Statement of Confidentiality

Some of the descriptive materials and related information in this proposal contain information that is considered proprietary, trade secret, or confidential to EDS. Following the guidance of RFP 30-DHHS-1228-08-R Section 30.27 Confidentiality Related to Competitive Bidding Process and Post-Award Vendor Business Records, we have identified the information that we consider proprietary, trade secret, or confidential by marking the top and bottom of each page containing such information **CONFIDENTIAL**. This information is submitted for use by the State of North Carolina Department of Health and Human Services (the State) and its designees with the express understanding that it will be held in strict confidence and will not be disclosed, duplicated, or used, in whole or in part, for any purpose other than evaluation of this proposal or otherwise in connection with the resulting contract. The release, use, or distribution of this information to organizations outside the State would subject EDS to harm and the loss of competitive advantage.

Table of Contents

Section A—Transmittal Letter and Execution Page

RFP Reference: RFP Addendum 4 – North Carolina Replacement MMIS Updated Requirements

In compliance with Addendum 4 of the RFP, the following section contains the Transmittal Letter and Execution Page (updated by RFP Addendum 6) for this Technical Proposal Supplement.

August 5, 2008

Ms. Susan W. Lewis
Department of Health and Human Services
DHHS Procurement and Contracting
801 Ruggles Drive, Hoey Building
Raleigh, NC 27603-2001

RE: Bid Number 30-DHHS-1228-08-R

Dear Ms. Lewis:

EDS is pleased to submit our Technical Proposal Supplement in response to RFP Addendum 4 – North Carolina Replacement MMIS Updated Requirements and RFP Addendum 5 – North Carolina Replacement MMIS Questions and Answers. In accordance with these addenda, we provide the following information.

1. Itemization of all materials and enclosures forwarded in response to RFP Addenda 4 and 5:

- Two (2) certified signed originals of the Technical Proposal Supplement
- Thirty (30) electronic copies of the Technical Proposal Supplement, each on a separate CD, including an electronic copy of our Oral Presentation Slide Deck from February

2. Listing of all addenda

We acknowledge receipt of RFP 30-DHHS-1228-08-R Addendum 4 on 7/7/08, Addendum 5 on 7/21/08, and Addendum 6 on 7/22/08.

3. A statement confirming that the Offeror has read, understands, and agrees to all the provisions of the RFP, without qualification, including the addenda

EDS has read, understands, and agrees to all the provisions of the RFP without qualification, including any and all addenda.

10. A statement identifying any and all subcontractors

Health Information Designs (HID) will perform the Retrospective Drug Utilization Review (Retro-DUR) function. HID will provide the technology and the processing support for Retro-DUR.

SunGard will perform data capture, Optical Character Recognition/Intelligent Character Recognition (OCR/ICR), and data correction.

14. Completed and signed Execution Page (Page 1 of 3 of RFP Cover Page)

The completed and signed Execution Page follows this Transmittal Letter.

15. A statement that the offer is valid for a minimum of 330 days from the proposal's submission date

EDS' offer will remain valid for 330 days from the proposal's submission date.

Thank you for the opportunity to continue our long-standing relationship with North Carolina. I speak for the entire Raleigh-based EDS team and the newest members of our proposed team when I say we would be proud to continue serving the State of North Carolina. If you have questions regarding our proposal, please contact me or my representative, John Fortuna.

We look forward to working closely with you in this endeavor.

Sincerely,

Barbara Anderson

Vice President, EDS Government Health & Human Services

Kara L. Moore
Signature Notary Public

July 30th, 2008
Date

Kara L. Moore
Commission Expires 10-27-2010
Notary Public-State at Large, KY

STATE OF NORTH CAROLINA **Department of Health and Human Services** DHHS Office of Procurement and Contracts	**REQUEST FOR PROPOSAL NO. 30-DHHS-1228-08-R** Technical Proposal Supplement Due Date and Time: 2:00 p.m. ET, August 5, 2008 Contract Type: Agency Specific
Refer ALL Inquiries to: Susan Lewis Telephone No. 919-855-4086	Date RFP Issued: July 7, 2008 Commodity: 920-Data Processing Services and Software North Carolina Replacement Medicaid Management Information System
E-Mail: Susan.Lewis@ncmail.net	Using Agency Name: Department of Health and Human Services
(See page 2 for delivery instructions.)	Agency Requisition No. N/A

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

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

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

VENDOR: Electronic Data Systems Corporation		FEDERAL ID OR SOCIAL SECURITY NO. 75-2548221	
STREET ADDRESS: 5400 Legacy Drive		P.O. BOX:	ZIP:
CITY & STATE & ZIP: Plano, TX 75024		TELEPHONE NUMBER: 972 605 6000	TOLL FREE TEL. NO 1 800 566 9337
Will any work under this contract be performed outside the United States? Where will services be performed: _____		YES_____	NO___X___
TYPE OR PRINT NAME & TITLE OF PERSON SIGNING: Barbara Anderson Vice President, EDS Government Health and Human Services		FAX NUMBER: 972 605 9951	
AUTHORIZED SIGNATURE:	DATE: August 5, 2008	E-MAIL: barbara.anderson@eds.com	

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

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

FOR NC DHHS USE ONLY

Offer accepted and contract awarded this ____ day of _____, 20_____, as indicated on attached certification,

by _____ (Authorized representative of NC DHHS).

Section C—Executive Summary

RFP Reference: RFP Addendum 4 – North Carolina Replacement MMIS Updated Requirements

"When you're finished changing, you're finished." —*Benjamin Franklin*

The State of North Carolina (the State) has taken another step forward in responding to the challenge of delivering superior healthcare to a diverse state population efficiently and cost-effectively. The Addendum Statement of Objectives (7/21/08) outlines the changes to the Replacement MMIS requirements in two major areas:

- Adding the following benefit programs to the multi-payer system: North Carolina Health Choice (NCHC), including Kids' Care; Medicaid Community Alternatives Programs for Mental Retardation or Developmental Disabilities and for Children (CAP-MR/DD and CAP-C); and Health Coverage for Workers with Disabilities (HCWD)
- Assuming the Retrospective Drug Utilization Review (Retro-DUR) responsibilities shortly after the contract award date

As our response to RFP Addenda 4 and 5, this Technical Proposal Supplement demonstrates the versatility of the Replacement MMIS' common, unified, and flexible multi-payer functionality. The interChange design easily incorporated the additional programs identified in the Addendum Statement of Objectives while maintaining the 30-month DDI time frame that was identified in the BAFO.

DDI Changes

interChange is designed to accommodate multiple programs, business functions, and benefit package processing. Additional healthcare programs require additional data transfer and conversion; because this data resides in multiple systems, the complexity of the conversion is increased. To avoid disruption in access and quality of healthcare for recipients and claims processing for providers, we will implement and configure the multi-payer interChange MMIS for the added populations, benefit plans, and reimbursement rules.

interChange's design will easily accommodate the State healthcare programs identified in Addendum 4. We will make some changes to the solution described in our Technical Proposal BAFO to support the additional programs. We have identified five major changes: **(1) Adding data conversions—**The health programs require additional data transfer and conversion, and because this data resides in multiple systems, the complexity of the conversion is increased;

(2) Processing recipient claims—Our Supplement response describes the system and business processes we have designed to support payment to recipients; **(3) Meeting expanded premium payment requirements—**We are bidding the interChange Premium Billing and Collections capability, which will allow recipients to use a wide variety of options (cash, check, money order, and credit/debit cards) to pay their premiums; **(4) Assuming Retro-DUR operations—**While Addendum 4 made Retro-DUR a requirement, we proposed Retro-DUR as one of our early implementation recommendations in our original proposal, so we had already done the research and planning and easily moved it into the implementation work pattern; **(5) Expanding operations teams to support increased recipient activity and program volumes—**We expanded the operations teams in many areas, with a larger impact to recipient contact center activities, prior approval/claims, and financial dispositions.

Outside of these major changes, other work associated with Addenda 4 and 5 was incorporated into existing work streams that had already been developed for the technical and operational solutions described in the Technical Proposal BAFO.

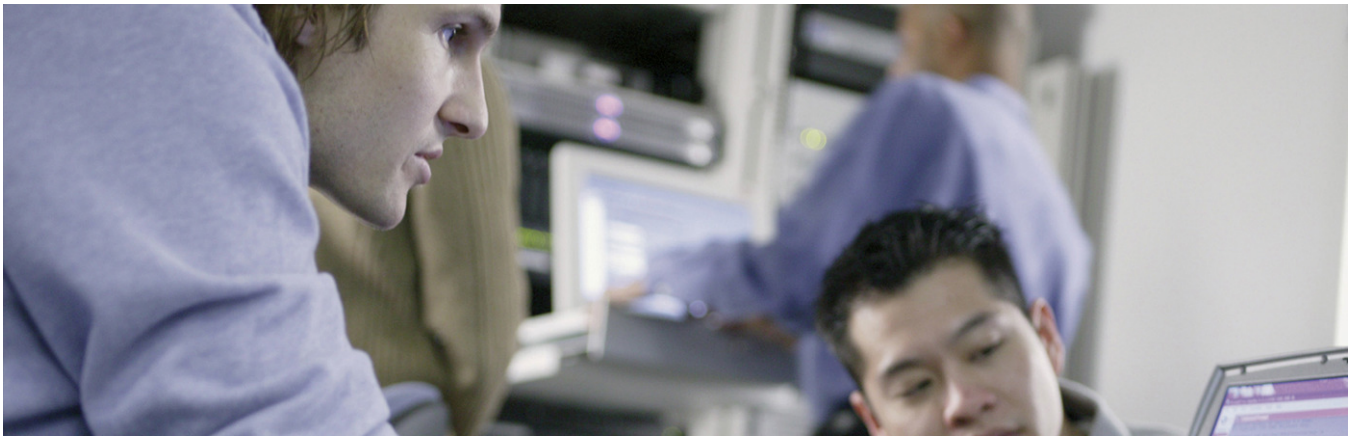
Operations Changes

To support the growing recipient-centric healthcare programs, EDS will accomplish the following:

- Implement interChange Premium Billing and Collections capability to provide premium billing and collections services and incorporate EDS*PAY and EDS OpenBill Express application services for online payment and online secure access
- Respond to recipient issues or questions by telephone or in writing, using the CTMS and Web portal, through our Recipient Services team
- Manage recipient ID card and Benefit Plan Booklet distribution
- Process recipient-submitted claims
- Process pre-admission certification requests
- Implement Retro-DUR operations by teaming with Health Information Designs, Inc. (HID)

Through our understanding of the existing MMIS data and HID's 32 years of experience in more than 25 states, we will implement RxExplorer, HID's flexible reporting tool for pharmacy services, within the first 60 days of the contract.

We look forward to demonstrating the flexibility and user-configurability of the Replacement MMIS' multi-payer environment to the State. By incorporating system and operational modifications to meet enhanced performance standards, EDS will continue to support the State to serve recipients and providers in changing times.



Section D—Proposed Solution Details

RFP Reference: RFP Addendum 4 – North Carolina Replacement MMIS Updated Requirements

In compliance with the requirements of RFP Addendum 4 – North Carolina Replacement MMIS Updated Requirements, this section of our Technical Proposal Supplement contains the following items:

- Changes to Overview of System Solution and Solution for DDI
- Addendum State Requirements Matrix
- Addendum SOO Requirements Matrix
- Changes to Adjusted Function Point Count
- Changes to Proposed Solution for Operations
- Changes to Statement of Work

Our Best And Final Offer (BAFO) proposal continually refers to our ability to serve the needs of the North Carolina Division of Medical Assistance (DMA), Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH), Division of Public Health (DPH), and the Migrant Health Program in the Office of Rural Health and Community Care (ORHCC), as required by the original and revised RFPs. In addition to these programs, RFP Addendum 4 added the following benefit programs to the multi-payer system: North Carolina Health Choice (NCHC), including Kid's Care; Medicaid Community Alternatives Program for Persons with Mental Retardation or Developmental Disabilities and (CAP-MR/DD) and Medicaid Community Alternatives Program for Children (CAP-C) where families pay part of the cost of services; and Health Coverage for Workers with Disabilities (HCWD), a Medicaid program under Ticket to Work-Work Incentives Improvement Act

(TWWIIA). As a general convention, most references to the original four programs should also include references to the additional programs required by Addendum 4. Therefore, please consider our references to the four State divisions to also include the additional required programs, where applicable.

Similarly, we proposed a Retro-DUR solution as part of our early implementation activities, and we referred to it throughout our BAFO proposal as such. Please consider our references to the Retro-DUR solution as a required early implementation instead of an optional early implementation.

The following table, EDS Compliance With RFP Addendum 5 Page Limitations, demonstrates that we have complied with the required page limitations of this section:

EDS Compliance With RFP Addendum 5 Page Limitations

Proposal Section	Page Range	Number of Pages	RFP Page Limit	EDS Complies
Changes to Overview of System Solution and Solution for DDI	S—D-3 to S—D-52	50	50	Yes
Addendum State Requirements Matrix	N/A	N/A	N/A	Yes
Addendum SOO Requirements Matrix	N/A	N/A	N/A	Yes
Changes to Adjusted Function Point Count	N/A	N/A	N/A	Yes
Changes to Proposed Solution for Operations	S—D-59 to S—D-88	30	30	Yes
Changes to Statement of Work	N/A	N/A	N/A	Yes

Changes to Overview of System Solution and Solution for DDI

Following the guidance provided by the State in RFP Addendum 4 and Addendum Questions and Answers, July 21, 2008, this section presents changes to Technical Proposal BAFO section 50.2.4.1.1 Overview of System Solution and Solution for DDI in the following manner:

- We provide "pointers," in boldface text, that reference the area of the BAFO proposal that is changed by the Supplement.
- We provide the affected sections "in-line"—meaning in context-appropriate locations—by including the original headings, introductory language, or surrounding paragraphs, where applicable.
- For all changes, we clearly identify the original text that was removed and the new text that was added by marking the deletions in red stricken text and the additions in blue underlined text.

Technical Proposal BAFO page D-3:

The multi-payer Medicaid Management Information System (MMIS) described in the RFP will present a unified positive shift in the way work is performed by the North Carolina Division of Medical Assistance (DMA), Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH), Division of Public Health (DPH), and the Migrant Health Program in the Office of Rural Health and Community Care (ORHCC). The Replacement MMIS will support these divisions and will 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.

Technical Proposal BAFO page D-29:

Response to Multi-Payer Requirements

The following table, EDS Response to Multi-Payer Requirements, describes how we will meet the requirements set forth in the RFP. Where appropriate, we have listed the existing interChange user interface panels, reports, and processes that meet the stated requirements. We also have identified when an integrated COTS piece of software is used to meet the requirements.

EDS Response to Multi-Payer Requirements

RFP No.	RFP Requirement	EDS Response
40.1.1.1	Provides capability in a Replacement MMIS ~~to provide~~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	Met by interChange. interChange supports processing for both Title XIX and Title XXI within configuration of its benefit plan structure. Configuration activity includes the configuration of the benefit populations, the covered benefit plans, and the reimbursement rules where the populations, covered benefits, and provider contracts come together in the interChange Benefit Plan Administration (BPA) module. When processing services, interChange determines recipient eligibility from the claim submitted and the recipient and provider data on file. interChange also uses a benefit plan hierarchy table to determine the payer and coordinate benefits if the recipient is eligible for multiple benefit plans and more than one benefit plan covers the service details provided. Within the interChange BPA component, the recipient plan, provider contract, and the reimbursement agreements interact and allow the State to use different pricing methodology for the same service depending on the recipient and provider data on the claim. Each claim detail is processed independently, enabling multi-payer capability across the claim. To enable the interrelationships of the BPA processing, interChange has many online panels where business analysts define and configure the relationships, including the Health Program panel, Provider Contract panel, and Reimbursement Agreement Panel. These panels form the foundation that enables interChange MMIS to have a single system administer the claims of multiple healthcare programs for North Carolina.

Technical Proposal BAFO page D-176, added after table:

Recipient System Requirements

The following table, EDS Response to Recipient System Requirements, describes how we will meet the requirements set forth in RFP Addendum 4.

EDS Response to Recipient System Requirements

RFP No.	RFP Requirement	EDS Response
40.2.1.124 (New)	Provides capability to produce NCHC original and replacement recipient identification cards	Met by interChange, with a portion of the requirement requiring customization code. interChange produces original and replacement ID card extract files containing recipient

RFP No.	RFP Requirement	EDS Response
		information, including name and ID number. The ID card meets ANSI standards and does not contain eligibility information. The ID card file is then securely transmitted to the vendor, who physically creates and mails the card to the recipients. The Recipient ID Cards panel is used to view and verify ID card issuance for a recipient and allows the user to request a new ID card for the recipient. It also includes the reason for reissue. The Web portal will be updated to allow recipients to request an ID card directly. Another new feature will be the automatic issuance of new ID cards annually to all NCHC and Kids Care recipients. ID cards will be in English only. As part of the implementation, new cards will be issued to all eligible NCHC beneficiaries to reflect the new information, including the Bank ID Number (BIN) and contact information. Additionally, like the current process, the recipient ID cards generated through the Replacement MMIS will identify the different co-payment amount depending on the qualifications of the recipient.
40.2.1.125 (New)	Provides capability to produce NCHC original and replacement recipient benefit booklets	Met through customization of interChange. The NCHC Handbook will be sent to recipients upon their enrollment into the program. If multiple family recipients are enrolled at the same time, only one booklet will be sent to the family. The Emergency Respite Care and Information for Children with Special Healthcare Needs and Their Families will only be sent when requested. The Web portal will be updated to allow a recipient to request a copy of the booklet be sent to his or her home or to directly download the booklets from the Web. The interChange recipient panels also will be updated to allow a service representative to order a booklet on behalf of a recipient. The content of these booklets will be static, containing general plan descriptions, and will be created by EDS with final approval by the State. The booklets will be printed in black and white. As part of implementation, each NCHC family that is converted will receive an updated plan booklet, giving them the details regarding new contact numbers.

Technical Proposal BAFO page D-176:

RFP No.	RFP Requirement	EDS Response
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	Met through customization of interChange. A change will be made to the Eligibility Verification panel to display the reference number. interChange will create and store the reference number whenever an EVS eligibility inquiry is made. All eligibility verification mechanisms provide the reference number only to providers making DMA/Medicaid and/or NCHC eligibility queries through EVS. The EVS system "speaks" the EVS reference number to the provider along with the eligibility information. The EVS transaction stored includes the dates and program that the recipient is eligible for based on the inquiry. This verification number, processing time, and results are available through the Eligibility Verification panel within the recipient functional area.

Technical Proposal BAFO page D-181:

40.4.1 AVRS System Requirements

Making information easily available to providers and recipients is a critical facet of any healthcare service system, and much of it can be automated. An Automated Voice Response System (AVRS) allows callers to gain immediate access to information without requiring human operator contact. The interChange AVRS gives providers multiple inquiry choices to verify eligibility, check the status of a claim, and much more. Recipients are able to inquire on eligibility, managed care enrollment, third-party liability, Medicaid and NCHC, Medicare coverage, NCHC cost-sharing information, well child checkup dates, and hospice eligibility. These services are available to providers and recipients — 24 hours a day, 7 days a week, except for agreed downtime for maintenance.

Technical Proposal BAFO page D-182:

Approach to Customization and Modifications

Most of the AVRS requests for data will depend on information retrieved in real time from the Replacement MMIS. Almost every AVRS request handler will require at least some customization of interChange. NCHC call flows that include cost sharing information will be either new call flows or updates to the Medicaid call flows, depending on the requirement. This new NCHC

information, such as cost sharing data request, will require the DDI team to create the associated data services to accept the request, then pull the requested data from the interChange database and pass the results to the AVRS for relaying to the requestor.

With the addition of the NCHC, Kids' Care, Ticket To Work, CAP-MR/DD, and CAP-C programs and the associated additional recipient stakeholders and services, the AVRS has been scaled up to accommodate the increased call traffic, as follows:

- An additional T1 communication line to expand the simultaneous call volume
- Added capacity for the PBX through 16 additional telephones for the call center agents
- Increased number of trunk lines coming into the building

These modifications scale the base leveraged AVRS solution to accommodate the anticipated call volumes in support of the additional healthcare programs that fall within the Statement of Objectives for the Replacement MMIS.

Technical Proposal BAFO page D-183:

General AVRS System Requirements

The following table, EDS Response to General AVRS System Requirements, describes how we will meet the requirements set forth in the RFP.

EDS Response to General AVRS System Requirements

RFP No.	RFP Requirement	EDS Response
40.4.1.12	Provides capability to process inquiries made by Medicaid and NCHC recipients entering the recipient's ~~Medicaid~~ ID number, DOB, and SSN	Met through customization of interChange. A submenu will be provided for the caller to specify the ~~M~~ recipient ID or SSN and DOB to make an eligibility inquiry.
40.4.1.22	Provides capability for call flows for the following provider inquiry types: • Claim status • Checkwrite • Drug coverage • Procedure code pricing • Modifier verification • Procedure code and modifier combination • Procedure code pricing for Medicaid Community	Met through configuration of interChange parameters and features. Items new to AVRS are PA for DPH benefits, referrals, and Medicaid and NCHC Carolina ACCESS Emergency Authorization Overrides. Also, the existing inquiry capabilities for Medicaid will be expanded to include those items noted as NCHC, namely: • NCHC dental benefit limitations • NCHC refraction and eyeglass benefits • NCHC prior approval for durable medical equipment (DME), orthotics, and prosthetics

RFP No.	RFP Requirement	EDS Response
	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	• NCHC service limits These call flows will be addressed and included in the AVRS solution.
40.4.1.24	Provides capability for call flows for responses for the following Medicaid recipient inquiry types: • Medicaid eligibility • Managed care enrollment information, including the primary care provider name, address, and daytime and after-hours phone numbers • Third party liability • Medicare coverage • Well child checkup dates • Hospice eligibility • Cost sharing, such as premium payments, deductibles, co-payments, and balances	Met through customization of interChange. Providers and recipients will call in to obtain eligibility and enrollment information or hospice eligibility. During the eligibility call flow, besides a basic ~~Medicaid~~ NC Healthcare eligibility indication, additional TPL, transfer of assets, Medicare coverage, and well child checkup dates will be given. Hospice eligibility will have its own call flow and submenu for requests. On the enrollment call flow, the PCP name, address, and daytime and evening telephone numbers will be repeated back to the caller. The recipient call flow will be expanded to include cost sharing, such as premium payments, deductibles, co-payments, and balances. A new data services component will be created that allows access to this data from the AVR system, the Web portal, and the interChange panels. ~~Hospice eligibility will have its own call flow and submenu for requests.~~
40.4.1.26	Provides capability to return a reference number to a provider for DMA/Medicaid and NCHC eligibility verification inquiry and responses issued from the AVRS	Met through customization of interChange. interChange will create and store the reference number. All eligibility verification mechanisms provide the reference number only to providers making DMA/Medicaid and NCHC eligibility queries through the AVRS. Authorized users can access the AVRS response and reference number through the Eligibility Verification panel.
40.4.1.38 (New)	Provides capability to support call flows for responses for the following NCHC recipient inquiry types:	Met through customization of interChange. The recipient call flow inquiry types will include the following:

RFP No.	RFP Requirement	EDS Response
	• 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	• NCHC eligibility • Managed care enrollment information, including the primary care provider name, address, and daytime and after-hours telephone numbers • Third Party Liability • Cost sharing, such as premium payments, co-payments, deductibles and deductible balances and out-of-pocket thresholds A new data services component will be created that allows access to the cost sharing data from the AVR system, the Web portal, and the interChange panels.

Technical Proposal BAFO page D-183:

Web Inquiry Requirements

The following table, EDS Response to Web Inquiry Requirements, describes how we will meet the requirements set forth in the RFP. The Web portal will be updated to include the NCHC data that will allow a recipient to inquire on his or her information.

EDS Response to Web Inquiry Requirements

RFP No.	RFP Requirement	EDS Response
40.4.1.29	Provides capability to return a reference number to a provider for ~~any~~ DMA/Medicaid and NCHC eligibility verification inquiry and responses issued from the Web	Met through customization of interChange. interChange will create and store the reference number. All eligibility verification mechanisms provide the reference number only to providers making DMA/Medicaid and NCHC eligibility queries through the Web. Authorized users can access the AVRS response and reference number through the Eligibility Verification panel. The eligibility reference data stored includes the device type used to initiate the query—Web, telephone, POS—as well as the date and time of the inquiry and the resulting eligibility information and dates.
40.4.1.39 (New)	Provides capability for NC Health Choice recipient access to recipient eligibility and enrollment information, including but not limited to: • NCHC eligibility • Managed care enrollment information to include the primary care provider name, address, and daytime	Met through customization of interChange. The Web portal will be updated to include the following: • NCHC eligibility • Managed care enrollment information to include the primary care provider name, address, and daytime and after-hours telephone numbers

RFP No.		RFP Requirement	EDS Response
		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	• Third Party Liability • Cost sharing, such as premium payments, co-payments, deductibles and deductible balances and out-of-pocket thresholds A new data services component will be created that allows access to this data from the AVR system, the Web portal, and the interChange panels. ~~While the Replacement MMIS will store pertinent primary care provider data, the NCHC recipients do not fall under the guidelines of capitated managed care; therefore, there is no customization required to treat these recipients as managed care recipients.~~

Technical Proposal BAFO page D-230:

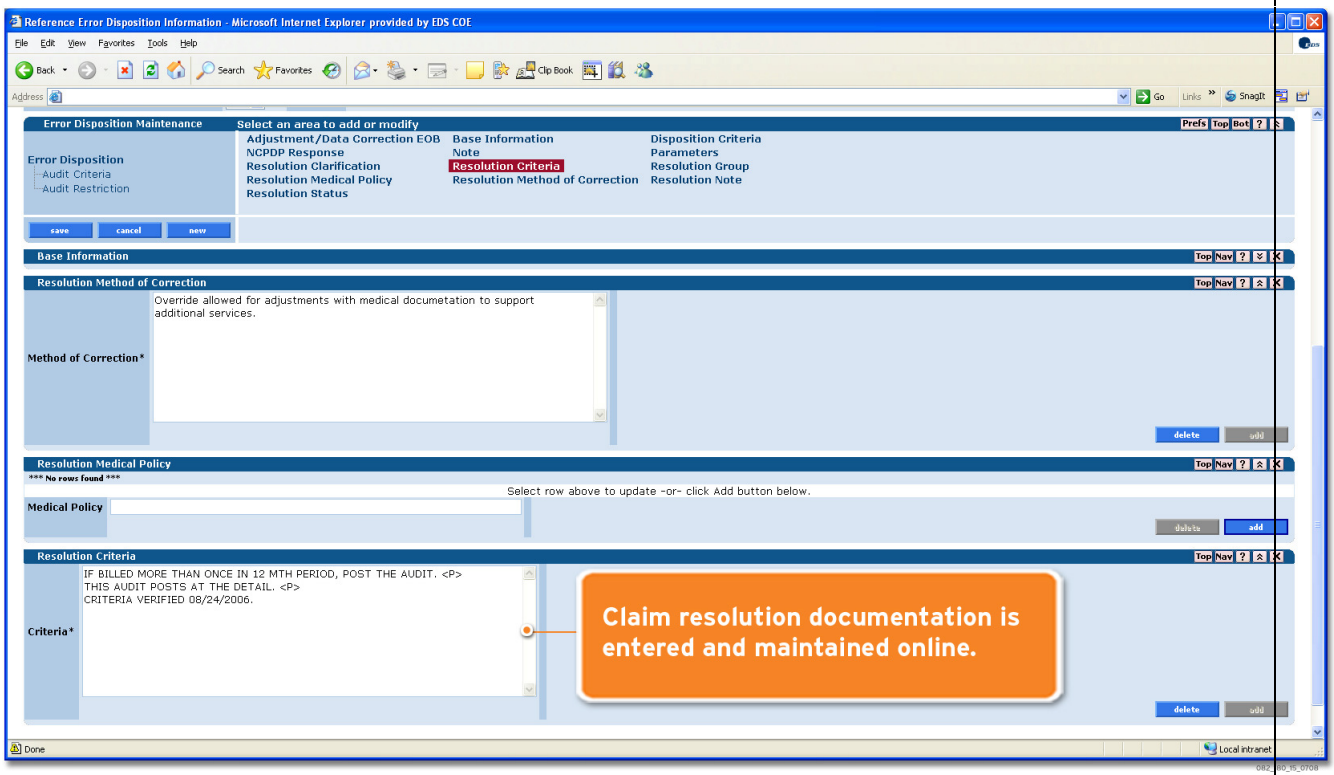
The reference function will orchestrate the information required for accurate claims processing, whether that information is maintained under BA, code sets, or edits and audits. Updates are applied in real time, without the need for technical resources. This means that the State can focus its resources and time on the right policy development, knowing the Replacement MMIS powered by interChange can quickly handle the resulting changes.

