	D	E
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.1.4.12-19	Y
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.1.4.12-18	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	Y	N	**D.1.4.12.4.6;** D.1.4.12-13	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.1.4.12-19	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.1.4.12-19	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.1.4.12-20	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.1.4.12-20	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.1.4.12-20	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.1.4.12-20	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.1.4.12-20	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.1.4.12-20	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.1.4.12-20	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.1.4.12-20	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.1.4.12-20	Y
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.1.4.12-20	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.1.4.12-20	Y

Requirement #	Requirement Description	A	B	C	D	E
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.1.4.12-21	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.1.4.12-21	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.1.4.12-21	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.1.4.12-21	Y
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.1.4.12-21	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.1.4.12-21	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	N	N	N	**D.1.4.12.8;** D.1.4.12-21	Y
40.12.1.65	Provides capability to produce a Monthly Balance Report to summarize the balance	N	N	N	**D.1.4.12.8;** D.1.4.12-21	Y

Requirement #	Requirement Description	A	B	C	D	E
	due per labeler per quarter and across all labelers					
40.12.1.66	Provides capability to produce a report of payments received for drugs with CMS URA of zero	N	N	N	**D.1.4.12.8;** D.1.4.12-21	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.1.4.12-21	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.2.1.4-18 **D.2.1.4.4.16.5;** D.2.1.4-24	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.2.1.4-18	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.2.1.4-24	Y

Requirement #	Requirement Description	A	B	C	D	E
40.12.2.4	Fiscal Agent shall deposit labeler checks.				**D.2.1.4.4.16.4;** D.2.1.4-24	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.2.1.4.4.16.7;** D.2.1.4-25	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.2.1.4-24	Y
40.12.2.7	Fiscal Agent shall perform end-of-month balancing process.	N	N	N	**D.2.1.4.4.10;** D.2.1.4-20	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 Rebate history on a quarterly basis.	N	N	N	**D.2.1.4.4.16.1;** D.2.1.4-23	Y
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.2.1.4-24	Y
40.12.2.10	Fiscal Agent shall receive, log, and process labeler disputes.				**D.2.1.4.4.16.7;** D.2.1.4-25	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.2.1.4-19	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.2.1.4-24	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.2.1.4-24	Y
40.12.2.14	Fiscal Agent shall produce a Recapitulation Report.	N	N	N	**D.2.1.4.4.16.7;** D.2.1.4-25	Y
40.12.2.15	Fiscal Agent shall send Recapitulation Report to NC DHHS Auditor(s) for review and approval.	N	N	N	**D.2.1.4.4.16.7;** D.2.1.4-25	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.2.1.4.4.16.7;** D.2.1.4-25	Y

Requirement #	Requirement Description	A	B	C	D	E
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.2.1.4-23	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.2.1.4-23	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.2.1.4-22	Y
40.12.2.20	Fiscal Agent shall attend CMS-sponsored Drug Rebate Labeler Dispute meetings as required by the State and based on relevance of agenda.				**D.2.1.4.4.15.1;** D.2.1.4-23	Y

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.2.1.4-27	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.2.1.4-28	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.2.1.4-28	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.2.1.4-28	Y
40.12.3.5	Fiscal Agent shall deposit all labeler checks within one (1) State business day of				**D.2.1.4.5;** D.2.1.4-28	Y

Requirement #	Requirement Description	A	B	C	D	E
	receipt.					
40.12.3.6	Fiscal Agent shall perform interest calculation on outstanding Drug Rebate balances and apply results to Drug Rebate accounts receivable ninety-nine and nine tenths (99.9) percent of the time, as directed by the State.	N	N	N	**D.2.1.4.5;** D.2.1.4-28	Y
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.2.1.4-28	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.2.1.4-28	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.2.1.4-28	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.2.1.4-28	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.2.1.4-29	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.2.1.4-29	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.2.1.4-29	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.2.1.4-29	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.2.1.4-29	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.2.1.4-29	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.2.1.4-29	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.2.1.4-29	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
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

Requirement #	Requirement Description	A	B	C	D	E
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 ▪ 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	N	Y	N	**D.1.4.13.1.1;** D.1.4.13-4	Y
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

Requirement #	Requirement Description	A	B	C	D	E
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.1.4.13.6;** 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
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	N	Y	N	**D.1.4.13.1.1;** D.1.4.13-4	Y

Requirement #	Requirement Description	A	B	C	D	E
	▪ 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					
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
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

Requirement #	Requirement Description	A	B	C	D	E
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.1.4.14-33	Y
40.14.1.2	Provides capability to create withholds, advance payments, and recovery of advance payments	N	N	N	D.1.4.14.2.3 D.1.4.14-11	Y
40.14.1.3	Provides capability to record liens and levy data	N	N	N	D.1.4.14.2.3 D.1.4.14-23	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.1.4.14-32	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.1.4.14.2.11 D.1.4.14-27	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.1.4.14-11	Y

Requirement #	Requirement Description	A	B	C	D	E
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.1.4.14.21 D.1.4.14-5	Y
40.14.1.8	Provides capability to automatically compute financial participation (State, Federal, county, and other)	N	N	N	D.1.4.14.2.15 D.1.4.14-32	Y
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.1.4.14-32	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.1.4.14-27	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	1 D.1.4.14.2 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.1.4.14-23	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.1.4.14-31	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.1.4.14-35	Y
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.1.4.14-33	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.1.4.14-27	Y

Requirement #	Requirement Description	A	B	C	D	E
40.14.1.17	Provides capability to interface with NCAS for accounts receivable and accounts payable functions	N	N	N	D.1.4.14.2.14 D.1.4.14-31	Y
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.1.4.14-31	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.1.4.14-20	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.1.4.14-20	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.1.4.14-20	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.1.4.14-21	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.1.4.14-21	Y
40.14.1.24	Provides capability to generate a stop payment or cancel transaction	N	N	N	D.1.4.14.2.6 D.1.4.14-21	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	Y

Requirement #	Requirement Description	A	B	C	D	E
					D.1.4.14-13	
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.1.4.14-21	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.1.4.14-10	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.1.4.14-20	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.1.4.14-28	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.1.4.14-20	Y
	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.1.4.14-26	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.1.4.14-27	Y

Requirement #	Requirement Description	A	B	C	D	E
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.1.4.14-27	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.1.4.14-21	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.1.4.14-22	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.1.4.14-23	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.1.4.14-27	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.1.4.14-23	Y
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.1.4.14-27	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.1.4.14.2.3 D.1.4.14-19	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.1.4.14-24	Y
40.14.1.43	Provides capability to set up receivables and recoup payments to the provider for	N	N	N	D.1.4.14.2.11	Y

Requirement #	Requirement Description	A	B	C	D	E
	services after a recipient's date of death				D.1.4.14-27	
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.1.4.14-22	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: ▪ Percent ▪ Dollar amount ▪ Total amount	N	N	N	D.1.4.14.2.11 D.1.4.14-27	Y
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.1.4.14-27	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.1.4.14-28	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.1.4.14-27	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.1.4.14-21	Y
40.14.1.50	Provides capability to remove accounts and produce reports on a monthly basis when	N	N	N	D.1.4.14.2.7 D.1.4.14-23	Y

Requirement #	Requirement Description	A	B	C	D	E
	a provider record has been inactive for one (1) year					
40.14.1.51	Provides capability to generate transactions to the system for each accounts receivable item created and invoiced, accounts receivable adjustments, payments received and, recouped and write-offs	N	N	N	D.1.4.14.2.11 D.1.4.14-27	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.1.4.14.2.3 D.1.4.14-19	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, cancellation notices, receipts, and refunds	N	N	Y	D.1.4.14.2.12 D.1.4.14-28	Y
40.14.1.54	Provides capability to collect recipient premium payments	N	N	Y	D.1.4.14.2.12 D.1.4.14-28	Y
40.14.1.55	Provides capability to produce refunds of recipient premiums	N	N	Y	D.1.4.14.2.12 D.1.4.14-28	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.1.4.14-28	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.1.4.14-28	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.1.4.14-28	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.1.4.14-28	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.1.4.14-29	Y

Requirement #	Requirement Description	A	B	C	D	E
	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.1.4.14-33	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.1.4.14.2.2 D.1.4.14-6	Y
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.1.4.14-32	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.1.4.14-27	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.1.4.14.2.2 D.1.4.14-7	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.1.4.14.2.2 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.1.4.14.2.2 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.1.4.14-31	Y
40.14.1.69	Provides capability to produce reporting on providers required by the Federal False Claims Act	N	N	N	D.1.4.14.2.2 D.1.4.14-9	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	N	N	N	D.1.4.14.2.16 D.1.4.14-35	Y

Requirement #	Requirement Description	A	B	C	D	E
	at the appropriate rate					
40.14.1.71	Provides capability to ensure that all financial reports can be tied into the basic financial activity recorded in Provider History	N	N	N	D.1.4.14.2.16 D.1.4.14-33	Y
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.1.4.14-31	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.1.4.14-27	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.1.4.14.2.17 D.1.4.14-32	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.1.4.14.2.12 D.1.4.14-30	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.1.4.14.2.12 D.1.4.14-30	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.1.4.14.2.12 D.1.4.14-30	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.1.4.14.2.12 D.1.4.14-30	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.1.4.14.2.12 D.1.4.14-3012	Y
40.14.1.80	Provides capability to report year-to-date provider 1099 earnings	N	N	N	D.1.4.14.2.29 D.1.4.14-	Y
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.1.4.14.2.12 D.1.4.14-29	Y

Requirement #	Requirement Description	A	B	C	D	E
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.1.4.14.2.12 D.1.4.14-29	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.1.4.14.2.12 D.1.4.14-29	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.1.4.14.2.1 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.1.4.14.2.3 D.1.4.14-19	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.1.4.14.2.3 D.1.4.14-19	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.1.4.14.2.3 D.1.4.14-19	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 is directed for dispositioning when there is no matching account receivable	N	N	Y	D.1.4.14.2.5 D.1.4.14-19	Y
40.14.1.89	Provides capability to account for disposition of all program cash receipts and adjustments within the month of receipt	N	N	N	D.1.4.14.2.5 D.1.4.14-19	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.1.4.14-19	Y

