

Supplement to 30 May 2008 Technical Proposal Best and Final Offer Addenda 4/5

RFP Number: 30-DHHS-1228-08-R

Prepared for:
North Carolina Department of
Health and Human Services
Office of Medicaid Management
Information System Services

Prepared by:
Computer
Sciences
Corporation

5 August 2008

**Supplement to 30 May 2008
Proposal Best and Final Offer
Addenda 4/5**



Redacted Version

With Confidential Pages Removed





Table of Contents

A – Transmittal Letter and Execution Page

C – Executive SummarySupplement.C.1-1

D.1 – Proposed System Solution and Solution for DDI.....Supplement.D.1-1

D.1.8 – Early Implementation.....Supplement.D.1.8-1

D.1.17.2 – Addendum State Requirements MatrixSupplement.D.1.17.2-1

D.1.17.3 – Addendum SOO Requirements MatrixSupplement.D.1.17.3-1

D.1.18 – Adjusted Function Point Count.....Supplement.D.1.18-1

D.2 – Proposed Solution for OperationsSupplement.D.2-1

D.3 – Statement of WorkSupplement.D.3-1

E.2 – Integrated Master Plan (IMP) Supplement.E.2-1

E.3 – Integrated Master Schedule Supplement.E.3-1

E.5 – Team CSC Approach to Staffing Supplement.E.5-1

E.8 – Initial Risk Assessment Supplement.E.8-1

G – Contract Data Requirements ListSupplement.G-1

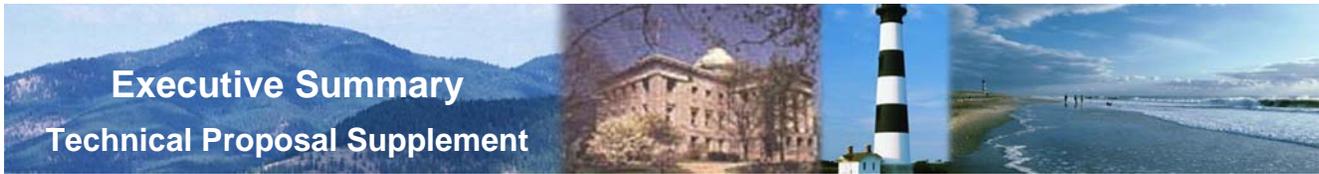
J.1 – Relevant ExperienceSupplement.J.1-1

K – Oral Presentation and Demonstration.....Supplement.K-1





The Transmittal Letter and Execution Page contain confidential information.



The Current Operations and Capital Improvements Appropriations Act of 2008 enables the Department of Health and Human Services to take the next step beyond the original RFP in realizing its vision for an enterprise-wide multi-payer, multi-benefit plan management information system solution. Team CSC's originally proposed solution to the Replacement MMIS was designed to provide a configurable solution capable of efficiently and effectively supporting an unlimited number of these payers and programs. We have therefore included all RFP Addenda 4 and 5 requirements without increasing the total time in the DDI schedule proposed in our Technical Volume BAFO response.

C.1 UNDERSTANDING THE ADDENDUM

Team CSC has reviewed and evaluated the language in *The Current Operations and Capital Improvements Appropriations Act of 2008* and the new and revised sections of the RFP released in Addendum 4 and 5, gaining an appreciation for the complexity of the new payer programs, benefits, and their impact on Replacement MMIS and Fiscal Agent operations requirements. We view these changes and additions as a next step in the DHHS vision and the strategies detailed in your Business Plan. From the beginning of our detailed response to the Replacement MMIS RFP, Team CSC has planned for a solution capable of supporting these programs. The Addendum's detailed requirements allow Team CSC to further refine and augment the capabilities of our solution. We are pleased to submit our Technical Proposal Supplement providing a description of the solution and services we offer DHHS.

Team CSC understands the complexity and appreciates the importance of providing a seamless transition for the North Carolina Health Choice for Children (NCHC) program.

Experienced in the Title XXI programs in other States, our leadership team has an understanding of the differences in benefits and services provided to and expected by the children this program covers. In our response, we considered cultural differences, expectations and continuity of program excellence. As funding allows, the addition of the NC Kid's Care has been anticipated in our analysis of the Title XXI programs. Team CSC also respects the



importance of supporting the Medicaid eligibles in the CAP-MR/DD, CAP Children's Program and the other relevant waiver population groups including the innovative Medicare 646 waiver. While the numbers of recipients in these populations are not as large as other programs, supporting the requirements for these programs allows DHHS to effectively provide alternatives for healthcare services to some of those most in need. Extending our configurable benefit plan capabilities, our Replacement MMIS solution supports and provides the automation and efficient services necessary for the management of enrollment fees and monthly premiums allowing those eligible for the Health Coverage for Workers with Disabilities Medicaid program to take advantage of the Federal Ticket to Work program. Team CSC is privileged to have the opportunity to serve these populations as we support DHHS' mission.

Team CSC has selected First Health Services Corporation to assist Team CSC provide the Retrospective Drug Utilization (RetroDUR) solution and services. Their proven solution and experience with the legacy MMIS+ allows Team CSC to assume this responsibility within ninety days of contract award, if not sooner. (SOO S.1.1-1, SOO S.1.1-2, SOO S.1.1-3, SOO S.1.1-4, SOO S.1.1-5, SOO S.2-1, SOO S.2-2)

C.1.1 Overview of Proposed Changes

Team CSC is committed to delivering a Replacement MMIS which supports all of the new and revised RFP Section 40 requirements and the Addendum Statement of Objectives (SOO) Requirements Matrix as updated July 21, 2008. Our methodical, quality-driven approach





ensures that each requirement is logically mapped to one of our solution Builds and our approach to operations is enhanced to meet or exceed your expectations. Our accompanying response provides the following section revisions as required by the Addendum 4 and 5 requirements and instructions.

Technical Proposal Supplement Section	BAFO Technical Proposal Section Reference/Description
A	A – Transmittal Letter and Execution Page, A.1, A.2, A.3, A.10, A.14, A.15
C	C - Technical Proposal Supplement Executive Summary
D	D.1 - Proposed System Solution and Solution for DDI updates D.1.8 – Early Implementation update D.1.17 - Addendum State Requirements Matrix; Addendum Statement of Objectives Requirements D.1.18 – Adjusted Function Point Count D.2.1 – Proposed Solution for Operations updates D.3 – State of Work updates
E	E.2 – Integrated Master Plan updates E.3 – Integrated Master Schedule E.5 - DDI and Operations Phase Organization Charts revisions E.8 - Initial Risk Assessment updates
G	G - CDRL Updates
J	J.1 - Relevant Experience Updates
K	Oral Presentation Slides on CD

With the updates to the BAFO Technical Proposal, Team CSC addresses each of the new and revised requirements within the architectural design, features and functions of the proposed Replacement MMIS solution. Based upon our original analysis of the DHHS Business Plan, and the legislative directions provided in *The Current Operations and Capital Improvements Appropriations Act of 2007*, Section 10.40 (a), we architected our proposed solution with the addition of these programs in mind. Our Replacement MMIS will truly be an enterprise-wide platform serving the varied DHHS programs. Our approach to operations is founded in efficient processes delivering quality results to the different population groups we serve while

maintaining a sensitivity and respect for all recipients and members of DHHS’ programs, its stakeholders and staff. Our Technical Proposal Supplement describes our proposed solutions and capabilities for:

Premium Billing and Collection	Team CSC brings corporate and staff experience and a fully integrated solution
RetroDUR Early Implementation	Proven solution and North Carolina experience through our partner First Health Services Corporation
NCHC and NC Kid’s Care programs	Configurable benefit plan design delivers the agility to transition this program smoothly and efficiently and ensure continuity of care
Recipient/Member enrollment and premium billing	Separation of duties within the Operations organization ensures quality services to the recipient/member constituency
Conversion of historical data from external sources	Proven iterative conversion process, leveraging the SAS ETL tool, and staff familiar with State data structures ensures data integrity and validity
Member websites & call center services	Team CSC proposes a separate NC <i>Tracks</i> portal section for the NCHC & NC Kid’s Care members and a separate 1-800 service
NCHC & NC Kid’s Care Member Education	Team CSC respects the cultural differences in these programs and fully understands how to mitigate concerns that may occur in their transition

Team CSC fully appreciates the new challenges facing DHHS and is prepared to partner with you to achieve your mission and vision.

We at Team CSC are fully committed to your success.





Page D.1-1 contains confidential information.

**Change From: Exhibit D.1.4.1.18-1, Bullets in Right Column Under
'DMA/DMH/DPH/ORHCC/DVR State Users'**

- “ ...
- Fraud Alerts
- Third Party Recovery, cost avoidance, etc.”

Change To:

- “ ...
- Fraud Alerts
- Third Party Recovery, cost avoidance, etc.
- Provide data to Ticket to Work”

Pages D.1.4.1-41**Requirement(s): 40.1.1.1**

Change From: In the Second Column: “NC Division of Vocational Rehabilitation (DVR). DVR’s Disability Determination Unit determines individual’s eligibility for Federal SSA disability benefits making them automatically eligible for Medicaid.”

Change To: “NC Division of Vocational Rehabilitation (DVR). DVR’s Disability Determination Unit determines individual’s eligibility for Federal SSA disability benefits making them automatically eligible for Medicaid and administers the Ticket to Work Program.”

Pages D.1.4.1-41**Requirement(s): 40.1.1.1**

Change From: In the Third Column: “DHHS Division of Mental Health, Developmental Disabilities, & Substance Abuse Svcs (DMH/DD/SAS) Provides svcs & spt for NC residents w/ or at risk of mental illness, developmental disabilities, & substance abuse problems. Also supervises the local Mngt Entities (LME).”

Change To: “DHHS Division of Mental Health, Developmental Disabilities, & Substance Abuse Svcs (DMH/DD/SAS) Provides svcs & spt for NC residents w/ or at risk of mental illness, developmental disabilities, & substance abuse problems. Also supervises the local Mngt Entities (LME) and administers CAP MRDD Program.”

Pages D.1.4.1-41 +**Requirement(s): 40.1.1.1**

Change From: In the Third Column: “DHSS Division of Medical Assistance (DMA). Responsible for planning & operational oversight of the NC Medicaid, Health Choice for Children & related programs.”



Page D.1-3 contains confidential information.

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)**”

Change To: “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)**”

The Replacement MMIS will provide the capability to produce unique member identification cards to support the NCHC program. The system will support the generation of original as well as replacement identification cards. In addition to the identification cards the Replacement MMIS will provide the capability to produce NCHC original and replacement member benefit booklets. **(40.2.1.124, 40.2.1.125)**

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)**”

Page D.1.4.2-17

Requirement(s): 40.14.1.55, SOO S.1.1-2

Change From: “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)**”

Change To: “Team CSC will work with State to design and implement premium management activities that will fully support generally accepted accounting principles with the appropriate level of processing controls. The premium management processes will include:

- Generation of correspondence including but not limited to 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 and adjustments
- Process financial records for premium payments, refunds and adjustments
- Generate premium payment and cost-sharing applied report
- Generate premium refund and adjustment reporting



- Compute a recipient’s cost-sharing factor subject to a maximum cross-payer threshold for the family and premium payment due to the State. **(40.2.1.50 – 40.2.1.59, 40.14.1.55, SOO S.1.1-2)”**
-

Page D.1.4.3-8

Requirement(s): 40.3.1.8

Change From: “Our eCommerce application code and associated X12N 271 mapping will be modified to pass the reference number only to providers in response to their DMA/Medicaid eligibility queries.”

Change To: “Our eCommerce Eligibility Verification System (EVS) application code and associated X12N 271 mapping will be modified to pass the reference number only to providers in response to their DMA/Medicaid and NCHC eligibility queries. **(40.3.1.8)”**

Page D.1.4.4-7

Requirements: 40.4.1.26

Change From: “Both replacement MMIS AVRS scripts and Web pages will be developed with the capability to provide the Reference Number information for DMA/Medicaid eligibility verification queries/response to providers only.”

Change To: “Both replacement MMIS AVRS scripts and Web pages will be developed with the capability to provide the Reference Number information for DMA/Medicaid and NCHC eligibility verification queries/response to providers only.”

Page D.1.4.4-7

Requirement(s): 40.4.1.22

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

- Claim status
- Checkwrite
- Drug coverage
- Procedure code pricing
- Modifier verification
- Procedure code and modifier combination
- Procedure code pricing for Medicaid Community Alternatives Program services
- Prior approval for procedure code
- Managed care overrides
- Medicaid dental benefit limitations
- Medicaid refraction and eyeglass benefits



- Medicaid prior approval for durable medical equipment (DME), orthotics, and prosthetics
- Prior Approval Submissions
- Pricing
- Prior Approval for DPH benefits
- Provider Checkwrite
- Recipient eligibility, enrollment, and Medicaid service limits
- Sterilization consent and hysterectomy statement inquiry
- Referrals
- Medicaid Carolina ACCESS Emergency Authorization Overrides.”

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

- Claim status
- Checkwrite
- Drug coverage
- Procedure code pricing
- Modifier verification
- Procedure code and modifier combination
- Procedure code pricing for Medicaid Community Alternatives Program services
- Prior approval for procedure code
- Managed care overrides
- Medicaid and NCHC dental benefit limitations
- Medicaid and NCHC refraction and eyeglass benefits
- Medicaid and NCHC prior approval for durable medical equipment (DME), orthotics, and prosthetics
- Prior Approval Submissions
- Pricing
- Prior Approval for DPH benefits
- Provider Checkwrite
- Recipient eligibility, enrollment, and Medicaid and NCHC service limits
- Sterilization consent and hysterectomy statement inquiry
- Referrals
- Medicaid and NCHC Carolina ACCESS Emergency Authorization Overrides. **(40.4.1.22).**”

Page D.1.4.4-10

Requirement(s): 40.4.1.24, 40.4.1.38

Change From:

- “...

- Well-child checkup dates
- Hospice eligibility.”

Change To:

- “...
- Well-child checkup dates
- Hospice eligibility
- Cost sharing, such as premium payments, deductibles, co-payments, and balances.