Claims Resolution

The Replacement MMIS includes the ability to maintain claims resolution material online and have that information automatically update the online documentation presented in iTRACE, thus reducing the long-term documentation maintenance costs and increasing the timing of documentation updates through the real-time update capabilities.

The following exhibit, Reference Error Disposition Information, demonstrates the Resolution Method of Correction, Criteria, and Medical Policy panels.

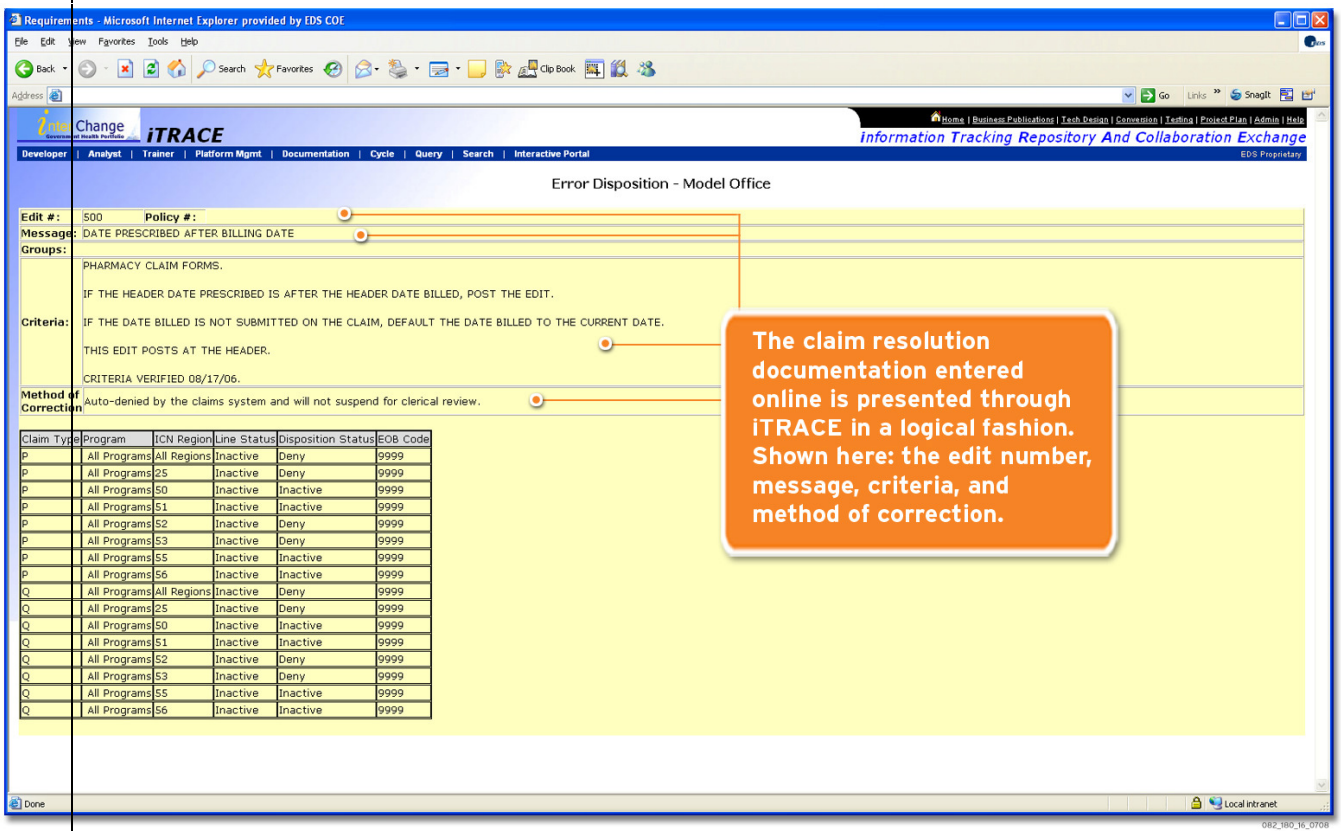
Reference Error Disposition Information



Claims resolution material can be maintained online.

Data that is entered through the online panels is automatically pulled into the iTRACE Claims Resolution documentation presented in iTRACE, as shown in the following exhibit, iTRACE Claims Resolution Page.

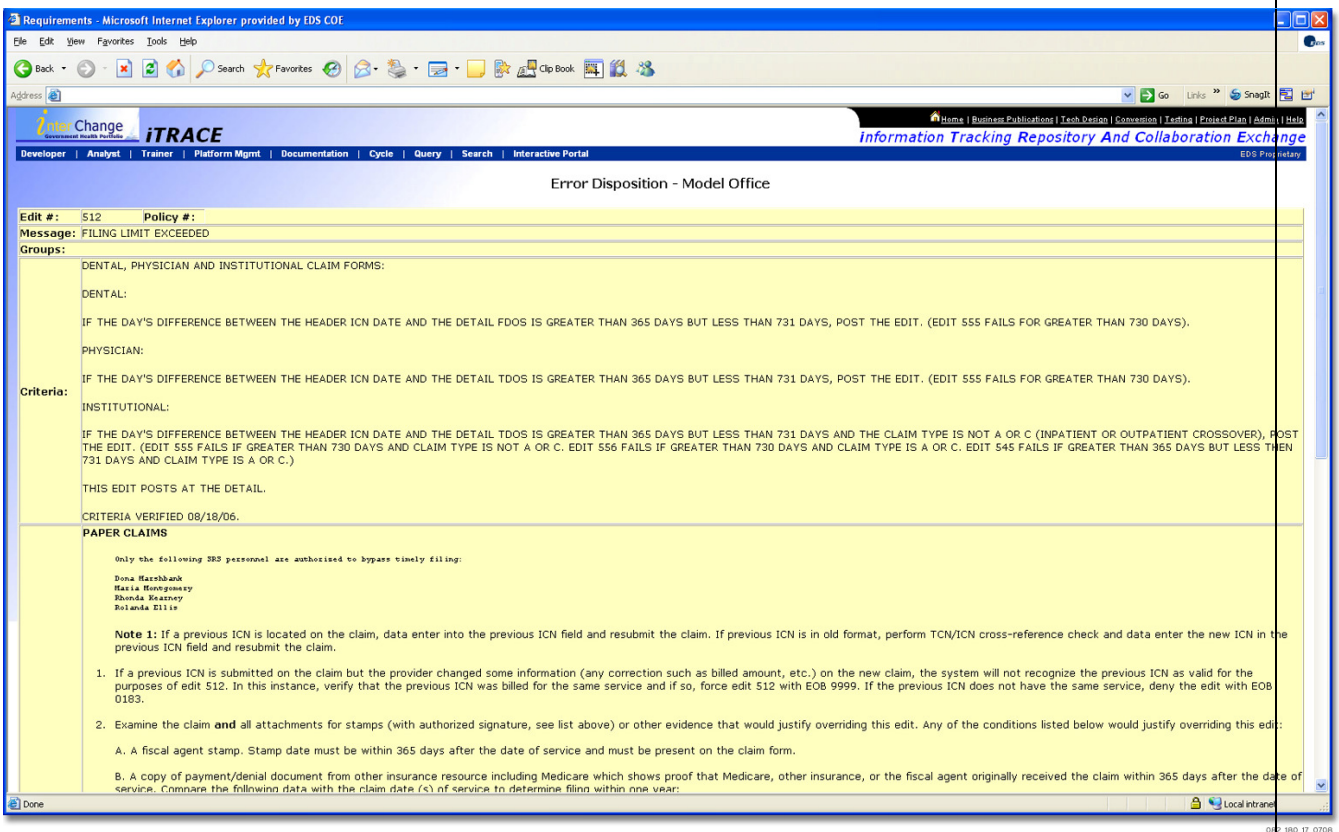
iTRACE Claims Resolution Page



Claims resolution information is automatically updated in iTRACE's documentation.

The following exhibit, iTRACE Claims Resolution Documentation, is an example of the timely filing claims resolution documentation maintained online and presented through iTRACE.

iTRACE Claims Resolution Documentation



Error disposition information and criteria can be viewed in iTRACE.

Technical Proposal BAFO page D-231:

For any MMIS implementation, the task of translating the legacy reference data into the interChange reference data should not be underestimated. Policy and reference experts from EDS and the State will need to work together to translate and develop the conversion and translation rules needed to populate the reference data in the Replacement MMIS. The EDS team will use our policy transition business practices to guide the process of collecting the policy from the existing disparate systems and configuring interChange with the required policy. The ability to use these proven DDI process is one of the most important aspects of the implementation. The critical success of the multi-payer project is directly dependent on the policy configuration. EDS has successfully transitioned policy into interChange over the past five years.

The approach to customization and configuration of the Replacement MMIS is through EDS business analysts working with the State representatives to define, then configure the benefit plans using the interChange Benefit Plan Administration panels.

The additional configuration work required by the addition of new programs in the Replacement MMIS parallels the same work patterns used for the original four programs defined in the RFP.

Due to the additional health programs in RFP Addendum 4, EDS' approach includes additional business analysts to focus on these programs and their associated policies requiring configuration.

Technical Proposal BAFO page D-235:

RFP No.	RFP Requirement	EDS Response
40.6.1.23 (Revised 7/21/08)	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: • 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: – Recipient eligibility – Pricing Action Code – Category of service	This requirement was changed by Appendix 50, Attachment C, Exhibit 1: Addendum State Requirements Matrix, Updated July 7, 2008. The requirement was reverted back to its original language by Appendix 50, Attachment C, Exhibit 1: Addendum State Requirements Matrix, Updated July 21, 2008. We therefore present no changes to our response to this requirement. Met through configuration of interChange parameters and features. interChange meets the functional requirements of storing and accessing the data including a seven-character diagnosis for ICD-10 and a six-character procedure code. The reference diagnosis, DRG, drug, drug labeler, error disposition, modifier, procedure, revenue, benefit administration, and related data Web panels and pages provide access to the basic configuration of these code sets. Pricing data is accessible through the benefit administration subpanels. Nearly all of the pricing tables are configurable by a rate type that is associated to one or more reimbursement agreements. This allows for multiple prices to be configured for each pricing methodology. Nearly all of the stated features are enabled through interChange, but the relational database storage methodology is significantly different than the current MMIS. Because interChange is designed to support multiple programs and multiple payers, the majority of the reference configurability is related to rules associated through those programs.

RFP No.	RFP Requirement	EDS Response
	– 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 – 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	

RFP No.	RFP Requirement	EDS Response
40.6.1.43	Provides capability to apply State-approved policy to: • HCPCS, including CPT, American Dental Association (ADA) codes, HCPCS Level II codes, NDCs, State local codes, International Classification of Diseases diagnosis and procedure codes (ICD-9) and future ICD codes • Drug codes • Edits • Rate methodology and calculations • Professional services fees • NCHC-specific services	Met by interChange and through configuration of interChange parameters and features. The base system provides the information panels within reference as a single point to maintain the entities listed for this functional requirement. The specific panels are the Health Program panel defining which program a recipient is eligible for, the Provider Contract panel defining what services a provider is able to perform, and the Reimbursement Agreement panel defining for the provider and recipient combination what reimbursement rule should apply. The Benefits Classification panel also defines parameters within the BPA module. Policy is configured through the rule authoring pages and the editing and auditing pages. Pricing methodologies can be configured to meet state policy using the available data and panels in interChange. For the services specific to NCHC processing, the process of configuration is performed in the same manner as the other health programs, where the standard healthcare code sets, such as HCPCS, ICD-9, and NDC codes, are updated based on standard update files received from CMS or FDB. This keeps the set of available values in compliance with HIPAA processing requirements.
40.6.1.89	Provides capability to create Fee Schedule reports detailed in the bullets below: • Adult Care Home Personal Care • Ambulance • Ambulatory Surgical Centers/Birthing Centers • Behavioral Health (separate schedules) • Certified Clinical Supervisor and Addictions Specialist • Children's Developmental Service Agencies • Licensed Clinical Social Worker and Licensed Professional Counselor and 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	Met through customization of interChange. The base system provides features within the Provider Web Portal to query fee schedule data from reimbursement rules. The Web Portal Publications panel is where the information can be located. This is a central location where static content is published and available for downloading as needed by providers and recipients. Searches can be performed by financial payer, provider contract, benefit group, or procedure for a given date of service (DOS).

RFP No.	RFP Requirement	EDS Response
	• 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 • NCHC services	
40.6.1.94 (New)	Provides capability to create NC Title XXI Tables Manual and edit resolution documents	Met through configuration of interChange parameters and features. In a unified multi-payer system, reference data for the NC Title XXI programs will be included in the interChange database schema. The NCHC benefit plan edits and edit dispositions will be configured specifically to meet the plan components. The NC Title XXI Tables Manual and the edit resolution documentation will be available as part of the Replacement MMIS Tables Manual and edit resolution documentation. The edit resolution documentation is maintained through a

RFP No.	RFP Requirement	EDS Response
		series of panels in the reference section of interChange. An example of the maintenance panel and subsequent iTRACE resolution documentation is in section 40.6.1 Reference System Requirements. The specific panels used to maintain this information are the Resolution Method of Correction panel, Resolution Status panel, Resolution Criteria panel, and Resolution Medical Policy panel. Additionally, free-form text can be added to explain why certain updates or steps were added through the Resolution Note panel.
40.6.1.95 (Deleted 7/21/08)	~~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~~	Cancelled. This requirement was deleted by Appendix 50, Attachment C, Exhibit 1: Addendum State Requirements Matrix, Updated July 21, 2008.

Technical Proposal BAFO page D-265:

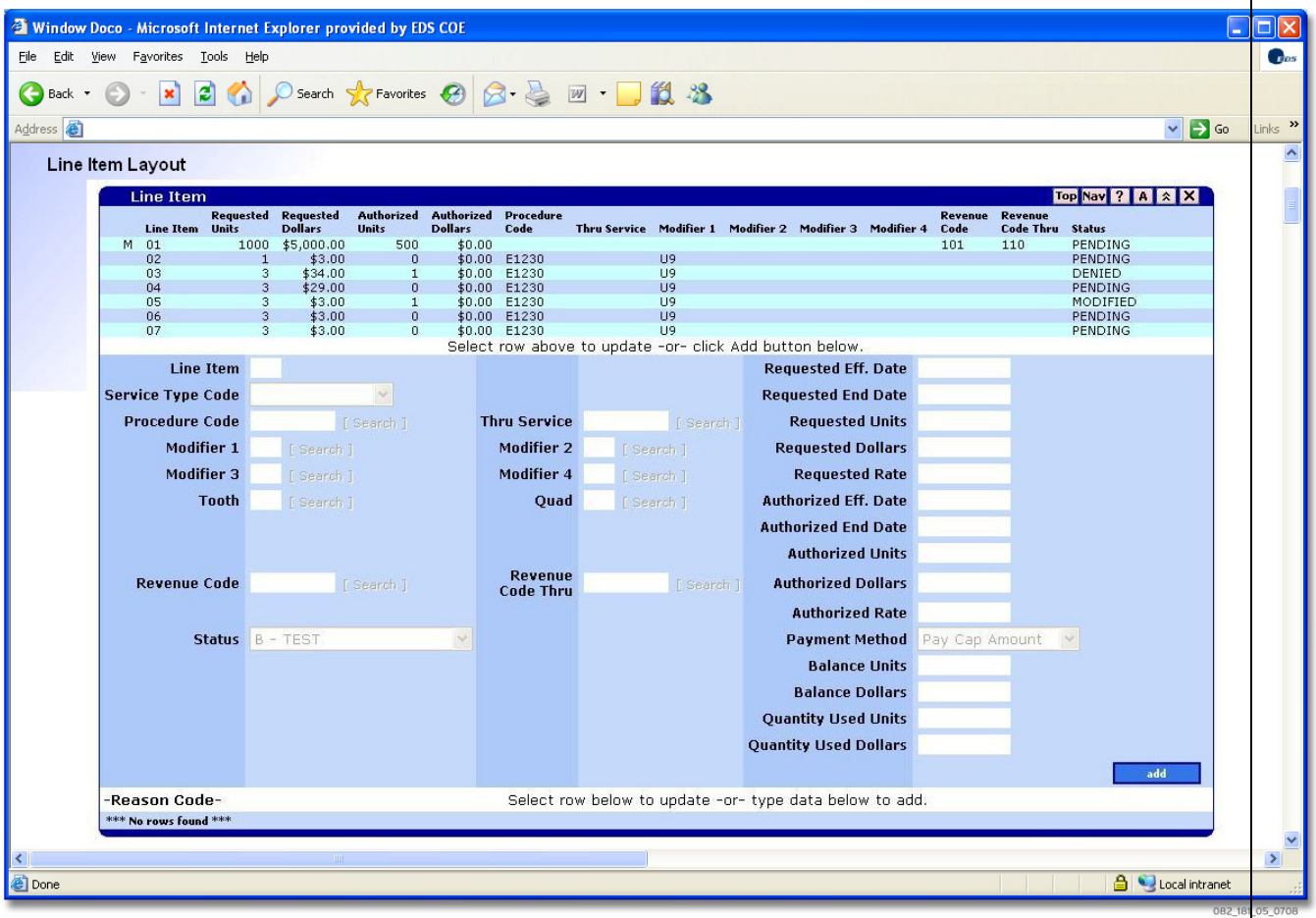
Using the proposed EDS solution, PA, override, and referral request forms will be imaged and made available for viewing in the Replacement MMIS. These imaged files, including notes or even scans of medical photographs, will be accessible by hypertext link from the PA pages. To maintain proactive control over PA receipt, each page of the request will be imaged on receipt in the mail room, and the electronic image will be routed through the electronic workflow process to the appropriate staff.

The overall approach to meeting the pre-admission certification is to extend the existing interChange MMIS PA module and make the required customizations to meet the specific needs of these requests.

The EDS DDI team intends to employ the inRule COTS rules engine to automate pre-admission certification requirements whenever possible. These guidelines are generally based on certain diagnosis codes. Defining these within rules make the pre-admission determination and length-of-stay process more efficient and consistent. Additionally, the EDS pre-admission reviewers have access to Milliman Care Guidelines, which are the approved industry guidelines in their criteria.

A specific example of how interChange will be customized for North Carolina is that the PA Detail panel, shown in the following exhibit, Current PA Detail Panel, will be modified for pre-admission certification processing.

Current PA Detail Panel



The PA Detail panel will be modified for pre-admission certification processing.

During DDI, the team will add a type to the PA detail, which will indicate the scope of services being requested; in this case, "pre-admission certification." The effective and end dates (requested and authorized) will represent the length of stay recommendations. Units and dollar limits can also be enforced. The PA can link the recipient to the provider (hospital or institution) and the dates. Notes can define any extenuating circumstance. The diagnosis is available, as are the authorized revenue codes.

Technical Proposal BAFO page D-266:

- Provide the capability for online searchable tracking of therapeutic leave in child care facilities, nursing facilities, and intermediate care facilities for the mentally retarded
- Provide additional search capabilities for covered drugs

Existing interChange PA panels will be enhanced to capture data specific to pre-admission certifications. The Replacement MMIS uses an attribute called PA Type to control the scope of the approval. In this manner, different PA types can serve different purposes, including bypassing a limitation or authorizing an admission. This targets the scope of the PA and does not authorize services carte blanche. These pre-admission units will select a type of PA—pre-admission—which will initiate the approval process.

The PA Type will be used to direct the workflow reviews to the specific operational staff focused on pre-admission certification. Part of the review process includes the triggering of customized pre-admission approval or denial letters, which will include the length-of-stay limits supported by approval as well as any rights or appeals process necessary.

The claims system will be enhanced slightly to recognize the pre-admission type of PA and use that type only to authorize hospital and institutional claims.

Technical Proposal BAFO page D-275, end of table:

RFP No.	RFP Requirement	EDS Response
40.7.1.68** (New)	Provides capability to capture pre-admission certification and length-of-stay recommendations by the pre-certification reviewer	Met through customization of interChange and operational processes and procedures. The Prior Approval team will take pre-admission certification and length of stay calls and faxes, enter the data into interChange panels, and then respond by telephone and in writing with any questions regarding the request, as well as the outcome of the certification process. These certifications will be treated as a specific type of PAs within the Replacement MMIS. By defining PAs as a type, it is possible to limit the scope of the authorization to precisely target what is being authorized and to configure the specific letters or approval criteria are needed. This aids in reporting information such as how many PAs were approved for pre-admission certification versus limitation exceptions.
40.7.1.69** (New)	Provides capability to process claims based on pre-admission and length-of-stay recommendations	Met by interChange. After the pre-admission and length of stay have been entered into interChange, the claims processing will handle them as PAs. The adjudication rules for claims that exceed the approved pre-certification length of stay will be determined during DDI. These claims can be denied or set for suspense and manual review.

Technical Proposal BAFO page D-304:

During the implementation, the EDS team will perform detailed policy parallel testing on claims. The goal of the parallel testing is to minimize the impact of transitioning from the current systems to the new multi-payer Replacement MMIS. Through this testing effort, we can refine the configured business policy to match the policy translated from the base systems. This testing component is a key approach to our configuration of the policy.

Customizing the system to support the acceptance, adjudication, and reimbursement of recipient-submitted claims will require modification to the existing system across several MMIS subsystems. EDS will work with the State during the requirement validation sessions to define the scope of these capabilities. EDS' approach is to use existing functionality in interChange, as well as manual proceses, to enable these requirements. Some examples of this approach to customization include the following:

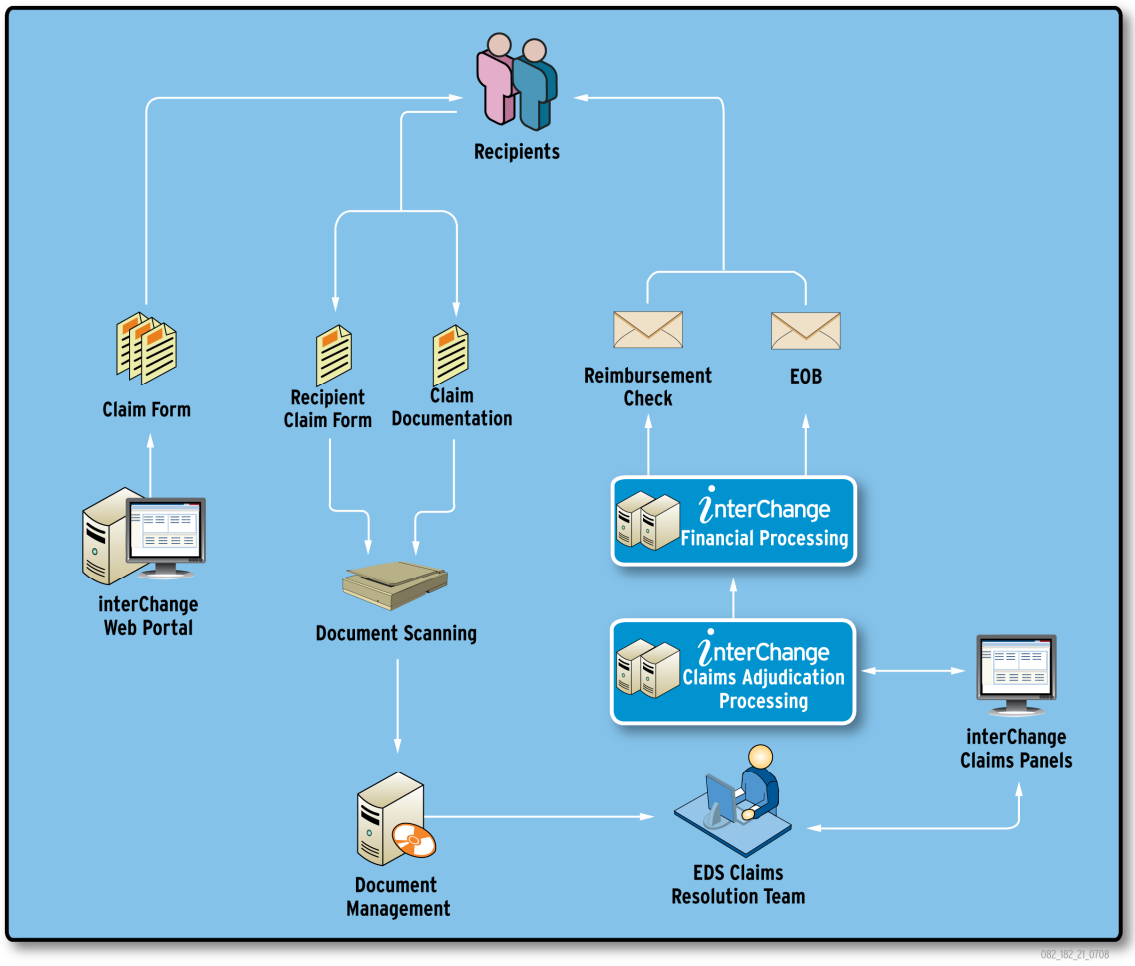
- **Edit Disposition panel—**Configures appropriate dispositions, which can be different for the different region claim type
- **Recipient Plan Benefit Coverage panel—**Defines the coverage rules
- **Prior Approval Information panels—**Allow PAs to be initiated to bypass some of the edits
- **Claims Data Correction panels—**Allow the override of the super-suspend and any other disposition edits
- **Financial Expenditure panel—**Issues a manual check

Through the development of our business design documentation, we will capture and document both the system modifications and the associated manual processes that interact with interChange MMIS for recipient-submitted claim processing.

If the NCHC recipient is unable to get the authorized provider to bill the claim for a covered service, the recipient can pay the provider directly and subsequently download a recipient claim form from the Replacement MMIS Web portal. The recipient will then fill it out completely, attach a copy of the receipt and documentation, and mail it to EDS for processing.

The following exhibit, NCHC Recipient Claim Submissions, provides a high-level diagram of the NCHC recipient claim form processing.

NCHC Recipient Claim Submissions



NCHC-submitted claims will be supported by interChange.

The proprietary recipient claim form will be scanned, imaged, and given a specific internal control number (ICN), then delivered to the claims unit for processing. The operations staff will review the claim form through the claim and attachments online through the document management system. The unit will perform certain verifications and reviews, then directly enter the claim information into the system. A default billing provider number will be used, with the actual performing provider listed on the claim. The claim will be set to "super-suspend"—an interChange feature causing suspension whether the claim would pay or deny—so that it can be reviewed and possibly manually priced by the claims unit. This unit will pay or deny the claim according to approved policy.

The finalized claims will then flow through financial, where they will be included on the remittance advice of the default billing provider. An Explanation of Benefits (EOB) document will be initiated to the recipient. This EOB and claim will be intercepted and routed back to the claims unit. This unit will review the

documentation and issue a manual check to the recipient for the amount allowed on their recipient submitted claims. The EOB, claim image, and manual check will be electronically linked together in the system for auditability. The funds payable to the default provider will be automatically deposited back into the same fund that the manual check is issued from.

This approach is specifically designed to take advantage of the existing functionality within the interChange MMIS, while allowing for enhancements that would enable this recipient reimbursement methodology. This approach is a balance between the scope of alterations and the small volume of recipient financial transactions that need to be processed.

Technical Proposal BAFO page D-309:

- **Step 7—**Claims adjudication is complete and the financial cycle is initiated.

Recipient-Submitted Claims

There are a number of customizations needed in the Replacement MMIS to support recipient-submitted claim requirements. These changes include the following:

- One or more new claim forms need to be designed, developed, and published.
- Minor document scanning and indexing changes will be made to allow these claim forms and receipts to be imaged, ICN'd and routed to the claims unit for entry.
- A new claim entry panels will be needed, which will allow entry of received information and default other claim information that is not supplied.
- The claims system will be configured to apply the appropriate coverage and processing rules and appropriately bypass or disposition edits encountered.
- A new process will be created to generate a recipient EOB for the NCHC claims. It will be leveraged to support the issuance of a manual check.
- Service limitations audits will be applied at the family level as the family is identified through the EIS system.