Requirement #	Requirement Description	A	B	C	D	E
	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.1.4.14-8	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.1.4.14-10	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.1.4.14-16	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.1.4.14-34	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 from third parties Refer to *Approved AR-AP Requirements & Business Rules—Updated 12-19-06* in the Procurement Library.	N	N	N	D.1.4.14.2.8 D.1.4.14-24	Y

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. Once a provider becomes delinquent in the payment schedule, the recoupment process shall be implemented until the debt is resolved.	N	N	N	**D.2.1.2.1.13;** D.2.1.2-11	Y
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.2.1.2-4 **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

Requirement #	Requirement Description	A	B	C	D	E
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.2.1.2.1.7;** 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
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	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				**D.2.1.2.1.10;**	Y

Requirement #	Requirement Description	A	B	C	D	E
	checkwrite.				D.2.1.2-7	
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.2.1.2.1.14;** D.2.1.2-11	Y
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	Y

Requirement #	Requirement Description	A	B	C	D	E
40.14.2.29	Fiscal Agent shall complete the Office of State Controller Internal Control Self Assessment upon request by the NC DHHS Controller and provide a signed original to the NC DHHS Controller.				**D.2.1.2.1;** D.2.1.2-2	Y
	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 State.	N	N	N	**D.2.1.2.1.13;** D.2.1.2-11	Y

Requirement #	Requirement Description	A	B	C	D	E
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.2.1.2-4	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
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

Requirement #	Requirement Description	A	B	C	D	E
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.2.1.2-13	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
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				**D.2.1.2.1.9;** D.2.1.2-7	Y

Requirement #	Requirement Description	A	B	C	D	E
	reported.					
	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 these funds daily into the designated State Treasurer's Account.				**D.2.1.2.1.11;** D.2.1.2-8	Y
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 **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				**D.2.1.2.1.5;** D.2.1.2-5	Y

Requirement #	Requirement Description	A	B	C	D	E
	on Fiscal Agent-controlled checking accounts.					
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
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.2.1.2-9	Y
	Production and Distribution of Management and Financial Reports					Y
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.2.1.2-17	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
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.2.1.2-18	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	N	N	N	**D.2.1.2.5;** D.2.1.2-18	Y

Requirement #	Requirement Description	A	B	C	D	E
	immediately via Operations Incident Reporting procedures.					
40.14.3.11	Fiscal Agent shall process check voucher information from the State Controller's Office accurately ninety-nine and nine tenths (99.9) percent of the time and within one (1) State business day of receipt.	N	N	N	**D.2.1.2.5;** D.2.1.2-18	Y
40.14.3.12	Fiscal Agent shall ensure that weekly budget reporting is accurate and consistent ninety-nine and nine tenths (99.9) percent of the time with the costs allocated during the checkwrite.	N	N	N	**D.2.1.2.5;** D.2.1.2-18	Y
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.2.1.2-18	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.2.1.2-18	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

Requirement #	Requirement Description	A	B	C	D	E
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 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.	N	N	N	**D.2.1.2.5;** D.2.1.2-18	Y
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.2.1.2-19	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.2.1.2-19	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.2.1.2-19	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.2.1.2-19	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.2.1.2-19	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
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	N	N	N	**D.2.1.2.5;** D.2.1.2-19	Y

Requirement #	Requirement Description	A	B	C	D	E
	Agent shall deposit these funds daily into the State-designated State Treasurer's Account ninety-nine and nine tenths (99.9) percent of the time.					
40.14.3.29	Fiscal Agent shall perform monthly bank account reconciliation and submit State-approved reports within ten (10) State business days of each calendar month unless the Fiscal Agent notifies the State the reports have not been received from the banking institution in a timely manner.	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.2.1.2-20	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.2.1.2-20	Y
40.14.3.34	Fiscal Agent shall assure that Checkwrite Financial Summary and FPR Reports are completed the day after each checkwrite.	N	N	N	**D.2.1.2.5;** D.2.1.2-20	Y
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.2.1.2-20	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

Requirement #	Requirement Description	A	B	C	D	E
40.14.3.37	Fiscal Agent shall produce and maintain MMIS Medicaid Accounting System Reporting.	N	N	N	**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
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.2.1.2-21	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.2.1.2-21	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.2.1.2-21	Y
40.14.3.50	Fiscal Agent shall process and post transactions for all program cash receipts received	N	N	N	**D.2.1.2.5;** D.2.1.2-21	Y

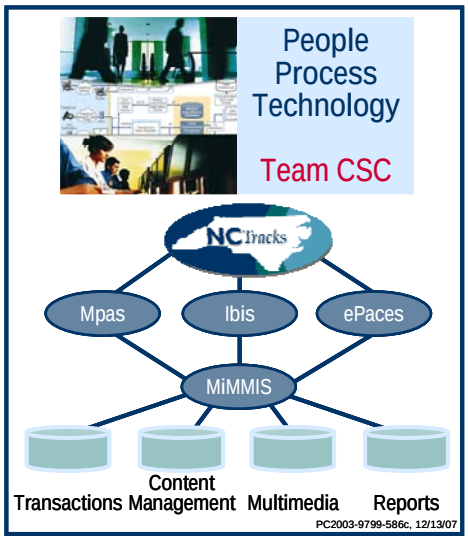
Requirement #	Requirement Description	A	B	C	D	E
	in Fiscal Agent/bank-managed lock boxes designated by the State.					
40.14.3.51	Fiscal Agent shall disposition all program cash receipts and adjustments within the month of receipt to the applicable program division, benefit plan, NCAS CAC code and period code, reason code, service, and county code.	N	N	N	**D.2.1.2.5;** D.2.1.2-21	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.2.1.2-21	Y

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

Business/Functional Area	Baseline Adjusted FP	Enhancement Adjusted FP	New Capabilities Adjusted FP	Notes
Financial	2,609	212	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.
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

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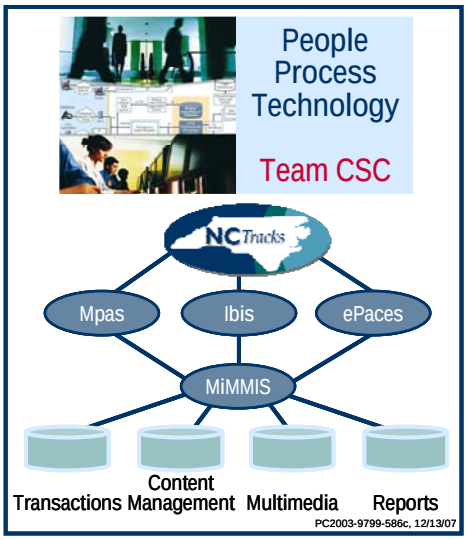
Pages D.2.1-1 through D.2.1-6 contain confidential information.

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 and pay 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 innovated, 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 6 prescription per month limitation or 24 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.

Level 1 and Level II claims specialists who are responsible for resolving suspended claims and entering adjustments and edit overrides.

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 area performs for operating the NC Replacement MMIS and address the RFP requirements for the three claims processing units:

- Claims distribution (mail processing, screening, and printing)
- Claims acquisition (scanning, OCR/ICR, and key from image data entry)
- Claims resolution (adjustment processing, manual review, and claim overrides)**.**

In addition, we identify all required performance standards and present our approach and procedures for meeting the defined standard.

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 these responsibilities:

Distribution	Acquisition	Pend Resolution
• 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

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Exhibit D.2.1.1.2-1. Claims Management Operations Responsibilities. *Clear responsibilities for successful claims processing.*

(40.8.2.1) For more details on the Claims Processing Subsystem, refer to Section D.1.4.8 of our proposal. **(40.8.2.1**)

To meet these responsibilities, our Claims 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 and manually monitored 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:

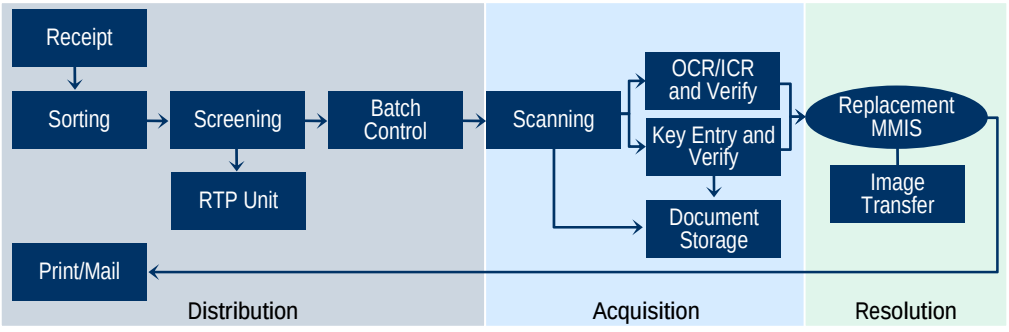
- Research and analyze problem areas at the request of the State
- Review processing procedures and policies to ensure compliance with State requirements
- Provide consultation on complex cases and advise when to refer to the Fiscal Agent's medical consultant and/or the State.
- (40.8.2.53) Reviewing, analyze, and recommend changes that affect State operations: **(40.8.2.53)**

The Claim Management component of the 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 efficiencies to the North Carolina contract while simultaneously seek new avenues for 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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PC2003-9799-334a, 10/22/07

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 Claims Distribution Services

Claims Distribution Services encompasses those processes that initiate claims processing operations. Among the activities performed by this area are 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. Distribution activities occur in the Mailroom and Team CSC staff follows written procedures and policies that are closely monitored by the unit supervisors.