For NCHC recipient inquiries, Team CSC will develop new AVRS scripts using ScriptBuilder to accommodate responses to the following types of inquiries:

- NCHC eligibility
- Managed care enrollment information, including the primary care provider name, address, and daytime and after-hours phone numbers
- Third Party Liability
- Cost sharing, such as premium payments, co-payments, deductibles and deductible balances and out-of-pocket thresholds. **(40.4.1.38)**”

Page D.1.4.4-10

Requirement(s): 40.4.1.12

Change From: “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.”

Change To: “The AVRS user verification process will determine the recipient’s identity based on recipient’s Identification 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 both Medicaid and NCHC recipient-based inquiries and to route these to the appropriate subsystem.”

Page D.1.4.4-11

Requirement(s): 40.4.1.29

Change From: “Team CSC will enhance the existing Web-based eligibility verification process to return or display the Reference Number to the provider for DMA/Medicaid eligibility verification inquiries only, and other inquiries as needed.”

Change To: “Team CSC will enhance the existing Web-based eligibility verification process to return or display the Reference Number to the provider for DMA/Medicaid and NCHC eligibility verification inquiries only, and other inquiries as needed.”

Page D.1.4.4-12

Requirement(s): 40.4.1.39

Change From:

“...

- Hospice eligibility.

The Recipient area of the Web-site will support gathering the information necessary...”

Change To:

“...

- Hospice eligibility.

For NC Health Choice recipient inquiries, Team CSC will implement Replacement MMIS Web-pages for NCHC members which are separate and distinct from the Medicaid population’s Web-pages. In addition, Team CSC will provide capabilities through *NCTracks* to support NCHC recipient access to the following NCHC eligibility and enrollment information:

- NCHC eligibility
- Managed care enrollment information, including the primary care provider name, address, and daytime and after-hours phone numbers
- Third Party Liability
- Cost sharing, such as premium payments, co-payments, deductibles and deductible balances and out-of-pocket thresholds. **(40.4.1.39)**

The Recipient areas of the Medicaid and NCHC Web-pages will support gathering the information necessary...”

Page D.1.4.6-6

Requirement(s): 40.6.1.43

Change From: “The Reference Subsystem accommodates procedure codes (including CPT, American Dental Association (ADA) codes, HCPCS Level II codes, NDCs, State local codes, International Classification of Diseases diagnosis and procedure codes (ICD-9), and future ICD codes), drug codes, edits, rate methodologies and calculations, and professional fees that calculations, and professional fees that reflect specific State policy. Team CSC...

...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.”



Change To: “The Reference Subsystem accommodates procedure codes (including CPT, American Dental Association (ADA) codes, HCPCS Level II codes, NDCs, State local codes, International Classification of Diseases diagnosis and procedure codes (ICD-9), and future ICD codes), drug codes, edits, rate methodologies and calculations, professional service fees and NCHC-specific services that that can be configured to reflect specific State-approved policy for all NC benefit programs. Team CSC...

...other supporting information as required by the RFP. During the DDI phase, we will analyze the data files from the legacy MMIS and legacy NCHC systems to expedite the creation of the pricing rate and other applicable code tables with automation tools. **(40.6.1.43)**”

Page D.1.4.6-10

Requirement(s): 40.6.1.94

Change From: “Team CSC will work with the State during the DDI phase to construct the edit rules, customize the code values for the Claim Edit and Utilization Control tables, configure the required audits, categorize the edits, cross-reference new codes to the edits and audits, implement a report of edits/audits associated with end-dated codes, create or enhance the online NC Title XIX Manuals and Edit Resolution Manuals, and establish the Edit manuals. **(40.6.1.14, 40.6.1.16 – 40.6.1.21, 40.6.1.33, Comment CSC263, SOO 10.9-12, SOO 10.12.7-2)**”

Change To: “Team CSC will work with the State during the DDI phase to construct the edit rules, customize the code values for the Claim Edit and Utilization Control tables, configure the required audits, categorize the edits, cross-reference new codes to the edits and audits, implement a report of edits/audits associated with end-dated codes, create or enhance the online NC Title XIX and Title XXI Tables Manuals and Edit Resolution Manuals, and establish the Title XIX and Title XXI Edit manuals. **(40.6.1.14, 40.6.1.16 – 40.6.1.21, 40.6.1.33, 40.6.1.94, Comment CSC263, SOO 10.9-12, SOO 10.12.7-2)**”

Page D.1.4.6-21

Requirement(s): 40.6.1.89

Change From: “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.”

Change To: “During the DDI phase, Team CSC will work with the State to define the detailed requirements for the additional fee schedule reports including NCHC-specific services detailed in the bullets below:

- Adult Care Home Personal Care
- Ambulance
- Ambulatory Surgical Centers/Birthing Centers
- Behavioral Health (separate
- CAP/DA
- CAP/Mentally Retarded-Development Disability (MR-DD)
- DRG Weight Table



- schedules)
- Certified Clinical Supervisor and Addictions Specialist
 - Children’s Developmental Service Agencies
 - Licensed Clinical Social Worker and Licensed Professional Counselor and Licensed Marriage and Family Therapist
 - Licensed Psychological Associate
 - Mental Health Enhanced Services
 - Mental Health (LME)
 - Mental Health Non-Licensed Clinical Fee Schedule
 - Nurse Practitioner
 - Nurse Specialist
 - Prospective Rates
 - Psychologist
 - Residential Treatment Level III and IV
 - Community Alternatives Program (CAP) Rates (separate rates)
 - CAP/AIDS
 - CAP/Children
- 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
 - Nursing Facility Rates
 - Occupational Therapy
 - Orthotics and Prosthetics
 - Physical Therapy
 - Physician Drug Program
 - Respiratory Therapy
 - Rural Health Center
 - Speech and Audiology Services
 - NCHC –specific services

(40.6.1.89)”

Page D.1.4.8.-3

Requirement(s): 40.1.1.1

Change From: “We will modify the Baseline System to permit the incorporation of efficient claims processing for DMA, DMH, DPH, and the Migrant Health Program administered by ORHCC. Our approach to developing a multi-payer solution will allow us to incorporate additional North Carolina medical/benefit programs in the future without significant development or modification.”

Change To: “We will modify the Baseline System to permit the incorporation of efficient claims processing for DMA (including Title XIX and Title XXI), DMH, DPH, and the Migrant Health Program administered by ORHCC. Our approach to developing a multi-payer solution will allow us to incorporate additional North. Carolina medical/benefit programs in the future without significant development or modification. (40.1.1.1)”

Page D.1.4.8-3

Requirement(s): 40.8.1.384, 40.8.1.385

Change From: "...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..."

Change To: "...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.

In addition to processing claims submitted by providers enrolled in the North Carolina Health Choice (NCHC) program, Team CSC will enhance the proposed baseline system to provide the capability to reimburse NCHC recipients for eligible out of pocket claims payments. Team CSC will work with DHHS during the DDI phase of this project to design recipient-submitted claim forms that will be similar to the claim forms currently in use by the NC State Health Plan.

(40.8.1.384)

The recipient will submit a hardcopy claim form and an attached itemized bill from the provider to Team CSC. Claims filed by recipients must include the appropriate information furnished by the service provider (including, but not limited to, service description and diagnosis) and proof that the service was already paid by the recipient. Claims filed by providers for reimbursement to recipients will be required to indicate that the charges have been paid to the provider.

A recipient-submitted claim is processed through the Replacement MMIS exactly like a provider-submitted claim. Recipient-submitted claims are subjected to the same edit and audit processing as provider-submitted claims. A claim submitted by a recipient will be encoded as such so it can be easily identified during adjudication processing. This will allow the Replacement MMIS to produce a check or EFT for the recipient.

CSC will send the check for all recipient-submitted claims to the recipient mailing address on file for the recipient that submitted the claim(s). Remittance Advices are not required for recipient-submitted claims. NCHC recipients will receive explanation of benefits (EOB) reports for all claims, whether the claims have been filed by providers or by recipients. (40.8.1.385)

Authorized users are able to view claims history, resolve suspended claims, check on the status of..."

Page D.1.4.8-60

Requirement(s): 40.7.1.69

Change From: "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)”

Change To: “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. (40.7.1.69, 40.8.1.123, 40.8.1.129, 40.8.1.217).”

Page D.1.4.8-89

Requirement(s): 40.8.1.200, 40.8.1.201, 40.8.1.202, 40.8.1.203, 40.8.1.387, 40.8.1.388

Change From: “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:

- 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)”

Change To: “Team CSC will implement a COTS based Retro DUR solution to fully satisfy the NC MMIS Retro DUR requirements. **We will analyze the data necessary for Retro DUR reports and produce customized extracts from the Replacement MMIS as inputs to the Retro DUR COTS solution.** We will work with the State in specifying the criteria set(s) to be used for Retro DUR processing and reporting.



Team CSC will produce the *Annual Report* in accordance with SSA 1927 (g)(3)(D), that includes the required information, charts and statistics pertaining to the Drug Use Review Program. This information will be produced in the media and timing as directed by the State. **(40.8.1.203)**

Team CSC will also develop an online update capability that will be used to enter DUR Board recommendations for overrides to the First DataBank defined alerts and limitations. These overrides will allow the capability to input DUR Board recommendations and immediately impact real-time pharmacy claim adjudication. Online updates will have the ability to impact edits/audits, limitations and informational alerts. **(40.8.1.388)**

Our Retro DUR COTS solution has the capability to generate ad hoc reports and scheduled reports for recipient and provider profiling and provider report cards as required. **(40.8.1.387).**”

Page D.1.4.9-12

Requirement(s): 40.9.1.20

Change From:

- “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)**”

Change To: “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)**”

Page D.1.4.11-13

Requirement(s): 40.14.1.104

Change From: “The TPL Subsystem provides the HIPP functionality to support DHHS in replacing Medicaid coverage for qualified beneficiaries with other less-costly health insurance options.”

Change To: “The TPL Subsystem provides the HIPP functionality to support DHHS in replacing Medicaid and NCHC coverage for qualified beneficiaries with other less-costly health insurance options.”



Page D.1.4.11-13

Requirement(s): 40.14.1.104

Change From: “The HIPP database contains HIPP policy information and payments, HIPP cost analysis for policies, and annual Medicaid expenditures used in cost analysis.”

Change To: “The HIPP database contains HIPP policy information and payments, HIPP cost analysis for policies, and annual Medicaid and/or NCHC expenditures used in cost analysis.”

Page D.1.4.11-14

Requirement(s): 40.14.1.104

Change From: “The Financial Subsystem generates payments (checks or EFTs) as well as corresponding remittances for all approved HIPP transactions. (40.11.1.36)”

Change To: “The Financial Subsystem generates payments (checks or EFTs) as well as corresponding remittances for all approved HIPP transactions. (40.11.1.36, 40.14.1.104)”

Page D.1.4.12-2

Requirement(s): 40.12.1.71

Change From: “Team CSC’s Baseline System Drug Rebate Subsystem provides a drug rebate component that ensures compliance with the Centers for Medicare and Medicaid Services (CMS) Drug Rebate program, established under the Omnibus Budget Reconciliation Act of 1990 (OBRA-90). This program assesses and recovers rebates from drug manufacturers that have signed the CMS drug rebate agreement and are eligible to have their products purchased by the State Medicaid programs. The Drug Rebate Subsystem uses the data provided by CMS, and other government agencies, to assess rebates and generate invoices on a quarterly basis and provides all the functionality necessary to perform all associated activities. Exhibit D.1.4.12.1-1 illustrates the primary Replacement MMIS interactions. (SOO 10.12.6-6)”

Change To: “The baseline system operates multiple drug rebate programs. One program assesses and recovers rebates from drug manufacturers that have signed the CMS drug rebate agreement and are eligible to have their products purchased by the State Medicaid programs. The second program assesses and recovers rebates from drug manufacturers who have signed drug rebate agreements to provide rebates on non-Medicaid (Federal Non-Participating) pharmacy claims. The third program assesses and recovers rebates from drug manufacturers who have signed drug rebate agreements to provide additional rebates (Supplemental) for products purchased by the State Medicaid programs.

Team CSC’s Drug Rebate Component uses the data provided by CMS and DHHS to generate program specific invoices on a quarterly basis while ensuring full compliance with the Centers for Medicare and Medicaid Services (CMS) Drug Rebate program, established under the Omnibus Budget Reconciliation Act of 1990 (OBRA-90).

The baseline Drug Rebate Component stores all data at the program code level enabling separate processing for each Drug Rebate program. Applicable data is accessed at the program level and

used, to generate invoices on a quarterly basis, and provide all the functionality necessary to perform all associated activities. **Exhibit D.1.4.12.1-1** illustrates the primary Replacement MMIS interactions. **(40.12.1.71, SOO 10.12.6-6)**

Page D.1.4.12-3

Requirement(s): 40.12.1.71

Change From: “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.** “

Change To: “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). All inquiry pages provide users with the ability to filter data by program. See **Exhibit D.1.4.12.5.2.1** below for an example how all current the Drug Rebate inquiry pages allow users to filter data by program code. **Drug Rebate Subsystem data is stored and maintained in an integrated relational database that enables availability of current, accurate Drug Rebate information by program throughout the system.**”
(40.12.1.71)

Page D.1.4.12-4

Requirement(s): 40.12.1.3, 40.12.1.20

Change From: “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)”

Change To: “D.1.4.12.2.4 Unit Conversion Table

The unit conversion factors allow for correction of drug units of measure mismatches between pharmacy claim data and manufacturer rebate data for consistency and reporting of exceptions. 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 billed per claim to CMS/State units billed and units paid to CMS/State units paid per claim for all applicable drug rebate programs. **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 the provider for each individual Drug Rebate program. (40.12.1.3, 40.12.1.20)**

Page D.1.4.12-8

Requirement(s): 40.12.1.72

Change From: “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)”

Change To: “Automated information may also be received from the State. Team CSC will work with DHHS to determine the format of these updates and develop a conversion process to accommodate this information. Team CSC will support an additional interfaces(s) of manufacturer data for the State’s Supplemental Drug Rebate program. The format of frequency of these interfaces will be finalized during the DDI phase. (40.12.1.34, 40.12.1.72)”

Page D.1.4.12-8

Requirement(s): 40.12.1.71

Change From: “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)”

Change To: “CMS 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 NC MMIS Drug Rebate system will also support an interface for per unit rebate amounts from DHHS for the State Supplemental Program. The format and frequency of this interface will be defined during the DDI phase.