From a reporting aspect, all the claims can be reviewed by looking for claims billed by the default billing provider number. The MMIS can use a specific EOB for the manual check reasons so the claims are grouped appropriately.

Technical Proposal BAFO page D-312 and following:

RFP No.	RFP Requirement	EDS Response
40.8.1.25 (Revised 7/21/08)	Provides capability to allow payment for all medically necessary services approved for EPSDT and NCHC Special Needs Plan-eligible recipients ~~Provides capability to override service limitations for Early Periodic Screening, Diagnosis, and Treatment (EPSDT) eligible recipients~~	Met by interChange. interChange can use the age-based configuration for both coverage and audit limitations to allow different coverages or service limits for recipients who qualify for EPSDT than their adult counterparts. The ability to configure the services authorized for a specific population, such as EPSDT or NCHC Special Needs Plan eligible recipients, completely differently than other populations sets the interChange system apart. Coverage rules and conditions can be configured independently for every benefit plan. These can be further refined by requiring prior approval or medical necessity review on that subset of services where more program control is advised. The ability to override service limitations is part of the claims processing functionality within the Replacement MMIS. Therefore, if a claim is denied for a service that exceeds service limitations or is ordinarily not covered under core benefits of the HCHC program and meets Medicaid medical necessity criteria, the claim can be paid if the recipient qualifies for the NCHC Special Needs Plan. If a claim suspends, the claims engine allows limited audit overrides for the claims with a suspended status. The Audit Limitation panel is used to configure the age limitation, and the Audit Criteria Base panel is where the benefit plan limitation is set.
40.8.1.384 (New)	Provides capability to reimburse NCHC recipients for eligible out of pocket claims payment	Met through customization of interChange and operational processes and procedures. The interChange claims processing, financial and reporting functionality will need to be updated to allow for reimbursement of NCHC recipients for out of pocket claims expenses. The recipient proprietary claim forms can be submitted by the recipient or the provider on the recipient's behalf. Operational processes will be updated to allow for the scanning of new, proprietary claims forms and receipts or provider-itemized bills. The data required to process these claims must be present on the claims form; otherwise, the claim will be suspended or denied based on the defined adjudication rules. These claims will use a combination of automated and manual processing to meet the defined policy. Reimbursements for the recipient out-of-pocket expenses that are reimbursable will be sent by check directly to the recipient.

RFP No.	RFP Requirement	EDS Response
40.8.1.385 (New)	Provides capability to process claims filed by NCHC recipients	Met through customization of interChange and operational processes and procedures. The interChange claims processing and financial functionality will need to be updated to process recipient proprietary claim forms filed by NCHC participants. Operational processes will be updated to allow for the scanning of new, proprietary claims forms and receipts or provider-itemized bills. The data required to process these claims must be present on the claims form; otherwise, the claim will be suspended or denied based on the defined adjudication rules. These claims will be processed through interChange using a combination of automated and manual checkpoints, requiring manual edits and audits in accordance with the same rules as claims submitted by a provider. Reimbursements will be by check and sent directly to the recipient or provider, depending on the information on the claim form. Additionally, EOBs will need to be sent to all NCHC recipients, regardless of whether the claim was filed by the recipient or the provider. interChange supports this through the use of the Targeted EOB Request panel. This panel allows authorized users to select EOB notices to be produced based on configurable criteria. Included in that configurable criteria is the percentage of claims to select—up to 100 percent—as well as the benefit plans to select. Therefore, all paid claims and adjustments for the NCHC population can be automatically targeted as EOB request.
40.8.1.386 (New)	Provides capability to apply service limitations across multiple health care programs and benefit plans as applicable	Met by interChange. The Audit Criteria panels allow authorized users to define service limitation audits using a number of parameters including same/different selection criteria for benefit plans and/or healthcare programs (financial payers). This allows for certain audits to apply only within the benefit plan or payer and other audits to apply across benefit plans and payers. Other configurable parameters also are available.

Technical Proposal BAFO page D-318:

RFP No.	RFP Requirement	EDS Response
40.8.1.61	Provides capability ~~for PRO-DUR and Retroactive DUR~~ 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	Met through configuration of interChange parameters and features. The edit/audit processing function validates claim records in accordance with the State's claim processing policy. The Drug Utilization Pro-DUR page meets this requirement. We will configure the Pro-DUR function of

RFP No.	RFP Requirement	EDS Response
		interChange in accordance with State-specific requirements. The retroactive DUR (Retro-DUR) is supported by the HID RxExplorer application. The data extract process in interChange is a monthly, automatically scheduled batch process. We will provide and deliver the extracted data to ~~the valid Retro-DUR contractor.~~ HID monthly. HID then processes the data using the intervention parameters and loads it into the RxExplorer application, which users access from their desktops.
40.8.1.62	Provides capability to process all pharmacy claims in POS/PRO-DUR ~~inclusive with edits/audits/overrides consistent with current State policy~~, applying edits/audits/overrides, informational alerts, and intervention/conflict/outcomes codes, compliant with State policy at all times	Met through customization of interChange. The edit/audit processing function validates claim records in accordance with the State's claim processing policy. The system's Pro-DUR function processes pharmacy claims in POS inclusive with edits/audits and overrides. A pharmacist is able to override State-approved alerts that are set through the Pro-DUR capability. DUR alert dispositions can be set based on FDB-supplied interaction severity per alert type to allow post and pay, pharmacist override, denial, or PA approval required. We will configure the Pro-DUR functions of interChange in accordance with State-specific requirements. We will design and develop specific customization required to meet this requirement.

Technical Proposal BAFO page D-339:

Retrospective Drug Utilization Review Requirements

The following table, EDS Response to Retrospective Drug Utilization Review Requirements, describes how we will meet the requirements set forth in the RFP.

Please note that while requirements 40.8.1.200–202 have been cancelled by the State, EDS will need to provide HID with files of paid drug claims, physician, clinic, hospital, and pharmacy provider data, and recipient data, as a basis for performing other Retro-DUR requirements. For detailed information regarding the Replacement MMIS Retro-DUR solution, please refer to the Proposed Early Implementations section later in this Supplement and in the Technical Proposal BAFO. These sections describe the EDS and HID solution and its capabilities and demonstrate how together we can deliver these capabilities within the first 60 days of the contract.

EDS Response to Retrospective Drug Utilization Review Requirements

RFP No.	RFP Requirement	EDS Response
Requirement Deleted 40.8.1.200	~~Provides capability to generate a file of paid drug claims to the Retrospective DUR Vendor~~	Cancelled. This requirement was deleted by RFP Addendum 4 — North Carolina Replacement MMIS Updated Requirements, July 7, 2008.~~Met through customization of interChange. interChange has a standard extract process to support Retro-DUR processing. It will be customized to meet the needs of the Retro-DUR vendor.~~
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~~	Cancelled. This requirement was deleted by RFP Addendum 4 — North Carolina Replacement MMIS Updated Requirements, July 7, 2008.~~Met through customization of interChange. interChange has a standard extract process to support Retro-DUR processing. It will be customized to meet the needs of the Retro-DUR vendor. Every month, there is an automatic batch extract for the required claims history and related provider and recipient data. We will provide the extracted data and deliver it to the valid Retro-DUR vendor.~~
Requirement Deleted 40.8.1.202	~~Provides capability to generate a file of the recipient data to the Retrospective DUR Vendor~~	Cancelled. This requirement was deleted by RFP Addendum 4 — North Carolina Replacement MMIS Updated Requirements, July 7, 2008.
40.8.1.203	Provides capability to ~~produce the CMS Annual Drug Utilization Review Report~~ generate 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 in the media and timing as directed by the State	Met through ~~customization of interChange~~operational processes and procedures. EDS and HID will work together to generate 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 in the media and timing as directed by the State. The Annual Report will be a combination of reports produced by both HID and EDS. The reports will be generated through the EDS and HID staff interaction with the HID RxExplorer application.~~interChange will create and produce the CMS Annual Drug Utilization Review Report.~~
40.8.1.387 (New)	Provides capability to generate ad hoc reports and scheduled reports for recipient and provider profilings and provider report cards	Met by HID reporting and operational processes and procedures. HID's RxExplorer application has the capability to generate ad hoc reports and scheduled reports for recipient and provider profilings and provider report cards. These reports, recipient and provider profilings, and provider report cards will be created quarterly, based on criteria established by the DUR Board and the State.
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	Met by interChange and operational processes and procedures. interChange has the capability of applying edits/audits, limitations, and information alerts to the POS claims processing system. HID will support this effort by making recommendations to the board. After these recommendations are approved by the board, the EDS team will be responsible for configuring

RFP No.	RFP Requirement	EDS Response
		the edits/audits and limitations and informational alerts within the Replacement MMIS pharmacy process.

Technical Proposal BAFO page D-365:

RFP No.	RFP Requirement	EDS Response
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~~	Cancelled. This requirement was deleted by RFP Addendum 4 – North Carolina Replacement MMIS Updated Requirements, July 7, 2008.~~Met through customization of interChange. This requirement can be accomplished by an 834 transaction. It may also be an electronic file containing the recipients and their assignments, along with demographic data determined by the State.~~

Technical Proposal BAFO page D-405 and following:

RFP No.	RFP Requirement	EDS Response
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	Met by interChange. The Drug Rebate CMS Unit Discrepancy report will display the differences in units of measure whether it is a CMS or State drug rebate. The Replacement MMIS receives information from CMS related to the rebatable units of measure differences between CMS and FDB. This update is loaded into the drug rebate system and used in calculating the appropriate rebate invoices. EDS will not be required to administer, either technically or operationally, a Medicaid supplemental drug rebate program. EDS will be able to support drug rebate activities for other non-Medicaid State programs. The source, format, media, and frequency of the State drug rebate data file are assumed to model the CMS National Drug Rebate Program, although this will be finalized during DDI.
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 comments	Met by interChange. The drug rebate capability function within interChange meets this functional requirement. The Drug Rebate L~~l~~abeler S~~s~~earch panel allows users to view all invoices generated. They also can view the specific invoice amounts, payments made, write-offs, interest billed and paid, and balances due as of that day through the Drug Rebate Invoice Detail panel. The Drug Rebate Detail Related Claim panel shows all claims data for a specified NDC and

RFP No.	RFP Requirement	EDS Response
		quarter. It also allows users to export this data into Microsoft Excel and send the file directly to the drug manufacturer. Audit trails allow the CMS drug data to be viewed. Operational comments can be entered at the invoice and NDC level. Separate invoices are prepared for the CMS versus State Drug Rebate programs. It is possible to track and collect those invoices and monies separately. As noted in Requirement 40.12.1.18, there will be five years of data available through online access.
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	Met by interChange. The Drug Rebate Related Data Unit Conversion Maintenance table will provide this functionality, since the State's policies will follow the existing NC Medicaid Drug Rebate Program policies. The user interfaces with the Drug Rebate Unit Conversion panel for this information.
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	Met by interChange. The drug rebate capability function within interChange meets this functional requirement. The Drug Rebate Related Claims panel contains all the claims associated to a specific NDC and quarter. As adjustments process, this panel is updated so that the most current units are listed. There is functionality to display the Jcode NDC conversion and unit conversion based on unit of measure issues (Drug Rebate CMS Unit Discrepancy report) for every claim on the invoice.
40.12.1.29	Provides capability to make available to the State the total Medicaid expenditures for multiple source drugs (annually) as well as other drugs (every three [3] years); provides capability to include mathematical or statistical computations, comparisons, and any other pertinent records to support pricing changes as they occur, by drug rebate program	Met through customization of interChange. The Business Intelligence and Analytical Reporting (BIAR) MMIS ad hoc component will contain the data enabling the State to build reports of the total Medicaid expenditures for multiple source drugs and other drugs including mathematical or statistical computations and comparisons in support of pricing changes. These computations can be done by drug rebate program.
40.12.1.71** (New)	Provides capability to capture State determined drug unit rebate amount and units of measure by drug rebate program	Met through customization of interChange. The State-determined drug unit rebate amount can be calculated based on a percentage of the CMS rebate per unit or determined by a methodology approved by the State. The units of measure should be consistent for all programs, but interChange can be configured to meet circumstances where a different unit of measure is needed. The Drug Rebate Units Conversion Maintenance panel is where these units would be viewed or maintained. This panel holds the unit type and conversion factors as well as effective and end dates for each NDC where there is a conversion factor. Like our rebate efforts for other states, we will assume that for non-Medicaid programs, the manufactures will honor the CMS-negotiated rates. If the manufactures will not honor those negotiated rates, or if a PDL or supplemental list

RFP No.		RFP Requirement	EDS Response
			comes into play, EDS will work with the State to consider alternative approaches.
40.12.1.72** (New)		Provides capability to build and maintain the State's Drug Rebate Labeler Data	Met by interChange. The CMS Drug Rebate Labeler Data panel will be used as the State's Drug Rebate Labeler Data, thereby providing consistency across drug rebate labels. The labeler information available online includes the preferred invoice media, mailing and contact information, status, comments, and dates.

Technical Proposal BAFO page D-433:

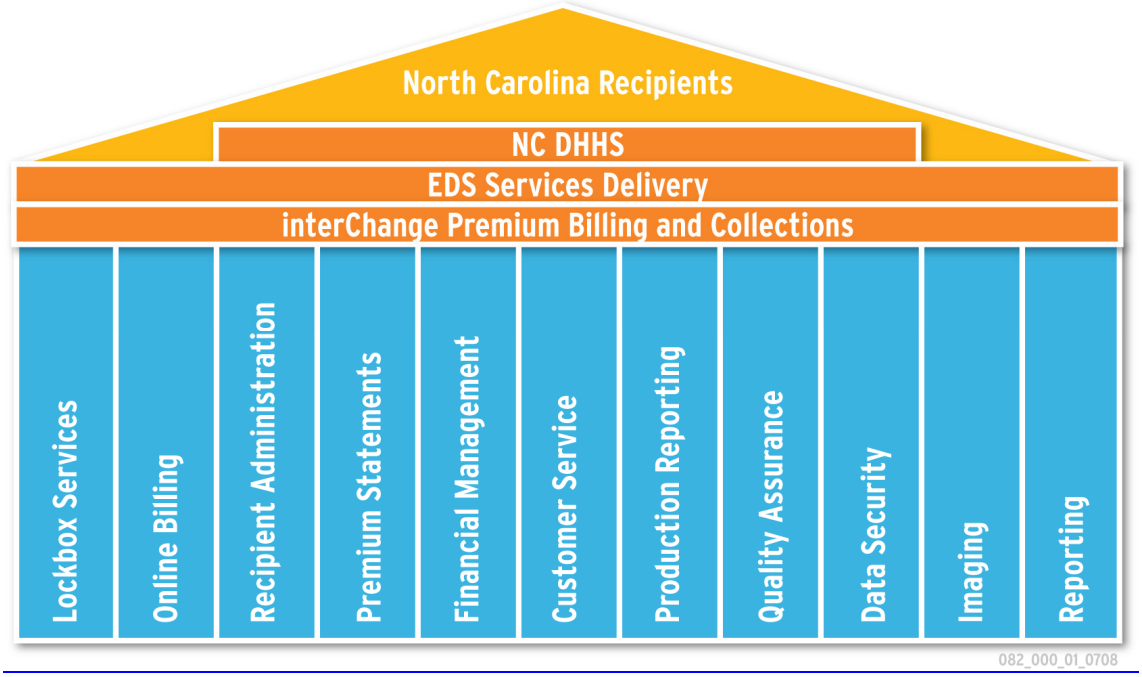
The financial balancing process within interChange is executed every week as part of the financial cycle.

Premium Payments

To meet the new requirements for premium payments presented in Addenda 4 and 5, interChange will require modifications to its existing premium billing and collections functionality. Also, additional EDS service offerings, EDS*PAY and OpenBill *Express*, will be added to the interChange suite, providing North Carolina recipients multiple, convenient options for premium payments.

The following exhibit, interChange Premium Billing – An Integrated Solution, illustrates how interChange premium billing capabilities takes the functions for each subprocess and presents them to the State and its recipients as a fully integrated output. This includes the ability for recipients to go to a State-branded premium payment Web site, check the status of their statements, and choose the most convenient way to make their payments.

interChange Premium Billing – An Integrated Solution



interChange Premium Billing presents premium billing and collections functions and services as a fully integrated output.

To meet the State's objectives, the Replacement MMIS and fiscal agent services must provide the following:

- The capability to correctly handle financial transactions with recipients given the more complex, family-oriented eligibility cost-sharing definitions
- The capability to handle various payment methods, including at a minimum cash, check, money order, and credit or debit card
- Collection and refunding methodologies such as mail, telephone, electronic check through Automatic Clearinghouse (ACH), and Web that are flexible and cost-effective
- Recipient management, including activities related to notification, collection, and application of recipient premiums for Medicaid and NCHC programs
- Mechanisms for recipient communication concerning claims payment, PAs, covered services, and other non-eligibility–related issues

By enhancing the existing capabilities within interChange and introducing new services, we will be able to meet and surpass these expectations.

Our solution includes a suite of electronic payment alternatives, including various pay-by-telephone and pay-by-Internet services for credit and debit card

and ACH direct pay, and electronic bill presentment. These are not new services to EDS. We have more than 35 years of credit card processing experience supporting more than 45 million credit card accounts and 1.3 billion transactions annually in 18 countries, producing more than 320 million statements annually. We also support more than 1.8 million merchant accounts, processing more than 4.1 billion transactions annually.

For additional details regarding the premium payment solution, please refer to section 40.14.2 Financial Management and Accounting Operational Requirements of this Supplement.

The following table, EDS Solution Components, provides an overview of the new technical components included in our solution to meet the new requirements, and the business function each component supports.

EDS Solution Components

Solution Component	Business Function
interChange Premium Billing	• Recipient administration • Premium processing business rules • Account and payment financial management • IVR access to recipient premium payment information • Data storage • Generation of output files such as financial management and eligibility files • Disbursement of funds • Generation of premium statements and other correspondence • Management of premium payment frequency • User access for inquiries, recipient updates, and payment posting • Management of automated payment agreements
EDS*PAY	• Online or AVR access for nonrecurring, one-time payment by credit or debit card or drafts from checking or savings accounts
EDS OpenBill *Express*	• Secure online account registration • Generation of online premium statements and access by registered users • Online self-service access by registered users to manage recurring payments, maintain address information, view payment history, and add and maintain e-mail addresses • Automated e-mail notifications to registered users regarding statement availability and payment activity

Solution Component	Business Function
Lockbox services	• On award, service established with Bank of America to include the receipt of payment data and corresponding image files
Interactive voice response (IVR)	• Processing of payments through drafts from checking or savings accounts by telephone
Contact Tracking Management System (CTMS)	• Documentation of customer service inquiries to agents by recipient account number • Documentation of correspondence received by recipient account number • Retrieval of contact history • Tracking of issues and staff involved from receipt through final resolution • Categorization of inquiries for trending • Historical profiles of recipient contacts • Management reporting for trending • Service-level compliance reporting
Avaya Automated Call Distributor	• Call management from receipt by telecommunications carrier to customer service agent or IVR • High-level educational messages to callers on hold • Menu options to facilitate telephone payments
Avaya CentreVu 9.0	• Agent resource allocation • Agent productivity reporting • Center productivity reporting • Real-time reporting through a GUI that supports access to service-level data including current center performance and call activity and historical performance and call production
NICE CallFocus	• Recording of calls received and handled by agents • Retrieval of recorded calls by date and time and agent ID • Real-time monitoring of current calls • Storage of recorded call data for future retrieval • Desktop access to retrieve recent calls • Archive library access to retrieve past calls

Solution Component	Business Function
BusinessObjects	• Online browser-based ad hoc reporting to selected interChange Premium Billing and CTMS data elements • Scheduled generation and distribution of established production reports

Our solution provides payment management support to recipients in the form of premium statements, online billing, interactive voice response (IVR), and caring customer service agents. Our payment management resources are supported by industry-leading business services such as Bank of America's lockbox service, NICE call recording, Avaya call management, and EDS online services delivered through EDS*PAY and OpenBill *Express*. These applications, coupled with the interChange premium billing module, comprise the entire EDS solution, and they support our mission to deliver quality customer service to the State's recipients.

Data contained on recipient input files and the State business rules will drive the generation of premium statements. The interChange premium billing component will process recipient eligibility and premium data received from the State's eligibility system to support the following business functions:

- Production of hard-copy premium statements
- Generation of online premium statements
- Distribution of e-mail notifications to recipients registered through OpenBill *Express*
- Maintenance of historical recipient eligibility and premium data
- Management of recipient demographic and contact data
- Premium eligibility history

Overview

The generation of premium statements, the posting of payments received, and the management of funds are the most critical components of premium billing services. Generating statements containing accurate information notifies recipients of their premium obligations. Posting premium payments to recipients' files will determine whether their coverage continues or is possibly ended due to nonpayment. Managing the receipt and transfer of funds requires detailed operational controls and accurate reporting.

Recipient data drives the production of premium statements and the generation of new premium obligations. Eligibility and demographic information, such as

family income levels, determine premium amounts. Accordingly, it is critical that recipient data is maintained accurately and promptly.

interChange Premium Billing will receive daily recipient premium eligibility files for recipients, indicating the programs in which they can participate. We anticipate that the eligibility interface will be the same, regardless of the program.

Financial Management and Accounting Systems

EDS acknowledges the State's requirements for being able to handle all financial aspects of processing the premium payments, including payments, refunds, adjustments, collection, processing, tracking, imaging, recording, and reconciliation, all in accordance with GAAP and State policies. During DDI, we will review State rules and regulations regarding direct bill recipient processing with the State. We will apply our understanding of State rules toward our business processes and interChange Premium Billing component processing logic.

The EDS solution includes multiple payment options for recipients. Premium statements will be generated based on data received on the recipient files. EDS Customer Service will use a daily BusinessObjects report to review recipient records received on the most recent daily recipient file. Billing frequency will be stored in the recipient's file. This data will be used during the generation of statements to bill the recipient for the amount due that corresponds to the frequency of billings, such as monthly or quarterly premium totals. We are anticipating that most recipients will be billed monthly; however, recipients in the Ticket to Work program also will be required to pay an initial fee if their income level is over 200 percent of the federal poverty level (FPL).

The following table, Payment Methods Supported, lists the payment methods included in EDS' solution and how the method chosen by the recipient will be stored on the recipient record.

Payment Methods Supported

Payment Method	Recipient Record
Check, money order, or cash mailed by recipient	• Method code to indicate that the recipient has actively indicated an intent to mail a check, money order, or cash in response to receiving premium statements • Money orders, cash, or checks sent directly to a defined lockbox for processing • Frequency updated to reflect recipient choice so that statements are generated accordingly

Payment Method	Recipient Record
Recipient calls the IVR to pay with credit or debit card or draft from checking or savings account	• Method code to indicate the recipient wishes to continue receiving hard-copy statements and will call to make payments by telephone • Frequency updated to reflect recipient choice so that statements are generated accordingly
Online nonrecurring payment	• Method code to indicate that the recipient has actively indicated an intent to access the EDS*PAY site to conduct nonrecurring payments • Frequency updated to reflect recipient choice so that statements are generated accordingly
Online secure account	• Method code to be updated on the recipient file when the recipient registers with OpenBill *Express* to indicate that the recipient has actively elected to use OpenBill *Express* to manage premium payments • Frequency updated by agent to reflect choice so that statements are generated accordingly

Based on responses from the State, EDS assumes 17,000 payments per month, 40 percent of which would be set up as nonrecurring credit or EFT, 20 percent of which would be set up through EDS OpenBill *Express* for online recurring charges, and 40 percent of which would be standard lockbox payments.

Besides storing the method and frequency of payments on the recipient record, each payment received and posted to a recipient's account includes a source code to indicate how the payment was received.

Our end-to-end solution provides the State its own privately branded payment management site, where recipients can view their status, make demographic changes, and pay their premiums. This site will be linked to the Replacement MMIS Recipient Web Portal. Additionally, the online functions provided can be easily leveraged for future premium payment programs or other programs requiring the collection of fees for other agencies.

To meet the requirement to display recipient premium data online, multiple changes will be made to interChange. First, the Recipient Portal will be updated to include payment history of all payments, refunds, and adjustments. It also will be updated to include deductibles and co-payments, as appropriate. interChange panels also will be updated to provide the Recipient Service Representatives with online access to this data. Lastly, recipients who chose to use the OpenBill *Express* premium payment option will be able to see their payment history data online.

An interface will exist between the Replacement MMIS and OpenBill *Express* and EDS*PAY, allowing the recipient to see all payments, whether initiated through lockbox payment, online payment, or IVR payment.

While most payment notices will be sent on the 15th of the month, with due dates of the first of the following month, this feature will be configurable through the Replacement MMIS based on benefit plan.

interChange Premium Billing will accept and process daily eligibility file updates to process recipient adds, changes, and terminations. Because premiums are expected to vary by program and within each program by income level, this requirement will be met through configuration and customization. The Replacement MMIS will apply the premium amounts based on eligibility and income information received in the nightly EIS update. We will receive information on premium amounts from the State. Premium amounts may change based on State and/or federal mandates. Data provided on the recipient eligibility file will be compared to benefit plan data configuration to make sure the recipient is billed the appropriate premium amount.

Online notification of premium payment status to the Eligibility Information System (EIS) will be accomplished by enhancing the daily eligibility interface file between EIS and the Replacement MMIS. Regardless of their method of payment, all payment records that were updated that day will be sent to the EIS to make sure recipients' payment status is kept current so as not to interrupt coverage.

Identification of family members and different patient obligation codes will allow us to make sure 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. Therefore, a recipient will not be given a payment notice when he or she has already met the family threshold for annual payments.

To pay the cost for dependent coverage provided under a private insurance for NCHC recipients who are eligible under State-defined criteria, the Replacement MMIS will be able to transfer funds from a State account to cover the presentments. The payment method will be either check or EFT.

The process to create the CMS64-21 file will need to be updated to exclude any recipient premiums, co-payments, or other cost-sharing fees from the file.

Technical Proposal BAFO page D-444:

RFP No.	RFP Requirement	EDS Response
40.14.1.53	Provides capability to produce and send correspondence related to recipient premiums in the recipient's preferred language~~, including invoices, notices of non-payment, cancellation notices, receipts, and refunds~~	Met by interChange, with a portion of the requirement requiring customization code. The interChange premium payment system handles invoices, payments, refunds, notices of nonpayment, and cancellation notices. The DOC1 letter generator component of interChange will use letter templates developed during implementation in the required languages to address the need for invoices, notices of non-payment, cancellation notices, receipts, ~~and~~ refunds, and adjustments. Within the recipient demographic data, interChange stores the preferred language of each recipient to identify the preferred language for correspondence. DOC1 allows for language-specific letter templates to be defined and used within the system.
40.14.1.55	Provides capability ~~to produce refunds of recipient premiums~~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	Met by interChange and operational processes and procedures. The interChange premium payment system handles invoices, payments, refunds, notices of nonpayment, and cancellation notices. The processing is rooted in GAAP, and internal controls are established, enabling timely, complete, and accurate processing and payment of refunds and adjustments of recipient premium payments.
40.14.1.56	Provides capability to process financial accounting records for ~~premium payments and refunds~~recipient premiums, including payments, refunds and adjustments, for retroactive, current, and future months	Met by interChange with a portion of the requirement requiring customization code. ~~-~~ The interChange premium payment and financial modules will be updated to handle ~~premium~~ premium payment ~~system handles~~ invoices, payments, refunds, adjustments, notices of nonpayment, and cancellation notices for retroactive, current, and future months. These transactions are tied directly to the financial system. Business processes and procedures will be developed and implemented to make sure the allowable updates conform to State policy.
40.14.1.57	Provides capability to produce reports for recipient ~~premium payment~~ premiums, including payments, refunds, adjustments and cost sharing (e.g., recipient co-insurance, deductibles, co-payments, etc.) processes	Met by interChange, with a portion of the requirement requiring customization code. There is a series of online reports ~~that meet this requirement~~that will be updated to meet this requirement. For additional reports, users will be able to generate online reports that meet these needs through the BIAR function.
40.14.1.59	Provides capability to ensure ~~cost sharing does not exceed threshold for the family group~~ 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	Met by interChange, with a portion of the requirement requiring customization code. Currently, ~~S~~spend-down credits are tracked at the case level to make sure a family does not jointly exceed the limitations. All members of the case can contribute to the same spend-down limitation. Patient liability for long-term institutional facilities is processed similarly to spend-down. The interChange case spend-down interface is the Case Spenddown panel. The recipient premium payment

RFP No.	RFP Requirement	EDS Response
		plan also is capable of handling premiums on an individual or family basis. The Replacement MMIS will need to be customized to set and monitor family-based cost-sharing limitations for both Title XIX and NCHC. It will be modified to allow for new recipient obligation types, thereby being able to affect different policies based on the type of obligation. The ability for the Replacement MMIS to process at a family level is dependent on the eligibility system's ability to identify, update, and communicate recipients as a family.