D.2.1.1.3.1 Mailroom

The Mailroom, located in the Team CSC MMIS facility in NC is the focal point for preparing and processing all incoming and outgoing mail. Mailroom staff distributes mail received from the Post Office, collected for inter-office distribution, and deposited by the courier. All incoming paper documents are sorted, screened, and batched by type; these documents are then all scanned and imprinted with a unique control number that contains the date of receipt, batch number, and a sequence number within the batch. During the scanning process, an imprint of the number is placed on the physical document and the number becomes part of the digital image. This process records the day Team CSC receives the paper and ensures that all mail, including claims, claim attachments, adjustments, and other claims-related documents, is date stamped at the earliest time possible. These Mailroom procedures also allow Team CSC to meet and, in some cases exceed, the requirement that all mail be date-stamped with date of receipt within one (1) business day of receipt. **(40.8.2.4, 40.8.2.8)**

(40.8.2.4, 40.8.2.8)

Hand-delivered mail is controlled at the main entrance of the 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 taken to the Mailroom for delivery to the appropriate management personnel or functional unit. Once received 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

To avoid confusion and the misplacement of mail, all incoming mail, including claims, tapes, diskettes, cash, and checks, is placed in appropriately marked containers in the Mailroom. Distribution clerks perform a check of each container to verify the correct mailbox identifier is shown and that the contents are processed according to policy. They also perform spot checks to ensure that the mail is in the correct container and that non-CSC mail has not been accidentally delivered to Team CSC. Any mail not belonging to Team CSC or NC DHHS is placed in the Returns container and picked up by US Postal Service at the end of the day. **(40.8.2.7)**

(40.8.2.7)

All mail addressed to the Team CSC facility is checked to determine if the items should be redirected to NC DHHS. If found, this mail is delivered by the courier service to NC DHHS. Incoming mail for Team CSC is sorted by department and individual and prepared for distribution on a daily basis.

Claims Preparation clerks sort and organize incoming mail in preparation for screening, scanning, and data capture. Mail is sorted into stacks, based on form types and the presence of attachments. In some cases, forms may be rejected during this initial process because key provider information is missing or incomplete. The return envelope is needed. This mail is

set aside, scanned as Return to Provider (RTP) mail, and forwarded to the RTP Unit for review and return to the provider with a request for the required information.

D.2.1.1.3.3 Courier Service

Team CSC provides a courier service between the Team CSC facility and the designated NC DHHS office. 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. Mail deposited at the Team CSC facility by the courier undergoes the routine checks and date-stamping procedures prior to internal distribution. **(40.8.2.5)**

(40.8.2.5)

D.2.1.1.3.4 Mail Delivery Services

Distribution clerks are also responsible for logging each package of mail designated to be picked up and delivered by the courier service. 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 electronic log for the particular package and obtains a signature from the individual accepting the package at its destination. **(40.8.2.9)**

(40.8.2.9)

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.

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 denial, 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. 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)**

(40.8.2.11)

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.

D.2.1.1.3.6 Postage Costs

(40.8.2.12)

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)

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.

Page D.2.1.1-9 through D.2.1.1-10 contains confidential information.

to Provider (RTP) team. This team views the rejected claim online and initiates a RTP letter for printing or sending to a secure inbox followed with an emailed alert. These systematically generated RTP letters identify the missing data elements, and instruct the provider to complete the form and resubmit for processing. **(40.8.2.14, 40.8.2.15)**

Scanning and RTP
All paper documents are scanned, including claims, attachments, written correspondence, etc allowing for a review and tracking of any information received. In lieu of processing claims with missing data that will ultimately deny, Team CSC will initiate return to provider notifications educating the provider of the missing data elements

This process eliminates the need for manual pre-screening of claims. The data entry software can determine if the forms are legible for scanning, that required signatures are present, and that specific fields have been completed. **All paper documents are controlled at the initial entry point into the system through the use of OCR, Verify Data Capture, and the Ibis workflow resulting in a decrease in incomplete claims entering the Replacement MMIS and thus improved operational efficiencies and quality control.**

D.2.1.1.4.1 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 sort, log, and batch these documents and all supporting documentation. The batches are then sent to imaging for tracking and control. The scanners imprint each hard copy document with a Document Control Number (DCN) that contains the date of receipt, batch number and sequence number within the batch.**

(40.8.2.16, 4.8.2.17, 40.8.2.19)

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. Resolution 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, 4.8.2.17, 40.8.2.19)**

(40.8.2.20)

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)**

(4.8.2.18)

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. **(4.8.2.18)**

(40.8.2.21)

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 low risk approach to handling and controlling incoming paper claims and documents. (40.8.2.21)**

Page D.2.1.1-12 contains confidential information.

Team CSC staff. All provider documents, contracts, agreements, enrollment applications, attachments, training and publication material and forms, on-site visit documentation, training evaluations as well as all written communications and Team CSC/State responses undergo the imaging process.

Each scanned document is automatically assigned a DCN, and linked to the provider number if available on the document. Those imaged documents lacking provider numbers are queued for Provider Relations staff for research. These individuals enter the provider number into the system and this information is retained on the image. All images are housed in the electronic document management system and accessible to authorized State and Team CSC personnel. **(40.5.2.4, 40.5.2.61)**

(40.5.2.4, 40.5.2.61)

The Team CSC imaging procedures are also instrumental in creating complete provider profile data, including site visits and training activities. Team CSC images all on-site visit written materials, such as visit requests, correspondence, summary reports, and other support material. Provider training workshop materials, summaries, and evaluations are also 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)

During the DDI Phase, Team CSC works with State staff to review all front-end processing procedures. **Their goal is to work in partnership with the State to improve the current methods and develop new processes to expedite claims operations.** They 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,

Pages D.2.1.1-15 through D.2.1.1-17 contain confidential information.

provider. Pend severity can also be used to dictate the edit resolution sequence in which multiple edits should be presented for review. Certain pend severities can be chosen to override a deny status edit situation if so desired. The severity level also is used when the 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; All	• 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

	Performance Standards	Team CSC Meets this Standard by:
	non-clean claims within thirty (30) calendar days of the date of correction of the condition that caused the claim to be unclean.	• 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
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 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.	• 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.**

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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 most timely 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)

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 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) 40.14.2.13, 40.14.2.7, 40.8.3.19, 40.14.2.14, 40.14.2.71, 40.14.2.41, 40.14.2.42

(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 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.

CSC – Transforming Claims Processing

For years, adjusters at West Bend Mutual used paper forms to record claim information, which was then entered into their claims system by a team of clerical workers. West Bend Mutual contracted with CSC to integrate CSC's Exceed Claims component with the company's legacy policy administration system and new software for check processing and payment reconciliation. The new system has allowed West Bend Mutual to transform its claim handling process. Claims are now administered directly by West Bend Mutual's adjusters, allowing the company to redeploy clerical staff and consolidate office locations for an approximate savings of $150,000 annually.

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 authorized transactions to be transferred to providers' accounts as well as an authorized check 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.

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 is very effective, and has virtually eliminated the possibility of counterfeit presentations.

D.2.1.2.1.7 Support for Positive Pay

The North Carolina Department of State Treasurer (NCDST) provides a "Positive Pay" program which provides for the detection of counterfeit State warrants (checks) that may be presented against an agency's account. It also allows for an upfront reconciliation of presented warrants to be performed by the NCDST, minimizing the after-the-fact reconciliation process for the agency. Another benefit of the program is that it prevents payment of warrants that have been escheated or are stale dated. In order to provide data required for Positive Pay, Team CSC will submit to NCDST a check-issuance file containing the warrant data for all warrants issued, at the conclusion of each cycle's financial processing. This file will be similar to the authorized check file described above, and will include data elements such as account number, warrant number, amount, and issue date, and payee name. Using this file, NCDST can: 1) detect any counterfeits presented; and 2) correct upfront any amount and warrant number encoding errors.

During the transition period, Team CSC will work closely with State officials to develop file layouts and transfer procedures designed to ensure that Positive Pay is well coordinated. (40.14.2.11) **(40.14.2.11)**

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) **(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.

(40.8.2.55)

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 request 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)**

(40.14.2.3 40.14.2.12 40.14.2.21 40.14.2.22)

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 provider then makes digital images of receipt documentation available to Team CSC through a secure data transmission. These images can then be 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.

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.

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)** Adjustments can arise from a number of sources, as follows: (40.12.2.5)

1) Provider-Submitted Adjustments

Team CSC will offer processing to input provider-identified adjustments using procedures that are identical 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. 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)**

(40.14.2.35 40.14.2.36 40.14.2.38)

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

(40.14.2.22)

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.

- 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 Project Accounting Function

The second major component to Financial Management is the Project Accounting unit. This unit is assigned a range of traditional accounting responsibilities designed to properly record all revenues earned and expenses incurred by Team CSC in operating the North Carolina MMIS. Presented below are some highlights of Team CSC's approach for Project Accounting.

Team CSC's internal accounting unit will follow all regulations of the IRS, North Carolina Department of Revenue, and any other applicable laws and regulation in recording all transactions relating to the Replacement MMIS project. In addition, all financial statements will be prepared in conformity with Generally Accepted Accounting Principles. **(40.14.2.25, 40.14.2.26, 40.14.2.27)** (40.14.2.25-27)

In order to develop the most cost-effective solution for North Carolina, we will leverage the capabilities of several Team CSC centralized accounting functions which normally support projects such as the Replacement MMIS. Services to be provided by these centralized units include Procurement/ Accounts Payable, and Payroll.

The associated transaction-level records, as well as the associated general ledger, and all financial statements will be available throughout the life of the contract, and will be maintained for a period after the termination of the contract which is sufficiently long to meet the retention requirements of RFP section 30.19.1 **(30.19.1)** (30.19.1)

Consistent with the requirements of 45 CFR part 74, Team CSC will maintain accounting records relating to revenues and administrative costs of the contact and will make them available to the NC DHHS, State Auditor, other State and Federal agencies providing funds, and the Comptroller General of the United States. Team CSC will provide an audit liaison to these audit agencies in order to facilitate any audit activities they may pursue. **(30.19.3)** (30.19.3)

Team CSC intends to use existing automated and manual systems to record transactions associated with the Replacement MMIS project. These robust systems have been in use for

a number of years. 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)

Monthly financials will be prepared carefully to accurately depict the results of operations during the month. The financial statements will be made available to NC DHHS on the 10th business day following the end of the month. Team CSC's Finance Manager and other Project Accounting staff will be available to meet with the State to discuss financial statement details as requested. **(30.19.2)**

(30.19.2)

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 ensue that all transactions are properly recorded and cash promptly deposited to bank accounts.