The Drug Rebate component reads the file to find the changes made to previous quarter per-unit rebate data and makes adjustments to the appropriate program's accounts receivable database, based upon those changed per-unit rebate amounts. **The Reference Subsystem maintains a historical record of each drug 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, 40.12.1.71)”

Page D.1.4.12-17

Requirement(s): 40.12.1.21

Change From: “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)”

Change To: “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. We will also implement the capability to maintain units paid (as used to calculate claims pricing) and units billed for Drug Rebate on the claims history detail records. This information, as with all Drug Rebate information, will be maintained at the drug program level. (40.12.1.18, 40.12.1.21, 40.12.1.35)”

Page D.1.4.12-18

Requirement(s): 40.12.1.29

Change From: “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.”



Change To: “Drug Rebate financial information and drug information is available in the relational database and Drug Rebate tables, along 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 are maintained at the program code level allowing multiple payers to have multiple entries and 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 based on the Drug Rebate program code 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. **(40.12.1.29)”**

Page D.1.4.12-18

Requirement(s): 40.12.1.14

Change From: “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)”**

Change To: “Team CSC’s Replacement MMIS will have a near-line archival storage approach for retaining Drug Rebate information for all drug rebate programs — including CMS and State invoice, payment, drug, claim, and operational comments data — to provide the capability to maintain and retrieve drug rebate 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)”**

Page D.1.4.14-18

Requirement(s): 40.14.1.105

Change From: “The financial reports also capture the appropriate FFP rate based upon the recipients program and benefit plan eligibility and their associated category of service. **(SOO 10.12.3-5)”**

Change To: “The financial reports also capture the appropriate FFP rate based upon the recipients program and benefit plan eligibility and their associated category of service. The Replacement MMIS currently provides the capability to subtract co-payments and other cost-sharing fees from the service cost prior to reporting the FFP amount for collection. The Replacement MMIS will be enhanced to provide capability to subtract recipient premiums from the service cost as well. The **Consolidated Weekly Shares Report – Total Expenditure Breakdown and Federal Participation Data** and the **Medical Systems Expenditures by**



Source of Funds Report will summarize the Federal, State, and Local participation and respective shares for all counties. **(40.14.1.105, SOO 10.12.3-5)”**

Page D.1.4.14-30

Requirement(s): 40.14.1.53, 40.14.1.55, 40.14.1.56, 40.14.1.57, 40.14.1.96, 40.14.1.97, 40.14.1.100, 40.14.1.101, 40.14.1.102, 40.14.1.103, SOO S.1.1-4, SOO S.1.1-5, SOO S.1.1-6

Change From: “Our Baseline System will be enhanced to support recipient premium invoicing, collections, notices of non-payment as well as recipient premium receipts and refund processing and cancellation notices when appropriate. The Baseline System already supports this functionality, including system-generated correspondence in required recipient languages and associated accounts payable/accounts receivable transactions.”

Change To: “The Replacement MMIS will apply recipients’ premium amounts based on their eligibility and income information received in the nightly update from the DHHS Eligibility Information System (EIS). The premium payment amount due for a particular recipient will be automatically calculated by the Replacement MMIS using the eligibility and income information on file for that recipient. The proposed baseline system will be enhanced to maintain both current and historical premium payment amounts for the various eligibility and income categories and will include functionality to allow authorized staff to change premium amounts using the Mpas application. Historical premium payment amounts are maintained because premium amounts may change over time based on State and/or Federal mandates. Maintaining both current and historical premium payment data will allow the Replacement MMIS to calculate appropriate premium payment, refunds or adjustments amounts (due to overpayment, change in eligibility status, etc.) for a recipient (if necessary) for retroactive, current and future months. Documented internal controls based on generally accepted accounting principals (GAAP) are utilized by Team CSC Operations Phase staff to ensure all processing and payment of refunds and adjustments occurs in a timely, complete and accurate manner. **(40.14.1.55, 40.14.1.56, 40.14.1.97)**

If a refund is processed and sent to a recipient and the mail is returned as undeliverable or an EFT is rejected by the financial institution, an accounts payable record will be established for the recipient within the Replacement MMIS. This process will allow for the tracking and reporting of unpaid refunds. **(40.14.1.102)**

Any recipient that is required to make a monthly premium payment will be sent an invoice on the date determined by DHHS-defined business rules. Correspondence related to recipient premiums will be produced in the recipient’s preferred language as indicated on the recipient’s Replacement MMIS eligibility record. The format of the invoice will be determined by DHHS during the DDI phase. **(40.14.1.53, 40.14.1.100)**

The recipient will be provided with several flexible and cost effective options for submitting premiums. Recipients can utilize mail, phone, web, bank card and EFT options to submit premiums. Along with a premium due invoice, recipients will be sent pre-addressed envelopes for returning their premium checks to the bank lockbox vendor. The bank lockbox vendor’s address is on the pre-addressed envelope. Phone transactions for bank card premium submissions are handled through the Call Center. Our baseline system will be enhanced to provide a web



interface that will allow recipients to initiate secure bank card transactions through the web. CSC will utilize a cost effective, commercial service for handling online payment transactions.

The baseline system currently supports generation of EFT payment files for providers. The Replacement MMIS will leverage the comprehensive EFT functionality developed in the baseline to support Recipient EFT transactions. New online screens will be provided for capturing the data required to correctly set up a recipient for EFT transactions. The system will run a collection cycle and generate an EFT file for collecting recipient's premiums. The EFT file will be routed to the bank to trigger the premium collections. **(SOO S.1.1-5, SOO S.1.1-6)**

When an invoice is created and sent to a recipient, premium amounts due will be automatically tracked by the Replacement MMIS at both the recipient and accounts receivable levels. All payments for outstanding premiums received from recipients will be imaged and logged within the baseline systems Funds Received Process. The Financial Receipt Disposition Page (detailed in Exhibit D.1.4.14-7) will be used to allocate all payments to the appropriate accounts receivable(s). If payment for the premium owed is not received by the payment due date, the recipient will be sent a notice of non-payment. For NCHC recipients who share in their cost of care via premium payments, claims will not be paid until the associated premiums have been received by Team CSC. The Replacement MMIS will ensure that all claims submitted for a recipient with an overdue premium are subjected to any recipient eligibility edits as defined by DHHS. **(40.14.1.96, 40.14.1.101)**

In addition to invoices and notices of non-payment, the Replacement MMIS will also issue notices of cancellation, receipts, refunds and adjustments to recipients as required by DHHS-defined business rules. The format and frequency at which these items are issued will be determined during the DDI phase. All recipient invoices, payments, and correspondence related to recipient payment collections will be imaged, tracked, and reconciled in accordance with GAAP. **(40.14.1.101, SOO S.1.1-4)**

Replacement MMIS online pages will be created to provide a historical view of all recipient premium payment invoicing and collection information. These pages will allow for navigation to and from the Financial Accounts Receivable Pages so that detailed collection data pertaining to each individual premium payment can be viewed online by authorized users. **(40.14.1.96, 40.14.1.100)**

The Replacement MMIS will be enhanced to produce specific reports to report information for recipient premium processing including payments, refunds adjustments, and cost-sharing, including recipient co-insurance, deductibles and co-payments. These new recipient premium processing reports are available to authorized staff at DHHS and CSC at their desktop through the Mobius on-line report management application. **(40.14.1.57)**

The Replacement MMIS will have the capability to generate online notification of recipient premium payment status to the DHHS Eligibility Information System (EIS). The content and format of this new interface with the EIS will be determined during the DDI phase. **(40.14.1.103)**

Page D.1.4.14-31

Requirement(s): 40.14.1.59



Page D.1-21 contains confidential information.

Change To: “The Baseline System provides two methods of overriding service limitations. The Recipient UT/Co-Pay Mpas page presents current service limit (utilization threshold) and co-pay balances for a recipient. Special authorization is required to update the override limit. The Recipient Utilization Threshold (UT) limits can also be increased via the Medicaid Override Application System (MOAS). This system uses a paper form that must be completed. These forms are imaged and the data collected via Optical Character Recognition (OCR). The updates are then applied to the Service Utilization Limits maintained on the Recipient database. The multi-payer flexibility of the Replacement MMIS will allow service limits to be easily tracked at the service level within a specific health care program and benefit plan. New functionality will be added to efficiently apply service limitations across multiple health care programs and benefit plans based on RFP requirements and business rules defined by DHHS during DDI phase. (40.8.1.25, 40.8.1.149, 40.8.1.156, 40.8.1.158, 40.8.1.386, Comment CSC308).”

Page D.1.14.30-31

Requirement(s): 40.14.1.53, 40.14.1.55, 40.14.1.56

Change From: “(40.8.1.216, 40.8.1.373, 40.8.1.374, 40.8.1.375, 40.8.1.376, 40.8.1.377, 40.8.1.378, 40.14.1.53, 40.14.1.54, 40.14.1.55, 40.14.1.56) Our Baseline System will be enhanced to support recipient premium invoicing, collections, notices of non-payment as well as recipient premium receipts and refund processing and cancellation notices when appropriate. The Baseline System already supports this functionality, including system-generated correspondence in required recipient languages and associated accounts payable/accounts receivable transactions.”

Change To: “(40.8.1.216, 40.8.1.373, 40.8.1.374, 40.8.1.375, 40.8.1.376, 40.8.1.377, 40.8.1.378, 40.14.1.53, 40.14.1.54, 40.14.1.55, 40.14.1.56) Our Baseline System will be enhanced to support recipient premium invoicing, collections, notices of non-payment as well as recipient premium receipts and refund processing and cancellation notices when appropriate. The Baseline System already supports this functionality, including system-generated correspondence in required recipient languages and associated accounts payable/accounts receivable transactions. The baseline system will be modified to support retroactive, current and future processing for recipient premiums including payments, refunds, adjustments and collection by automatic bank draft.”

Page D.1.15-2

Requirement(s): 40.1.2.19

Change From: “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)”

Change To: “CSC recognizes that the data to be converted includes not only legacy data from NC DHHS, but also legacy data from DMA, DMH, DPH, Migrant Health Program in the ORHCC, NCHC non-pharmacy data from Blue Cross and Blue Shield of North Carolina and



NCHC pharmacy data from Medco. In addition to the legacy data Team CSC will fully migrate all images present in the NCHC vendors' systems. (40.1.2.19)"

Page D.1.15-5

Requirement(s): 40.1.2.20

Change From: "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)"

Change To: "Team CSC will convert all legacy data from the legacy MMIS+ in addition to data from DMA, DMH, Migrant Health Agency in the ORHCC, NCHC non-pharmacy data from Blue Cross and Blue Shield of North Carolina and NCHC pharmacy data from Medco to maintain benefit plans, data relationships in a multi-group aspect and history. In addition to the legacy data Team CSC will fully migrate all images present in the NCHC vendors' systems. (40.1.2.20)"

Page D.1.15-7

Requirement(s): 40.1.2.19

Change From: "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."

Change To: "Identifying discrepancies between the source and target early in the DDI phase (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 source systems and those in the Replacement MMIS. Legacy source systems include legacy MMIS+, systems that support DMA, DMH, the Migrant Health Program in the ORHCC, Blue Cross and Blue Shield of North Carolina systems that contain NCHC non-pharmacy data and Medco systems that contain NCHC pharmacy data. (40.2.1.19)"

Page D.1.15-8

Requirement(s): 40.1.2.19

Change From: "If existing data problems are allowed to pass through from the legacy MMIS+ to the Replacement MMIS, it will undermine the credibility of the Replacement MMIS. Determining and addressing data quality issues as part of the conversion and migration process is imperative in producing a Replacement MMIS that is accepted by the State and its stakeholders"



Change To: “If existing data problems are allowed to pass through from the legacy source systems to the Replacement MMIS, it will undermine the credibility of the Replacement MMIS. Determining and addressing data quality issues as part of the conversion and migration process is imperative in producing a Replacement MMIS that is accepted by the State and its stakeholders **(40.2.1.19)**”

Page D.1.15-8

Requirement(s): 40.1.2.19

Change From: “Team CSC’s 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”

Change To: “Team CSC’s methodology places a substantial emphasis on the Data Quality Assessment phase, in which the actual data values in the legacy source systems are evaluated for completeness, consistency, and accuracy **(40.2.1.19)**”

Page D.1.15-13

Requirement(s): 40.1.2.19

Change From: “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.”

Change To: “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 source systems in an indexed and retrievable format on the FileNet system”

Page D.1.15-14

Requirement(s): 40.1.2.19

Change From: “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.”

Change To: “In addition, Team CSC understands that it is unlikely that all data needed for the Replacement MMIS can be converted from the existing legacy source systems. 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 source system that are required to be parsed into separate data elements in the Replacement MMIS.”

Page N/A

Requirement(s): 40.6.1.23

Baseline system already supports the requirement so no additional text is necessary.

Page N/A

Requirement(s): 40.7.1.68

Baseline system already supports the requirement so no additional text is necessary.

Page N/A

Requirement(s): 40.8.1.61

Baseline system already supports the requirement so no additional text is necessary.

Page N/A

Requirement(s): 40.8.1.62

Baseline system already supports the requirement so no additional text is necessary.





Page D.1.8-1 contains confidential information.



Appendix 50, Attachment C, Exhibit 1: Addendum State Requirements Matrix Updated July 21, 2008

Table Legend:

- (A) System capability is in the Baseline System or COTS and configuration is required via manual table updates to meet proposed solution (Y/N)*
- (B) System capability is in the Baseline System or COTS and software modification is required to meet proposed solution (Y/N)*
- (C) System capability is not in the Baseline System and requires new functionality via software modification to meet proposed solution (Y/N)
- (D) Enter the Proposal Section (A–L) that reflects the fulfillment of the Section 40 of this RFP requirement and page number(s).
- (E) Will meet requirement (Y/N)

* If both A and B above apply, indicate Yes (Y) in each column.