Technical Proposal BAFO page D-450, added after table:

Premium Payment and Collection Requirements

The following table, EDS Response to Premium Payment and Collection Requirements, describes how we will meet the requirements set forth in RFP Addenda 4 and 5.

EDS Response to Premium Payment and Collection Requirements

RFP No.	RFP Requirement	EDS Response
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	Met by customization of interChange. The interChange premium billing capabilities will be updated to include processing recipient premiums in accordance with GAAP, including payments, refunds, adjustments, collection, processing, tracking, imaging, recording, and reconciliation. It also will include delinquency processing functions to track delinquent invoices and trigger the appropriate delinquency notices and related actions. There also will need to be an integration component to the State eligibility system to make sure the recipients' status of premium payment—and therefore entitlement—is kept in synch between the two systems. The EDMS solution will include imaging of correspondence and linking it to the appropriate recipient. All financial transactions and reconciliations are done in accordance with recognized GAAP processes. The inquiry and update capability for all premium- and payment-related data will be available through the interChange premium payment and recipient cost-sharing panels. Operational processes and procedures will be established to support this activity.

RFP No.	RFP Requirement	EDS Response
40.14.1.97 (New)	Provides capability for automated calculation of recipient premiums on a sliding scale	Met by configuration of interChange. interChange will apply the premium amounts based on eligibility and income information received in the nightly EIS update. We will receive information on premium amounts from the State, and configure the premiums amounts accordingly. Because premium amounts may change based on state and/or federal mandates, this configuration will ease the process of making these changes over time. With the premium amounts stored within interChange, the monthly premium determination is then an automated process using the recipient's income level data classification to select the appropriate premium amount for each recipient. EDS will work with the State during DDI to define how the various premium income levels will be communicated between the State eligibility system and the Replacement MMIS.
40.14.1.98 (New)	Provides capability for online display of recipient premium payment history to include all payments, refunds and adjustments	Met by interChange, with a portion of the requirement requiring customization code. The interChange premium billing panels and Web portal will be updated to include displaying recipient historical payment data, including all payments, refunds, and adjustments. If a recipient chooses to use the EDS OpenBill *Express* function for online payments, any payments made through OpenBill *Express* will be available through that service offering. An interface will be established between the OpenBill *Express* service and the Replacement MMIS to keep the data in synch so the payment results will be available in the Replacement MMIS.
40.14.1.99 (New)	Provides capability for online display of recipient cost-sharing data such as premiums, deductible, co-pays, etc.	Met by interChange, with a portion of the requirement requiring customization code. The Web portal will be updated to display the cost-sharing data of premiums, deductibles, and co-payments. The interChange panels also will show this data for internal operational support of these services.
40.14.1.100 (New)	Provides capability for determining and tracking premium due dates	Met by interChange, with a portion of the requirement requiring customization code. The interChange premium billing function will be updated to determine and track premium due dates. The delinquency processing allows for automated follow-up of delinquent invoices. It is anticipated that the bills will be issued on the 15th of the month, with payment due by the first of the following month. The system also will be configured to issue an initial fee as well as monthly fees for recipients in the Ticket to Work program whose annual income is in excess of 200 percent of the FFP.
40.14.1.101 (New)	Provides capability for issuance of recipient premium notices, including invoices, notices of non-payment, cancellation notices, receipts, refunds and	Met by interChange, with a portion of the requirement requiring customization code. The interChange premium billing function will be updated to provide the capability to issue

RFP No.	RFP Requirement	EDS Response
	adjustments within the specified time frame for each recipient	premium notices, including invoices, notices of non-payment, cancellation notices, receipts, refunds, and adjustments. Events will be created to produce non-payment and cancellation notices and other standardized correspondence using the DOC1 letter generation software.
40.14.1.102 New (Revised 7/21/08)	Provides capability for accounts payable functionality to track ~~and age~~ all unpaid refunds	Met by interChange. The interChange financial subsystem tracks all unpaid refunds. The process will include paying the oldest refunds first.
40.14.1.103 New (Revised 7/21/08)	Provides capability to generate online notification of premium payment status to the Eligibility Information System (EIS) ~~in near real time~~	Met by customization of interChange. The interface between interChange and the State's eligibility system will be updated to include notification of premium payment status. This will keep the two systems in synch. This information will be sent from interChange to the EIS daily and will indicate which premiums have been paid, whether through EDS*PAY, OpenBill *Express*, or lockbox deposits at the bank. It also will indicate which payments have been withheld from the financial institution for insufficient funds. We will work with the State and EIS during the requirements validation sessions to fully define the crediting process and any timing restrictions, such as whether proof of sufficient funds should be a prerequisite to sending the payment status update transaction. The Replacement MMIS will be the database of record for all these premium payment statuses.
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	Met through customization of interChange. The interChange Health Insurance Premium (HIP) functionality will be modified to allow the State to pay the costs of insuring certain NCHC recipients through private insurance. Banking and cash control requirements for the NCHC program, including payment of premiums, will be identical to those of other programs. EDS will issue premium payments from the bank account. As "presentments" are made on the account, EDS will be able to transfer funds from a State account to cover the presentments. The payment method will be either check or EFT.
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	Met through customization of interChange. The process that creates the CMS64 file will need to be updated to exclude any recipient premiums, co-payments, or other cost-sharing fees before the FFP calculation is performed. This will require reducing the individual claim reimbursement amount to the provider by the recipient obligation and also deducting any premium payment money collected directly from the recipients from the total program reimbursement expenditure.

RFP No.	RFP Requirement	EDS Response
40.14.1.106 New (Deleted 7/21/08)	~~Provides capability for actuarial determination of premiums for recipients who purchase coverage in State health programs~~	Cancelled. This requirement was deleted by Appendix 50, Attachment C, Exhibit 1: Addendum State Requirements Matrix, Updated July 21, 2008.

Technical Proposal BAFO page D-478:

Retro-DUR

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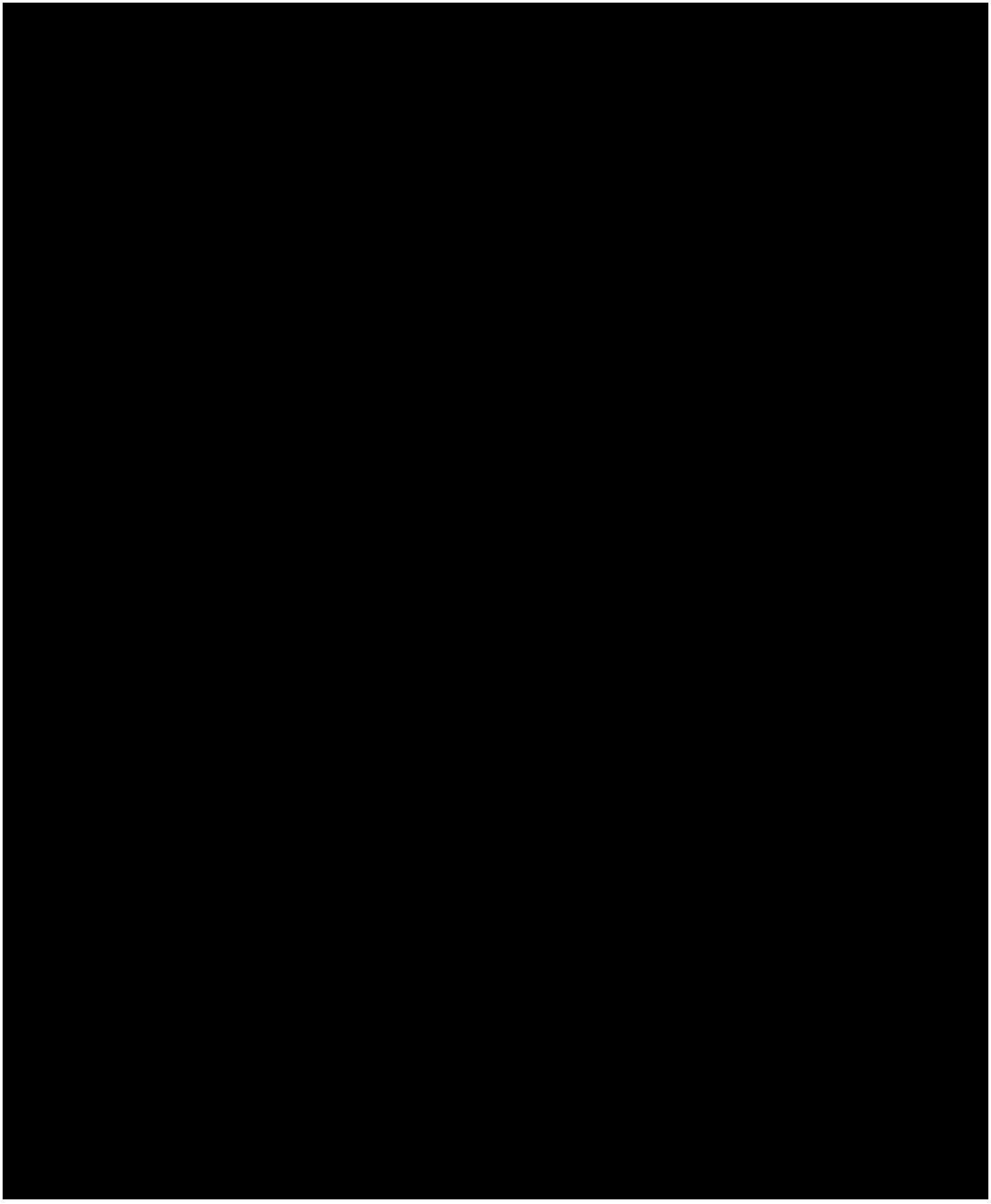

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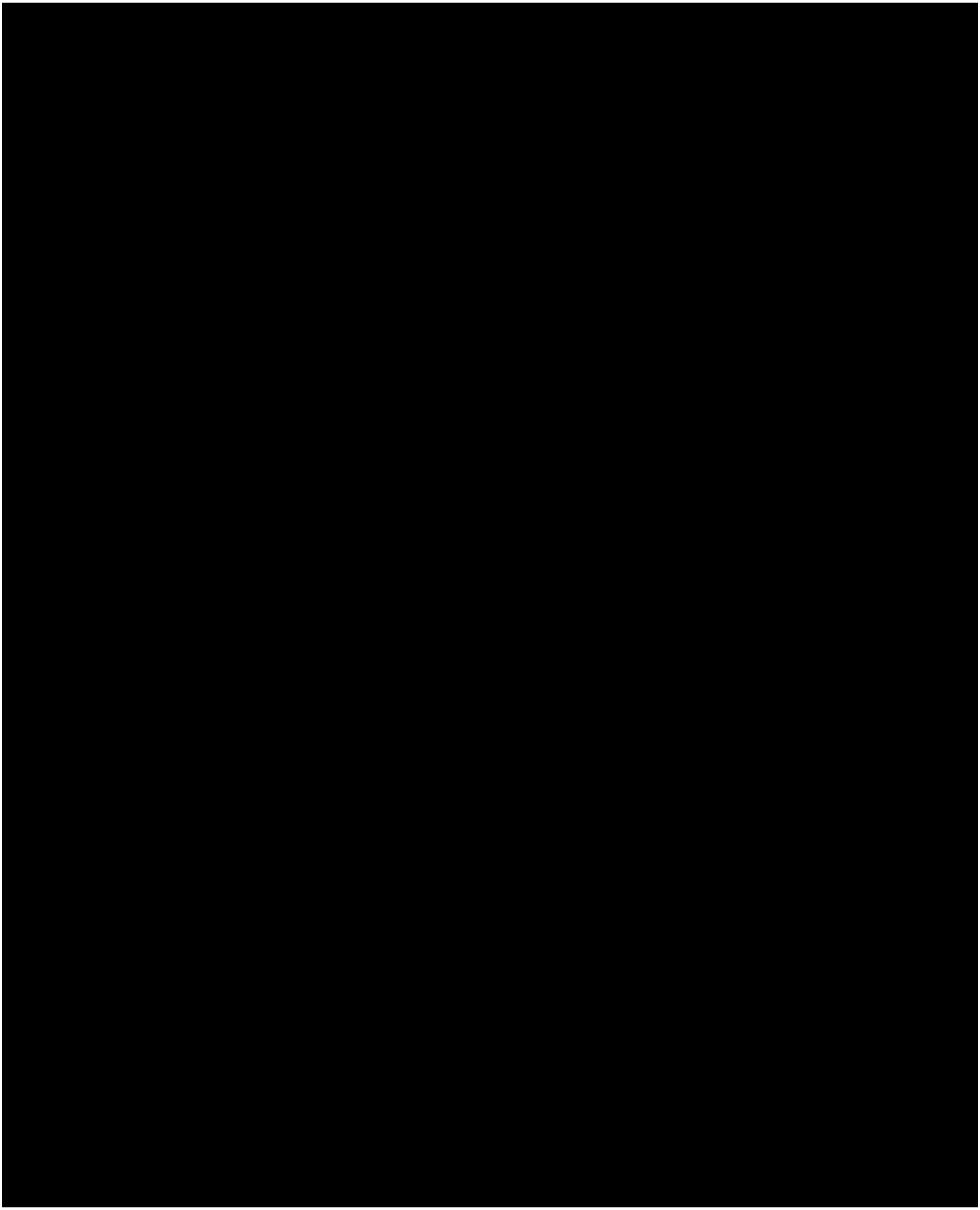

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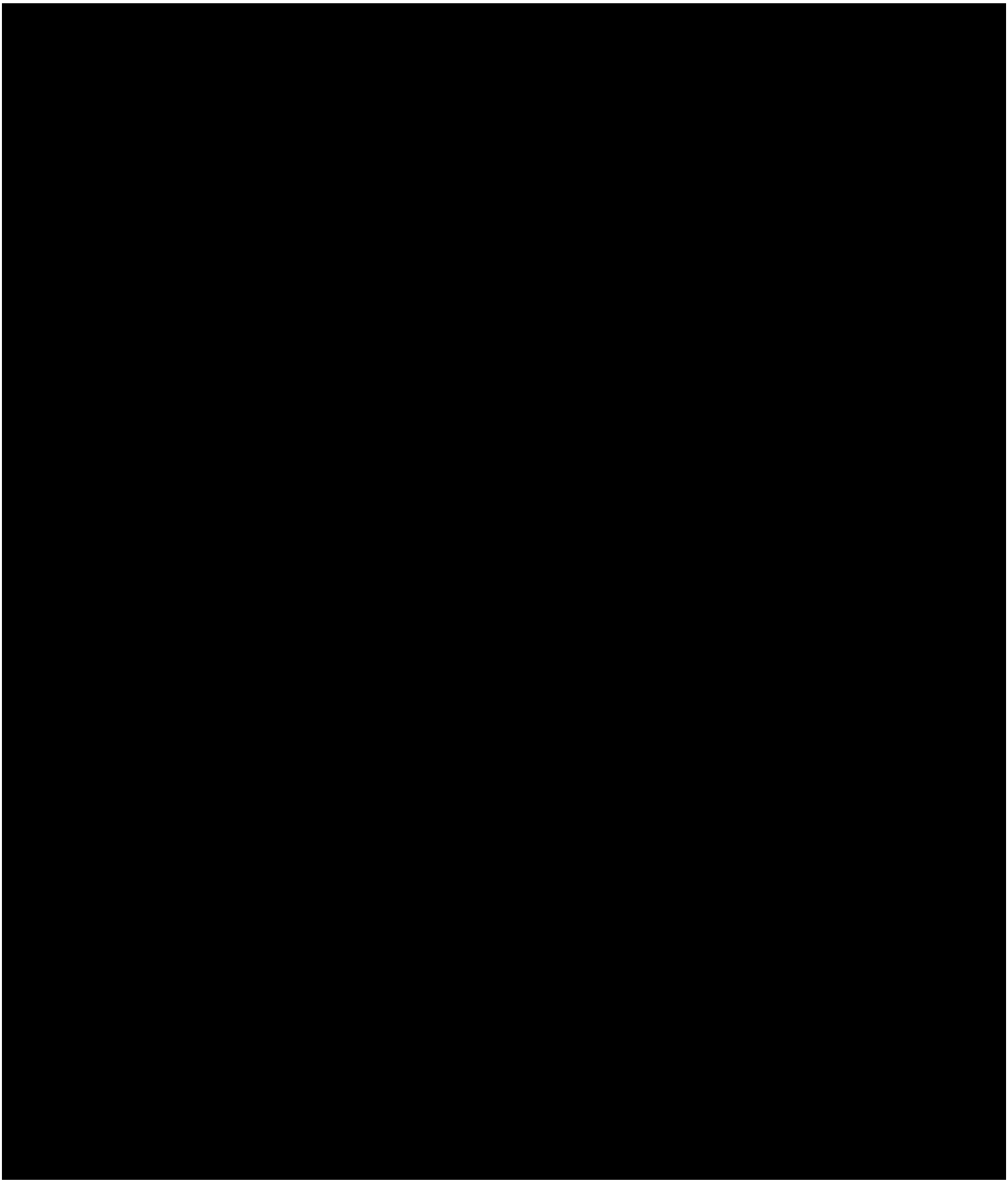

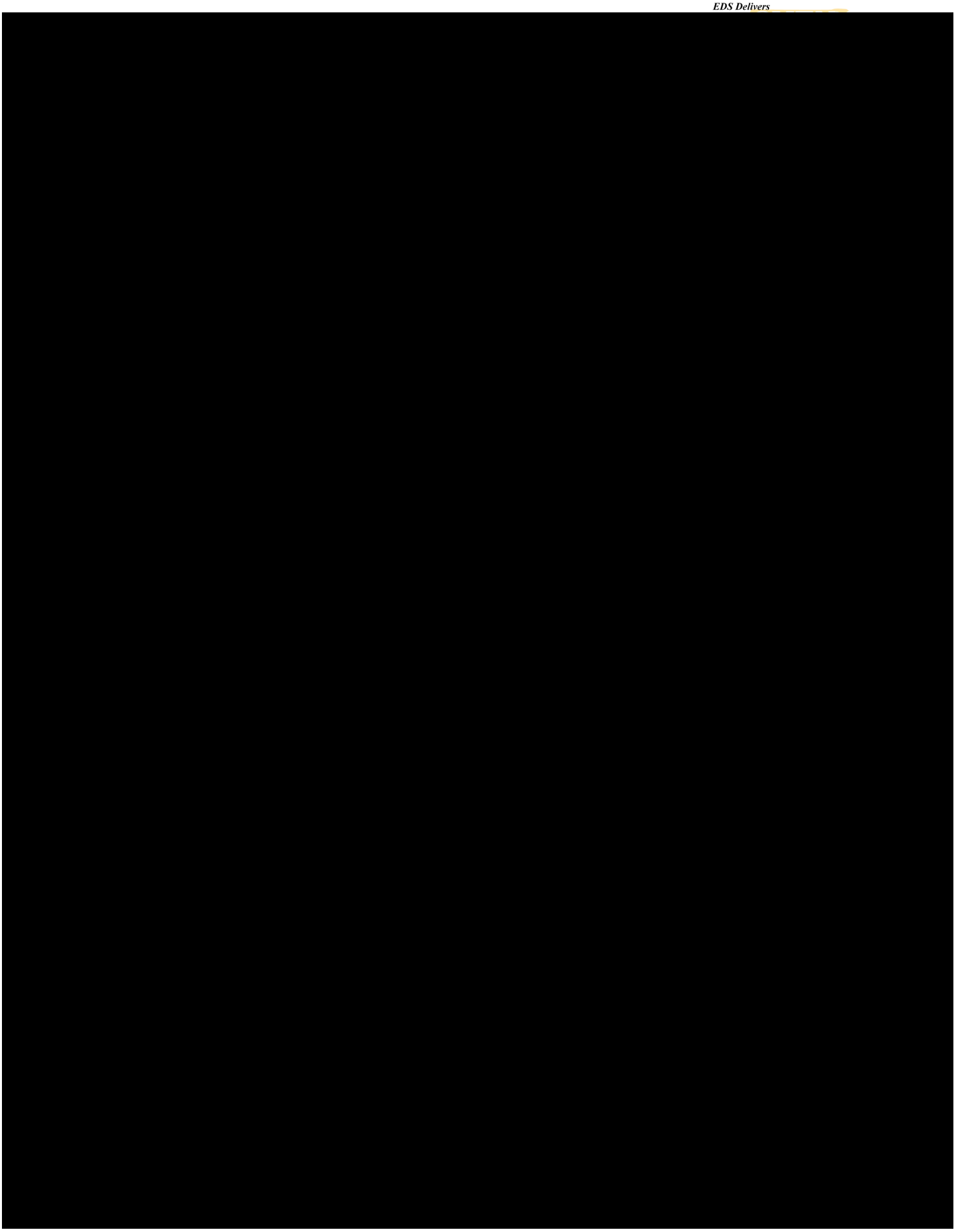

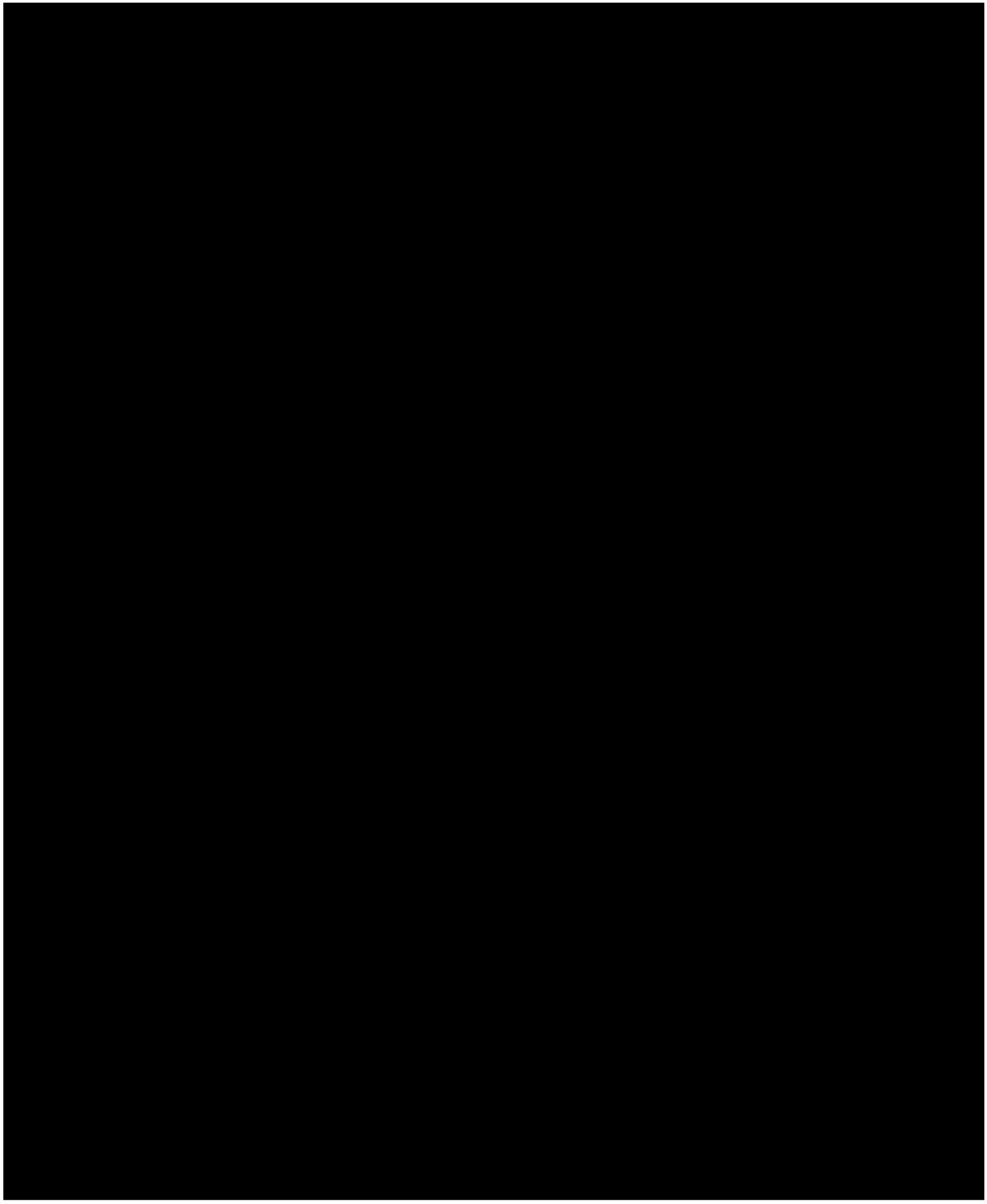

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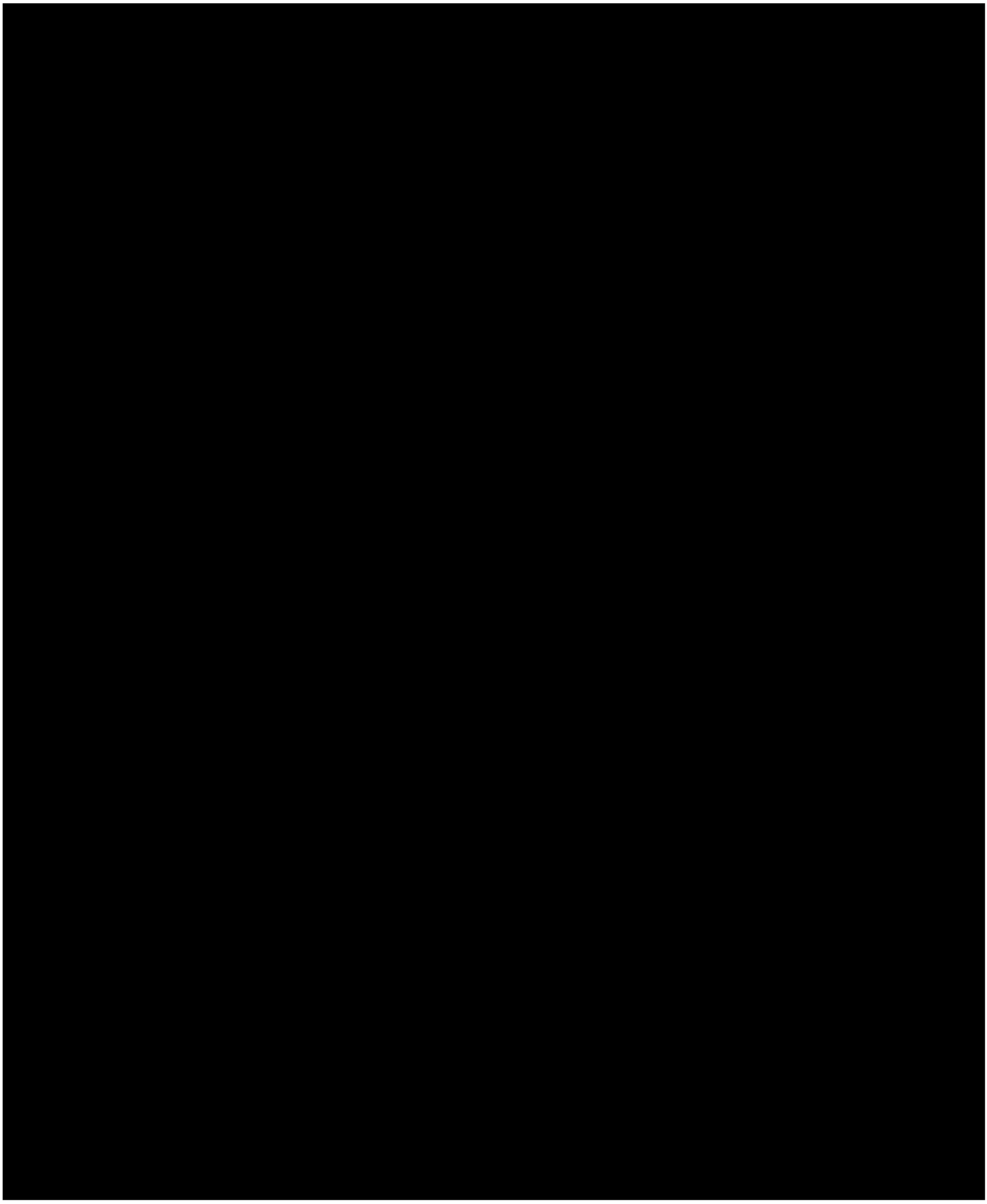


Addendum State Requirements Matrix

On the following page, we provide our completed Addendum State Requirements Matrix, which was updated by the State on July 21, 2008. To complete this matrix, we followed the same approach that we described on Technical Proposal BAFO pages D-627 to D-629.