9799-999

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

9799-999

Exhibit D.2.1.2.2-1. 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 suspends 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 Medicaid recipients with multiple coverages. We will offer processing designed to ensure that the NC Medicaid Program is truly the "Payer of Last Resort", effectively serving to reduce the overall Medicaid costs wherever appropriate.

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 addresses 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

(40.11.2.1) contractor. **(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

(40.8.2.52) which will be subject to normal collection processing steps **(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 from the State of 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

(40.11.2.2) accounts receivable. **(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 forms are forwarded to the State's TPR unit, where they are reviewed and entered to a file of updates. Team CSC anticipates that this file will be electronically transferred to Team CSC, where it will be input to the Replacement MMIS to update the recipient eligibility file, reflecting any changes in Third Party coverage for each recipient included in the data exchange. After the recipient master file is updated, the Replacement MMIS will prepare individual carrier update transactions which will be transmitted back to the State for its own processing purposes. These updates will be made available to the state on a weekly basis, reflecting all update activity processed during the previous weekly cycle. **(40.11.2.5)** (40.11.2.5)

In order to support processing for the Automated Collections and Tracking System (ACTS), Team CSC will extract and process TPL data transmitted by ACTS from the DIR electronic File Cabinet. Team CSC will work closely with the State during the Takeover phase of the project to make sure that the appropriate infrastructure has been established to support these TPL data transmissions. Testing procedures will be established and exercised to be certain that this data transfer process is functioning as intended prior to commencement of operations**. (40.11.2.6)** (40.11.2.6)

In order to ensure availability of the most current data to support ACTS, CSDW and EIS, Team CSC will produce a daily extract of TPL carrier and recipient resource data. This extract will be taken from the most current Recipient database, which in turn will have been updated with all updates to recipient profiles, including TPL status, during the previous 24 hour period. **(40.11.2.7-8)** (40.11.2.7-8)

D.2.1.2.5 Performance Standards Attainment Approach

Team CSC Recognizes its responsibility for Performance Standard attainment and the importance to NC DHHS of meeting standards. We understand that delivery of a quality product is very important, and consistent attainment of performance requirements will be a

Pages D.2.1.2-16 through D.2.1.2-21 contain confidential information.

D.2.1.2.5 Conclusion

Team CSC will offer the State of North Carolina a Financial Management capability that emphasizes good stewardship over financial transactions, supported at all times by careful and well-controlled processing. Our approach offers best practices for financial processing, including timely and accurate reporting, advanced banking services, and segregation of transactions among the various benefit programs and lines of business that must be supported in a true multi-payer environment.

Equally important, our excellent technical and business solution will be supported by Team CSC's commitment to unparalleled customer service.

Pages D.2.1.3-1 through D.2.1.3-10 contain confidential information.

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

The Provider Data Maintenance function receives provider add/delete/change information applicable to provider program participation. Accurate processing of provider data is imperative to ensure satisfaction and retention of certified medical service providers to care for and treat North Carolina medical assistance program beneficiaries.

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. In addition, the Provider Enrollment Specialist is able to initiate State-approved indicators that support provider monitoring-related issues.

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.1.2.1.5, 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 input forms from the State. 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.**

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 existing state policies and procedures in a systematic manner that supports the implementation and operation of the State-approved approach for the Team CSC Provider Enrollment Unit. Upon receipt of state policies and procedures, Team CSC develops internal procedures. We address Provider Master File updates for initial provider participation enrollment, changes in participation status or personal information, and disenrollments. **We include a quality review procedure ensuring the appropriateness of the updates and that updates are complete or identify that a change is warranted.** Team CSC also meets with other State vendors as required for managed care plan participation updates to establish procedural processes to ensure that we update the Provider Database in accordance with receiving the information or identifying that a change is warranted. Whenever a change occurs, we submit draft changes to the protocols for State approval as required to ensure the continued integrity of the program, provider satisfaction, and continuous improvement in efficiencies.

No provider change is implemented in the database without receiving written correspondence or electronically through **NC***Tracks* with electronic signature. Physical correspondence is date stamped by the mailroom and forwarded to the Provider Enrollment Unit. It is properly batched, a cover form validating our review for the appropriateness of the request, recorded in **NC***Tracks*, and forwarded for imaging. It is identified with a Transaction Control Number and available in the provider-specific directory for future review. When the change is made, **NC***Tracks* generates a letter via secure email or hard copy mail on the day the change request was entered advising the provider that the change request was completed. Changes that affect "credentialing" will trigger credentialing specialists to revalidate the provider. This may involve state approval for some changes.

D.2.1.3.1.10 Urgent Reviews

Team CSC provides a State-approved process to support "urgent reviews" regarding the reduction, suspension or termination of a provider's continuing participation in the North Carolina medical assistance programs outside routine recredentialing procedures. Team CSC proposes the following urgent review procedures and workflow as depicted in **Exhibit D.2.1.3.1.10-1**, Urgent Review and Appeal Process, to support this function and will refine this process prior to start of Contract Operations. **(40.5.2.24)**

(40.5.2.24)

Pages D.2.1.3-13 through D.2.1.3-18 contain confidential information.

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.** CSRs 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 CSR. • Listening on another headset while using business applications as the seasoned CSR works the call or working the call while the seasoned CSR uses the business applications. • Working the call while the seasoned CSR 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 CSRs. The CSR 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 CSR how information is organized in the knowledge base and how to most effectively use its search capabilities

9799-999

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 "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 their applications 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 (NCAMES) • 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	• 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 (NHA) • North Carolina Medical Group Manager's Association (NCMGMA) • North Carolina Medical Society • North Carolina Opticians Association • North Carolina Pediatric Society • North Carolina Physician Advisory Group (NCPAG) • Old North State Medical Society.

9799-999

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 Carolina DHHS programs confront each day and our desire to build a positive relationship with all the associated entities.

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

9799-999

Exhibit D.2.1.3.3-2. Potential Health Related Needs

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 ensures the provider community of Team CSC's and the State's desire to assist. **(40.1.2.77)**

(40.1.2.77)

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. 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.

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:

- 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
- 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, 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
(40.5.2.47) attendance at a training session and provide an on-site visit, if requested. **(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
(40.5.2.50) registration card. **(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
(40.5.2.46) met high standards for these services. **(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,
- Incorporate State identification of problems received in its offices, as well as

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, telephone number and email address for follow-up. A copy of the online sign-in form is forwarded to the State with a summary of the training session information. The originals are retained at Team CSC in accordance with contract record keeping requirements. A status of provider workshop attendance is added to the CRM to identify the training for each provider. **(40.5.2.55)**

(40.5.2.55)

Team CSC includes a State-approved training evaluation form in each training package as well as sends an email for an online survey completion. They are asked to complete either the online survey or the evaluation form and leave it at a designated site at the end of the session or mail it to the address provided.

We use the Training Evaluation surveys and forms to evaluate the workshop and on-site visit, the trainer's performance, the materials used in training, and the need for follow-up to a specific provider's questions. The evaluation survey and forms are regarded as additional tools to meet providers' ongoing needs and to improve our training effort. **(40.5.2.53)**

(40.5.2.53)

We propose to use a Likert-type scale of 1-5 for measuring satisfaction with the training session if approved by the State. This allows results to be tabulated in Team CSC computerized format for State reporting. The online survey and the evaluation form are converted to an image, linked to the provider in the provider tracking database, and maintained for the contract period. The evaluation criteria are summarized and reported to the State within five business days from the training date. Both provider evaluation images and summaries are accessible to the State online. In the event the provider has included a specific question on the evaluation form, the Team CSC trainer contacts the provider with a response either by email, telephone, or written correspondence within the approved time frames established by the State. **(40.5.2.54)**

(40.5.2.54)

Pages D.2.1.3-27 through D.2.1.3-29 contain confidential information.

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 NPI number 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
- Hospital Services
- Provider 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

Trainings 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 their 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 in the Medicaid Program and DHHS medical assistance programs: the Division of Medical Assistance, the Division of Mental Health, Developmental Disability and Substance Abuse Services, the Division of Public Health, and the Office of Rural Health and Community Care, including the Migrant Worker 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.**

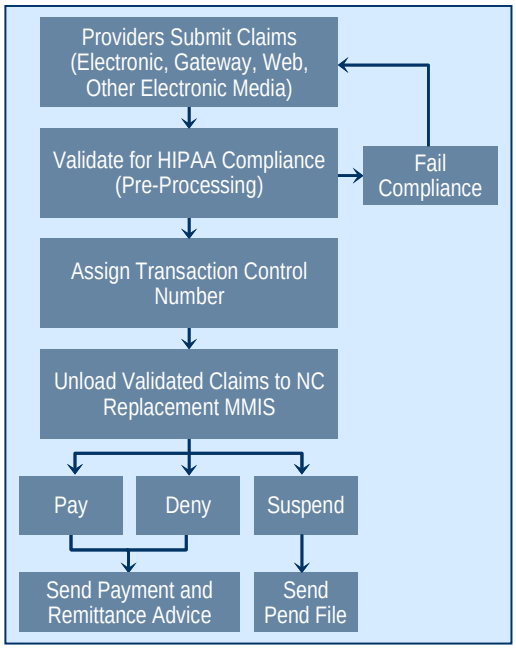
Three-Prong Administrative Program to Support EDI
• Providing full functional, easy to use MMIS features that are available to providers 24 hours a day, 7 days a week • Implementing a proactive campaign of marketing the benefits of EDI that included the following activities: – Monthly Medicaid Updates 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.

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.



PC2003-9799-373b, 12/17/07

Exhibit D.2.1.3.6-1. EDI/ECS Process Flow. *Process Flow* provides *an overview of the electronic processing for the Replacement MMIS.*

The Replacement 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)**

(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			✓		
834 Enrollment		✓			
837 Dental Batch	✓	✓		✓	✓
837 Institutional Batch	✓	✓		✓	✓

Inbound Transaction	Dialup Batch Electronic Gateway	Dialup Batch FTP	Real Time Direct Connection	Web-based Batch eXchange	Web-based ePACES
837 Professional Batch	✓	✓		✓	✓
837 Professional Interactive			✓		✓
276 Claim Status	✓	✓		✓	✓

9799-999

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.1.2.1.8, 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.2.1.3-35 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)

ECS/EDI Help Desk

(40.8.2.31, 40.8.3.3)

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 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)**

(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 certificate of credible 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 COCC 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

(40.2.3.1)

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)

(40.2.3.1)

- State entities' eligibility edit/error reports by 7:00 A.M. Eastern Time **(40.2.3.1)**
- Eligibility Reconciliation Reports

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.1.2.1.1, Recipient Subsystem, 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.1.2.1.1, Recipient Subsystem, 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.1.2.1.1, 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)

As described in Proposal Section D.1.2.1.1, Recipient Subsystem, State Mental Health Updates, Team CSC will implement a process 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)

As described in Proposal Section D.1.2.1.1, 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 (RFP 40.10.2.1 through 13)

(40.10.2.1 through 13)

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.