** Non-Medicaid only

Note: The page numbers in column D refer to pages in our August 5, 2008 Proposal Supplement

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 for a single system process to coordinate recipient benefits among the DMA (including Title XIX and Title XXI), DMH, DPH, 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.1-1; D.1-2; D.1-3; D.1-10; D.1-21; D.2-1; D.2-1	Y



40.1.2 General Operational Requirements

Requirement #	Requirement Description	A	B	C	D	E
	Regulatory Compliance					
40.1.2.12	<p>Fiscal Agent (DDI and Operations Phases) shall ensure that the Replacement MMIS incorporates compliance with appropriate Federal and State regulations, statutes, and policies concerning the protection of personally identifiable information and/or financial information. Regulations, statutes, and policies include, without limitation:</p> <ul style="list-style-type: none"> • 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 • Omnibus Budget Reconciliation Act of 1990 (OBRA'90) • Federal MMIS certification standards • Financial Accounting Standards Board Generally Accepted Accounting Principles (GAAP) • Part 11 of the State Medicaid Manual • North Carolina State Plans for Medicaid, Mental Health, Developmental Disabilities, and Substance Abuse, and Public Health • US DHHS Title VI Language Access Policy • Recipient eligibility policies from the NC DHHS Eligibility Information System (EIS) and the Common Name Data Service (CNDS) • NC State Law S 1048 (Identity Theft Protection Act) • 10A NCAC Chapters 21 & 22, Medical Assistance 	N	N	N	BAFO Proposal D.1.4.1-2; H-2	Y



Requirement #	Requirement Description	A	B	C	D	E
	<ul style="list-style-type: none"> 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 Title XXI of the Social Security Act Applicable State Law (currently, GS 108A-70.20 [NCHC]) DHHS Cash Management Plan (http://www.ncdhhs.gov/control/index.htm) Federal Section 508 (http://www.section508.gov) 					
	Data Transfer and Conversion					
40.1.2.19	Fiscal Agent (Operations Phase) shall convert all legacy data from DMA, DMH, DPH, the Migrant Health Program in the ORHCC, and NC Health Choice (NCHC)	N	Y	N	D.1-1; D.1-22; D.1-23 D.1-24	Y
40.1.2.20	Fiscal Agent (Operations Phase) shall convert all legacy data from DMA, DMH, DPH, the Migrant Health Program in the ORHCC, and NC Health Choice (NCHC) to maintain	N	Y	N	D.1-1; D.1-22	Y



Requirement #	Requirement Description	A	B	C	D	E
	benefit plans and data relationships in a multi-payer environment					

40.2 Recipient Requirements

40.2.1 Recipient System Requirements

Requirement #	Requirement Description	A	B	C	D	E
40.2.1.124 (New)	Provides capability to produce NCHC original and replacement recipient identification cards	N	N	Y	D.1-3	Y
40.2.1.125 (New)	Provides capability to produce NCHC original and replacement recipient benefit booklets	N	N	Y	D.1-3; D.2-7	Y

40.2.2 Recipient Operational Requirements

Requirement #	Requirement Description	A	B	C	D	E
40.2.2.9 (New)	Fiscal Agent shall respond to recipients by telephone and/or in writing to issues or questions related to premium payment and cost sharing				D.2-4; D.2-47	Y
40.2.2.10 (New)	Fiscal Agent shall address and respond to all NCHC recipient inquiries about claims payment, prior approval and any other questions except those regarding eligibility				D.2-4; D.2-4; D.2-47	Y
40.2.2.11 (New)	Fiscal Agent shall respond to requests to issue replacement recipient benefit booklets for NCHC recipients	N	N	Y	D.2-4	Y



Requirement #	Requirement Description	A	B	C	D	E
40.2.2.12 (New)	Fiscal Agent shall respond to requests to issue replacement recipient identification cards for NCHC recipients	N	N	Y	D.2-5	Y

40.3 Eligibility Verification System Requirements

40.3.1 EVS System Requirements

Requirement #	Requirement Description	A	B	C	D	E
40.3.1.8	Provides capability to issue a reference number to a provider for Medicaid and/or NCHC eligibility inquiry and responses issued from the EVS	N	N	Y	D.1-5	Y

40.4 Automated Voice Response System Requirements

40.4.1 AVRS System Requirements

Requirement #	Requirement Description	A	B	C	D	E
40.4.1.12	Provides capability to process inquiries made by Medicaid and NCHC recipients entering the recipient's ID number, DOB, and SSN	N	N	Y	D.1-7	Y
40.4.1.22	Provides capability for call flows for the following provider inquiry types: <ul style="list-style-type: none"> • Claim status • Checkwrite • Drug coverage • Procedure code pricing • Modifier verification 	N	N	Y	D.1-5	Y



Requirement #	Requirement Description	A	B	C	D	E
	<ul style="list-style-type: none"> • Procedure code and modifier combination • Procedure code pricing for Medicaid Community Alternatives Program services • Prior approval for procedure code • Medicaid and NCHC dental benefit limitations • Medicaid and NCHC refraction and eyeglass benefits • Medicaid and NCHC prior approval for durable medical equipment (DME), orthotics, and prosthetics • Prior Approval for DPH benefits • Recipient eligibility, enrollment, cost sharing and Medicaid and NCHC service limits • Sterilization consent and hysterectomy statement inquiry • Referrals • Medicaid and NCHC Carolina ACCESS Emergency Authorization Overrides 					
40.4.1.24	<p>Provides capability for call flows for responses for the following Medicaid recipient inquiry types:</p> <ul style="list-style-type: none"> • 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 • Cost sharing, such as premium payments, deductibles, co-payments, and balances 	N	Y	N	D.1-6	Y
40.4.1.26	<p>Provides capability to return a reference number to a provider for DMA/Medicaid and NCHC eligibility verification inquiry and responses issued from the AVRS</p>	N	N	Y	D.1-5	Y
40.4.1.38 (New)	<p>Provides capability to support call flows for responses for the following NCHC recipient inquiry types:</p> <ul style="list-style-type: none"> • NCHC eligibility • Managed care enrollment information, including the primary care provider name, 	N	N	Y	D.1-6	Y



Requirement #	Requirement Description	A	B	C	D	E
	<ul style="list-style-type: none"> address, and daytime and after-hours phone numbers Third Party Liability Cost sharing, such as premium payments, co-payments, deductibles and deductible balances and out-of-pocket thresholds 					
	Web Inquiry					
40.4.1.29	Provides capability to return a reference number to a provider for DMA/Medicaid and NCHC eligibility verification inquiry and responses issued from the Web	N	N	Y	D.1-7	Y
40.4.1.39 (New)	Provides capability for NC Health Choice recipient access to recipient eligibility and enrollment information, including but not limited to: <ul style="list-style-type: none"> NCHC eligibility Managed care enrollment information to include the primary care provider name, address, and daytime and after-hours phone numbers Third Party Liability Cost sharing, such as premium payments, co-payments, deductibles and deductible balances and out-of-pocket thresholds 	N	N	Y	D.1-8	Y

40.6 Reference Requirements

40.6.1 Reference System Requirements

Requirement #	Requirement Description	A	B	C	D	E
40.6.1.23 (Revised)	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, ICD-9 procedure codes, and can accommodate the future ICD-10 procedure codes, and 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:	N	Y	N	D.1-25	Y



Requirement #	Requirement Description	A	B	C	D	E
	<ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> ○ Recipient eligibility ○ Pricing Action Code ○ Category of service ○ Specialty ○ Lab certification ○ Recipient age/sex restrictions ○ Allowed diagnosis codes ○ Prior approval required ○ Medical review required ○ Place of service ○ Pre- and post-operative days ○ Appropriate diagnosis ○ Acceptable place of service ○ Units of service ○ Once-in-a-lifetime indicator ○ Attachments required ○ Valid provider type/specialty ○ NDC codes and units ○ Claim type ○ Purge criteria 					



Requirement #	Requirement Description	A	B	C	D	E
	<ul style="list-style-type: none"> ○ Provider subspecialty ○ Drug Coverage (effective/term dates) ○ Health Check reporting indicator ○ Family Planning indicator ○ Family Planning Waiver Indicator ● Narrative language of procedure codes in both short and long description ● Indication of when or whether claims for the procedure can be archived from online history (such as once-in-a-lifetime procedures) ● Indication of TPL actions, such as cost avoidance, benefit recovery, or pay and chase by procedure code ● Indication of third party payers, non-coverage by managed care organizations by managed care organization type ● Other information, such as accident/trauma indicators for possible TPL, Federal cost-sharing indicators, and Medicare coverage indicator 					
40.6.1.43	<p>Provides capability to apply State-approved policy to:</p> <ul style="list-style-type: none"> ● 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 ● NCHC-specific services 	N	Y	N	D.1-8	Y
40.6.1.89	<p>Provides capability to create Fee Schedule reports detailed in the bullets below:</p> <ul style="list-style-type: none"> ● 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 Licensed Marriage and Family Therapist 	N	Y	N	D.1-9	Y



Requirement #	Requirement Description	A	B	C	D	E
	<ul style="list-style-type: none"> • 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 • Nursing Facility Rates • Occupational Therapy • Orthotics and Prosthetics • Physical Therapy • Physician Drug Program • Respiratory Therapy • Rural Health Center • Speech and Audiology Services 					



Requirement #	Requirement Description	A	B	C	D	E
	<ul style="list-style-type: none"> NCHC services 					
40.6.1.94 (New)	Provides capability to create NC Title XXI Tables Manual and edit resolution documents	N	Y	N	D.1-9	Y
Requirement Deleted 40.6.1.95	Provides capability to indicate whether pricing is performed on the revenue code or the NCHC-specific service when a combination of the two is billed	n/a	n/a	n/a	n/a	n/a

40.7 Prior Approval Requirements

40.7.1 Prior Approval System Requirements

Requirement #	Requirement Description	A	B	C	D	E
	Pre-Admission Certification					
40.7.1.68** (New)	Provides capability to capture pre-admission certification and length-of-stay recommendations by the pre-certification reviewer	N	N	Y	D.1-25; D.2-19	Y
40.7.1.69** (New)	Provides capability to process claims based on pre-admission and length-of-stay recommendations	N	N	Y	D.1-11; D.2-19	Y



40.7.2 Prior Approval Operational Requirements

Requirement #	Requirement Description	A	B	C	D	E
Pharmacy Benefits Management						
40.7.2.25	Fiscal Agent shall prepare and present to the State and the DUR Board the <i>Annual Report</i> , in accordance with SSA 1927 (g)(3)(D), that includes the required information, charts and statistics pertaining to the Drug Use Review Program in the media and timing as directed by the State	N	N	N	D.2-23	Y
40.7.2.26	Fiscal Agent shall assure functionality of the Pharmacy Point-of-Sale Business Area, including both PRO-DUR and Retrospective DUR Program Activities, is in compliance with State policy at all times	Y	N	N	D.2-12: D.2-12	Y
40.7.2.30	The Fiscal Agent shall assure that targeted interventions / communications and education of providers occur through its performance of Retro-DUR activities, as directed by the State and in accordance with Federal Regulations Subpart K, 42CFR (456.700-456.725), Section 4401 of the Omnibus Budget Reconciliation Act of 1990 (OBRA'90), and Social Security Act Section 1927 (g)	Y	N	N	D.2-12: D.2-25	Y
40.7.2.35	Fiscal Agent shall conduct targeted provider interventions/communications using claims data findings, such as aberrant drug patterns, and provide supporting educational references/materials and activities reports (e.g., number of claims reviewed, number of exception profiles generated per recipient) as approved by the State	Y	N	N	D.2-25	Y
40.7.2.43 (New)	The Fiscal Agent shall develop criteria for DUR activities using predetermined standards in accordance with Federal Regulations Subpart K, 42CFR (456.700-456.725), Section 4401 of the Omnibus Budget Reconciliation Act of 1990 (OBRA'90), Social Security Act Section 1927 (g) and existing evidence-based materials that conform to CMS, national and local standards	Y	N	N	D.2-26	Y
40.7.2.44 (New)	The Fiscal Agent shall develop criteria for DUR activities, including using therapeutic criteria from other DMA initiatives, as directed by the State	Y	N	N	D.2-26	Y



Requirement #	Requirement Description	A	B	C	D	E
40.7.2.45 (New)	The Fiscal Agent shall, upon approval by the State, poll other states for alternative practices to resolve DUR Board- or State-identified issues				D.2-26	Y
40.7.2.46 (New)	Fiscal Agent shall identify providers who are candidates for interventions based on standards pre-defined and approved by the State	Y	N	N	D.2-26	Y
40.7.2.47 (New)	Fiscal Agent shall track all provider communications such as letters, telephone calls, and/or face to face meetings from targeted interventions	Y	N	N	D.2-13: D.2-17: D.2-26	Y
Prior Approval Review (New Subsection)						
40.7.2.48** (New)	Fiscal Agent shall perform expedited reviews of a denied prior approval or claim when requested during an appeal	Y	N	N	D.2-20	Y
40.7.2.49** (New)	Fiscal Agent shall perform retrospective reviews of services provided without required prior approval and determine if prior approval should be authorized retroactively	Y	N	N	D.2-20	Y
Pre-Admission Certification						
40.7.2.50** (New)	Fiscal Agent shall perform pre-admission certifications (medical necessity) and length-of-stay approvals (based on industry guidelines) for NCHC recipients prior to hospital inpatient admissions	Y	N	N	D.2-19	Y

40.7.3 Prior Approval Operational Performance Standards

Requirement #	Requirement Description	A	B	C	D	E
Requirement	Fiscal Agent shall meet monthly with DUR, the State and/or Retrospective DUR vendors	n/a	n/a	n/a	D.2-29	n/a



Requirement #	Requirement Description	A	B	C	D	E
40.7.3.11	and Community Care Program and include minutes in bi-weekly Project Status Report					
40.7.3.14 (New)	Fiscal Agent shall deliver all meeting minutes to the State within five (5) business days following each meeting				D.2-29	Y
40.7.3.15 (New)	Fiscal Agent shall provide DUR Board agenda and meeting materials to the State no less than twenty (20) State business days prior to the scheduled quarterly meeting				D.2-29	Y