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

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	N	N	N	S—D-4	Y

Requirement #	Requirement Description	A	B	C	D	E
	Health Program in the Office of Rural Health and Community Care (ORHCC), and to ensure the proper assignment of the financially responsible payer, benefit plan, and pricing methodology for each service tendered in a claim					

40.1.2 General Operational Requirements

Requirement #	Requirement Description	A	B	C	D	E
	Regulatory Compliance					
40.1.2.12	Fiscal Agent (DDI and Operations Phases) shall ensure that the Replacement MMIS incorporates compliance with appropriate Federal and State regulations, statutes, and policies concerning the protection of personally identifiable information and/or financial information. Regulations, statutes, and policies include, without limitation: • 45 CFR Parts 160, 164 (Health Insurance Portability and Accountability Act) • 42 U.S.C. 1320(d) (Public Health, Approval of Special Projects) • 42 CFR Parts 2, 51, 431 (Confidentiality of Mental Health and Substance Abuse information) • 42 CFR Parts 430-502 (Applicable to Medicare/Medicaid) • 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act. • Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d et. seq. • Title XIX, Section 1903 (42 U.S.C. 1396b) Social Security: Payment to States • Title XIX, Section 1927 (42 U.S.C. 1396r-8) Social Security: Payment for covered outpatient drugs • Omnibus Budget Reconciliation Act of 1990 (OBRA'90) • Federal MMIS certification standards • Financial Accounting Standards Board Generally Accepted Accounting Principles	N	N	N	S— D-59	Y

Requirement #	Requirement Description	A	B	C	D	E
	(GAAP) • Part 11 of the State Medicaid Manual • North Carolina State Plans for Medicaid, Mental Health, Developmental Disabilities, and Substance Abuse, and Public Health • US DHHS Title VI Language Access Policy • Recipient eligibility policies from the NC DHHS Eligibility Information System (EIS) and the Common Name Data Service (CNDS) • NC State Law S 1048 (Identity Theft Protection Act) • 10A NCAC Chapters 21 & 22, Medical Assistance • 10A NCAC 26B (Confidentiality Rules For Mental Health, Developmental Disabilities, and Substance Abuse Services) • 10A NCAC Chapter 45, DPH Payment Programs • NC DHHS OSP. 2005. DHHS Application Security Policy. • NC OSCIO. 2004. Application Security Policy with Guidelines, Statewide Information Technology Policy. • N.C.G.S. §126: State Personnel System • N.C.G.S. § 131D: Inspection and Licensing of Facilities • N.C.G.S. §131E: Health Care Facilities and Services • N.C.G.S. § 132: Public Records • The Privacy Act of 1974 5 U.S.C. § 552a • NCAC 10A Chapter 13 - NC Medical Care Commission • 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					

Requirement #	Requirement Description	A	B	C	D	E
	• 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	N	Y	S—D-62	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 benefit plans and data relationships in a multi-payer environment	Y	N	N	S—D-62	Y

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	Y	N	S—D-4	Y
40.2.1.125 **(New)**	Provides capability to produce NCHC original and replacement recipient benefit booklets	N	N	Y	S—D-5	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				S—D-64	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				S—D-64	Y
40.2.2.11 **(New)**	Fiscal Agent shall respond to requests to issue replacement recipient benefit booklets for NCHC recipients	N	N	Y	S—D-64	Y
40.2.2.12 **(New)**	Fiscal Agent shall respond to requests to issue replacement recipient identification cards for NCHC recipients	N	Y	N	S—D-64	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	S—D-6	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	S—D-7	Y
40.4.1.22	Provides capability for call flows for the following provider inquiry types: • Claim status • Checkwrite • Drug coverage • Procedure code pricing • Modifier verification • Procedure code and modifier combination • Procedure code pricing for Medicaid Community Alternatives Program services • Prior approval for procedure code • Medicaid 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	Y	N	N	S—D-7	Y
40.4.1.24	Provides capability for call flows for responses for the following Medicaid recipient inquiry	N	N	Y	S—	Y

Requirement #	Requirement Description	A	B	C	D	E
	types: • Medicaid eligibility • Managed care enrollment information, including the primary care provider name, address, and daytime and after-hours phone numbers • Third party liability • Medicare coverage • Well child checkup dates • Hospice eligibility • Cost sharing, such as premium payments, deductibles, co-payments, and balances				D-8	
40.4.1.26	Provides capability to return a reference number to a provider for DMA/Medicaid and NCHC eligibility verification inquiry and responses issued from the AVRS	N	N	Y	S— D-8	Y
40.4.1.38 **(New)**	Provides capability to support call flows for responses for the following NCHC recipient inquiry types: • 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	N	N	Y	S— D-8	Y
	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	S— D-9	N
40.4.1.39	Provides capability for NC Health Choice recipient access to recipient eligibility and enrollment information, including but not limited to:	N	N	Y	S— D-9	N

Requirement #	Requirement Description	A	B	C	D	E
(New)	• 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					

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: • 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	Y	N	N	S— D-14	Y

Requirement #	Requirement Description	A	B	C	D	E
	• 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: ○ 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 ○ Provider subspecialty ○ Drug Coverage (effective/term dates) ○ Health Check reporting indicator ○ Family Planning indicator ○ Family Planning Waiver Indicator					

Requirement #	Requirement Description	A	B	C	D	E
	• 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	Provides capability to apply State-approved policy to: • HCPCS, including CPT, American Dental Association (ADA) codes, HCPCS Level II codes, NDCs, State local codes, International Classification of Diseases diagnosis and procedure codes (ICD-9) and future ICD codes • Drug codes • Edits • Rate methodology and calculations • Professional services fees • NCHC-specific services	Y	N	N	S—D-16	Y
40.6.1.89	Provides capability to create Fee Schedule reports detailed in the bullets below: • Adult Care Home Personal Care • Ambulance • Ambulatory Surgical Centers/Birthing Centers • Behavioral Health (separate schedules) • Certified Clinical Supervisor and Addictions Specialist • Children's Developmental Service Agencies • Licensed Clinical Social Worker and Licensed Professional Counselor and Licensed Marriage and Family Therapist • Licensed Psychological Associate	N	N	Y	S—D-16	Y

Requirement #	Requirement Description	A	B	C	D	E
	• 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					

Requirement #	Requirement Description	A	B	C	D	E
	• Respiratory Therapy • Rural Health Center • Speech and Audiology Services • NCHC services					
40.6.1.94 **(New)**	Provides capability to create NC Title XXI Tables Manual and edit resolution documents	Y	N	N	S— D-17	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~~				S— D-18	

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	S— D-20	Y
40.7.1.69** **(New)**	Provides capability to process claims based on pre-admission and length-of-stay recommendations	N	N	N	S— D-20	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 *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 in the media and timing as directed by the State	N	N	N	S—D-65	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				S—D-65	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)				S—D-65	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	N	N	N	S—D-66	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				S—D-66	Y

Requirement #	Requirement Description	A	B	C	D	E
	and local standards					
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				S—D-66	Y
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				S—D-66	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				S—D-66	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				S—D-66	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				S—D-67	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				S—D-67	Y
	Pre-Admission Certification					
40.7.2.50**	Fiscal Agent shall perform pre-admission certifications (medical necessity) and length-of-stay approvals (based on industry guidelines) for NCHC recipients prior to hospital	N	Y	N	S—D-67	Y

Requirement #	Requirement Description	A	B	C	D	E
(New)	inpatient admissions					

40.7.3 Prior Approval Operational Performance Standards

Requirement #	Requirement Description	A	B	C	D	E
Requirement Deleted 40.7.3.11	~~Fiscal Agent shall meet monthly with DUR, the State and/or Retrospective DUR vendors and Community Care Program and include minutes in bi-weekly Project Status Report~~				S— D-68	
40.7.3.14 **(New)**	Fiscal Agent shall deliver all meeting minutes to the State within five (5) business days following each meeting				S— D-68	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				S— D-68	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	Provides capability to allow payment for all medically necessary services approved for	N	N	N	S—	Y

Requirement #	Requirement Description	A	B	C	D	E
(Revised)	EPSDT and NCHC Special Needs Plan-eligible recipients				D-24	
40.8.1.384 **(New)**	Provides capability to reimburse NCHC recipients for eligible out of pocket claims payment	N	N	Y	S—D-24	Y
40.8.1.385 **(New)**	Provides capability to process claims filed by NCHC recipients	N	N	Y	S—D-25	Y
40.8.1.386 **(New)**	Provides capability to apply service limitations across multiple health care programs and benefit plans as applicable	N	N	N	S—D-25	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	N	N	S—D-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	Y	S—D-26	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~~				S—D-27	

Requirement #	Requirement Description	A	B	C	D	E
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~~				S—D-27	
Requirement Deleted 40.8.1.202	~~Provides capability to generate a file of recipient data to the Retrospective DUR Vendor~~				S—D-27	
40.8.1.203	Provides capability to generate 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 in the media and timing as directed by the State				S—D-27	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				S—D-27	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	S—D-27	Y

40.8.2 Claims Processing Operational Requirements

Requirement #	Requirement Description	A	B	C	D	E
	Drug Utilization Review					
Requirement Deleted	~~Fiscal Agent shall produce information to support the State in completing the CMS Annual Utilization Review Report~~				S—D-68	

Requirement #	Requirement Description	A	B	C	D	E
40.8.2.39						
40.8.2.40	Fiscal Agent shall prepare State-approved agendas, associated meeting materials and minutes for the DUR Board quarterly meetings	N	N	N	S—D-69	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~~				S—D-69	
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 exceed the service limit	N	N	N	S—D-69	Y
40.8.2.57 **(New)**	Fiscal Agent shall attend quarterly DUR Board meetings				S—D-70	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	N	N	Y	S—D-70	Y
40.8.2.59 **(New)**	Fiscal Agent shall provide the State with DUR Programs Project Status Reports on a biweekly basis				S—D-70	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				S—D-70	Y
40.8.2.61	Fiscal Agent shall prepare the agenda and minutes for its monthly meetings with the				S—	Y

Requirement #	Requirement Description	A	B	C	D	E
(New)	State				D-70	
40.8.2.62 **(New)**	Fiscal Agent shall be available to the State for DUR-related consultation during normal business hours				S— D-70	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~~				S— D-70	

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~~				S— D-28	

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~~				S—D-71	

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	S—D-28	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 comments	N	N	N	S—D-28	Y
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	S—D-29	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	N	S—D-29	Y
40.12.1.29	Provides capability to make available to the State the total expenditures for multiple	N	N	Y	S—	Y

Requirement #	Requirement Description	A	B	C	D	E
	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				D-29	
40.12.1.71**	Provides capability to capture State determined drug unit rebate amount and units of measure by drug rebate program	N	N	Y	S—D-29	Y
40.12.1.72**	Provides capability to build and maintain the State's Drug Rebate Labeler Data	N	N	N	S—D-30	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	Y	S—D-71	Y
40.12.2.21**	Fiscal Agent shall attend Drug Rebate Labeler Dispute meetings as required by the State				S—D-71	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	N	N	Y	S—	~~Y~~Y

Requirement #	Requirement Description	A	B	C	D	E
	ninety-nine and nine tenths (99.9) percent of the time, by drug rebate program				D-72	
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	S— D-72	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	Y	N	S— D-38	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	N	S— D-38	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	N	S— D-38	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-payments, etc.) processes	N	Y	N	S— D-38	Y

Requirement #	Requirement Description	A	B	C	D	E
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	Y	N	S—D-38	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	S—D-39	Y
40.14.1.97 **(New)**	Provides capability for automated calculation of recipient premiums on a sliding scale	Y	N	N	S—D-40	Y
40.14.1.98 **(New)**	Provides capability for online display of recipient premium payment history to include all payments, refunds and adjustments	N	Y	N	S—D-40	Y
40.14.1.99 **(New)**	Provides capability for online display of recipient cost-sharing data such as premiums, deductible, co-pays, etc.	N	Y	N	S—D-40	Y
40.14.1.100 **(New)**	Provides capability for determining and tracking premium due dates	N	Y	N	S—D-40	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	Y	N	S—D-40	Y

Requirement #	Requirement Description	A	B	C	D	E
40.14.1.102 **(Revised)**	Provides capability for accounts payable functionality to track all unpaid refunds	N	N	N	S— D-41	Y
40.14.1.103 **(Revised)**	Provides capability to generate online notification of premium payment status to the Eligibility Information System (EIS)	N	N	Y	S— D-41	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	Y	S— D-41	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	S— D-41	Y
Requirement Deleted 40.14.1.106	~~Provides capability for actuarial determination of premiums for recipients who purchase coverage in State health programs~~				S— D-42	

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	S— D-86	Y
40.14.2.72	Fiscal Agent shall establish operational accounting procedures for recipient premiums, in				S—	Y

Requirement #	Requirement Description	A	B	C	D	E
(New)	accordance with GAAP, including payments, refunds, adjustments, collection, processing, tracking, imaging, recording and reconciliation				D-86	
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	Y	N	S—D-86	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	Y	N	S—D-86	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	Y	N	S—D-86	Y
40.14.2.76 **(New)**	Fiscal Agent shall update recipient premium payment history online to reflect all payments, refunds and adjustments	N	Y	N	S—D-86	Y
40.14.2.77 **(New)**	Fiscal Agent shall establish a receipt system to handle cash premium payments and refunds	N	Y	N	S—D-87	Y
40.14.2.78 **(New)**	Fiscal Agent shall deposit funds into a State-owned account as required by State and Federal policy	N	N	Y	S—D-87	Y
40.14.2.79 **(New)**	Fiscal Agent shall prepare financial statements and expenditure reports and submit them as directed by the State	N	Y	N	S—D-87	Y
40.14.2.80	Fiscal Agent shall accept, at a minimum, cash, check, money order, and credit/debit card	N	N	Y	S—	Y

Requirement #	Requirement Description	A	B	C	D	E
(New)	for recipient premium payments				D-87	

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				S— D-88	Y

Addendum SOO Requirements Matrix

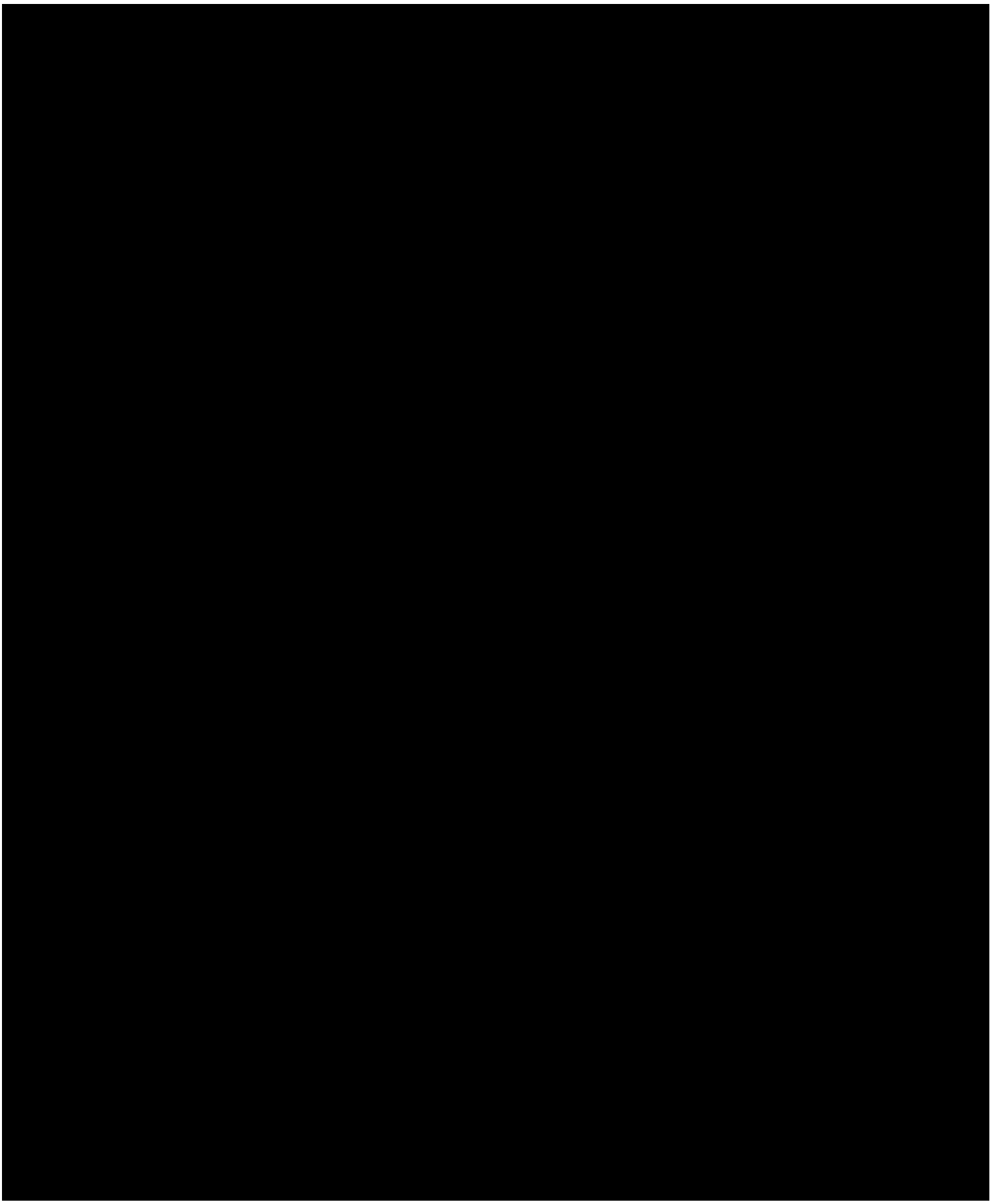
On the following page, we provide our completed Addendum SOO Requirements Matrix, which was submitted by the State on July 21, 2008.

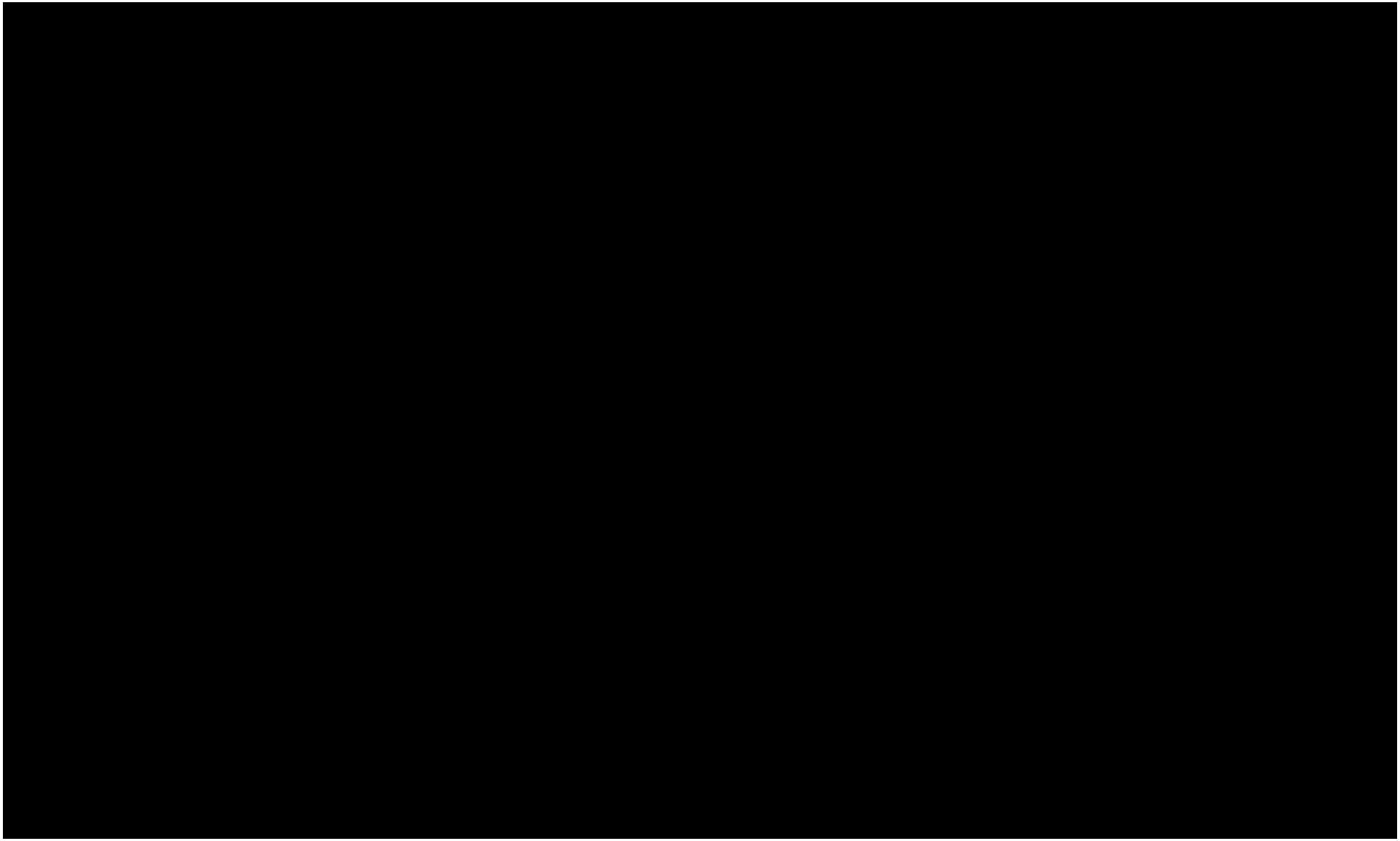
Addendum Statement of Objectives (SOO) Requirements Matrix, Updated July 21, 2008

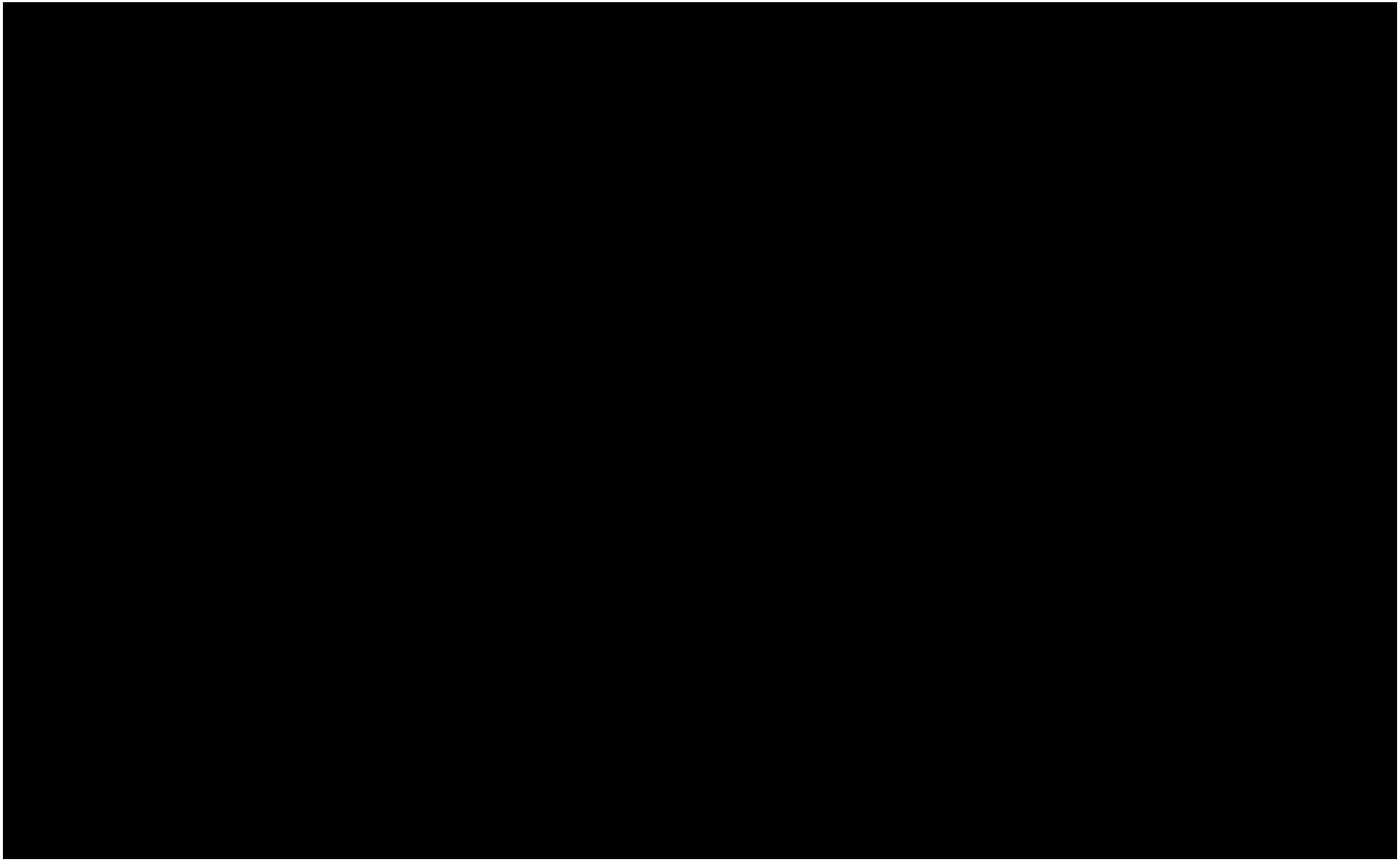
Section #	Page	Mandatory/ Non-Mandatory	Statement	Vendor will meet the requirement or objective (Y/N)	Proposal Page Reference(s)
S.1.1	1	Mandatory	...the Replacement MMIS shall "have the capability to fully implement the administration of NC Health Choice, NC Kids' Care, Ticket to Work, Families Pay 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	S—D-3
S.1.1	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	Premium Payments section, S—D-30 to S—D-34
S.1.1	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	Premium Payments section, S—D-30 to S—D-34 Premium Billing and Collections section, S—D 72 to S—D-85
S.1.1	1	Mandatory	...for NCHC and Kids' Care, the Fiscal Agent shall provide mechanisms for recipient communications concerning claims payment, prior approvals, covere services, and other non-eligibility related issues	Y	General AVRS System Requirements section, S—D-7 to S—9 Web Inquiry Requirements section, S—D-9 to S—D-10
S.1.1	1	Mandatory	[Premium] Payment methods shall include, at a minimum, cash, check, money order, and credit/debit card.	Y	Cash, check, money order: Processing, Depositing, and Posting Payments section, S—D-80 Credit/debit card: EDS*PAY section, S—D-83 to S—D-84 Payment Methods Supported table, S—D-35 to S—D-36
S.1.1	2	Mandatory	Offerors shall propose collection and refunding methodologies (e.g., mail, phone, EFT, Web, etc.) that are flexible and cost effective	Y	Collections: Payment Methods Supported table, S—D-35 to S—D-36 Collections and refunds: Premium Billing and Collections section, S—D 72 to S—D-88
S.2	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	S—D-42
S.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	S—D-45