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.1.2.1.10, Health Check Subsystem.

Telephone and Written Correspondence and Technical Support

(40.10.2.2) 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)**

(40.10.2.11)

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.1.2.1.9, 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

Pages D.2.1.3-48 through D.2.1.3-53 contain confidential information.

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 is comprised 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. Each member of the Health Program Services team members 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 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 and Medical Claims 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 within the Replacement MMIS.**

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, 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)**

At NC DHHS request, Medical Policy analysts enter updates to 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.**

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

40.6.2.8 Representatives and Training Specialists, to ensure that updated information is available throughout all affected areas of the Fiscal Agent operation. **(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)

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 on a daily basis 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, 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)**

(40.8.2.45)

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 the web portal, North Carolina Transparent Reporting Accounting Collaboration and Knowledge Management System, or **NC***Tracks*, 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. **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**

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, which enables 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 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, 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

Page D.2.1.4-7 contains confidential information.

Prior Approval Rosters

Team CSC generates Prior Approval rosters so that providers can see at a glance the authorized services and the prior approval number. Providers can specify generations of these rosters on a daily or weekly basis and receive rosters in their electronic inbox or via mail.

disposition letter, which includes the date of letter generation. Prior approvals that are approved as submitted are reported on a Prior Approval 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 (e.g., recipient ID, prior approval number for inclusion on the claim, etc.). The system automatically distributes Rosters, either nightly or weekly, depending on the provider type and preference.

Clinical Prior Approval Reviewers process suspended prior approval, referral, and override requests that the system automatically routes to the correct work queue (e.g., pharmacy, optical, surgical, etc.). Additionally, all transactions proceed through the 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)**

(40.7.2.14, 40.7.2.21)

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.2.1.2.2, 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
(40.8.2.40) Board recommendations in our Pharmacy POS/ProDUR program immediately. **(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.
(40.7.2.25, 40.8.2.39) 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)**
- 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
(40.7.2.26) control the rising costs of the North Carolina pharmacy program. **(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
(40.7.2.30) management and State staff. **(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 criteria therapeutic 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.2.1.4-15 through D.2.1.4-30 contain confidential information.

Pages D.2.1.5-1 through D.2.1.5-3 contain confidential information.

- Fire and smoke systems

Team CSC will provide daily system operation and administration support for mid-range and mainframe Replacement MMIS servers, and Replacement MMIS storage systems. Team CSC will provide 24x7x365 systems monitoring and support services to ensure availability and minimize production downtime to include:

- Backup/recovery management and reporting
- System administration
- Production control services
- Database administration services
- Configuration management
- Fault management
- Performance management
- Middleware management services
- Directory service administration

40.1.2.93

D.2.1.5.1.2 Network Services **(40.1.2.93)**

Team CSC will provide network management and monitoring services for all the wide area network (WAN), local area network (LAN), and voice network infrastructures. Network 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

9799-999

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.

D.2.1.5.1.3 Application Support IT Services

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 COB. This coverage will be provided by on-site and remote coverage. The single point of contact for critical application support will be the help desk. Application support is accountable to resolve the incident 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 and will be resolved according to agreed upon performance standards.

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

D.2.1.5.1.5 IT Security **(40.1.1.17, 40.1.2.10, 40.1.2.50)**

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 of user/group access to Team CSC Replacement MMIS resources including but not limited to applications, files, and data fields.
- User-ID and password administration across all platforms
- Monitoring, detecting, reporting, and investigating 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.
- Maintain a malicious software policy and investigating incidents involving malicious software
- Ensure security compliance of Team CSC issued laptops and cell phones.

Security Approach

Computer Security Incident Response Capability

- Linked to NOC,
- Linked to Call Center
- SLAs
- Alert/Vulnerability notification
- Patch Management
- Vulnerability Assessments

Technical Security Operations

- Security Device Management
- Updates with configuration files, hot fixes, and patches

Certification and Accreditation Support

- FISMA compliance
- Enforce Replacement MMIS policy
- Physical and logical LAN separation

Our goal in performing, safeguarding, and protecting information is to ensure there is no unauthorized access to critical business systems, prevent systems fraud, and limit access to Replacement MMIS proprietary data.

To protect data on portable devices such as laptops, we will use the CSC Managed Encryption Service (MES), which based on Pointsec technology. MES protects data on devices by encrypting the entire hard disk. The encryption key is known only by the user and the CSC Security Operations Center. To protect data within the data center, confidential data will be encrypted when stored. These keys are also known only by the CSC IT Security Service. All keys are archived in an offsite lockbox and will be made available to North Carolina.

Pages D.2.1.5-8 through D.2.1.5-10 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. 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"
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.
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

Req #	Requirement Description/Team CSC Commitment
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;
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.

Req #	Requirement Description/Team CSC Commitment
Commitment	Team CSC will comply.
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.
Commitment	Team CSC will comply
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.
Commitment	Team CSC will comply
40.6.2.8	Fiscal Agent shall update edit criteria and all applicable documentation and notify the State when updates occur.
Commitment	Team CSC will comply
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.
Commitment	Team CSC will comply
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.
Commitment	Team CSC will comply
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.
Commitment	Team CSC will comply

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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.

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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 - 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. 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.

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, 40.1.2.4)

- Fiscal agent local facility (DDI and Operations Phases) **(40.1.2.3)**
- Fiscal agent key personnel (DDI and Operations Phases) **(40.1.2.4)**
- Fiscal agent business units (DDI and Operations Phases) **(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)
- Network Operations Center for the Replacement MMIS (DDI and Operations Phases)
- Data and Imaging Center (DDI and Operations Phases)
- Storage of physical Medicaid files (DDI and Operations Phases)

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

Exhibit D.2.2-1 provides a more detailed listing of where our functions supporting the Replacement MMIS will be located.

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
Network Operation Center	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

Our current North Carolina facility complies 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. Telephone service as well as office supplies will also be provided. Team CSC will, for the length of the contract,

40.1.2.5 – 40.1.2.9

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)**

40.1.2.10

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)**

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.
- During working hours, 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. Offices 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 Program office will remain in the original facility (DDI Phase) until a specified period after contract award. We will begin re-locating key personnel that are assigned to the North Carolina office, in space dedicated to the Operational Phase of the contract. 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 and the Web Portal. 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.

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.

40.1.2.81 Refer to Client Services section D.2.1.3 **(40.1.2.81)**

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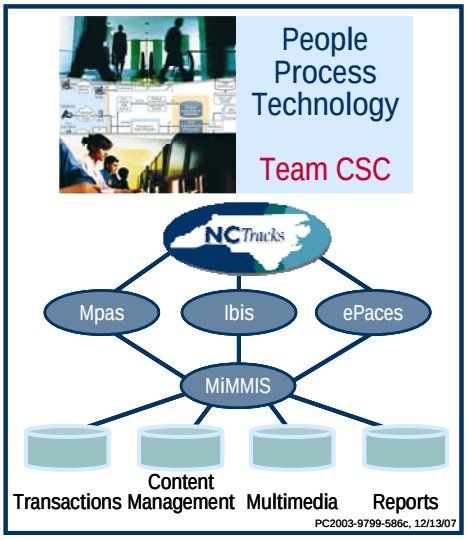
Pages D.3-1 through D.3-105 contain confidential information.

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.***

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 will 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 including NC DHHS MMIS stakeholders, MMIS Contract Management staffs, State and county stakeholders, providers and other State Medicaid contractors represent 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.

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.

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)**

(10.10

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.

Number of Staff	Location	Population Density
2	Charlotte	610K
2	Raleigh/Durham	544K
1	Greensboro	231K
1	Wilmington	96K
1	Asheville	72K

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)**

40.9.2.5

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.

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

(40.1.2.79) Implementation Training Committee for approval prior to conducting training workshops. **(40.1.2.79)**

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.

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) (40.1.2.80) (40.1.2.82) (40.5.2.50)**

(40.1.2.36)
(40.1.2.80)
(40.1.2.82)

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:

- 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.

(40.1.2.88)

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. **(40.1.2.83)**

The length of instructor-led classes will vary for subsystem and user requirements to be determined during the development phase.

(40.1.2.81) State-approved evaluations will be administered to all participants, the results of which will be tabulated and reported to the State. **(40.1.2.81)**

"Jason and Theresa were friendly, approachable, helpful, knowledgeable and kept everyone interested during the training session."
NYS Department of Health Representative:

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

(40.1.2.84) materials by contacting the Team CSC Call Center. **(40.1.2.84)**

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	

9799-999

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

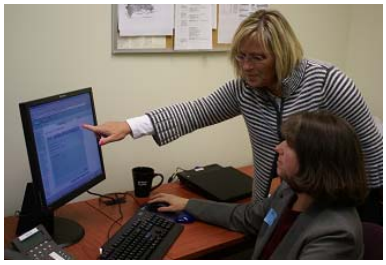
Pages D.4-11 through D.4-13 contain confidential information.

A training system will be available for users who will have hands on access to the Replacement MMIS, including Team CSC staff, State and local agency staff that will access the Replacement MMIS through their connection to the State's DMA or DMH networks. This training system will have the functionality of the new production Replacement MMIS with a smaller database of scrubbed provider and recipient data. The primary difference from production will be a smaller set of client and providers tables. The client and provider information for the training system will be chosen to represent as many valid combinations of types as possible. However, the information will be "mocked up" or scrubbed so that it can be shared during training sessions without compromising HIPAA requirements for protection of individual private health information. The training system's software and parameter tables will be refreshed from production on a regular schedule so that the training reflects what is happening in production.