40.8 Claims Processing Requirements

40.8.1 Claims Processing System Requirements

Requirement #	Requirement Description	A	B	C	D	E
	Claim Acquisition					
40.8.1.25 (Revised)	Provides capability to allow payment for all medically necessary services approved for EPSDT and NCHC Special Needs Plan-eligible recipients	N	N	N	D.1-21; D.2-; D.2-8	Y
40.8.1.384 (New)	Provides capability to reimburse NCHC recipients for eligible out of pocket claims payment	N	N	Y	D.1-10; D.2-1; D.2-2; D.2-3	Y
40.8.1.385 (New)	Provides capability to process claims filed by NCHC recipients	N	N	Y	D.1-10; D.2-1; D.2-4; D.2-5;	Y



Requirement #	Requirement Description	A	B	C	D	E
					D.2-6; D.2-8	
40.8.1.386 (New)	Provides capability to apply service limitations across multiple health care programs and benefit plans as applicable	N	N	N	D.1-21; D.2-3	Y
	Pharmacy Point of Sale					
40.8.1.61	Provides capability to support both Prospective DUR and Retrospective DUR programs to assure that functionality of the Pharmacy Point-of-Sale Business Area is compliant with State policy at all times	Y	Y	N	D.1-25	Y
40.8.1.62	Provides capability to process all pharmacy claims in POS/PRO-DUR, applying edits/audits/overrides, informational alerts, and intervention/conflict/outcomes codes, compliant with State policy at all times	N	N	N	D.1-25	Y
	Retrospective Drug Utilization Review					
Requirement Deleted 40.8.1.200	Provides capability to generate a file of paid drug claims to the Retrospective DUR Vendor	n/a	n/a	n/a	D.1-12	n/a
Requirement Deleted 40.8.1.201	Provides capability to generate a file of physician, clinic, hospital, and pharmacy provider data to the Retrospective DUR Vendor	n/a	n/a	n/a	D.1-12	n/a
Requirement Deleted 40.8.1.202	Provides capability to generate a file of recipient data to the Retrospective DUR Vendor	n/a	n/a	n/a	D.1-12	n/a



Requirement #	Requirement Description	A	B	C	D	E
40.8.1.203	Provides capability to generate the <i>Annual Report</i> in accordance with SSA 1927 (g)(3)(D), that includes the required information, charts and statistics pertaining to the Drug Use Review Program in the media and timing as directed by the State	N	Y	N	D.1-12	Y
40.8.1.387 (New)	Provides capability to generate ad hoc reports and scheduled reports for recipient and provider profilings and provider report cards	N	N	N	D.1-12	Y
40.8.1.388 (New)	Provides capability to apply DUR Board recommendations such as edits/audits, limitations, and informational alerts to the POS claims processing system upon approval by the State	N	N	N	D.1-12	Y

40.8.2 Claims Processing Operational Requirements

Requirement #	Requirement Description	A	B	C	D	E
Drug Utilization Review						
Requirement Deleted 40.8.2.39	Fiscal Agent shall produce information to support the State in completing the CMS Annual Utilization Review Report	n/a	n/a	n/a	n/a	n/a
40.8.2.40	Fiscal Agent shall prepare State-approved agendas, associated meeting materials and minutes for the DUR Board quarterly meetings				D.2-21	Y
Requirement Deleted 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	n/a	n/a	n/a	D.2-26	n/a
40.8.2.45 (Revised)	Fiscal Agent shall perform manual review when a claim for an EPSDT and NCHC Special Needs Plan-eligible recipient is denied for non-covered services or services that	Y	N	N	D.2-1; D.2-4; D.2-18	Y



Requirement #	Requirement Description	A	B	C	D	E
	exceed the service limit					
40.8.2.57 (New)	Fiscal Agent shall attend quarterly DUR Board meetings				D.2-26	Y
40.8.2.58 (New)	Fiscal Agent shall apply DUR Board recommendations such as edits/audits, limitations, and informational alerts to the POS claims processing system upon approval by the State	Y	N	N	D.2-26	Y
40.8.2.59 (New)	Fiscal Agent shall provide the State with DUR Programs Project Status Reports on a biweekly basis				D.2-26	Y
40.8.2.60 (New)	Fiscal Agent shall attend monthly meetings with the State and additional on-site meetings as requested by the State				D.2-26	Y
40.8.2.61 (New)	Fiscal Agent shall prepare the agenda and minutes for its monthly meetings with the State				D.2-26	Y
40.8.2.62 (New)	Fiscal Agent shall be available to the State for DUR-related consultation during normal business hours				D.2-26	Y

40.8.3 Claims Processing Operational Performance Standards

Requirement #	Requirement Description	A	B	C	D	E
Requirement Deleted 40.8.3.15	Fiscal Agent shall provide specified quarterly files to the DUR vendor within five (5) State business days of the start of the month following the quarter's end	n/a	n/a	n/a	D.2-29	n/a



40.9 Managed Care Requirements

40.9.1 Managed Care System Requirements

Requirement #	Requirement Description	A	B	C	D	E
Requirement Deleted 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/a	n/a	n/a	D.1-13	n/a

40.9.3 Managed Care Operational Performance Standards

Requirement #	Requirement Description	A	B	C	D	E
Requirement Deleted 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	n/a	n/a	n/a	D.1-24; D.2-17	n/a

40.12 Drug Rebate Requirements

40.12.1 Drug Rebate System Requirements

Requirement #	Requirement Description	A	B	C	D	E
40.12.1.3	Provides capability to validate units of measure from CMS and/or State drug rebate data file to Replacement MMIS drug file for consistency and reporting on exceptions	N	N	N	D.1-15	Y
40.12.1.14	Provides capability to maintain and retrieve drug rebate invoice and payment data indefinitely, including CMS drug data, State Drug rebate data, claim data, and operational	N	N	N	D.1-18	Y



Requirement #	Requirement Description	A	B	C	D	E
	comments					
40.12.1.20	Provides capability for unit conversion of units paid per claim to CMS/State units billed and CMS/State units billed to units paid per claim	N	N	N	D.1-15	Y
40.12.1.21	Provides capability to maintain units paid (as used to calculate claims pricing) and CMS/State units billed for drug rebate on Claims History	N	N	Y	D.1-17	Y
40.12.1.29	Provides capability to make available to the State the total 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, by drug rebate program	N	N	N	D.1-17	Y
40.12.1.71**	Provides capability to capture State determined drug unit rebate amount and units of measure by drug rebate program	N	N	N	D.1-14; D.1-15; D.1-16	Y
40.12.1.72**	Provides capability to build and maintain the State's Drug Rebate Labeler Data	N	N	N	D.1-16	Y

40.12.2 Drug Rebate Operational Requirements

Requirement #	Requirement Description	A	B	C	D	E
40.12.2.2	Fiscal Agent shall make available to the State the total expenditures for multiple source drugs (annually) as well as other drugs (every three [3] years); the record keeping for this requirement shall include data such as mathematical or statistical computations, comparisons, and any other pertinent records to support pricing changes as they occur by drug rebate program	N	N	N	D.2-26	Y
40.12.2.21**	Fiscal Agent shall attend Drug Rebate Labeler Dispute meetings as required by the State				D.2-28	Y



40.12.3 Drug Rebate Operational Performance Standards

Requirement #	Requirement Description	A	B	C	D	E
40.12.3.2	Fiscal Agent shall make available to the State the total expenditures 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, by drug rebate program	N	N	N	D.2-29	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, and for Medicaid within five (5) State business days from receipt of CMS tape	N	N	N	D.2-30	Y

40.14 Financial Management and Accounting Requirements

40.14.1 Financial Management and Accounting System Requirements

Requirement #	Requirement Description	A	B	C	D	E
MMIS Accounts Receivable Process						
40.14.1.53	Provides capability to produce and send correspondence related to recipient premiums in the recipient's preferred language	N	N	Y	D.1-18; D.1-22	Y
40.14.1.55	Provides capability for refund functionality based on generally accepted accounting principles with documented internal controls that ensure timely, complete and accurate processing and payment of refunds and adjustments of recipient premium payments	N	N	Y	D.1-4; D.1-18; D.1-22	Y
40.14.1.56	Provides capability to process financial accounting records for recipient premiums, including payments, refunds and adjustments, for retroactive, current, and future months	N	N	Y	D.1-18; D.1-22	Y
40.14.1.57	Provides capability to produce reports for recipient premiums, including payments, refunds, adjustments and cost sharing (e.g., recipient co-insurance, deductibles, co-	N	N	Y	D.1-18	Y



Requirement #	Requirement Description	A	B	C	D	E
	payments, etc.) processes					
40.14.1.59	Provides capability to ensure that the total annual aggregate cost sharing, including fees, for all children in a family receiving NCXIX or NCHC benefits shall not exceed a specified threshold of the family's income for the benefit year	N	N	Y	D.1-20	Y
	Premium Payment and Collection (New)					
40.14.1.96 (New)	Provides capability to process recipient premiums, including payments, refunds, adjustments, collection, tracking, imaging, recording and reconciliation, in accordance with GAAP, via system financial management and accounting functions with online update and inquiry capability	N	N	Y	D.1-18	Y
40.14.1.97 (New)	Provides capability for automated calculation of recipient premiums on a sliding scale	N	N	Y	D.1-18	Y
40.14.1.98 (New)	Provides capability for online display of recipient premium payment history to include all payments, refunds and adjustments	N	N	Y	D.1-3	Y
40.14.1.99 (New)	Provides capability for online display of recipient cost-sharing data such as premiums, deductible, co-pays, etc.	N	N	Y	D.1-3	Y
40.14.1.100 (New)	Provides capability for determining and tracking premium due dates	N	N	Y	D.1-18	Y
40.14.1.101 (New)	Provides capability for issuance of recipient premium notices, including invoices, notices of non-payment, cancellation notices, receipts, refunds and adjustments within the specified time frame for each recipient	N	N	Y	D.1-18	Y
40.14.1.102	Provides capability for accounts payable functionality to track all unpaid refunds	N	N	Y	D.1-18	Y



Requirement #	Requirement Description	A	B	C	D	E
(New) (Revised)						
40.14.1.103 (New) (Revised)	Provides capability to generate online notification of premium payment status to the Eligibility Information System (EIS)	N	N	Y	D.1-18	Y
40.14.1.104 (New)	Provides capability to pay the cost for dependent coverage provided under a private insurance for NCHC recipients who are eligible under State-defined criteria	N	N	N	D.1-13; D.1-14	Y
40.14.1.105 (New)	Provides capability to subtract recipient premiums, co-payments and other cost-sharing fees from the service cost prior to collecting FFP	N	N	Y	D.1-18	Y
Requirement Deleted 40.14.1.106	Provides capability for actuarial determination of premiums for recipients who purchase coverage in State health programs	n/a	n/a	n/a	n/a	n/a

40.14.2 Financial Management and Accounting Operational Requirements

Requirement #	Requirement Description	A	B	C	D	E
40.14.2.33	Fiscal Agent shall produce refunds and adjustments of recipient premiums	N	N	Y	D.2-14	Y
40.14.2.72 (New)	Fiscal Agent shall establish operational accounting procedures for recipient premiums, in accordance with GAAP, including payments, refunds, adjustments, collection, processing, tracking, imaging, recording and reconciliation	N	N	Y	D.2-13	Y



Requirement #	Requirement Description	A	B	C	D	E
40.14.2.73 (New)	Fiscal Agent shall accept and post recipient payments and issue refunds and adjustments for retroactive, current and future months	N	N	Y	D.2-14	Y
40.14.2.74 (New)	Fiscal Agent shall process and track all recipient premiums, including payments, refunds and adjustments and reconcile to the monthly bank statements to ensure a complete accounting and disposition of all financial transactions	N	N	Y	D.2-12	Y
40.14.2.75 (New)	Fiscal Agent shall ensure that all refunds returned as undeliverable are properly tracked as unpaid and that the financial data is adjusted accordingly	N	N	Y	D.2-14	Y
40.14.2.76 (New)	Fiscal Agent shall update recipient premium payment history online to reflect all payments, refunds and adjustments	N	N	Y	D.2-14	Y
40.14.2.77 (New)	Fiscal Agent shall establish a receipt system to handle cash premium payments and refunds				D.2-11	Y
40.14.2.78 (New)	Fiscal Agent shall deposit funds into a State-owned account as required by State and Federal policy				D.2-12; D.2-13	Y
40.14.2.79 (New)	Fiscal Agent shall prepare financial statements and expenditure reports and submit them as directed by the State	Y	N	N	D.2-15	Y
40.14.2.80 (New)	Fiscal Agent shall accept, at a minimum, cash, check, money order, and credit/debit card for recipient premium payments	N	N	Y	D.2-11; D.2-12	Y



40.14.3 Financial Management and Accounting Operational Performance Standards

Requirement #	Requirement Description	A	B	C	D	E
40.14.3.54 (New)	Fiscal Agent shall issue a refund to recipients within fifteen (15) business days from the time a corresponding entry is made into accounts payable ninety-nine and nine tenths (99.9) percent of the time	N	N	Y	D.2-15	Y



Addendum Statement of Objectives (SOO) Requirements Matrix, Updated July 21, 2008

(Note: The Proposal Page Reference(s) below refer to pages in our August 5, 2008 Proposal Supplement)