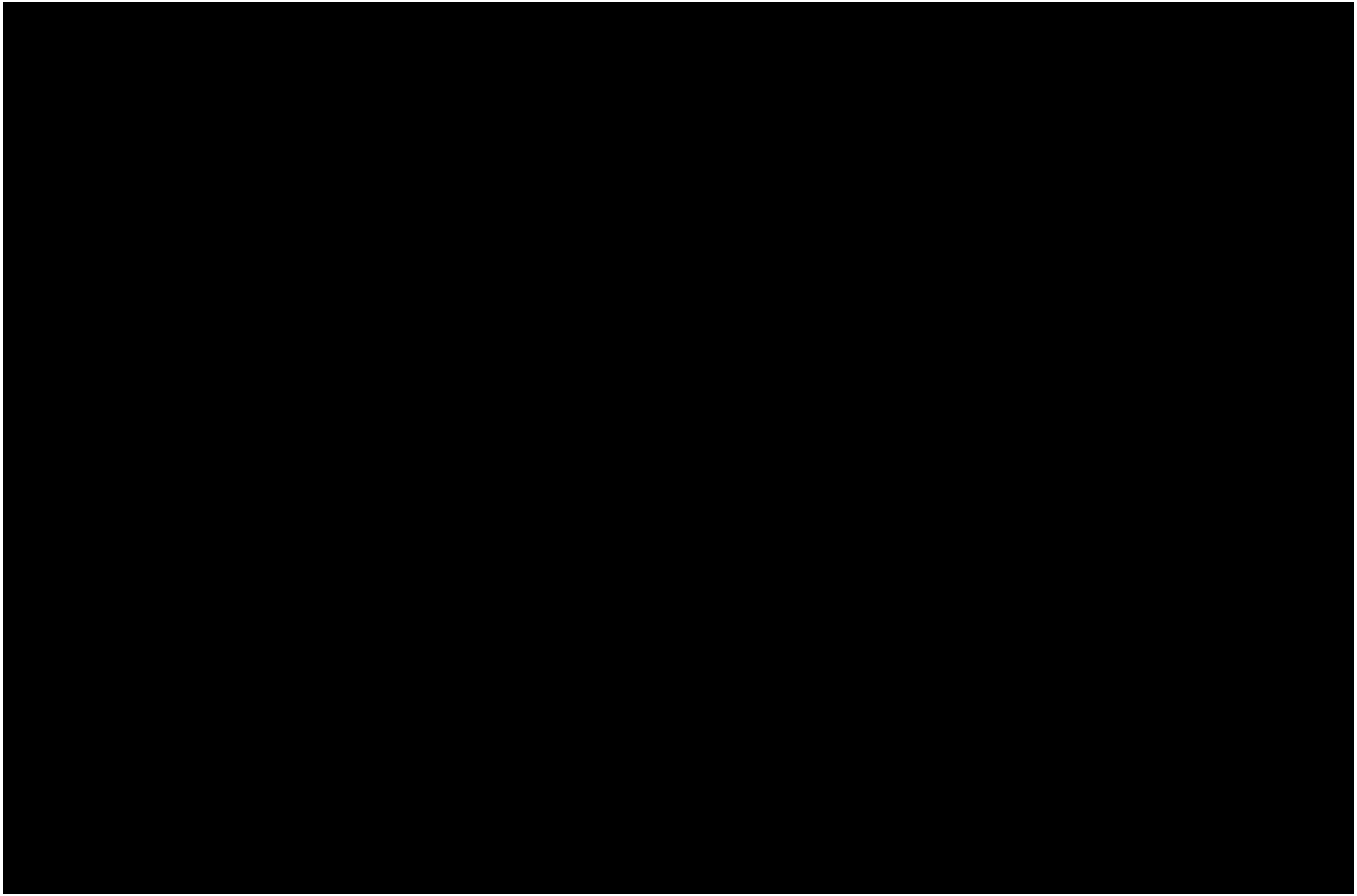
Changes to Adjusted Function Point Count

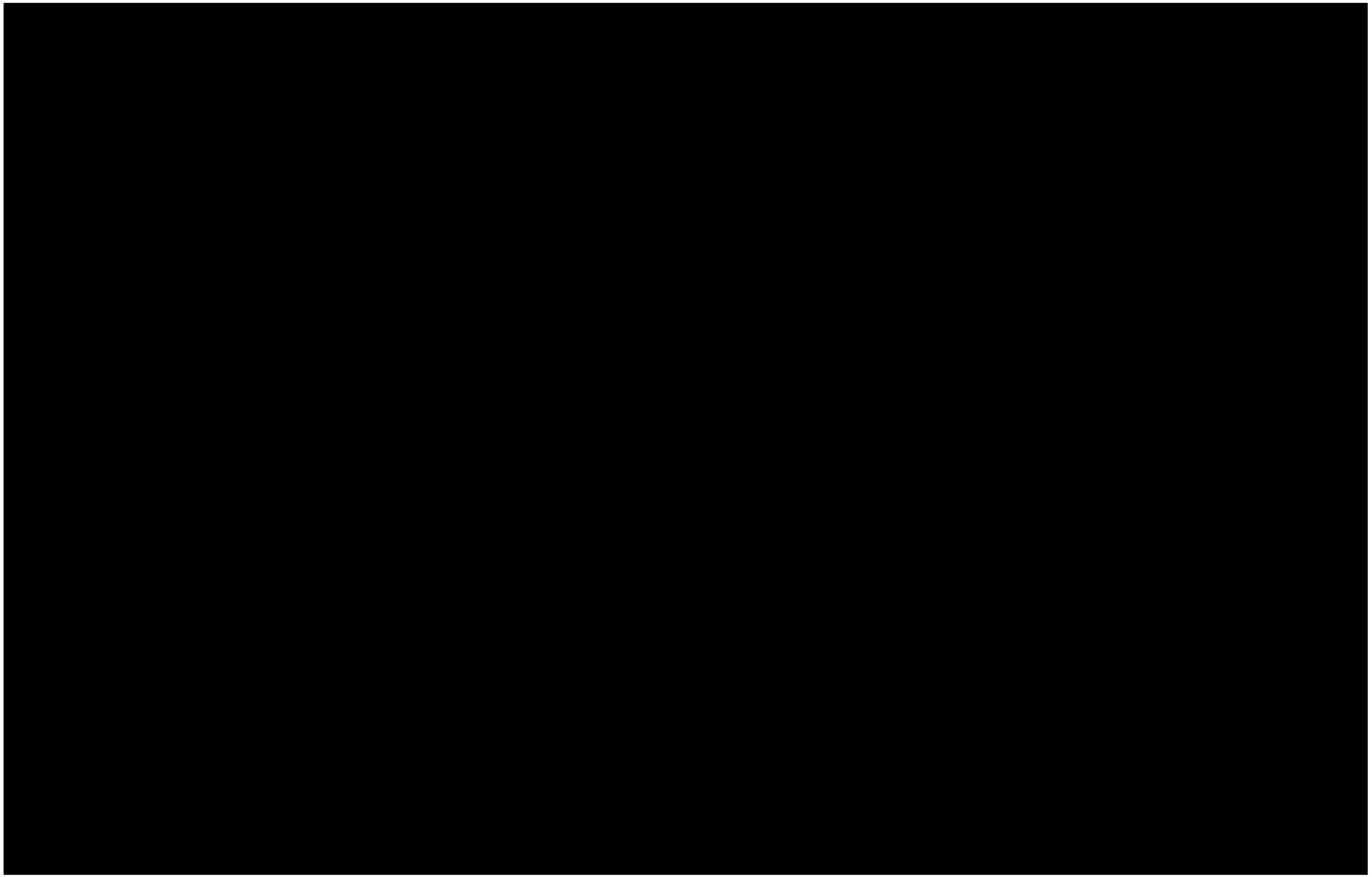
[redacted]

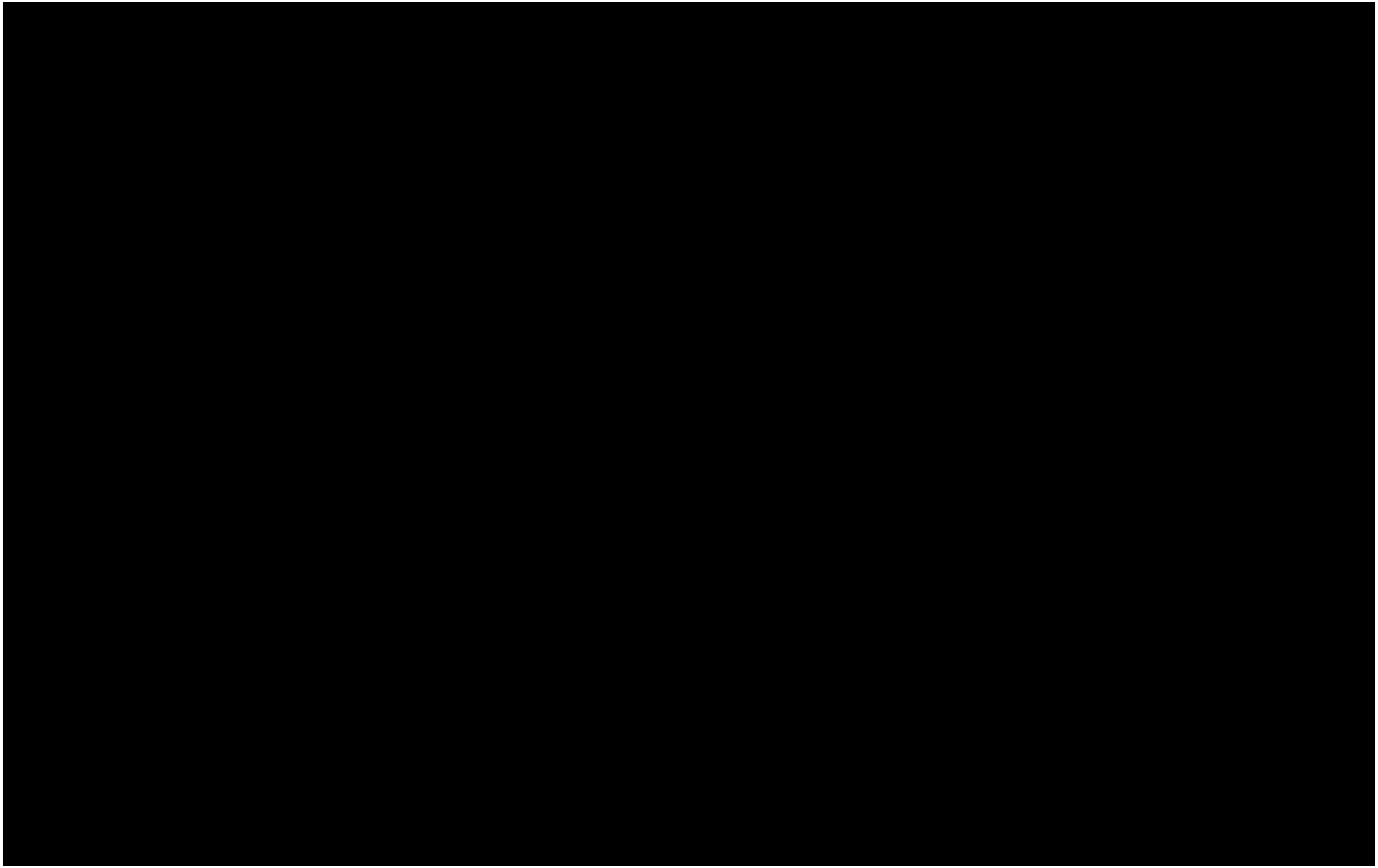


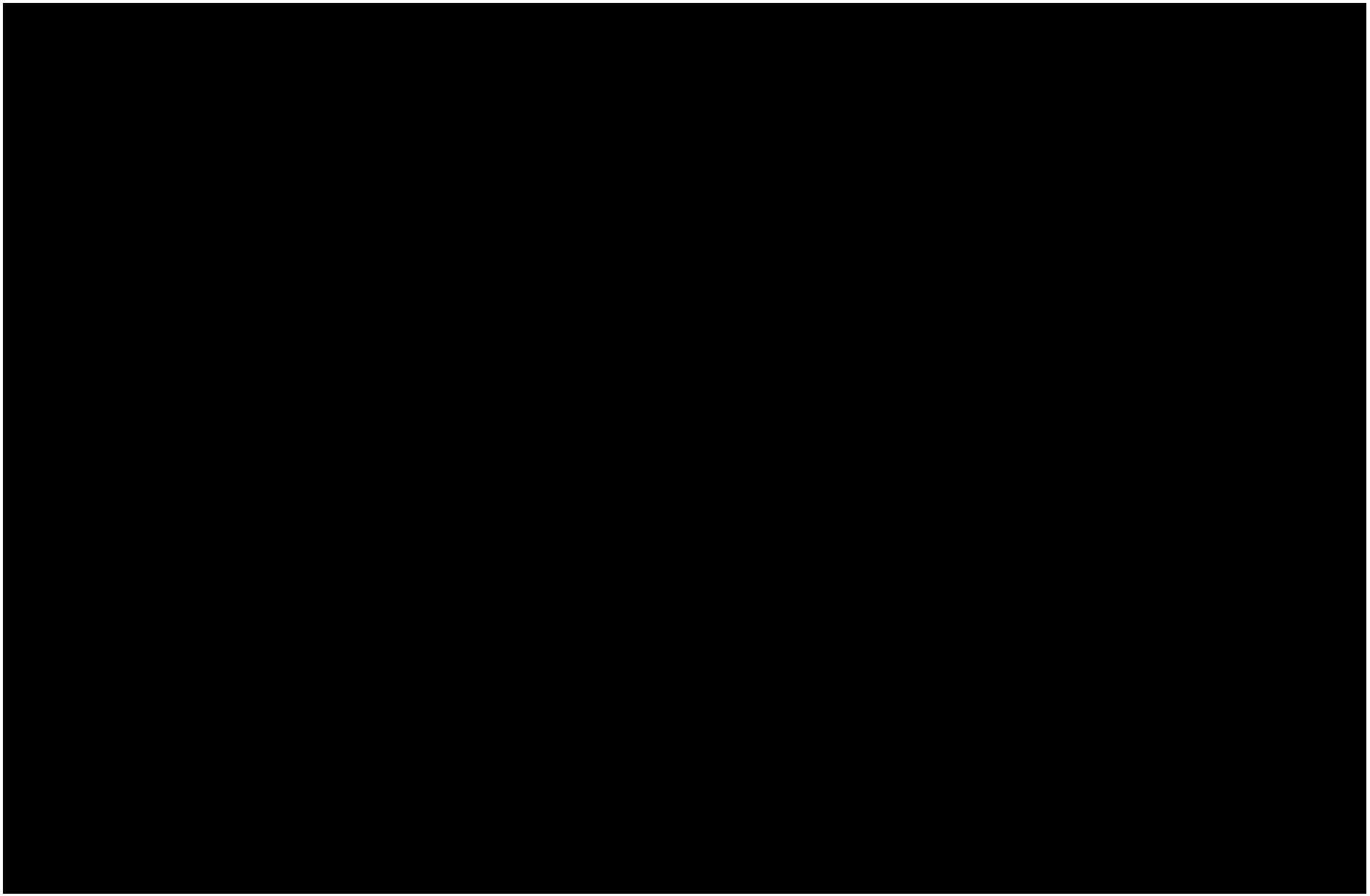


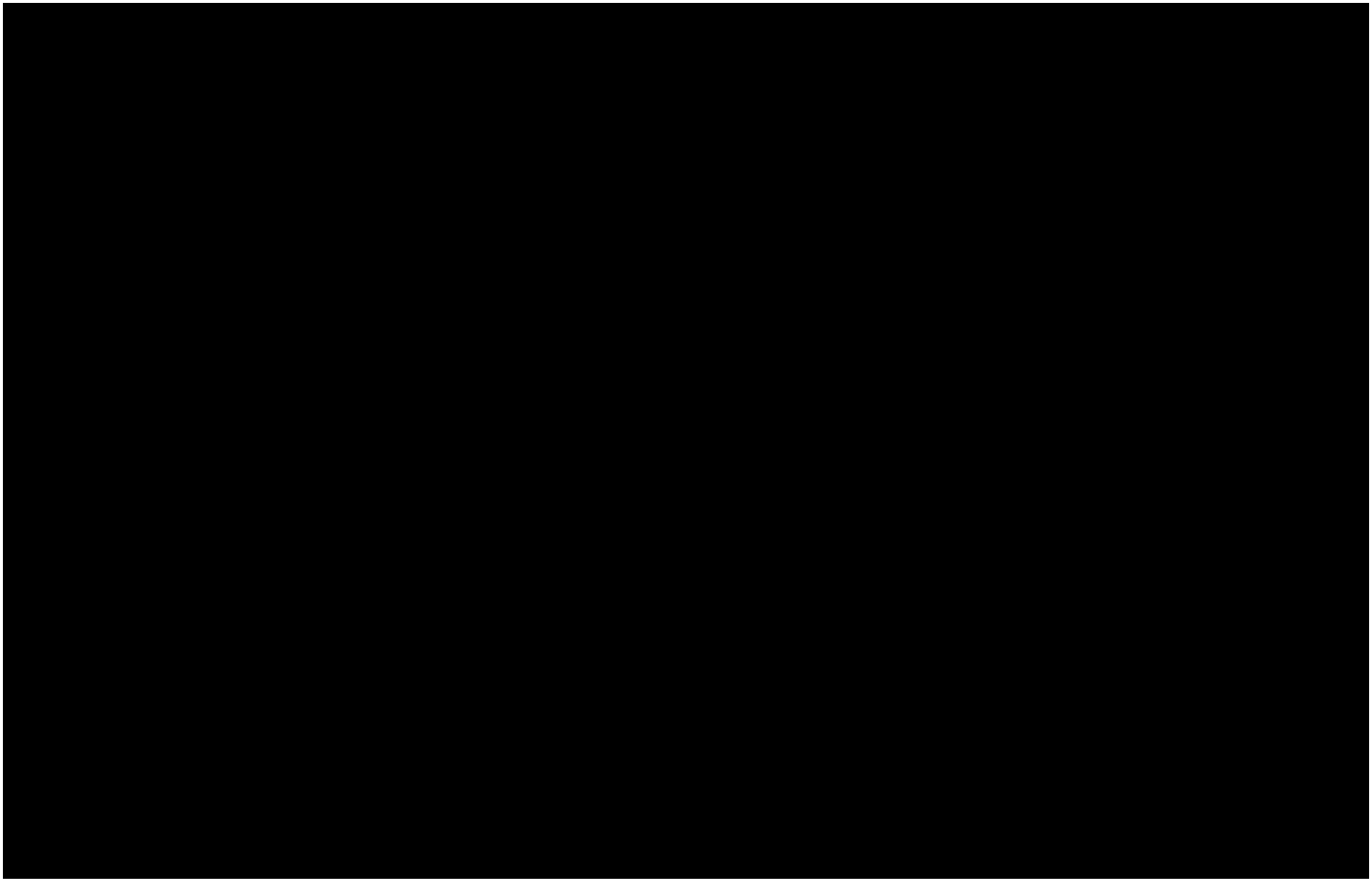


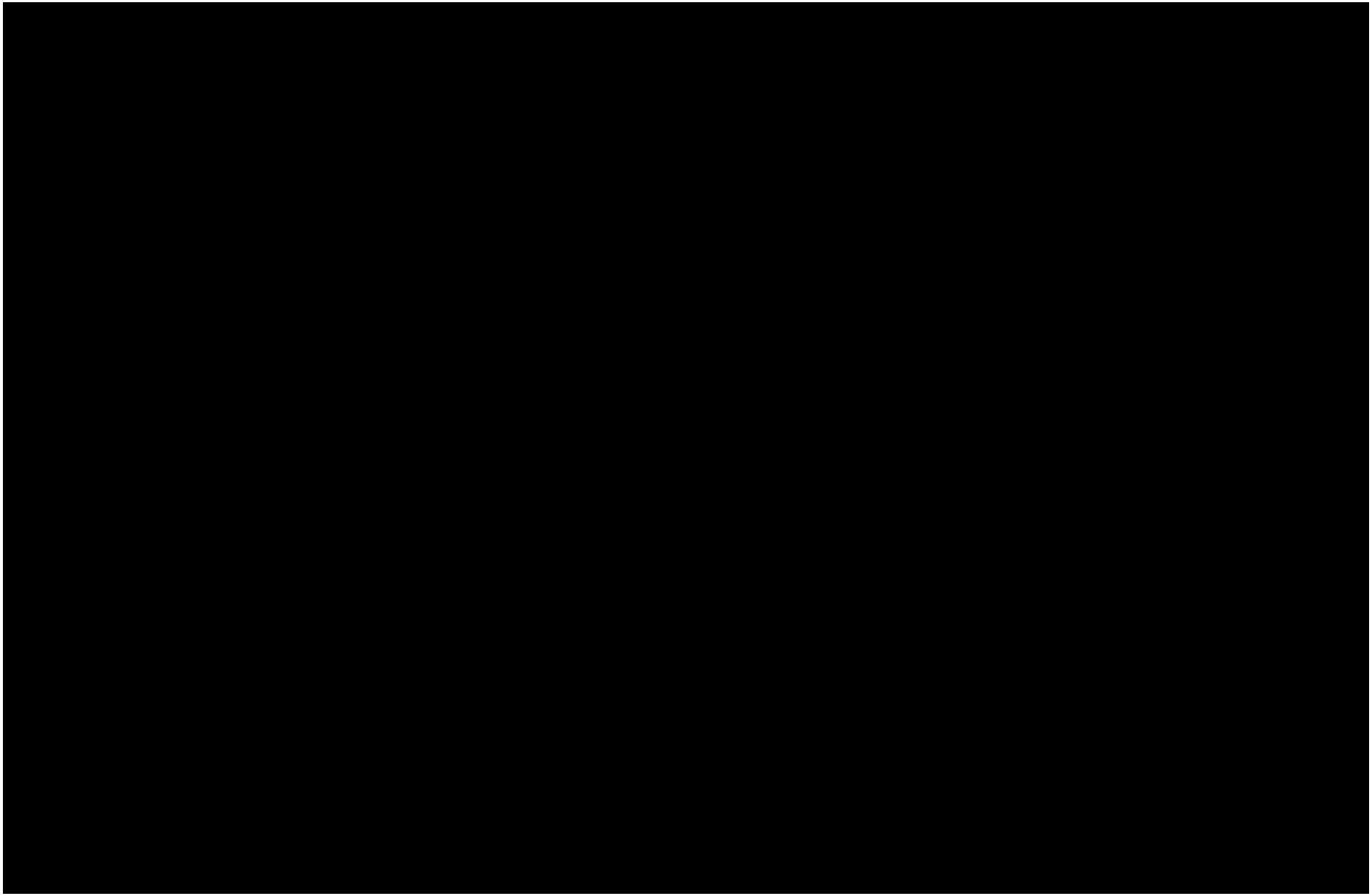


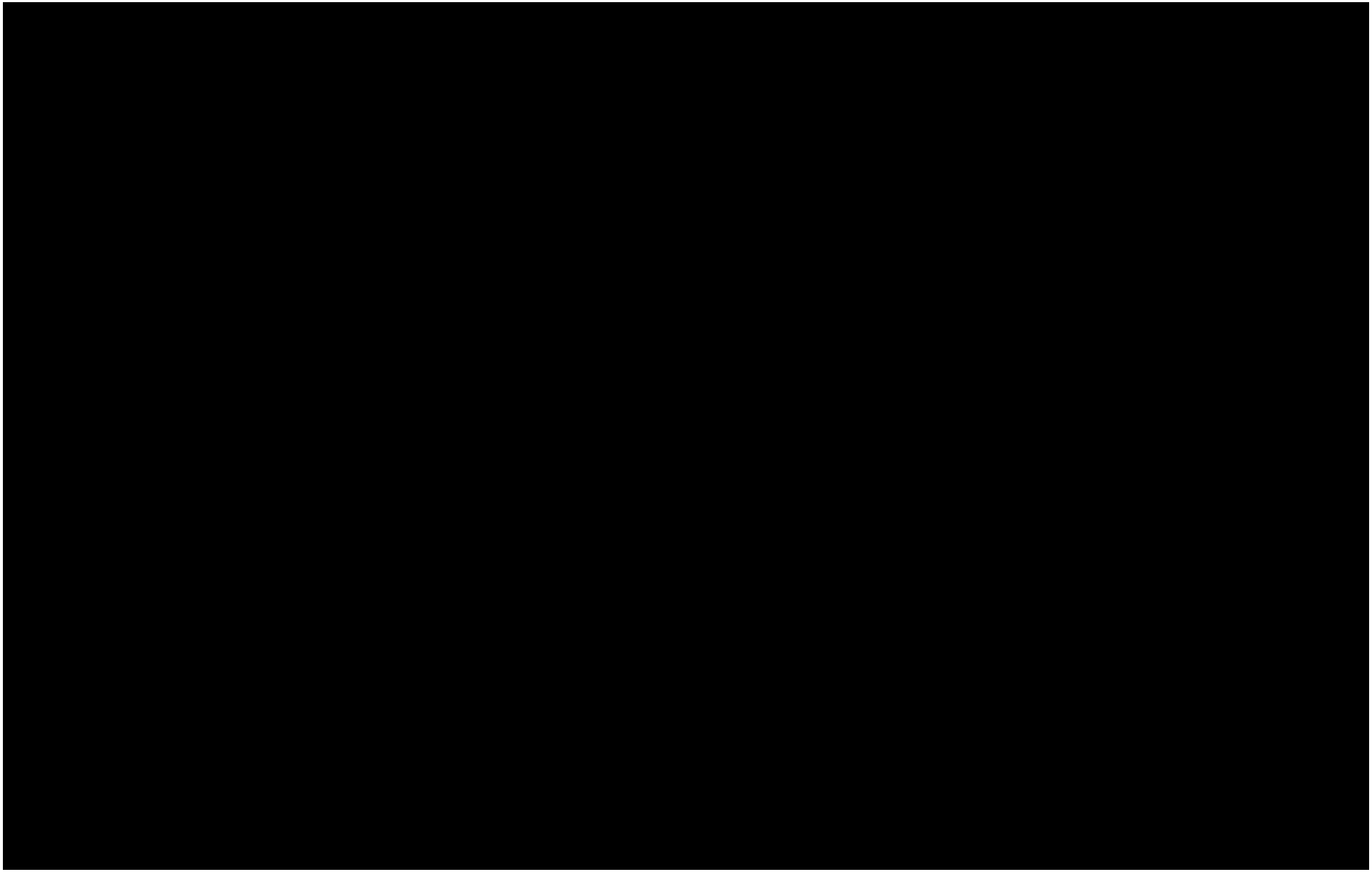


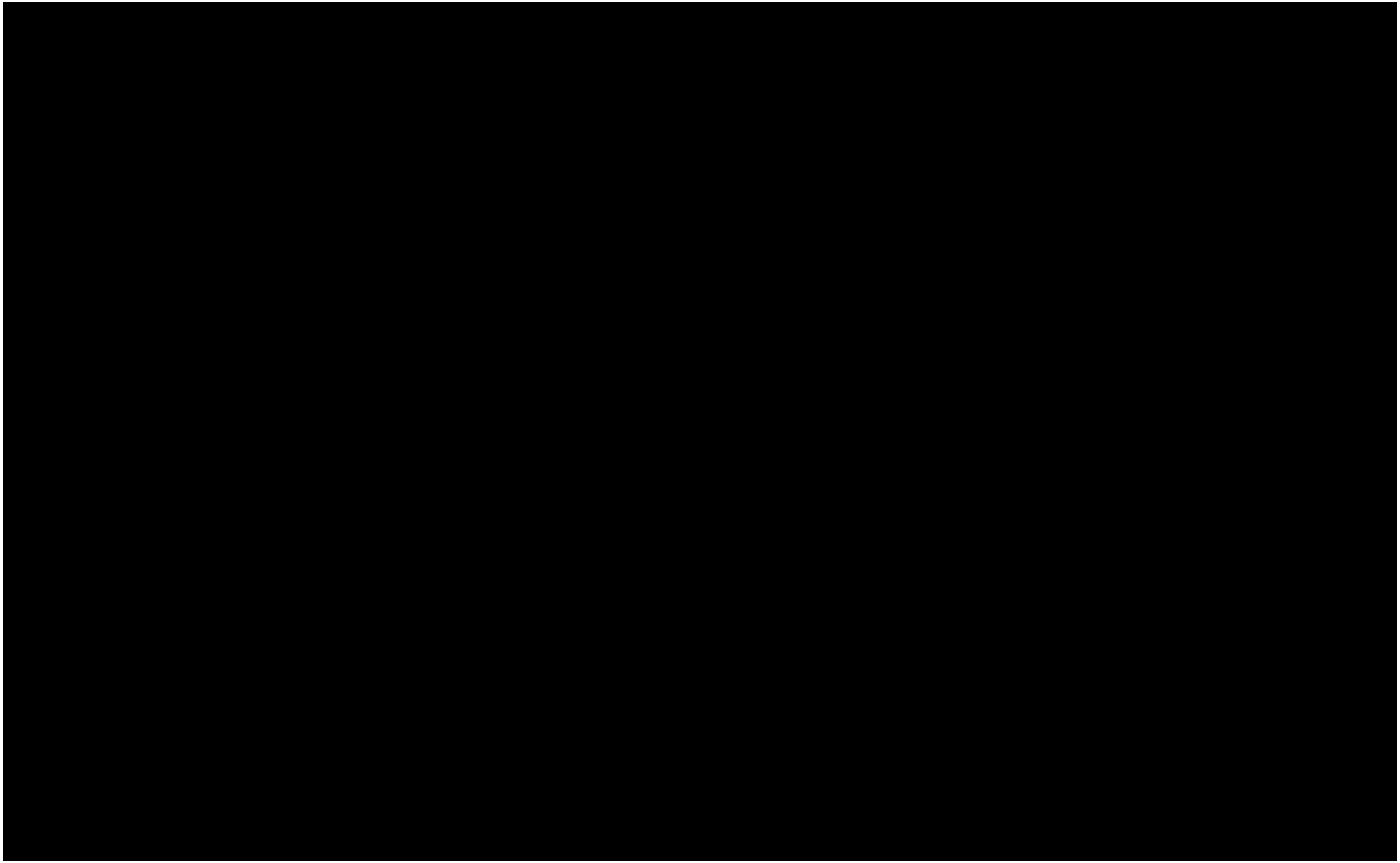












Changes to Proposed Solution for Operations

Technical Proposal BAFO page D-641:

RFP No.	RFP Requirement	EDS Response
40.1.2.12	Fiscal Agent (DDI and Operations Phases) shall ensure that the Replacement MMIS incorporates compliance with appropriate Federal and State regulations, statutes, and policies concerning the protection of personally identifiable information and/or financial information. Regulations, statutes, and policies include, without limitation: • 45 CFR Parts 160, 164 (Health Insurance Portability and Accountability Act) • 42 U.S.C. 1320(d) (Public Health, Approval of Special Projects) • 42 CFR Parts 2, 51, 431 (Confidentiality of Mental Health and Substance Abuse information) • 42 CFR Parts 430-502 (Applicable to Medicare/Medicaid) • 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act. • Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d et. seq. • Title XIX, Section 1903 (42 U.S.C. 1396b) Social Security: Payment to States • Title XIX, Section 1927 (42 U.S.C. 1396r-8) Social Security: Payment for covered outpatient drugs • 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	Met by interChange and operational processes and procedures. The Replacement MMIS incorporates compliance with appropriate federal and State regulations, statutes, and policies concerning the protection of personally identifiable information or financial information. Our design has taken in the appropriate federal and State regulations and statutes, and as a direct result, the interChange solution has always received CMS certification back to the first day of operations. EDS teams spend significant time reviewing legislation and designing solutions to comply with the specific intricacies of State policy. New legislation can often have an enterprisewide impact, and thorough understanding ahead of time enables quick impact assessments and incorporation into the implementation~~s~~.