Training materials will be updated as part of change management to keep the training in step with the production environment. Updated materials will be submitted for State approval in advance of planned training activities that will be scheduled prior to production changes. Significant changes that impact certain user groups will require special training and communications prior to implementation of the change to create knowledgeable users who will be ready for the change. All changes will be examined on a case by case basis to determine the right level of user education prior to the change.

Ongoing training for providers will be a continuation of methods used for the saturated training offered prior to system implementation. A minimum of 70 instructor-led training workshops, utilizing state-approved content will be conducted across the State annually for providers. A quarterly schedule of instructor-led training classes will be published on **NC***Tracks*, and users may register for these classes on the web. **(40.1.2.79, 40.1.2.85)**

(40.1.2.79, 40.1.2.85)



Team CSC will also assign the appropriate staff, as requested by the state, in semi-annual Finance and Reimbursement Officers (FARO) conferences. CSC's outreach representatives will also plan, organize and conduct the annual Medicaid Fair. **(40.1.2.86 - 87)**

(40.1.2.86 - 87)

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 training system for users who access the replacement system.

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 evaluations will be mandatory for all newly hired staff and for ongoing staff periodically. **(50.2.2.4, 40.1.1.130)**

(50.2.2.4, 40.1.1.130)

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. **(40.1.1.128, 40.1.1.129)**

(40.1.1.128, 40.1.1.129)

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 MMS 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.

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. **(40.1.2.88)**

(40.1.2.88)

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.

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)**

(50.2.4.4)

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 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. **(40.1.1.135, 40.5.2.54, 40.5.2.55)**

(40.1.1.135, 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.

Page D.4-20 contains 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

20 December 2007
Volume I — Technical Proposal

Book 3 of 4
Sections E-I

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Table of Contents

BOOK 2

BOOK 3

BOOK 4

List of Exhibits

BOOK 1

BOOK 2

BOOK 3

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 Distribution
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

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
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 Voice Response Unit
BA	Business Analysis
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
CA	Control Accounts
CAFM	Computer-Aided Facilities Management
CAM	Control Account Managers
CAP	Competitive Acquisition Program
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	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	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 Amendment
CLIN	Contract Line Item Number
CM	Configuration Management
CMM	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
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	Certificate 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	Communication Plan

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
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
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 Ssytem
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 Administration
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
DSR	Daily Service Review
DSS	Division of Social Services (organization within NC DHHS)
DSS	Department of Social Services (as part of county government)
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 Fund Transfer
EHR	Electronic Health Record
EI	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
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 Aka 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 Detection System
FAQ	Frequently Asked Questions
FARO	Finance and Reimbursement Officer
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
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
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
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	Health Finance Management Association
HHA	Home Health Aid
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	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
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
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
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	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
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 Collabortaive
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
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 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
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	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

PMP	Project Management Professional
PMPM	Per Member Per Month
PMR	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)
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
PST	Production Simulation Testing
PV	Planned Value
PVCS	Polytron Version Control System
QA	Quality Assurance
QAP	Quality Assurance Plan
QASP	Quality Assurance Surveillance Plan
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
SCC	Security Control Center
SCHIP	State Children's Health Insurance Program
SD	System Development
SD	Software Development
SDB	Small Disadvantaged Business
SDEP	Service Delivery Excellence Program
SDLC	Software Development Life Cycle
SDM	Service Delivery Manager
SE	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
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	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
UI	User Interface
UPC	Universal Product Code
UPIN	Unique Provider Identification Number
UPS	Uninterruptible Power Supply
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 E.1-1 through E.1-5 contain confidential information.

E.1 Project Management Plan

RFP Number: 30-DHHS-1228-08

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Office of Medicaid Management Information System Services

Prepared by:
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v1	15 November 2007	Initial draft submission

Reference Documents

Document Number	Document Name

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E.2 Integrated Master Plan

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v1	20 December 2007	Initial draft submission

Reference Documents

Document Number	Document Name

Pages E.2-2 through E.2-41 contain confidential information.

All pages of E.2, Gap Analysis, contain confidential information.

E.3 Integration Master Schedule

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Prepared by:
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Pages E.3-1 through E.3-6 contain confidential information.

E.3.3 Integrated Master Schedule

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 05/30/2012, however, once awarded and updated, these will continue through to the end of the contract.

- Event, Milestone and CDRL activities are identified as those that:
  - Require the State acknowledgement or approval
  - Indicate Team CSC's completion of an activity that we think the State should know about or will enable the State to perform a related activity
  - Deliverables to which the State must review or approve
  - Indicate Start/End of activities that the State must perform

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. All activities with 0 durations are automatically Milestones and are noted with a "yes" for reporting purposes. Team CSC further modified this field from No to Yes for any activity that Team CSC has determined is an Event in the IMP, is a Milestone that the State should be aware of, or is an activity that the State either participates is, must perform or must approve.
- **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.

Pages E.3-9 through E.3-140 contain confidential information.

Pages E.4-1 through E.4-18 contain confidential information.

Pages E.5-1 through E.5-23, including E.5 DDI Organizational Chart ½, and E.5 Operations Phase Organizational Chart ½ contain confidential information.

Pages E.5 Key Resumes-1 through E.5 Named Resumes-79 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

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Exhibit E.6.2-1. Communication Requirements in DDI Phase. *Team CSC understands communication requirements within the DDI phase of the Replacement MMIS project.*

Page E.6-5 contains confidential information.

Pages E.6-7 through E.6-10 contain confidential information.

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.

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.

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.*

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

20 December 2007
Volume I — Technical Proposal

Document History/Release Authorization

Change History

Version	Date	Description of Changes
v1	20 December 2007	draft submission with proposal

Reference Documents

Document Number	Document Name

TABLE OF CONTENTS

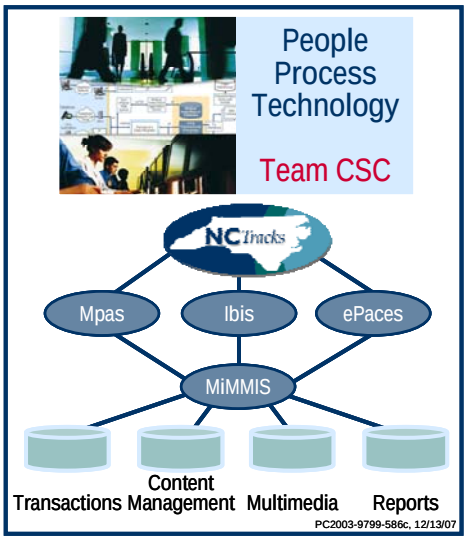
Pages E.7-3 through E.7-19 contain confidential information.

Pages E.8-1 through E.8-8 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. 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 candid, open communication. For any stakeholder who prefers to voice issues on-line, there will be an issues area on the portal which facilitates identification and communication of potential issues.

Pages E.9-2 through E.9-8 contain confidential information.

Our Team's software developers, system engineers, and program management staff are thoroughly trained in Catalyst-based approaches to change management, and will implement this approach for DHHS. The result will be an outcomes-driven Change Management Plan that is understood and fully endorsed by DHHS.

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

Outline of Team CSC's Change Management Plan		
Section	Section Title	Description of Section Contents
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
11.	*Metrics*	• Summary of change-specific metrics being collected, organized, and evaluated • Feeding change-specific metrics into SLA performance data and evaluation

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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 Account Executive Director (AED) 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.

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.**

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.

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

Pages E.9-13 through E.9-17 contain confidential information.

- Network architecture
- Network hardware
- System applications, including but not limited to software patches

A Configuration Change Control Board (CCCB) performs a parallel function to that of the project's broader CCB. The process of initiating, evaluating, and ultimately approving or denying a configuration change request is the same as the process used to prompt action by the CCB. The project management Portal serves as the location for all configuration changes documentation, including the CR.

The establishment of a distinct process leading to changes specific to the MMIS' configuration enables the project to leverage specialized expertise about system configuration from a narrower group of system engineers and information officers. 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.**

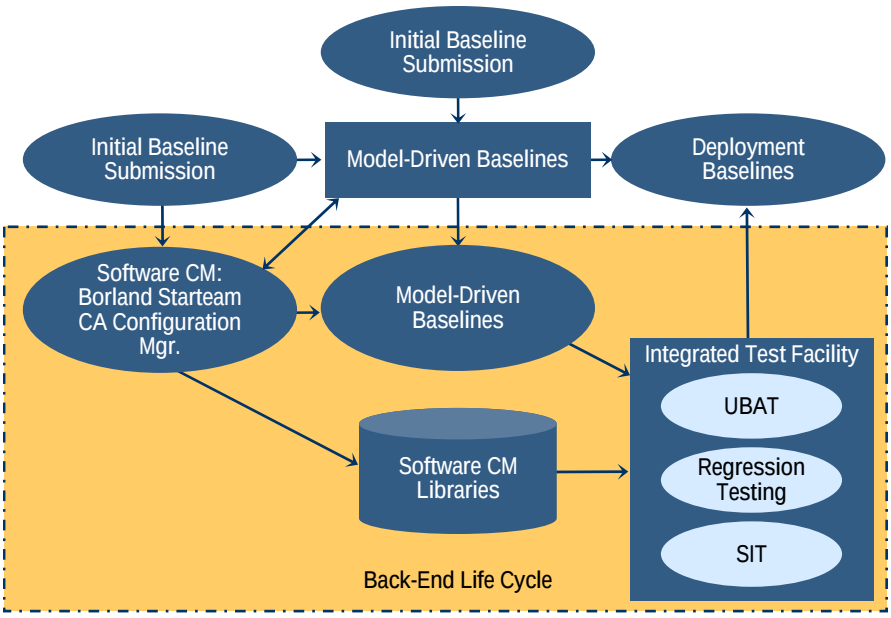

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Exhibit E.9.10-1. Front-end to Back-end CM Connection with Model-Based Approach. *Team CSC brings a process for semi-automated model-based software CM, Integration and Testing that find problems early and creates "reusable regression test" library.*

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 Dashboading 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 E.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 this Operations Phase role
- Deliver and support all required Fiscal Agent services
- Ensure the ongoing quality and success of the overall project.