Section #	Page	Mandatory/ Non- Mandatory	Statement	Vendor will meet the requirement or objective (Y/N)	Proposal Page Reference(s)
S.1.1-1	1	Mandatory	...the Replacement MMIS shall "have the capability to fully implement the administration of NC Health Choice, NC Kids' Care, Ticket to Work, Families Pay Part of the Cost of Services under the CAP-MR/DD, CAP Children's Program, and all relevant Medicaid waivers and the Medicare 646 waiver as it applies to Medicaid eligibles."	Y	C.1-1; D.1-1; D.2-1; D.2-3; D.2-6; D.2-7; D.2-8; D.2-9; D.2-10; D.2-11; D.2-17; D.2-18; D.2-19;
S.1.1-2	1	Mandatory	...the Replacement MMIS must have the capability to correctly handle financial transactions with recipients given the more complex, family-oriented cost-sharing definitions.	Y	C.1-1; D.1-5; D.2-1; D.2-12;
S.1.1-3	1	Mandatory	The Fiscal Agent shall assume greater responsibility for recipient management including activities related to notification, collection and application of recipient premiums for Medicaid and NCHC programs.	Y	C.1-1; D.2-10; D.2-15;
S.1.1-4	1	Mandatory	...for NCHC and Kids' Care, the Fiscal Agent shall provide mechanisms for recipient communications concerning claims payment, prior approvals, covered services, and other non-eligibility related issues.	Y	C.1-1; D.1-20; D.2-2; D.2-3; D.2-10; D.2-15; D.2-16;
S.1.1-5	1	Mandatory	[Premium] Payment methods shall include, at a minimum, cash, check, money order, and credit/debit card.	Y	C.1-1; D.1-20; D.2-1; D.2-10; D.2-12; D.2-16;
S.1.1-6	2	Mandatory	Offerors shall propose collection and refunding methodologies (e.g., mail, phone, EFT, Web, etc.) that are flexible and cost effective.	Y	D.2-1; D.2-2; D.2-10;



Section #	Page	Mandatory/ Non- Mandatory	Statement	Vendor will meet the requirement or objective (Y/N)	Proposal Page Reference(s)
S.2-1	3	Mandatory	The Replacement MMIS Vendor shall take over responsibility for performing Retrospective DUR operations as soon as practical after Contract award and continue throughout the life of the Contract.	Y	C.1-1; D.1.8-1; D.2-18; D.2-20; D.2-21; D.2-22; D.2-23; D.2-25; D.2-28;
S.2-2	3	Mandatory	In its Retrospective DUR solution, the Vendor shall address any necessary interaction with the legacy Fiscal Agent and/or interfacing with the Legacy MMIS+ prior to the Replacement MMIS Operational Start Date.	Y	C.1-1; D.1.8-1; D.2-18; D.2-27;





D.1.18 ADJUSTED FUNCTION POINT COUNT

Items marked by change bars in the table are values that have changed as a result of Addenda 4/5.

APPENDIX 50, ATTACHMENT C, EXHIBIT 2 (Comment CSC9)

Business/Functional Area	Baseline Adjusted FP	Enhancement Adjusted FP	New Capabilities Adjusted FP	Notes
Recipient	338	153	487	
EVS	35	11	6	
AVRS	90	0	96	
Provider	922	0	394	
Reference	768	453	210	
Prior Approval	404	138	184	
Claims	2,687	316	355	
Managed Care	14	6	203	
Health Check	491	102	84	
TPL	1,128	31	484	
Drug Rebate	719	56	112	
MARS	273	47	12	
Financial	2,609	194	364	
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	



Business/Functional Area	Baseline Adjusted FP	Enhancement Adjusted FP	New Capabilities Adjusted FP	Notes
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.
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.

9799-999

Appendix 50, Attachment C, Exhibit 2



Pages D.2-1 through D.2-3 contain confidential information.

Page D.2.1.1-6

Requirements: 40.8.1.385

Change From: “The in-bound mail may contain claims, claim attachments, prior approval requests, claim adjustments, x-rays, returned eyeglasses, State Memoranda, and any variety of State approved forms from providers.”

Change To: “The in-bound mail may contain claims, claim attachments, prior approval requests, claim adjustments, x-rays, returned eyeglasses, State Memoranda, and any variety of State approved forms from providers or NCHC members. (40.8.1.385)”

Page D.2.1.1-6

Requirements: 40.8.2.45

Change From: “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.”

Change To: “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. Other claims that would suspend for manual review include the EPSDT and NCHC Special needs claims that are marked to deny for a non-covered service or services that exceed the service limit. Following the guidelines established by State, the manual reviewer will finalize the claim and override those edits as appropriate. 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. (40.8.2.45)”



Page D.2-5 contains confidential information.

enter the processing cycle; they are routinely queued by Ibis for the RTP Unit to review and send the submitter an appropriate RTP letter, or potentially a message to a secure electronic mailbox followed with an email alert to the submitter. These systematically generated RTP letters identify the missing data elements, and instruct the provider to complete the form and resubmit for processing. In the case of NCHC member submitted claim that is missing required data, the flow is the same as described for RTP except that the return letters are created for the appropriate family member, or head of household in the case of children, detailing what is required for the claim to be considered for payment. **(40.8.2.14, 40.8.2.15)** This process eliminates the need for manual prescreening of all required fields on provider and NCHC member 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.”

Page D.2.1.1-12

Requirements: 40.8.2.22, SOO S.1.1-1, 40.8.1.385

Change From: “As previously stated, all paper documents are scanned into images and controlled in the front-end processing. Team CSC proposes using OCR capabilities to eliminate the need for data entry of most hard copy claims. For those claims and adjustments that require direct data entry (e.g., special pharmacy claims), Data Entry operators within the Claims Department key data directly into the Replacement MMIS using the stored images of the original paper claims. Performing data entry from images permits us to use any available trained operator to enter the claims information, rather than limiting us to using only those operators working in the same facility as the paper claims. **Exhibit D.2.1.1.4.2-1, Key from Image**, depicts the scanned document that appears to the Data Entry operators who are assigned to this task. **(40.8.2.22)”**

Change To: “For those claims and adjustments that require direct data entry (e.g., special pharmacy claims or NCHC member submitted claims), Data Entry operators within the Claims Department key data directly into the Replacement MMIS using the stored images of the original paper claims. Performing data entry from images permits us to use any available trained operator to enter the claims information, rather than limiting us to using only those operators working in the same facility as the paper claims. **Exhibit D.2.1.1.4.2-1, Key from Image**, depicts the scanned document that appears to the Data Entry operators who are assigned to this task. **(40.8.2.22, 40.8.1.385, SOO S.1.1-1)”**

Page D.2.1.1-13

Requirements: 40.8.1.385

Change From: “In addition to claims documents, the Imaging Unit is responsible for ensuring that all provider materials are controlled and available for retrieval and online viewing by State and Team CSC staff.”

Change To: “In addition to claims documents, the Imaging Unit is responsible for ensuring that all provider materials are controlled and available for retrieval and online viewing by State and Team CSC staff. This same capability will be provided for NCHC member submitted claims,

corresponding attachments, any return to member claim letters and any NCHC correspondence received. **(40.8.1.385)**”

Page D.2.1.1-13 / 14

Requirements: 40.2.1.125, 40.5.2.62, 40.5.2.63,

Change From: “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)**”

Change To: “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. A description of the provider materials, communication, and training can be found in proposal section, “Client Relations, D.2.1.3,” the NC Health Choice Recipient Benefits Booklet is described in CDRL P0012, Section G. The provider identification number is used on all materials for electronic document linking for future reference. For NCHC documents, those items are indexed and tracked by member data such as Member ID and date of birth. **(40.2.1.125, 40.5.2.62, 40.5.2.63)**”

Page D.2.1.1-14

Requirements: SOO S.1.1-1, 40.1.1.1

Change From: “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.”

Change To: “For the North Carolina contract, the Team CSC HCWD and Waiver Claims Resolution Unit receives extensive training in DMA, DMH, DPH, ORHCC, NCHC, HCWD and waiver 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. **(SOO S.1.1-1, 40.1.1.1)**”

Page D.2.1.1-14

Requirements: 40.8.1.24, 40.8.1.25, SOO S.1.1-1

Change From: “This capability results in increased operational efficiencies and enhanced provider satisfaction because payments are not delayed.”

Change To: “This capability results in increased operational efficiencies and enhanced provider and member satisfaction because payments are not delayed. (40.8.1.24, 40.8.1.25) (SOO S.1.1-1)”

Page D.2.1.1-16

Requirements: 40.8.1.385

Change From: “All claim transactions entering the Replacement MMIS are processed through the claims adjudication function, which applies a series of edits and audits to ensure that only valid claims for eligible recipients and covered services are reimbursed to covered providers.”

Change To: “All claim transactions entering the Replacement MMIS are processed through the claims adjudication function, which applies a series of edits and audits to ensure that only valid claims for eligible recipients and covered services are reimbursed to covered providers or NCHC, HCWD or waiver members.”

Page D.2.1.1-17

Requirements: 40.8.1.25

Change From: “During the processing cycle, Claims Resolution staff can approve or deny a claim line by overriding the edit. To force the approval or denial of a claim line, the user selects the appropriate action from the drop down ‘Status’ field. The user also has the option of selecting a specific remit code to explain the reason for the denial. The override remit codes are used during the production of paper remittances to provide further clarification to the provider as to the reason for denial. The remit code(s) are listed along with all other edits for the document. The override remit codes are viewable through the Pend Resolution pages.”

Change To: “During the processing cycle, Claims Resolution staff can approve or deny a claim line by overriding the edit. To force the approval or denial of a claim line, the user selects the appropriate action from the drop down ‘Status’ field. The user also has the option of selecting a specific remit or EOB code to explain the reason for the denial. The override remit or EOB codes are used during the production of paper remittances or member EOBs to provide further clarification to the provider or member as to the reason for denial. The remit or EOB code(s) are listed along with all other edits for the document. The override remit or EOB codes are viewable through the Pend Resolution pages. (40.8.1.25)”



Page D.2-9 contains confidential information.

Page D.2.1.2-1

Requirements: SOO S.1.1-1, SOO S.1.1-3

Change From: “Team CSC will provide fully complaint and responsive Financial Management services ...

- Receipt, deposit and reconciliation of returned funds from TPL recovery, submission of recipient premiums and returns of provider overpayments.”

Change To: “Team CSC will provide fully complaint and responsive Financial Management services ...

- Receipt, deposit and reconciliation of returned funds from TPL recovery, submission of recipient premiums, including NCHC and HCWD premium refunds, adjustments and return of provider overpayments.”
-

Page D.2.1.2-1

Requirements: 40.14.2.64, SOO S.1.1-1, SOO S.1.1-3

Change From: “Team CSC’s Financial Management organization will comprise two complementary functions needed to fully discharge Team CSC’s assigned fiscal agent responsibilities:

- Transaction Accounting. This section of the Finance Department is dedicated to performing functions needed to support all NC DHHS Programs. Activities include control over processing of provider disbursement checks, enrollment of providers in the Electronic Funds Transfer (EFT) pool, recoupment of overpayments, control of cash received from providers and premium payments. **(40.14.2.64)”**

Change To: ““Team CSC’s Financial Management organization will comprise two complementary functions needed to fully discharge Team CSC’s assigned fiscal agent responsibilities:

- Transaction Accounting. This section of the Finance Department is dedicated to performing functions needed to support all NC DHHS Programs. Activities include control over processing of provider disbursement checks, enrollment of providers and NCHC responsible parties in the Electronic Funds Transfer (EFT) pool, recoupment of overpayments, control of cash received from providers and NCHC and HCWD premium payments. **(40.14.2.64) (SOO S.1.1-1, SOO 1.1-3)”**
-

Page D.2.1.2-5

Requirements: SOO S.1.1-3, SOO S.1.1-4, SOO S.1.1-5, SOO S.1.1-6, 40.14.2.80

Change From: “...

- Lockbox services to facilitate receipts from providers and Buy-In payments from recipients”

Change To: “...

- Lockbox services to facilitate receipts from providers and premium payments from NCHC and HCWD members. The lockbox will be the physical mailing address for all ‘paper’ forms of premium payments. Team CSC will also offer EFT and a web based application for the payment of member premiums. **(40.14.2.80)**
-

Page D.2.1.2-5

Requirements: 40.14.2.62, 40.14.2.63, 40.14.2.77, SOO S.1.1-1

Change From: “D.2.1.2.1.5 Enhanced Banking Services

Prior to contract startup, Team CSC will contract with a State-approved banking institution to provide all required banking functionality for the Replacement MMIS project. This institution will be selected by Team CSC based on its ability to provide a comprehensive range of banking services to include the following:

- Lockbox services to facilitate receipts from providers and Buy-In payments from recipients
- Processing for the main disbursement accounts
- Processing for additional special accounts, such as a funds received account, a Buy-In account, and a manual advance account
- Full Support for EFT transactions. **(40.14.2.62)**

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)**

Change To: “D.2.1.2.1.5 Enhanced Banking Services

Team CSC will contract with a State-approved banking institution to provide all required banking functionality for the Replacement MMIS project. This institution will be selected by Team CSC based on its ability to provide a comprehensive range of banking services to include the following:

- Lockbox or walk in services to facilitate receipts from providers and any form of premium payment or refund (except EFT and web based receipts from a recipient).
- 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, including premium payments. **(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, 40.14.2.77)**

Page D.2.1.2-5**Requirements: 40.14.2.74, SOO S.1.1-3, SOO S.1.1-5**

Add the following text at the end of paragraph D.2.1.2.1.5: “In the following paragraph (D.2.1.2.1.6), Team CSC details the procedures for account controls and reconciliation procedures. While this section primarily addresses the claim payment controls, the same methodology and approach will be used for premium payments and adjustments. Team CSC will receive a daily file from the bank that contains the detail for premium payments deposited. Additionally, for the web based and EFT payments, a file will be generated from the MMIS that provides all of the details associated with those premium payments. Each premium payment will be tracked by date of receipt and posted by member. This data will feed the member’s eligibility file to ensure that the member’s coverage is adequately reflected for correct claims adjudication. The accounting and disposition of the activity related to premium payments will follow all of the accounting and reconciliation processes that Team CSC outlined for claim payments. (40.14.2.74, SOO S.1.1-3, SOO S.1.1-5)”

Page D.2.1.2-8**Requirements: 40.14.2.32, 40.14.2.58, 40.14.2.59, 40.14.2.60, 40.14.2.61, 40.14.2.68, 40.14.2.69, 40.14.2.75, 40.14.2.78, 40.14.2.80, SOO 10.12.1-19****Change From: “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 (by phone, mail, cash, check, money order and bank card)
- 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, 40.14.2.80)

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)

Receipt of incoming payments will be greatly enhanced by the use of separate lockboxes for each type of receipt. The Lockbox vendor provides digital images of receipt documentation to Team CSC through a secure data transmission. These images are used by Transaction



Accounting staff for researching remittances that arrived without adequate documentation, allowing for the proper accounting treatment to be applied. Because of the efficiency of scanned images, they offer the additional advantage of easy retention and retrieval, allowing images of check and documentation to be easily maintained throughout the contract term. Of course, access to check images will be limited to those who have the appropriate access authorization. (40.14.2.58, 40.14.2.59, 40.14.2.60)

Use of automated scanning procedures will facilitate the preparation of cash receipts logs, which will be prepared for each State business day. These logs will denote the date, time, and individual processing the check, and will be provided to NC DHHS for review on a daily basis. These logs will flow into the Ibis workflow tool and trigger dispositions of receipts. (SOO 10.12.1-19)

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.”