RFP No.	RFP Requirement	EDS Response
	Name Data Service (CNDS) • NC State Law S 1048 (Identity Theft Protection Act) • 10A NCAC Chapters 21 & 22, Medical Assistance • 10A NCAC 26B (Confidentiality Rules For Mental Health, Developmental Disabilities, and Substance Abuse Services) • 10A NCAC Chapter 45, DPH Payment Programs • NC DHHS OSP. 2005. DHHS Application Security Policy. • NC OSCIO. 2004. Application Security Policy with Guidelines, Statewide Information Technology Policy. • N.C.G.S. §126: State Personnel System • N.C.G.S. § 131D: Inspection and Licensing of Facilities • N.C.G.S. §131E: Health Care Facilities and Services • N.C.G.S. § 132: Public Records • The Privacy Act of 1974 5 U.S.C. § 552a • NCAC 10A Chapter 13 - NC Medical Care Commission • 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)	

Technical Proposal BAFO page D-643:

Data Transfer and Conversion Requirements

The addition of the NCHC program will require an additional data transfer and conversion to that which was submitted in BAFO. Because this data is resident in multiple systems, namely BCBSNC legacy and MEDCO, and because BCBSNC will be in the process of migrating this data to PowerMHS, the complexity of this conversion has increased. The added complexity comes from the analysis effort and verification of data mappings from disparate systems into the unified Replacement MMIS. The other new programs presented in RFP Addendum 4 also will require data conversion, but because the data will reside in the Legacy MMIS+ or the BCBSNC and MEDCO systems, the data mapping is already considered. The following table, Replacement MMIS Data Conversions, outlines our understanding of the data conversions required for the implementation of the Replacement MMIS.

Replacement MMIS Data Conversions

Heathcare Program	Originating Data Location	Notes
DMA	Legacy MMIS+	
DMH	Legacy MMIS+	
DPH	DPH Claims System	
Migrant Health Program in the ORHCC	ORHCC Claims System	
CAP-C	Legacy MMIS+	
CAP-MR/DD	Legacy MMIS+	
Medicaid Accounting System	MAS	
NCHC — children ages 0 - 5	Legacy MMIS+	
NCHC — children ages 6 - 18	BCBSNC MEDCO (pharmacy) PowerMHS	
Kids' Care	BCBSNC MEDCO (pharmacy) PowerMHS	July 2009 start
Ticket to Work	Legacy MMIS+	April 2009 start

Because CAP-C and CAP-MR/DD and children ages zero to five in NCHC are already in the Legacy MMIS+ application, and these are existing Medicaid programs, the data mapping for these programs was included in our original data conversion scope of work. Although programs have been added, the

process EDS has successfully used in past MMIS data conversions will remain unchanged.

The following table, EDS Response to Data Transfer and Conversion Requirements, describes how we will meet the requirements set forth in the RFP

EDS Response to Data Transfer and Conversion Requirements

RFP No.	RFP Requirement	EDS Response
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)	Met through customization of interChange. The data conversions for ~~the four~~all the payers will include electronic data required to process claims. Namely, claims, recipient, reference, provider, and financial electronic data will be converted. Additional electronic data will be considered for conversion based on the relation it has to processing and payment of claims for the in-scope payers. As displayed in the preceding table, the origination of the data for the conversion of each of the programs is in different systems; however, the majority of the data resides within the Legacy MMIS+ application. In essence, the following five database mappings need to occur: • DMA, DMH, CAP-C, CAP-MR/DD and Ticket to Work • Medicaid Account System • DMH • ORHCC • NCHC for Children ages 6-18, and Kids' Care Since the BCBSNC will be undergoing a system conversion while the DDI is under way, we may need to convert data from its legacy mainframe and the PowerMHS system. The existing premium payment data, while small in volume, also will need to be converted to retain the history of those payments. We will work with the State during DDI to understand the processing of the existing data, its layout, and the exact conversion requirements.
40.1.2.20	Fiscal Agent (Operations Phase) shall convert all legacy data from DMA, DMH, DPH, ~~and~~ the Migrant Health Program in the ORHCC, and NC Health Choice (NCHC) to maintain benefit plans and data relationships in a multi-payer ~~aspect~~ environment	Met through configuration of interChange parameters and features. The benefit plan data relationships for each of the multi-payers will be configured and maintained in the interChange Benefit Plan Administration Rules Module. For the plans that EDS currently supports through the MMIS+ application, namely DMA, DMH, NCHC for children ages zero – five, CAP MR/DD, and CAP C, there is an inherent understanding of the benefit plans that will lessen the risks associated with the configuration of the benefit plans. For the NCHC recipients ages 6-18 who are supported by the BCBSNC and MEDCO applications, as well as the DPH and ORHCC programs, State plan documentation and experts will

RFP No.	RFP Requirement	EDS Response
		be critical to the success of the benefit plan configuration. EDS will develop a detailed conversion plan to document how the electronic data required by the interChange system will be populated. The conversion strategy for recipient data is based on a proven methodology that has been successful in previous projects, including conversions from the ~~older L~~legacy MMISs~~+~~ to the interChange MMIS. For example, EDS was responsible for converting data for more than 762,000 recipients in Kansas. The data attributes were similar for Oklahoma, Kentucky, Tennessee, and Pennsylvania. Each ~~project~~ implementation allows us to ~~improve~~ refine our overall conversion approach and methodology. ~~EDS will develop a detailed conversion plan to document how the electronic data required by the interChange system will be populated.~~

Technical Proposal BAFO page D-670:

Response to Recipient Operational Requirements

EDS has included cross-training and specific customer relations staff to handle incoming calls and contacts from recipients. While the inquires are similar in nature and content to provider content, they have a different angle, which must be addressed. These contacts are generally longer in nature with more complex, less transactional questions. Our representatives will use the same tools to keep the process, data, and information consistent and timely. The foundation for interactions will be the call center, Web portal, and tracking of contacts through the CTMS within interChange.

Our operations organization chart indicates how the recipient functions are integrated within the outreach and customer service teams. Specialty functions—such as recipient premium, buy-in, and other important functions—are situated within those specific organizations to gain the knowledge and skill sets necessary within those specialties, but they have the same tools at their disposal.

To handle the expanded scope in dealing with recipients associated with NCHC, recipient premiums, and other programs, EDS has expanded our teams in these areas and built the infrastructure to handle the anticipated work loads. EDS processes recipient premiums in Indiana and Arkansas, and multiple other Medicaid clients are moving in this direction. Our technology teams have already started building a leverageable solution within Medicaid, which can use

standard EDS offerings for ACH and credit and debit card processing. Our processes for dispositions are already established, and with a separate lockbox, we will be prepared for quick dispositions of check, money order, or cash receipts.

The following table, EDS Response to Recipient Operational Requirements, describes how we will meet the requirements set forth in the RFP. Where appropriate, we have listed the existing interChange user interface panels, reports, and processes that meet the stated requirements.

EDS Response to Recipient Operational Requirements

RFP No.	RFP Requirement	EDS Response
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	Met by operational processes and procedures. The Recipient Relations team will respond to recipients by telephone and/or in writing to issues or questions related to premium payment and cost sharing using the CTMS and Web portal.
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	Met by operational processes and procedures. The Recipient Relations team will address and respond to all NCHC recipient inquiries about claims payment, prior approval, and any other questions, except those regarding eligibility. DMA Recipient Services will respond to questions regarding eligibility using the CTMS and Web portal.
40.2.2.11 (New)	Fiscal Agent shall respond to requests to issue replacement recipient benefit booklets for NCHC recipients	Met through customization of interChange and operational processes and procedures. The Recipient Relations team will respond to requests to issue replacement recipient benefit booklets for NCHC recipients. When possible, the NCHC recipient will be directed to the Member Portal to download the booklet directly and immediately. If the recipient cannot access the Web portal, the Recipient Relations team will initiate a request that will result in the generation of the booklet, and the booklet will be sent by U.S. mail to the recipient. The recipient can request the Emergency Respite Care, Information for Children with Special Healthcare Needs and Their Families, and NCHC Handbook through the Web or on request.
40.2.2.12 (New)	Fiscal Agent shall respond to requests to issue replacement recipient identification cards for NCHC recipients	Met by interChange, with a portion of the requirement requiring customization code, and through operational processes and procedures. The Recipient Relations team will respond to NCHC recipient requests to issue replacement recipient identification cards for NCHC and Kids Care recipients. The recipient also can order a replacement ID through the Web portal. The Replacement MMIS will process the card request, send it to the printer for printing, and then the card will be shipped to the recipient through U.S. mail.

Technical Proposal BAFO page D-713:

The following table, EDS Response to Pharmacy Benefits Management Requirements, describes how we will meet the requirements set forth in the RFP. Our EDS Pharmacy team, led by Sharon Greeson and assisted by HID, will support the State's pharmacy benefits management requirements. Sharon and HID's John Williams will work closely with the State to provide support for the following requirements.

EDS Response to Pharmacy Benefits Management Requirements

RFP No.	RFP Requirement	EDS Response
40.7.2.25	Fiscal Agent shall prepare and present to the State and the DUR Board 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 in the media and timing as directed by the State~~the CMS Annual Report that includes all information, charts, and statistics relating/pertaining to the Prospective and Retrospective DUR Programs in the format and media as directed by the State.~~	Met by interChange and operational processes and procedures. The EDS Pharmacy team, led by Sharon Greeson, ~~We~~ and with assistance from HID, will ~~prepare~~ prepare and present to the State and the DUR Board 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 in the media and timing as ~~program–related CMS annual report in the format and media~~ directed by the State.
40.7.2.26	Fiscal Agent shall ~~coordinate with the DUR Contractor to~~ assure functionality of the Pharmacy Point-of-Sale Business Area, including both PRO-DUR and Retrospective DUR Program Activities, is in compliance with State policy at all times~~adding edits, PRO-DUR informational alerts and intervention, conflict, and outcome codes (NCPDP 5.1 standards) and shall assist DUR Vendor with the Retrospective DUR Program.~~	Met by operational processes and procedures. The Pharmacy team, led by Sharon Greeson in conjunction with the State pharmacy staff, will provide Pro-DUR activities in sync with the point of sale pharmacy processing, thereby paying pharmacy claims according the applicable State policy. Additionally, Sharon, her team, and the State will meet with ~~the~~ HID ~~DUR contractor~~ monthly to discuss maintaining Retro-DUR~~Pro-DUR~~ activities in compliance with State policy at all times. This may include adding~~y,~~ intervention, conflict, and outcome codes and new edits that may be needed ~~in~~ to the POS system. ~~The Retro-DUR program also will be discussed for potential ideas or assistance.~~
40.7.2.30	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) ~~coordinate with the State's Drug Utilization Review Vendor or the State to ensure appropriate Pharmacy POS alerts for potential drug therapy problems are identified, shall meet each month, and shall prepare meeting minutes.~~	Met by operational processes and procedures. On a quarterly basis (or State-approved time frame), the members of the EDS ~~The~~ Pharmacy team and HID will conduct targeted interventions/communication and education of providers in accordance with direction from the State and federal regulations.~~will meet with the DUR vendor monthly to discuss POS Pro-DUR alerts and discuss potential drug therapy problems identified due to these alerts, intervention, conflict, and outcome codes and new edits that may be needed in the POS system. Monthly meetings will be held to discuss these patterns, and meeting minutes will be provided.~~

RFP No.	RFP Requirement	EDS Response
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~~coordinate with the State's Retrospective DUR Vendor or the State to capture claim data specific to aberrant drug patterns, shall meet each month, and shall prepare meeting minutes.~~	Met by interChange and operational processes and procedures. We will work with HID or the State to capture claim data specific to aberrant drug patterns. Monthly meetings will be held to discuss these patterns, and meeting minutes will be provided. Targeted provider interventions/communication will include supporting references and materials and activity reports.
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	Met by operational processes and procedures. EDS and HID will collaboratively develop criteria for Retro-DUR activities using predetermined standards in accordance with federal regulations and existing evidence-based materials that conform to CMS, national, and local standards. EDS will use information obtained through Retro-DUR activities to improve effectiveness of Pro-DUR.
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	Met by operational processes and procedures. EDS and HID will develop criteria for DUR activities, including using therapeutic criteria from other DMA initiatives, as directed by the State. After these criteria are reviewed and approved by the State, EDS, and HID criteria team, it will be entered into the RxExplorer application by the HID criteria manager.
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	Met by operational processes and procedures. EDS, with support from HID and on approval by the State, will poll other states for alternative practices to resolve DUR Board- or State-identified issues.
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	Met by operational processes and procedures. EDS and HID will identify providers who are candidates for interventions based on standards predefined and approved by the State. There are established provider profiles within the RxExplorer tool that the State and the EDS Pharmacy team can use for this requirement.
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	Met by operational processes and procedures. EDS and HID will track all provider communication, such as letters, telephone calls, and face-to-face meetings from targeted interventions. These contacts will be indexed and stored within the provider contacts, and the CTMS will be configured to show DUR interventions discussion as a contact type.

Prior Approval Review Requirements

The following table, EDS Response to Prior Approval Review Requirements, describes how we will meet the requirements set forth in the RFP.

EDS Response to Prior Approval Review Requirements

RFP No.	RFP Requirement	EDS Response
40.7.2.48** (New)	Fiscal Agent shall perform expedited reviews of a denied prior approval or claim when requested during an appeal	Met by operational processes and procedures. EDS will perform expedited reviews of a denied prior approval or claim when requested during an appeal. Our prior approval RN/LPNs and a licensed physician, Dr. Margaret Martin, will support this effort and be fully trained in the expedited review process established with the State.
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	Met by operational processes and procedures. The EDS Prior Approval team led by Sharlene Bryant will perform retrospective reviews of services provided without the required PA and determine if a PA should be authorized retroactively.

Pre-Admission Certification Requirement

The following table, EDS Response to Pre-Admission Certification Requirement, describes how we will meet the requirements set forth in the RFP.

EDS Response to Pre-Admission Certification Requirement

RFP No.	RFP Requirement	EDS Response
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	Met by COTS integration and through operational processes and procedures. The Prior Approval team will perform pre-admission certifications (medical necessity) and length-of-stay approvals (based on industry guidelines) for NCHC recipients prior to hospital inpatient admissions. EDS will subscribe to and use the Milliman Web-based tool to access industry-standard care guidelines. If the prior approval analysts are unable to find an optimal recovery guideline, they will refer the case to the nurse. Procedures that are potentially investigational, experimental, or cosmetic are reviewed under NCHC medical policies and will be referred to the EDS Medical Director, Dr. Margaret Martin, for review and decision. The Replacement MMIS will, whenever possible, use established rules for automated approval of pre-admission certifications based on specific diagnosis codes. These rules will be established through the InRule COTS rules engine. The advantage to this approach is that it frees up reviewers'

RFP No.	RFP Requirement	EDS Response
		time for the more detailed pre-admission requests for a closer inspection and review of the services requested.

Technical Proposal BAFO page D-718:

RFP No.	RFP Requirement	Metrics for Measurement
Requirement Deleted 40.7.3.11	~~Fiscal Agent shall meet monthly with DUR, the State and/or Retrospective DUR vendors and Community Care Program and include minutes in bi-weekly Project Status Report.~~	Cancelled. This requirement was deleted by RFP Addendum 4 – North Carolina Replacement MMIS Updated Requirements, July 7, 2008.~~Met by operational processes and procedures. We will meet monthly with DUR, the State, and/or Retro-DUR vendors and Community Care Program and include minutes in the biweekly Project Status Report as directed by the State.~~
40.7.3.14 (New)	Fiscal Agent shall deliver all meeting minutes to the State within five (5) business days following each meeting	Met by operational processes and procedures. The PA team will deliver all meeting minutes to the State within five business days following each meeting. These notes will be posted to iTRACE, and the State will be notified by e-mail that these notes are available. The advantage of this approach, besides fast delivery, is that all stakeholders have access to the historical meeting minutes as well. This provides a unified library of the notes and decisions that occur over time.
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	Met by operational processes and procedures. The Pharmacy team, led by Sharon Greeson and with support from HID, will provide DUR Board agenda and meeting materials to the State no less than 20 State business days prior to the scheduled quarterly meeting. The agenda and meeting materials will be posted to iTRACE, and the State will be notified by e-mail that these materials are available.

Technical Proposal BAFO page D-730:

RFP No.	RFP Requirement	EDS Response
Requirement Deleted 40.8.2.39	~~Fiscal Agent shall produce information to support the State in completing the CMS Annual Drug Utilization Review Report.~~	Cancelled. This requirement was deleted by RFP Addendum 4 – North Carolina Replacement MMIS Updated Requirements, July 7, 2008.~~Met by interChange and operational processes and procedures. We will produce the Pre-DUR Alert Summary report for the reported fiscal year.~~

RFP No.	RFP Requirement	EDS Response
		~~In conjunction with the Retro-DUR vendor, HID, supporting documentation, the State will be equipped to complete the CMS Annual Drug Utilization Review report.~~
40.8.2.40	Fiscal Agent shall prepare State-approved agendas, associated meeting materials and minutes for the DUR Board quarterly meetings~~attend the DUR board meetings, supply copies of the annual DUR Report, and apply all board recommendations to POS once approved by the State.~~	Met by interChange and operational processes and procedures. The EDS Pharmacy staff, led by Sharon Greeson and supported by HID, will prepare State-approved agenda, associated meeting materials, and minutes for the DUR Board quarterly meetings. ~~will attend the quarterly DUR board meetings and supply copies of the annual DUR report. After the DUR board meeting, the POS recommended changes will be discussed with State staff for clarification and approval.~~

Technical Proposal BAFO page D-730:

RFP No.	RFP Requirement	EDS Response
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.~~	Cancelled. This requirement was deleted by RFP Addendum 4 – North Carolina Replacement MMIS Updated Requirements, July 7, 2008.~~Met by operational processes and procedures and through customization of interChange. EDS will create a program for the Replacement MMIS to provide an extract of required information to the Retro-DUR vendor, HID, within the specified time frame.~~
40.8.2.45 (Revised 7/21/08)	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 exceed the service limit~~claim for EPSDT eligible recipient is denied for "non-covered" services.~~	Met by interChange and operational processes and procedures. We will develop a process, in conjunction with the State, to establish claim audit and edit criteria during the cycle process to suspend such potential EPSDT claims before denial. EDS will work with the State to establish the criteria to determine appropriate resolution of such claims, such as recipient aid category, in combination with EPSDT-specific procedure codes that will trigger suspension of these claims. The aid category will be used to direct the workflow review activity. ~~Met by interChange and operational processes and procedures. We will develop a process, in conjunction with the State, to establish claim audit and edit criteria during cycle process to suspend such potential EDPSDT claims prior to denial. EDS will work with the State to establish the criteria to determine appropriate resolution of such claims. If necessary,~~ EDS will engage the State staff for policy input, and we will do so according to our response to requirement 40.8.2.44.

RFP No.	RFP Requirement	EDS Response
40.8.2.57 (New)	Fiscal Agent shall attend quarterly DUR Board meetings	Met by operational processes and procedures. EDS, represented by Sharon and the EDS Pharmacy team, will attend the quarterly DUR Board meetings.
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	Met through customization of interChange and operational processes and procedures. EDS will apply DUR Board recommendations such as edits/audits, limitations, and informational alerts to the POS claims processing system on approval by the State. We support their recommendations through a number of tools, each targeted specifically at a specific condition. We will apply the right panels and criteria based on the specific recommendations. It could be PA, DUR+, Pro-DUR criteria, limits, step therapy, or coverage rule, to name a few. In essence, the Replacement MMIS brings an entire system that is configurable to enable the policy recommendations of the DUR Board, providing the right tool for the right policy.
40.8.2.59 (New)	Fiscal Agent shall provide the State with DUR Programs Project Status Reports on a biweekly basis	Met by operational processes and procedures. EDS, with support from HID, will provide the State with biweekly DUR program project status reports.
40.8.2.60 (New)	Fiscal Agent shall attend monthly meetings with the State and additional on-site meetings as requested by the State	Met by operational processes and procedures. When requested by the State, Sharon Greeson, EDS' lead pharmacist, with support from the local EDS team, will attend monthly meetings with the State and additional on-site meetings. HID will support EDS in preparing for these meetings, as needed.
40.8.2.61 (New)	Fiscal Agent shall prepare the agenda and minutes for its monthly meetings with the State	Met by operational processes and procedures. EDS will prepare the agenda and minutes for its monthly meetings with the State. HID will assist in creating the agenda for these meetings. The State will be sent an e-mail notification when the agenda and minutes are posted to iTRACE.
40.8.2.62 (New)	Fiscal Agent shall be available to the State for DUR-related consultation during normal business hours	Met by operational processes and procedures. EDS and HID staff will be available by e-mail and telephone during normal business hours from 8:00 a.m. to 5:00 p.m. Eastern.

Technical Proposal BAFO page D-736:

RFP No.	RFP Requirement	Metrics for Measurement
Requirement Deleted 40.8.3.15	~~Fiscal Agent shall provide specified quarterly extract files to the DUR Vendor within five (5) State business days of the start of the month following the quarter's end.~~	Cancelled. This requirement was deleted by RFP Addendum 4 – North Carolina Replacement MMIS Updated Requirements, July 7, 2008.~~Met by interChange and operational processes and procedures. We will create a~~

RFP No.	RFP Requirement	Metrics for Measurement
		~~program for the Replacement MMIS to provide an extract of required information to the Retro-DUR vendor, HID, within the contracted time frame.~~

Please note that, while this requirement has been deleted, EDS will still be required to send the associated data to HID in order for HID to meet other stated requirements.

Technical Proposal BAFO page D-741:

RFP No.	RFP Requirement	Metrics for Measurement
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.~~	Cancelled. This requirement was deleted by RFP Addendum 4 – North Carolina Replacement MMIS Updated Requirements, July 7, 2008.~~Met by interChange and operational processes and procedures. The Health Choice file will be sent to the State Health Plan using the 834 transaction by the third business day of each month.~~

Technical Proposal BAFO page D-757:

RFP No.	RFP Requirement	EDS Response
40.12.2.2	Fiscal Agent shall make available to the State the total ~~Medicaid~~ expenditures for multiple source drugs (annually) as well as other drugs (every three [3] years); the record keeping for this requirement ~~should~~ 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	Met through customization of interChange and operational processes and procedures. EDS will provide this data for reports that include total Medicaid expenditures for multiple source drugs annually and other drugs every three years by drug rebate program. Data such as mathematical or statistical computations, comparisons, and any other pertinent records to support pricing changes as they occur will be available for querying and report generation.
40.12.2.21** (New)	Fiscal Agent shall attend Drug Rebate Labeler Dispute meetings as required by the State	Met by operational processes and procedures. Sharon Greeson, as pharmacy director, will attend and support Drug Rebate Labeler Dispute meetings on request from the State. Sharon will address questions about detailed claims, and be able to explain the functions that EDS provides to the State.

Technical Proposal BAFO page D-760:

RFP No.	RFP Requirement	Metrics for Measurement
40.12.3.2	Fiscal Agent shall make available to the State the total ~~Medicaid~~ expenditures for multiple source drugs (annually) as well as other drugs (every three years) accurately and consistently ninety-nine and nine tenths (99.9) percent of the time, by drug rebate program~~.~~	Met through customization of interChange and operational processes and procedures. The checks will be entered in Web panels at the NDC level with the appropriate identification such as labeler check number and receipt date. A process will be developed to clearly identify the different programs and will apply manufacturer payments to the current drug rebate accounts receivable. Payments and accounts receivable activity will be tracked, monitored, and reported to the State.
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	Met by interChange and operational processes and procedures. EDS' Drug Rebate team will initiate the drug rebate invoicing process after the CMS tape arrives from each approved State and Medicaid program. The invoices will be sent out quarterly for labelers or manufacturers with agreements on file with CMS or the State. Invoices will be issued after quarter-end receipt of the CMS tapes within five State business days.

Technical Proposal BAFO page D-768:

Reconciliation

As we have described, the entire interChange financial functional area is predicated on linking each transaction to the supporting detail and accumulating this data at a summary level while maintaining and accounting for all dollars. The Replacement MMIS provides online access to financial transactions generated, and the EDS team will use these reports in conjunction with bank data to provide, monitor, and reconcile banking as well as generate the required financial statements and outputs necessary to support the State.

Premium Billing and Collections

The Replacement MMIS premium billing and collections capability will support the requirements of the RFP. Electronic bill payment, using credit and debit cards, will be supported by the EDS OpenBill *Express* system and EDS*PAY for Convenience (EDS*Pay). OpenBill *Express* provides electronic bill presentment and payment capabilities for users who wish to enroll to receive electronic bills instead of paper. OpenBill *Express* comprises all aspects of electronic bill presentment and payment—data acquisition, enrollment, marketing, presentment, payment, remittance, and administration—provided through an

intuitive user interface. EDS*PAY provides users with the capability to make electronic payments without enrolling to receive bills electronically. This service provides multiple payment channels, including the State-branded Web site. Both OpenBill *Express* and EDS*PAY allow users to pay by electronic check through Automatic Clearinghouse (ACH), credit card, or debit card.

The following sections address the billing, accounting, and reconciliation of premium payment:

- Premium Statements
- Options for Premium Payments
- Processing, Depositing, and Posting Payments and Wire Transfers
- Returned Checks and/or Adjustments
- Premium Refunds/Reimbursements
- Notification
- Delinquent Accounts

Premium Statements

For the healthcare programs that require premium payments, it is critical that premium statements are provided to the recipients promptly and accurately. The key to this is making sure the eligibility information received daily from the State EIS system includes premium information. Statements will be generated at the casehead level for recipients of the household and can be produced in the recipient's preferred language. Once that information is loaded into the Replacement MMIS recipient database, the generation of premium statements can take two paths.