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).

F.1.1 OUR UNDERSTANDING OF MEDICAID FISCAL AGENT CONTRACT AND OPERATIONS

Managing this project's Operations Phase requires a broad-based understanding of Medicaid Fiscal Agent operations and contractual requirements. Given CSC's current performance as the Medicaid Fiscal Agent for the State of New York (the eMedNY project), we possess a thorough understanding of the Fiscal Agent role and of the relevant importance of performance requirements within a Fiscal Agent contract. CSC's understanding of the role requirements has translated into superior Fiscal Agent performance:

- We process more Medicaid claims (approximately 450 million annually) and disburses more provider payments (nearly $40 billion) than any other MMIS or Fiscal Agent contract in the country
- We have never missed a weekly payment cycle, check or EFT
- We have reduced paper claims processing to 3% of the workload
- We deliver 100% system availability and services to over 50,000 active providers per year
- We are the NY Fiscal Agent operating in the County-base structure similar to NC, but in addition, serving New York City (in many ways a "State within a State")
- We provide:
  - Client services operations, including call centers that interact with members
  - Claims processing/claims payment operations
  - Clinical oversight services and specialized clinical programs (e.g., mental health, pediatrics)
  - Financial management operations

Pages F.1-3 through F.1-7 contain confidential information.

F.1.6 PROCESS IMPROVEMENT

Just as continuous improvement is at the core of the ISO 9001 quality standard and the Software Engineering Institute's Capability Maturity Model (CMM), it is a cornerstone of CSC's approach to delivering products and services to meet the rapidly changing and increasingly demanding needs of today's customers. The business environment in which CSC operates demands that its offerings be "better, faster, cheaper" in order for it to be competitive and to remain one of the world's leading information technology services companies. Consistent with this corporate management philosophy and its experiences since inception of the company in 1959, the projects performed by CSC's North America Public Sector (NPS) provide for an active improvement initiative program that encompasses every aspect of how the organization does business — both the technologies they employ and the work processes they use to develop their products and/or deliver their services.

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
- 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
- Tam 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.

F.1.8 PERFORMANCE METRICS

Team CSC approaches our operations management responsibilities from the perspective that our Medicaid Fiscal Agent performance should exceed pre-set standards. We establish performance metrics as useful quality management benchmarks, and then tailor our operations management activities to achieve standards-exceeding excellence.

Team CSC uses dashboard score card, alerts and reports solutions, which are an integral part of NC Tracks. The dashboard reports real time workload, permitting management to reprioritize resources to ensure successful achievement of operational performance standards.

In another example, Team CSC develops dashboard score card, alerts and reports solution to provide management with real-time information on telephone inquiry statistics and performance results. Operations management leads can quickly identify inquiry spikes, IVR traffic, and call completion rates, ensuring CSR resources are applied to workload demands to ensure successful achievement of performance standards.

In **Exhibit F.1-5**, we present an example of an operational dashboard presenting data about operational process performance.

Pages F.1-13 through F.1-14 contain confidential information.

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.*

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

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

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.

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).

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.

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.

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.

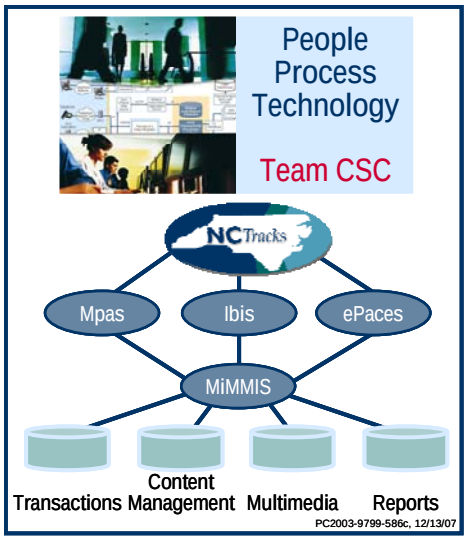
F.1.17 CONCLUSIONS

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.

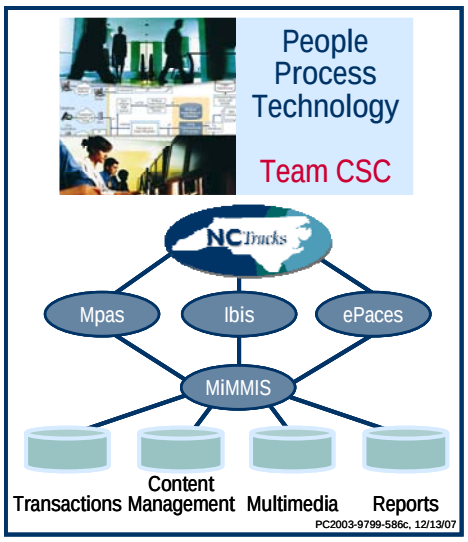
F.2 – Change and Configuration Management

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.

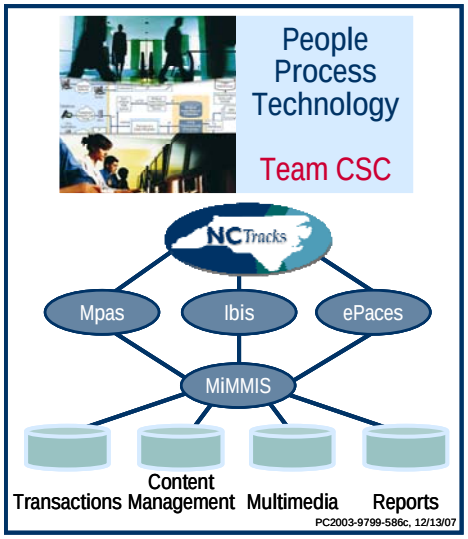


F.4. Business Continuity/Disaster Recovery Approach

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

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.



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.*

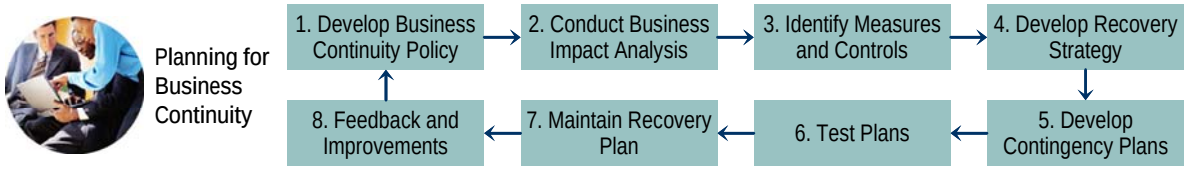
The plan will clearly identify individuals and their designees who have the authority to declare a disaster. We assume that NC DHHS will have ultimate authority for declaration of a disaster and activation of the business continuity/disaster recovery plan, while CSC, as the Replacement MMIS contractor 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.



PC2003-9799-309b, 12/14/07

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 the equipment 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.

A like situation is true with the communications facilities between New York and New Jersey. CSC provides dual OC-3 circuits with alternative routings between the two sites. There will likewise be dual circuits between Raleigh and New York and New Jersey for the North Carolina facility. 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.

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

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

The BCDR program currently in place for the Albany, NY site, falls into the High Availability category. Below is the Table of Contents for the BCDR plan currently in place, and tested to 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

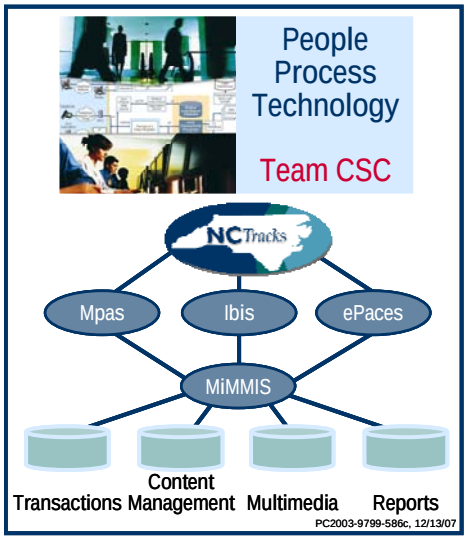
Exhibit F.4-3 Business Continuity / Disaster Recovery Plan Table of Contents. *Illustrates basis content of plan similar to the BCDR that CSC will develop for NC MMIS.*

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.

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.		

Pages G-8 through G-18 contain confidential information.

TITLE	MMIS Security Plan (Final)	**CDRL NUMBER**	M0023
VENDOR	Computer Sciences Corporation		
TYPE OF DATA	Planning/Execution	**DATA RIGHTS**	State Material
FREQUENCY DUE	Baseline Change	**1ST SUBMISSION DATE**	November 25, 2008
METHOD OF DELIVERY	Electronic		
DESCRIPTION	This document describes the DDI and Operations processes and the system features that will ensure that Contract requirements for security are met. The plan also describes how the FA intends to use current industry, State, and Federal standards during the DDI and Operations phases. Draft Security Plan Outline 1 SYSTEM IDENTIFICATION 1.1 System Name/Title 1.2 Responsible Organization 1.3 Information Contacts 1.4 Assignments of Security Responsibility 1.5 System Operation Status 1.6 General Description/Purpose 1.7 System Interconnection/Information Sharing 1.8 Applicable Laws or Regulations Affecting the System 1.9 General Description of Information Sensitivity 2 MANAGEMENT CONTROLS 2.1 Risk Assessment and Management 2.2 Review of Security controls 2.3 Rules of Behavior 2.4 Planning for Security in the Life Cycle 2.5 Authorize Processing 3 OPERATIONAL CONTROLS 3.1 Personnel Security 3.2 Physical and Environmental Protection 3.3 Production Input/Output Controls 3.4 Contingency Planning 3.5 Hardware and Systems Software Maintenance Controls 3.6 Integrity Controls 3.7 Documentation 3.8 Security Awareness & Training 3.9 Incident Response Capability 4 TECHNICAL CONTROLS 4.1 Identification and Authentication 4.2 Logical Access Controls 4.3 Audit Trails Appendix A: MMIS System Risk Assessment Appendix B: MMIS System Security Scan Results Appendix C: MMIS System Rules of Behavior Appendix D: MMIS System Change Request Appendix E: System Functional Test Case		

Pages G-20 through G-30 contain confidential information.