Change To: “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, including NCHC and HCWD 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 driven by operational accounting procedures, prepared in accordance with GAAP, ensuring that all funds are promptly deposited to appropriate State-owned bank accounts and allocated to the appropriate accounts within the Replacement MMIS. Our operational procedures govern payments, refunds, adjustments, collections, processing of receipts, and the tracking, imaging, recording and reconciliation of all financial instruments.(40.14.2.32, 40.14.2.61, 40.14.2.68, 40.14.2.72, 40.14.2.78)

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, undeliverable premium 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)

Receipt of incoming payments will be greatly enhanced by the use of separate lockboxes for each type of receipt. The Lockbox vendor provides digital images of receipt documentation to Team CSC through a secure data transmission. These images are used by Transaction Accounting staff for researching remittances that arrived without adequate documentation, allowing for the proper accounting treatment to be applied. Because of the efficiency of scanned images, they offer the additional advantage of easy retention and retrieval, allowing images of



check and documentation to be easily maintained throughout the contract term. Of course, access to check images will be limited to those who have the appropriate access authorization. (40.14.2.58, 40.14.2.59, 40.14.2.60)

Use of automated scanning procedures will facilitate the preparation of cash receipts logs, which will be prepared for each State business day. These logs will denote the date, time, and individual processing the check, and will be provided to NC DHHS for review on a daily basis. These logs will flow into the Ibis workflow tool and trigger dispositions of receipts. (SOO 10.12.1-19)

Use of separate lockboxes will allow 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 member premiums. (40.14.2.75)”

Page D.2.1.2-14

Requirements: 40.14.2.33, 40.14.2.73, 40.14.2.76

Change From: “D.2.1.2.1.12 Dispositioning & Adjustments

After cash receipts have been logged and deposited, Team CSC’s Transaction Accounting unit will proceed with dispositioning the cash payment. This process involves identifying the reason for the cash receipt and making appropriate decisions as to how the receipt should be handled and recorded. For example, funds received from providers relating to claim overpayments must be fully researched to accurately identify the claim which was overpaid, and the steps necessary to correct the error. Because the adjustment takes place at the detail claim line level, the Replacement MMIS automatically recalculates the amount of funding at the detail LOB level, effectively generating a credit back to the federal, state, local government, or other funding source based on actual system-maintained funding allocation tables. (SOO 10.12.6-2)”

Change To: “D.2.1.2.1.12 Dispositioning & Adjustments

After cash receipts, including premium payments, 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 online. For example, funds received from providers relating to claim overpayments must be fully researched to accurately identify the claim which was overpaid, and the steps necessary to correct the error. Because the adjustment takes place at the detail claim line level, the Replacement MMIS automatically recalculates the amount of funding at the detail LOB level, effectively generating a credit back to the federal, state, local government, or other funding source based on actual system-maintained funding allocation tables. (SOO 10.12.6-2)

Another example is the receipt of an NCHC premium payment. Upon research, the payment will be applied for the applicable month’s invoice (retroactive, current, or future periods). If the member overpaid, a transaction will be generated to issue a refund to the appropriate member or head of household. Some situations will require the Financial Team to adjust recipient premiums. These adjustments will be guided by appropriate desk procedures and workflow processes. Team



Pages D.2-15 through D.2-18 contain confidential information.

Page D.2.1.4-6

Requirements: 40.7.1.68, 40.7.1.69

Change From: “Staff receives and processes all non-pharmacy prior approval and other requests and is responsible for resolving all inquiries.”

Change To: “Staff receives and processes all non-pharmacy prior approval requests, including pre-admission certifications and is responsible for resolving all inquiries.”

Page D.2.1.4-6

Requirements: SOO S.1.1-1

Change From: “...

- Orthotics and prosthetics
- Pharmacy (see D.2.1.4.3 below)
- All services for DPH payment programs.”

Change To: “...

- Orthotics and prosthetics
 - Pharmacy (see D.2.1.4.3 below)
 - All services for DPH payment programs.
 - NCHC specific services (**SOO S.1.1-1**)”
-

Page D.2.1.4-6

Requirements: 40.7.2.50

Change From: Insert new text beneath the two columns bulleted list at the bottom of page D.2.1.4-6 and before to the paragraph starting “Because the underlying prior approval ...”

Change To: “Our Prior Approval Customer Service Center conducts pre-admission certification reviews and length-of-stay approvals for hospital inpatient admissions, using well-founded industry medical necessity guidelines. To ensure a smooth transition, we will use the Milliman guidelines for those reviews. (**40.7.2.50**)”

Page D.2.1.4-8

Requirements: 40.7.2.50

Change From: “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.)”

Change To: “Clinical Prior Approval Reviewers process suspended prior approval, pre-admission certification, referral, and override requests that the system automatically routes to the correct work queue (e.g., pharmacy, optical, surgical, etc.). (**40.7.2.50**)”

Page D.2.1.4-10

Requirements: 40.7.2.48

Change From: “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”

Change To: “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 perform expedited reviews of denied prior approval requests or claims when requested during an appeal. 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. (40.7.2.48)”

Page D.2.1.4-10

Requirements: 40.7.2.49

Change From: “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)”

Change To: “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)”

Retrospective reviews of services provided without the required prior approval can occur for members of the NC Health Choice program. Following State policy, Team CSC will conduct these reviews to determine if prior approval should be granted retroactively. (40.7.2.49)”

Page D.2.1.4-11

Requirements: SOO S.2-1, SOO S.2-2

Change From: 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.

Change To: "Team CSC and our partners, MemberHealth and First Health Services, 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 PRO DUR 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.**

In addition to handling the RetroDUR functions First Health clinical personnel are **bringing their extensive clinical and pharmacological experience from work with 25 State Medicaid programs and 6 commercial and State employee programs. First Health Services designed the first Retrospective DUR program used in the country in 1987. First Health's Retro DUR is supported by FirstIQ™ a clinical management decision support tool designed to perform menu-driven RetroDUR functions. FirstIQ™ allows for customized inquiries into North Carolina-specific data, and the results of these queries can be used to produce reports, files for further analysis, and graphs for use in monitoring clinical and economic trends in the pharmacy program. Team CSC drug utilization review programs are designed to identify, and ultimately correct, potentially dangerous prescribing, dispensing, and drug utilization patterns. (SOO S.2-1, SOO S.2-2)**

Page D.2.1.4-11

Requirements: 40.8.2.40

Change From: "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."

Change To: "The Team CSC Pharmacy Director and other pharmacy staff prepare State-approved agendas, meeting materials and publish the minutes for the quarterly Drug Utilization Review Board (DUR Board) meetings. (40.8.2.40)"



Page D.2.1.4-12

Requirements: SOO S.2-1

Change From: “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:”

Change To: “Team CSC recognizes the importance of the State’s Retroactive Drug Utilization Review (RetroDUR) functions in pharmacy benefits management. Several important components of Team CSC’s DUR activities include: analytics that address both high-risk and high-cost/utilization drug therapies for the drugs and disease states of the recipient population. The proposed RetroDUR Program for both recipients and pharmacy providers/prescribers provides the information needed by the DUR Board to educate pharmacists and prescribers by identifying excessive, inappropriate, or medically unnecessary drug usage. The primary emphasis is on intervention and education.

On a monthly basis, data on drug use are assessed against a global catalog of clinical criteria representing all major drug classes. Our experience with Medicaid and elderly pharmacy programs allows us to identify areas of inappropriate prescribing that have shown the greatest opportunity for improvement. The FirstIQ™ profiling system utilizes specific therapeutic criteria that Medicaid Agency and DUR Board approve. Criteria are revised as therapeutic problems are identified and/or eliminated and new drug products are released.

The program promotes therapeutic appropriateness of medications by checking for, but not limited to, early refills, brand versus generic utilization, drug-to-drug interactions, and therapeutic duplication. These RetroDUR edits detect potential adverse drug consequences of incorrect drug utilization. The RetroDUR system detects excessive use of medication and insufficient daily doses by comparing drugs selected for review to the submitted daily doses and the duration of therapy. This RetroDUR edit detects errors in dosage and duration, and also monitors recipient compliance. Clinical abuse/misuse can be determined so that remedial strategies can be introduced to improve quality of care and conserve program funds.

Team CSC also has therapeutic class criteria designed to reduce the incidence of drug therapy failure and drug-induced illness. The RetroDUR system detects drug-to-diagnosis contraindications, treatment failure, adverse reactions, and iatrogenic effects by evaluating drug, diagnostic, and laboratory and procedure data. Our current Therapeutic Criteria Catalogue contains over 3,000 drug therapy situations that could place beneficiaries at medical risk as a result of improper drug utilization. Team CSC’s RetroDUR services also has the ability to develop criteria that looks for opportunities to improve adherence to established and new evidence-based guidelines — for example, a criteria that looks for recipients with diabetes who could benefit from initiation of an angiotensin converting enzyme inhibitor (ACEI) to reduce the risk of diabetic complications.

The State and DUR board approved changes are communicated to the Pharmacy point of sale system team for configuration into the pharmacy point of sale system.



Team CSC understands and acknowledges the importance of the end to end activities that must occur in the RetroDUR processes. **(SOO S.2-1)**

Page D.2.1.4-12

Requirements: 40.7.2.25, 40.8.2.39

Change From: “...

- Prepare the CMS Annual DUR Report — During the Implementation Phase, Team CSC meets with the State and the RetroDUR vendor to define the detailed specifications for preparing this report. We determine the report contents, format, delivery schedule, and medium. Team CSC manages the Prospective DUR and DUR Board information. We collaborate with the RetroDUR vendor to obtain RetroDUR data needed to prepare the report and negotiate the format, timing, and delivery of the requested information. The Pharmacy Director, assisted by clinical and systems staff, prepares this report or furnishes information to the State, as requested, to support the preparation of the report. The Team CSC Quality Assurance staff participates in the process, verifying content and format prior to release. **(40.7.2.25, 40.8.2.39)”**

Change To: “...

- Prepare and present to the State and to the DUR Board the Annual Report (in accordance with SSA 1927 (g)(3)(D) — The Annual CMS DUR report will be provided annually by the Clinical Pharmacist to the Agency as required in 42 CFR 456.712. The report will be provided four weeks before the CMS deadline for submission of the report. Team CSC is experienced at production of these reports and currently produces an Annual DUR Report for many clients, including Virginia, Michigan, Alaska, and Oregon. **(40.7.2.25 40.8.2.39)”**
-

Page D.2.1.4-12

Requirements: 40.7.2.26

Change From: “...

- Assure functionality of the POS business area — The Pharmacy Director and POS Supervisor, supported by other Team CSC staff as needed, coordinates with the RetroDUR contractor to continuously review the effectiveness and currency of the pharmacy POS business area. We collaborate with the RetroDUR vendor to review existing edits, evaluate potential new edits, define POS alerts, implement approved DUR Board recommendations, and determine intervention, conflict, and outcome codes in accordance with National Council for Prescription Drug Programs (NCPDP) 5.1 standards. Our joint goal is to maximize the effectiveness of pharmacy prior approval and ProDUR processing to protect the health of North Carolina recipients and help control the rising costs of the North Carolina pharmacy program. **(40.7.2.26)”**

Change To: “...

- Assure functionality of the Pharmacy POS business area is compliant with State policies — The Pharmacy Director and POS Supervisor, supported by other Team CSC staff as needed,



continuously review the effectiveness and currency of the pharmacy POS business area. We review existing edits against State policies, evaluate potential new edits, define POS alerts, implement approved ProDUR and Retrospective DUR Program Activities and assure compliance with State policy at all times. Our joint goal is to maximize the effectiveness of pharmacy prior approval and all DUR Board recommendations to protect the health of North Carolina recipients and help control the rising costs of the North Carolina pharmacy program. **(40.7.2.26)”**

Page D.2.1.4-12

Requirements: SOO S.2-1, 40.7.2.30

Change From: “...

- Identify ProDUR alerts and collaborate at monthly meetings — Team CSC will conduct meetings with the RetroDUR vendor on at least a monthly basis. We will use these meetings as a forum to discuss known pharmacy problems, identify and agree on appropriate new alerts, explore ideas for detecting other potential drug therapy problems, set priorities for pursuing new initiatives, and define approaches for identifying improvement opportunities and implementing changes. Team CSC documents the results of these meetings in minutes that are published to all meeting attendees, and designated management and State staff. **(40.7.2.30)”**

Change To: “...

- The North Carolina Clinical Pharmacist will conduct a comprehensive review of the Criteria Exception Report (produced from the FirstIQ™ analytics), as well as reports of the top drugs and therapeutic classes in the North Carolina Medicaid Program, to look for opportunities for improvement. Team CSC’s Clinical Pharmacist will present potential academic detailing topics to the Medicaid Agency and the DUR Board. These presentations will include a complete analysis of the data behind the recommendation and literature references for best practices and other clinical considerations. The presentation will also include drafts of all communications and educational materials to be distributed to providers, based upon State approval, by the Team CSC Provider Representatives during their visits, as well the rationale for targeting particular providers. This approach will vary depending on the proposed topic to maximize targeting the most appropriate providers for each individualized topic.