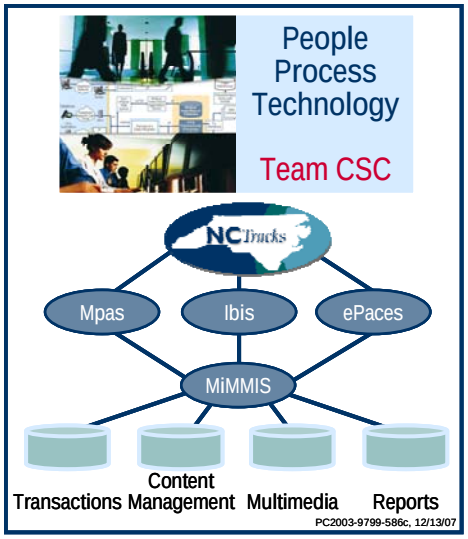
TITLE	User Training Plan and Schedule	**CDRL NUMBER**	D0019
VENDOR	Computer Sciences Corporation		
TYPE OF DATA	Planning/Execution	**DATA RIGHTS**	State Material
FREQUENCY DUE	Annually or more frequently	**1ST SUBMISSION DATE**	May 4, 2010
METHOD OF DELIVERY	Electronic		
DESCRIPTION	This document describes 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**	October 12, 2010
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.		

Pages G-32 through G-39 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.

H.1 USE OF CURRENT INDUSTRY, STATE AND FEDERAL HIPAA SECURITY AND PRIVACY MANDATES

40.1.2.12 **(40.1.2.12)** 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.

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. **Team CSC will leverage the Federal Information Security Management Act (FISMA) compliant solution sets produced in accordance with NIST standards, where applicable, and/or best practice procedures to enforce all DHHS security policies, standards, and guidelines for the Replacement MMIS.**

H.1.1 SECURITY FEATURES INHERENT IN THE SYSTEM DESIGN AND OPERATION

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.
- 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 of 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, within the perimeter fencing, 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.1.1.1.2 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 requires 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 users have the minimum authorization to resources as appropriate for their; 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

(40.1.2.3, 40.1.2.5, 40.1.2.10)
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 location 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 specified in the RFP. Laptops and cell phones will be provided to NC State employees 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 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. A connection to the State WAN will be established through redundant point-to-point circuits. 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/intrustion protection systems. Users at remote sites can connect to the infrastructure through an IPsec VPN. ConThe 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, 40.1.2.26, 40.1.2.35, 40.1.2.36, 40.1.2.42, 40.1.2.81, 40.1.2.84

(40.1.1.17, 40.1.2.26, 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.

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 include 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 services provides protection consistent with state, federal and organizational security policy	• Leverages FISMA-compliant solution sets in accordance with NIST standards • Enforces all state, federal and DHHS security policies and standards including HIPAA

Security Approach	DHHS Benefits and Key Outcomes
	• Provide policies, plans, practices, and procedures for NC MMIS personnel to follow
• Provide cleared, 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 Risk Management

40.1.2.26, 40.1.2.27, 40.1.2.29, 40.1.2.30, 40.1.2.37

(40.1.2.26, 40.1.2.27, 40.1.2.29, 40.1.2.30, 40.1.2.37)

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.

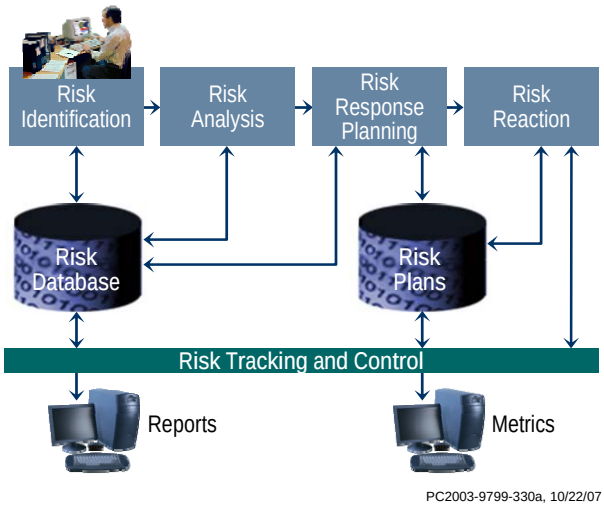


Exhibit H.1.2.1-1. Security Risk Management Process

Additional information about our risk approach is contained in our Risk and Issue Management Plan (RIMP) in Section E.7 of this proposal.

40.1.1.173, 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

H.1.2.2 Data Protection Assurance

(40.1.1.173, 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 (stored or 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 NS 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 sets (at rest) as well as any transmissions that may contain IIHI or PHI
- 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
- 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.

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.
- Document security testing and assessments, in accordance with DHHS Information security Manual.
- 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 **(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)**

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.
- During working hours, 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 server. 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 building 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 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.**

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.). Team CSC has well defined processes for its application developers. It starts with a requirements analysis review to determine if the requirement is valid. Next it is assigned to a programmer to develop the engine (process) that will satisfy the requirement. It is tested by the developer who then sends it to the next level of review. It is subjected to several levels of "peer" review and if satisfactory is sent for independent testing. When it passes the independent testing, it is sent to a supervisor who authorizes it to be posted to the final build for release. The CM manager, in conjunction with the Operations manager, authorizes the final release to the requesting agency. Where possible, Team CSC dedicates a separate network server to this single service to simplify the configuration management process, reduce the likelihood of configuration errors, and reduce or eliminate unexpected and unsafe interactions among the services that could present opportunities for misuse.

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.

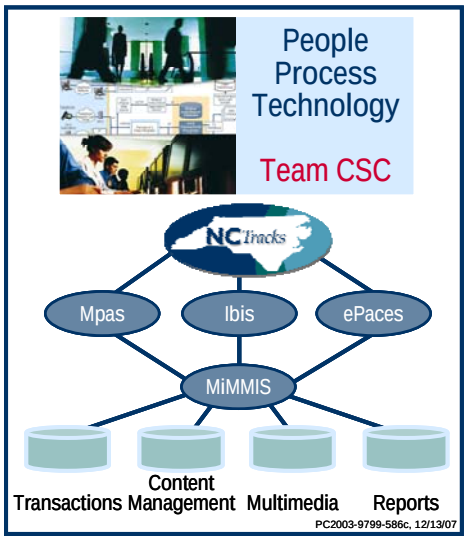
Team CSC's incident response capability for the Replacement MMIS will include identification, containment, eradication, recovery, and follow-up capabilities to ensure effective recovery from incidents. Incident response policies and procedures will be developed specifically for the Replacement MMIS to 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.

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.

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). **(RFP Sections: 10.12.2, 50.2.9, 40.15)**

(10.12.2, 50.2.9, 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-12 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

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Book 4 of 4
Section J

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Table of Contents

BOOK 1

BOOK 2

BOOK 3

BOOK 4

List of Exhibits

BOOK 1

BOOK 2

BOOK 3

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 Detection System
FAQ	Frequently Asked Questions
FARO	Finance and Reimbursement Officer
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
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
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
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	Health Finance Management Association
HHA	Home Health Aid
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	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
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
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
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	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
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 Collabortaive
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
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 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
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	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

PMP	Project Management Professional
PMPM	Per Member Per Month
PMR	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)
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
PST	Production Simulation Testing
PV	Planned Value
PVCS	Polytron Version Control System
QA	Quality Assurance
QAP	Quality Assurance Plan
QASP	Quality Assurance Surveillance Plan
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
SCC	Security Control Center
SCHIP	State Children's Health Insurance Program
SD	System Development
SD	Software Development
SDB	Small Disadvantaged Business
SDEP	Service Delivery Excellence Program
SDLC	Software Development Life Cycle
SDM	Service Delivery Manager
SE	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
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	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
UI	User Interface
UPC	Universal Product Code
UPIN	Unique Provider Identification Number
UPS	Uninterruptible Power Supply
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 J.1-1 through J.1-34 contain confidential information.

Pages J.2-1 through J.2-80 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 of 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.

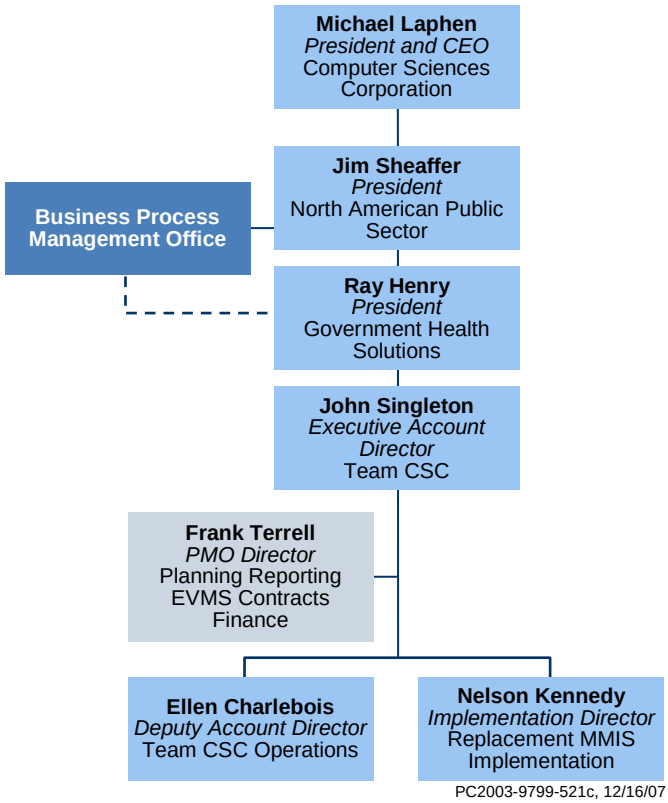

Exhibit J.4-1. MMIS Placement in CSC Corporate Structure. *The North Carolina Replacement MMIS project represents a strategically important opportunity to CSC. Its high placement within CSC's organization ensures appropriate support and oversight throughout the project's term.*

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 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 the 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.

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 of 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 providing an integrated set of products and services supporting the Replacement MMIS program operations throughout the lifecycle.

Page J.5-1 contains confidential information.