Once the topic and materials are approved, the Clinical Pharmacist will oversee the Provider Representatives’ development of a plan to efficiently visit the targeted providers. A letter will be sent to the provider introducing the program and its goals and alerting the provider that they will be contacted by a Team CSC Pharmacy Provider Representative who will make an appointment to visit and discuss a clinical topic related to their provision of services to North Carolina Medicaid recipients

This letter will be followed with a call by the Academic Detailing Program Scheduler to make an appointment for the visit. Every effort will be made to accommodate the providers’ schedules. Busy providers can typically only give 15 to 30 minutes of their time for this type of activity, and our Provider Representatives will be trained to make the most of this opportunity. They will emphasize the program goals in a concise manner and leave the provider with educational materials to assist them in incorporating the information into

their practice. This information may include, but is not limited to, best-practice guidelines, North Carolina Medicaid policy documents, “tip sheets”, chart reminders, and patient profiles. We have found that providers are most appreciative of the tip sheets, as they contain useful, concise information, and the patient profiles. Physician providers often comment that these profiles are the only time that they get an opportunity to see if their patients are actually taking the medications that they prescribe and whether they are also taking other medications that they may not be aware of.

Because there may not be sufficient time to discuss in detail each patient who was identified in the individual program, the Provider Representative will review all of the patients identified for the intervention and will select those with the most clinical relevance or identified criteria exceptions to discuss with the provider. An individualized chart reminder will be provided for each patient identified, whether or not the patient was discussed, to allow the provider to leave it in the patient’s chart as a reminder when the patient has their next visit.

The Provider Representative will also leave an evaluation form with the providers asking them to provide feedback on the usefulness of the information provided, as well as the actual visit.

Team CSC understands that provider education is an important outcome of the RetroDUR profiles and acknowledges what is required to educate the prescribing community.
(40.7.2.30)”

Page D.2.1.4-12

Requirements: SOO S.2-1

Change From: “...

- 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)”**

Change To:

- “Conduct targeted provider interventions/communications using claims data findings, such as aberrant drug patterns and provide supporting educational references/materials and activities reports. Examples include number of claims reviewed, and number of exception profiles generated per recipient. All interventions and communications are performed at State direction and approval. **(40.7.2.35)”**

Page D.2.1.4-12

Requirements: SOO S.2-1

Change From: “...

- 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)”**

Change To: Delete in its entirety

Page D.2.1.4-13**Requirements: (as shown below)****Change From:** “...

- 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.”

Change To: “Team CSC will perform the following additional DUR functions for the NC DHHS:

- Develop criteria for DUR activities using predetermined standards in accordance with Federal Regulations in Subpart K, 42 CFR 456.700 through 456.725, and section 4401 of the Omnibus Budget Reconciliation Act of 1990 (OBRA '90), Social Security Act Section 1927 (g) and existing evidence-based materials that conform to CMS, national and local standards. **(40.7.2.43)**
- Develop criteria for DUR activities, including using therapeutic criteria from other NC DMA activities, as directed by the State. **(40.7.2.44)**
- Conduct State-approved surveys of other States for alternative practices to resolve DUR Board identified or State-identified issues. **(40.7.2.45)**
- Identify providers who are candidates for interventions based on standards pre-defined and approved by the State. **(40.7.2.46)**
- Track all provider communications, including written correspondence, telephone calls, and/or face to face meetings concerning targeted interventions. **(40.7.2.47)**
- Attend quarterly DUR Board meetings. **(40.8.2.57)**
- Apply DUR Board recommendations, such as edits and audits, limitations, and informational alerts to the POS claims processing system upon approval by the State. **(40.8.2.58)**
- Provide the State with DUR Programs Project Status Reports on a biweekly basis. **(40.8.2.59)**
- Prepare agenda and attend monthly meetings with the State, memorializing each meeting with formal minutes. Attend additional on-site meetings upon State request. **(40.8.2.60, 40.8.2.61)**
- Be available to the State for any DUR-related consultation during normal business hours. **(40.8.2.62)”**



Page D.2.1.4-14

Requirements: SOO S.2-1, SOO S.2-2

Change From: “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.”

Change To: “Team CSC relies on the extensive knowledge of our clinical pharmacy staff and input from diverse resources that include surveys from other states, the CCNC, providers and prescribers, ePrescribers, drug manufacturers, and medical and pharmacy associations.”

Page D.2.1.4-16

Requirements: SOO S.1.1-1, SOO S.2-1

Change From: “Team CSC understands the importance of the CMS Drug Rebate program to the North Carolina Medicaid Program.”

Change To: “Team CSC understands the importance of Drug Rebate programs to the North Carolina DHHS Programs.”

Page D.2.1.4-18

Requirements:

Change From: “Team CSC also has the capability to administer a supplemental Drug Rebate program for manufacturers that have entered into rebate agreements with the State of New York since the underlying Drug Rebate Subsystem is able process supplemental programs. **Thus, Team CSC will be able readily to support implementation of supplemental programs in North Carolina, if mandated by NC DHHS in the future. This capability offers the State a convenient, low-cost solution that will enable increased revenue collection.**”

Change To: “Team CSC also has the capability to administer a supplemental Drug Rebate program for manufacturers that have entered into rebate agreements with the State of New York since the underlying Drug Rebate Subsystem is able process supplemental programs. **Thus, Team CSC will support drug rebate activities for other non-Medicaid State programs. This capability offers the State a convenient, low-cost solution that will enable increased revenue collection.**”

Page D.2.1.4-19

Requirements: 40.12.2.1, 40.12.2.2

Change From: “Using the repository, Team CSC will also make available to the State the total Medicaid expenditures for multiple source drugs (annually) as well as other drugs (every three years). (40.12.2.1, 40.12.2.2)”



Change To: “Using the repository, Team CSC will also make available to the State the total expenditures for multiple source drugs (annually) as well as other drugs (every three years). (40.12.2.1, 40.12.2.2)”

Page D.2.1.4-20

Requirements: 40.12.2.2

Change From: “In addition to protection and maintenance of files used in automated processing, Team CSC’s Drug Rebate records maintained will include data such as mathematical or statistical computations, comparisons, and any other pertinent records to support pricing changes as they occur. (40.12.2.2)”

Change To: “In addition to protection and maintenance of files used in automated processing, Team CSC’s Drug Rebate records maintained will include data such as mathematical or statistical computations, comparisons, and any other pertinent records to support pricing changes as they occur by the drug rebate programs. (40.12.2.2)”

Page D.2.1.4-21

Requirements: SOO S.2-1

Change From: “Another example of automated controls is the use of master files which accurately record standing data for all labelers who provide pharmaceuticals to the North Carolina Medicaid program. One important master file used is the file of labelers authorized to participate in the Drug Rebate program, supplied each quarter by CMS. **Use of these master files helps promote accuracy, and ensures that disbursement of rebate refunds, though rare, is made only on the basis of an authorized entry in the master file.**”

Change To: “Another example of automated controls is the use of master files which accurately record standing data for all labelers who provide pharmaceuticals to the North Carolina DHHS programs. One important master file used is the file of labelers authorized to participate in the Drug Rebate program, supplied each quarter by CMS. **Use of these master files helps promote accuracy, and ensures that disbursement of rebate refunds, though rare, is made only on the basis of an authorized entry in the master file. (SOO S.2-1)**”

Page D.2.1.4-24

Requirements: 40.12.2.21, 40.12.2.20

Change From: “These staff will also be available to attend CMS-sponsored labeler dispute meetings as required by the State and based on the relevance of agenda items to be discussed. (40.12.2.20) (SOO 10.12.6-6)”

Change To: “These staff will also be available to attend CMS-sponsored and other Drug Rebate labeler dispute meetings as required by the State and based on the relevance of agenda items to be discussed. (40.12.2.20, 40.12.2.21) (SOO 10.12.6-6)”



Pages D.2-29 through D.2-30 contain confidential information.



Pages D.3-1 through D.3-110 contain confidential information.



Page E.2-1 contains confidential information.

E.3 Integrated Master Schedule

RFP Number: 30-DHHS-1228-08-R

Prepared for:
North Carolina Department of
Health and Human Services
Office of Medicaid Management
Information System Services

Prepared by:
Computer
Sciences
Corporation

5 August 2008
Supplement to 30 May 2008
Proposal Best and Final Offer
Addenda 4/5

Volume I — Technical Proposal





Pages E.3-1 through E.3-16 contain confidential information.

E.3.7 Integrated Master Schedule Entry Legend

Team CSC has developed the IMS using MS Project and have provided it in its electronic native format. We will maintain the IMS and provide monthly updates or as required throughout the life of the Replacement MMIS Contract. We have use the following Notes, Comments, Assumptions regarding the IMS apply:

- Each deliverable is given a unique CDRL number that correlates to the NC Replacement MMIS phases as follows:
 - M00XX = Program Management (PMO)
 - D00XX = Design, Development, and Installation
 - P00XX = Operations
 - T00XX = Turnover

Early Implementation has not been assigned a unique CDRL number since deliverables during that phase have been included in the operations phase as program management deliverables. Each identified CDRL is listed in our Statement of Work (SOW), Integrated Master Schedule (IMS), and Integrated Master Plan (IMP) and are provided in proposal sections D.3 SOW, E.2 IMP, and E.3 IMS. Several CDRL deliverables that are submitted more than once during DDI have been given a unique suffix to the CDRL number to identify each of the recurring documents separately. For instance, Team CSC will prepare and deliver CDRL D0008 Technical Design Document a total of 15 times, one for each of the proposed solution Builds. The assigned CDRL number is presented as D0008-01, D0008-02, D0008-03, etc. to distinguish which CDRL should be associated with each system Build. All deliverables are listed in the IMS, IMP, and SOW.

- CWBS 1.1 Project Management Deliverables start with M
- Project management plans/deliverables are only shown once for the initial submission, however, they are subject to redelivery whenever appropriate and annually at a minimum.
- Repeating Technical deliverables for DDI (i.e. each Build) have a suffix after the CDRL number containing the Build number (effects deliverables D0006-D0017)
- CWBS 1.0 DDI deliverables start with D
- CWBS 2.0 and 3.0 Operations deliverables start with P
- CWBS 4.0 Turnover Deliverables start with T
- Project Management is shown in detail only once (1.1), however, it applies to 2.0, 3.0 and 4.0.
- CWBS 1.1 Project Management detail activities are only shown for 1 year (initial year). However, they repeat annually and will be updated when the IMS is updated to reflect at least 3 months into the future.
- CWBS 4.0 Turnover detail activities are shown as starting 64 months after contract start, however, Team CSC understands that they start upon notification by the State.
- This version only shows dates for Operations out to 01/04/2013, however, once awarded and updated, these will continue through to the end of the contract.

The IMS contains the following fields:

- **Column 1: ID:** This field is a sequential field assigned automatically by MS Project. This field is used as the activity identifier for predecessors (dependencies).
- **Column 2: CWBS Number/SOW Number:** This field is the standard WBS field supplied by MS Project. Team CSC lets MS Project generate the CWBS numbers automatically within certain parameters to easily facilitate updates and changes. The CWBS number is the key code used throughout this proposal and is used to identify the SOW. Operational, system and performance requirements are also assigned to the SOW via this number.
- **Column 3: Task Name:** This field is the standard Name field supplied by MS Project. This field contains the Summary, mid-level task/activity name and the CDRL name.
- **Column 4: Duration:** This field is the standard Duration field supplied by MS Project. This field contains the duration of each activity and is used to calculate the Finish date of an activity based upon the Start Date plus Duration
- **Column 5: Start:** This field is the standard Start field supplied by MS Project. This field contains the start date of each activity based upon either the previous activity or the Dependency.
- **Column 6: Finish:** This field is the standard Finish field supplied by MS Project. This field contains the finish date of each activity based upon the start date plus duration.
- **Column 7: Dependencies:** This field is the standard Predecessor field supplied by MS Project. This field contains the ID numbers for activities that are dependent upon others.
- **Column 8: CDRL Number:** This field is the standard “Text4” field supplied by MS Project and modified by Team CSC to contain the CDRL Number. The CDRL number is used to indicate deliverables. All deliverables are considered CDRLs by Team CSC. All CDRLs have a duration of 0 days.
- **Column 9: Event or CDRL or Milestone:** This field is the standard “Milestone” field supplied by MS Project and modified by Team CSC to indicate whether the Task or activity is a Project Event or a delivery of the CDRL or a Project Milestone.
- **Column 10: Level of Effort:** This field is the standard “Number1” field supplied by MS Project and modified by Team CSC to contain the estimated level of effort in hours for detail and summary activities.
- **Column 11: DHHS:** This field is the standard “Text1” field supplied by MS Project and modified by Team CSC to contain a “DHHS” for all activities that NC DHHS will participate in. It includes:
 - Activities where Team CSC submits a deliverable;
 - Activities where NC DHHS personnel lead or perform;
 - Activities where NC DHHS personnel review deliverables;
 - Activities where NC DHHS personnel approve deliverables;

- Activities where NC DHHS personnel participate such as BSD sessions and workshops; and
- Any activities of which NC DHHS personnel should be aware.
- **Gantt Chart:** This section of the chart shows Summary Rollups and detail tasks in accordance with the standard MS Project reporting. It also contains start and end dates for all detail activities. It shows CDRLs as diamonds with due dates.

No other fields are used at this time. NC DHHS should focus on these described and displayed fields. Hidden fields in the electronic version of this MS Project schedule should not be opened. They will be used by Team CSC as needed to be responsive to special information requests from the State.

E.3.8 Summary

In summary, the Team CSC IMS represents the output of the application of best estimating and planning practices, to provide the State with a realistic schedule that Team CSC can accelerate or decelerate working in partnership with the State to meet State priorities, opportunities and constraints while still satisfying the operational needs of all DHHS MMIS Stakeholders.



Pages E.3-20 through E.3-169 contain confidential information.



Pages E.5-1 through E.5-8/9 contain confidential information.



Pages E.8-1 through E.8-8 contain confidential information.



Pages G-1 through G-3 contain confidential information.



Pages J.1-1 through J.1-2 contain confidential information.



Pages K-1 through K-160 contain confidential information.