One path is that the Replacement MMIS system will generate the premium payment statement, and either send it to the recipient's home address or make it available for viewing on the Recipient Portal. Paper premium statements will be produced on white paper with a perforated detachable payment coupon for the recipient to return with payment.

The statements will contain the following information:

- Month invoiced
- Current amount due
- Any adjustments to the monthly amount due
- Previous balance
- Amount of last payment
- Any past due amount
- New balance
- Total amount due

Statements will be folded and inserted into a window envelope, with a business reply envelope. The detachable payment coupon will include the following:

- Casehead or policyholder name
- Mailing address
- Case or policy number
- Magnetic ink character recognition line with the following:
  - Case or policy number
  - Current premium amount
  - Date due
  - Balance due

The following exhibit, Sample Paper Statement, is an example of the typical statement offered for a single individual.

Sample Paper Statement

North Carolina Premium Processing Center
P.O. Box 123456
Raleigh, NC 66601-0061

John Q. Public
123 Main Street
Raleigh, NC 66601-0001

Document Number: 987654321
Billing Date: 03/15/2008

Your coverage through: The State of North Carolina Health Choice (NCHC)

This is your premium statement for your healthcare coverage through the above program. Continued coverage is based on receiving the total amount due by the due date below.

Coverage for: PUBLIC, JOHN Q

Acct Num: 123456789123456
Benefit Coverage Dates

5/1/2008 - 5/31/2008

Total Amount Due **$ 51.39**
Due By: **5/1/2008**

Prior Balance:	$ 0.00
Minus Payments:	$ 0.00
Minus Adjustments:	$ 0.00
Plus Late Fees	$ 0.00
Plus Past Due Amount:	$ 0.00
Plus Current Premium Amount	$ 51.39
Remaining Balance:	$ 51.39

We must have your premium payment by the 'Due By' date. If the full amount is not paid by the 'Due By' date, you will lose your coverage.

3 easy ways to pay:

Online – Access your statement and set up automatic payments at www.ncpremium.com. Or make a one-time payment using a credit/debit card or draft a payment from a checking or savings account at: www.edspay.com

Telephone Call us toll-free at 1-888-999-9999 to make a one-time payment using a credit/debit card or draft a payment from a checking or savings account.

Mail a check or money order – You may mail a check or money order to:

North Carolina Premium Processing Center
P.O. Box 123456
Raleigh, NC 66601-0001

1. Make check or money order payments out to: NC Premiums. Pay the Total Amount Due.
2. Write the amount paid on the bottom portion of the statement. Detach the bottom portion of the statement and return with your payment. Keep top portion for your records.
3. Write the Account Number on the front of the check or money order.
4. Do not staple the payment to the invoice or fold the invoice.

For questions about this statement, call the North Carolina Premium Processing Center toll-free at 1-888-999-9999 or for the hearing impaired, call the TDD/TYY line at (888) 999-9999. If your address have changed, please provide your new address below.

Please return this part with your payment in the supplied envelope. Do not send cash.

Make check or money order payable to: NC Premiums. Write your account number on your check or money order.

Insured: PUBLIC, JOHN Q
Policy Holder: PUBLIC, JOHN Q
Document Number: 987654321
Acct Num: 123456789123456
Please mail to:

North Carolina Premium Processing
P.O. Box 123456
Raleigh, NC 66601-0001

Coverage Dates 5/01/2008 - 5/31/2008
Premium Due Date: 05/01/2008
Payment Amount Due: $ 51.39

_____
Amount Paid

☐ Check Here for Address Change

_____

_____

_____ , _____ _____

MICR CODE MICR CODE MICR CODE MICR CODE MICR CODE

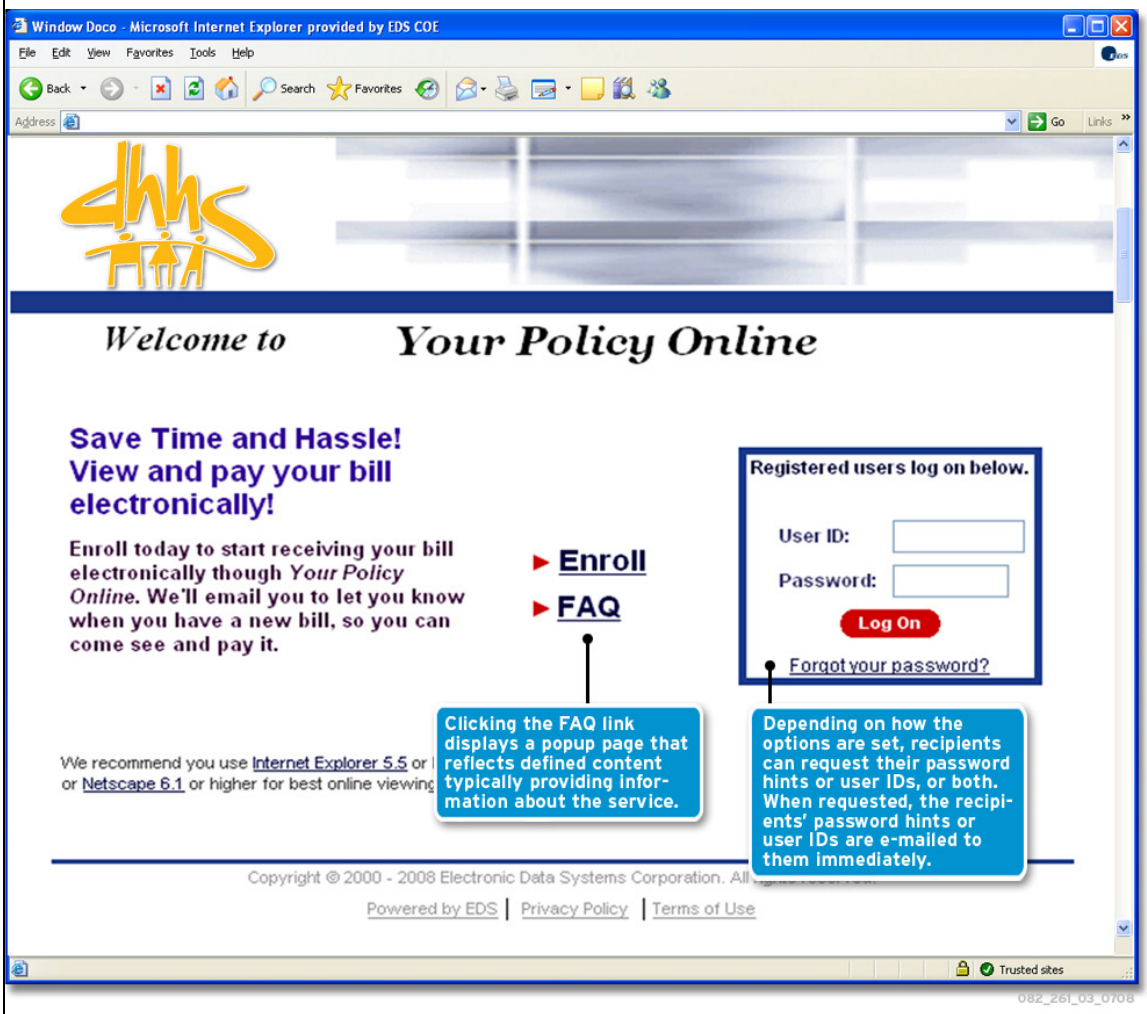
082_261_02_0708

Statements include variable text that can be modified to address the specifics of each program.

The other path is that the recipient enrolls in the OpenBill *Express* service, which will then present the statement online through the Web service. Navigation to this Web site will be provided as a link from the Recipient Web Portal. Recipients can access their premium statements in a viewable format or select the printable format option so they can print their statements from the Web. Once a recipient enrolls in OpenBill *Express*, he or she will no longer receive paper statements. The recipient must provide an e-mail address during the registration process so OpenBill *Express* can send an e-mail notifying the recipient that a premium statement has been posted to his or her account on the secure Web site. This approach is more secure than directly e-mailing statements to recipients, which would send Protected Health Information (PHI) over the Web.

Enrolling in OpenBill *Express* is a simple process. The following exhibit, Recipient Logon Page, shows how the pages might be customized to reflect the State's banner, messaging, product name, and FAQs.

Recipient Logon Page



Customized for the State, the logon page will be the recipient's entry point into bill payment and presentment.

Enrollment Pages

Enrollment establishes a recipient to a user ID (logon ID) so that the recipient can access the online application to view bills or statements and make payments. Recipient enrollment is a three-step process, where recipients provide personal information, account information, and logon information. The first step in the enrollment process prompts recipients to enter name and contact information. The next step will be to enter account information. Finally, the recipient will establish a user ID, password, and password hint. The State can define additional fields during the RV sessions. The recipient must agree to the terms of use before the enrollment can be processed. If the terms of use are declined, the user ID will not be activated, and the recipient cannot access the system.

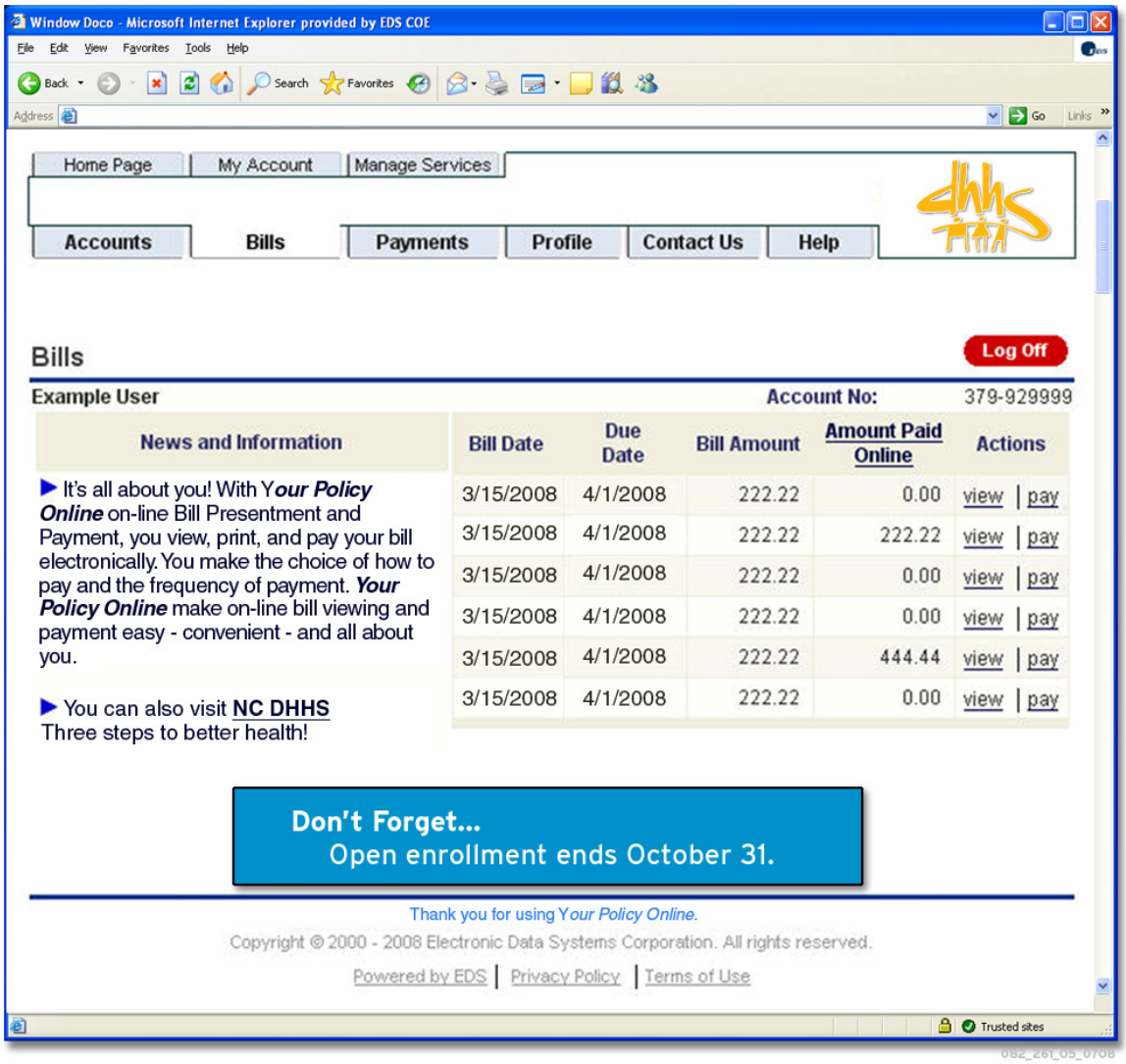
An enrollment confirmation page will confirm successful enrollment and display the State's customized confirmation message. After the recipient's enrollment is approved, OpenBill *Express* will send an e-mail to welcome the recipient and invite him or her to log on to the system.

Recipient Interface

After successfully enrolling, the recipient can log on to the State site. The Bills page can be accessed by clicking the Bills tab or selecting the View Bills link on the Account Information page. The page will display a list of statements available for viewing. From this page, a recipient can view a current statement and previous statements, the amount billed, and the amount the recipient has paid online. Payments made offline, such as by check, will not be reflected on this page.

The following exhibit, Bills Page, is an example of the page showing a list of bills the recipient can select to view or pay. This is the default page recipients see when they log on to the site.

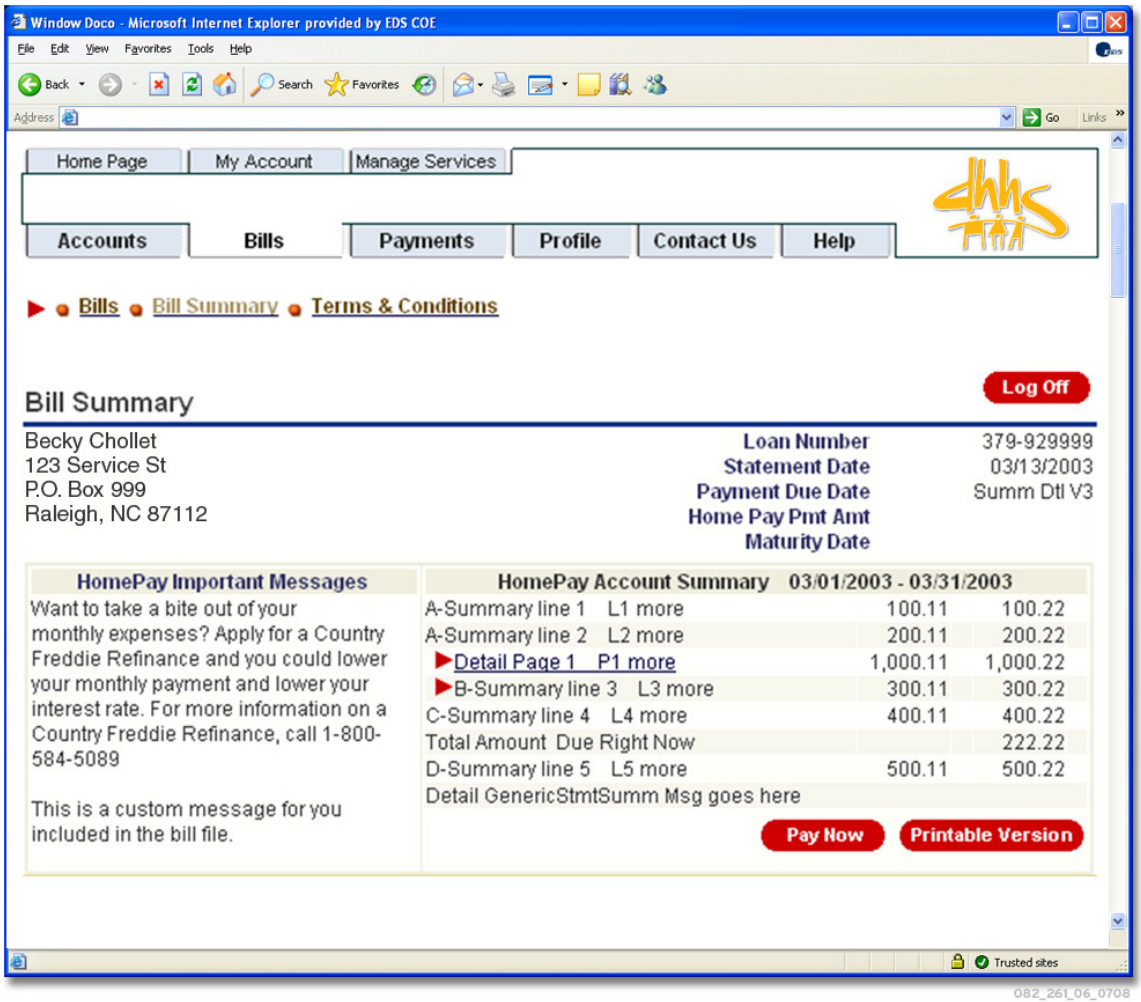
Bills Page



Recipients have the option of viewing or paying their bills from this page.

As shown in the following exhibit, Bill Summary Page, this page will provide summary information for the statement selected. From this page, the recipient can click the appropriate link to drill down to more detail, pay the bill, or print the statement.

Bill Summary Page



Recipients can use the Bill Summary page to get more details, pay the bill, or print the statement.

From the Bill Summary page, the recipient can click on a link to see the details of the statement. The online version of the statement will closely resemble the printed version.

OpenBill *Express* also provides a bill insert capability. This feature will allow the State to provide its recipients an electronic version of inserts they would have received with a printed and mailed statement. EDS can work with the State to match the rules used to differentiate the inserts received by recipients through printed statements. The Bill Summary and the Bill Detail pages will provide the "Just for You" links to the electronic versions of the bill inserts.

Options for Premium Payments

The Replacement MMIS will give recipients many premium payment options at no charge. Recipients can mail checks, money orders, or cash in the business

reply envelopes provided with their statements. Through OpenBill *Express* and EDS*PAY, recipients also have many electronic payment options; namely ACH, credit card, and debit card payments.

Processing, Depositing, and Posting Payments

EDS will establish a lockbox with Bank of America. Recipients who pay by check, cash, or money order will use the business reply envelopes included with their statements to mail their payments. The business reply envelopes will be preaddressed to the lockbox. Statement payment coupons and payments that match the amounts due from the coupons will be received by the lockbox. If a payment is received by the lockbox without a payment coupon or if the information on the check (name or amount) does not match the coupon, the payment will be reflected in a mismatched file. Calls will be made based on the contact information on the check to validate the account to which the payment should be credited.

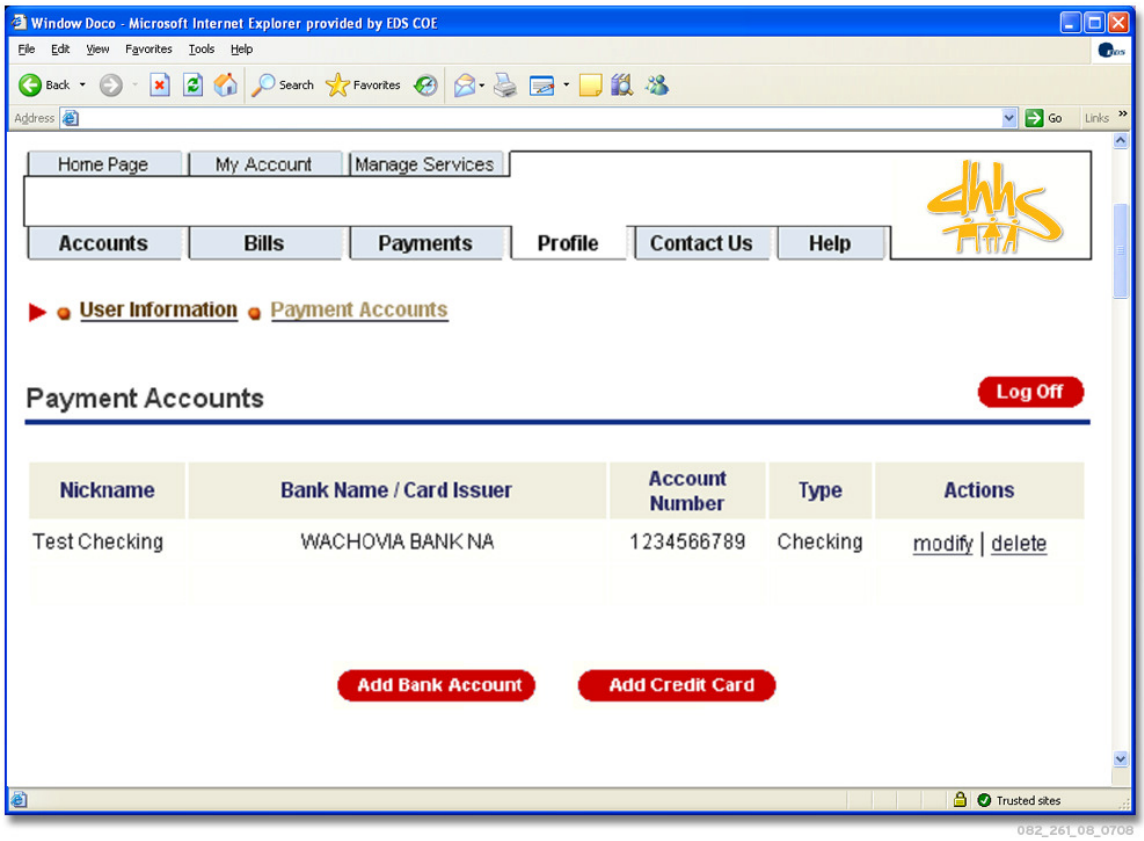
The EDS Operations team will check the bank's system daily to view the payments that have been received and will update the Replacement MMIS to indicate the payment data. They will note the type of payment, the amount, and the date. Receipts will be dispositioned against outstanding accounts receivables (ARs) using the Premium Accounts Receivable page. The user will enter the amount, review the fund code, and update it if necessary. Payments will be posted to the oldest obligation first.

OpenBill Express

Enrolled recipients must first set up a payment account before making an online payment. The system will automatically direct the recipient to a page that prompts him or her to set up a payment account. The system will collect the payment account information and allow the recipient to review the information, approve debits to the account, and record the payment information. The system will validate the bank routing information for an electronic check payment account. For a credit card or debit card payment account, the system will validate the card number and determine whether the card can be used to make payments.

Only the recipient who set up the payment account can see the payment account information, as shown in the following exhibit, Payment Accounts Page, and only that recipient can modify the information or delete the payment account.

Payment Accounts Page



Recipients can add, delete, or modify bank account or credit card information for use in paying premiums.

Recipient Payment Pages

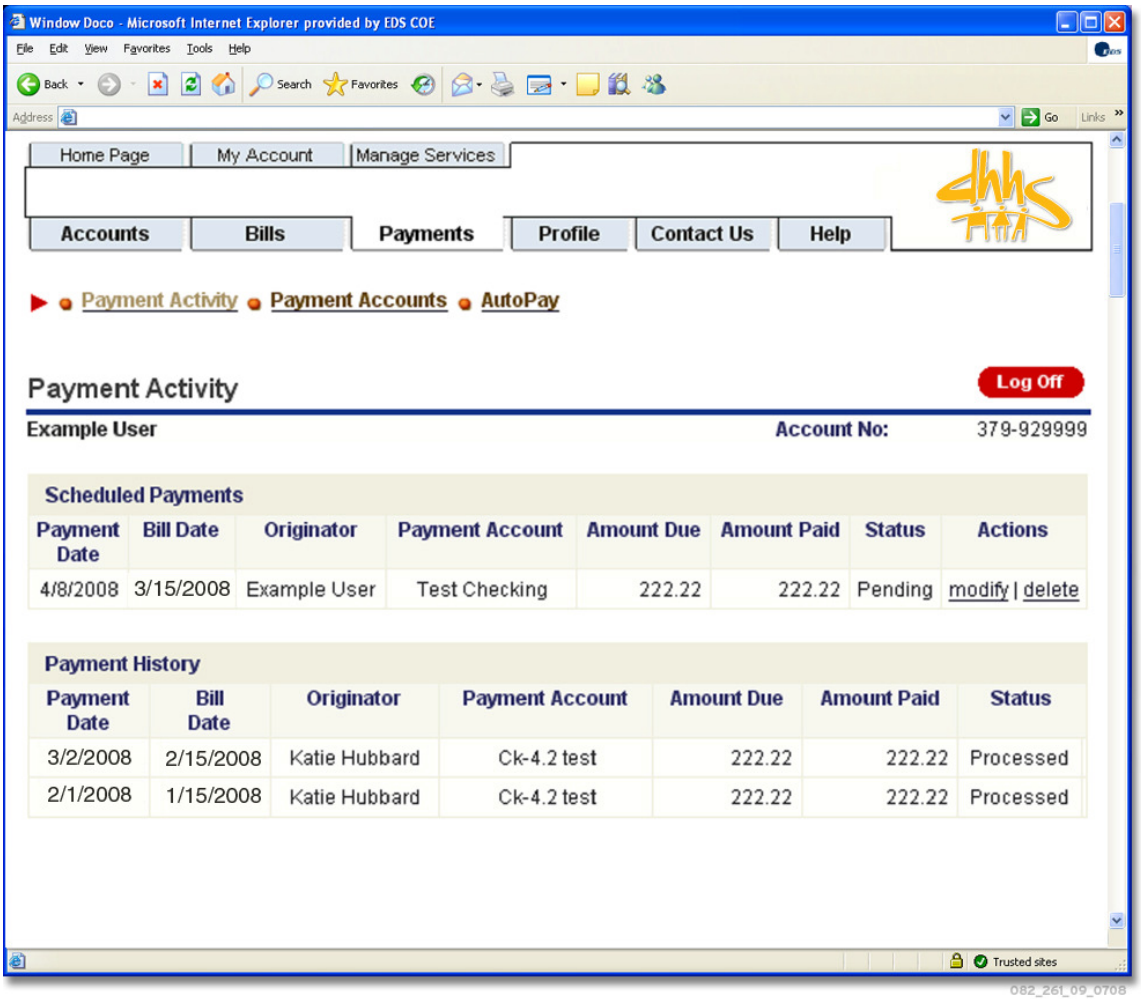
OpenBill *Express* will provide recipients multiple paths to initiate payment for a bill. Recipients can initiate payments from the Bills page, the Bill Summary page, or the Bill Detail page.

The payment process is easy. The system will default the amount to pay to the amount due from the bill the recipient is trying to pay, but the recipient can change the amount. The recipient can select which payment account to use from a drop-down menu of available accounts, then enter the date on which he or she wants the payment to be made.

After the recipient submits the payment request, OpenBill *Express* will display the Payment Review page. If satisfied with the payment request, the recipient will submit the request, and OpenBill *Express* will display the Payment Confirmation page. OpenBill *Express* will record which bill was paid and update the Replacement MMIS premium billing and collections function with the appropriate information. The system will show the amount paid online on the Bills page, confirming the bill payment to the recipient. As shown in the

following exhibit, Payment Activity Page, the recipient also can view scheduled payments and payment history for a selected account.

Payment Activity Page



From this page, recipients can modify or delete scheduled payments.

The Scheduled Payments section will provide a list of payments in pending status waiting to be processed. The Payment History section will provide a list of processed payments. When a pending payment is processed in the daily batch cycle, the line item will move from the Scheduled Payments section to the Payment History section. Scheduled payments that are deleted by the recipient will move to the Payment History section with a status of Deleted. Payment exceptions also will be listed on this page, such as ACH returns and declined and charged-back credit card transactions.

Recipients can modify or delete pending payments from this page. After the cutoff time on the payment date, the payment can no longer be modified or deleted. The system will process the payment at that time and initiate an ACH transaction or a credit card or debit card transaction. The status of the payment

will change to Processed, and the payment will display in the Payment History section.

If a payment is returned, fails, or is charged back, an e-mail will be generated automatically and sent to the recipient to inform the recipient of the issue with the payment. The exception also will be sent to the Replacement MMIS premium billing and collections team so the account can be appropriately updated.

AutoPay

The AutoPay feature of OpenBill *Express* will allow recipients to set up automatic payments of their bills based on recipient-defined payment rules. The AutoPay feature will provide the flexibility and control needed to meet a variety of recipient preferences. The AutoPay feature can be turned on and off based on the recipient's needs.

When a recipient turns on AutoPay, the system will automatically schedule a pending payment when each new statement is loaded, based on the options the recipient has set on the AutoPay page. The first auto payment will be scheduled with the next new bill. Once scheduled, the recipient can view the auto payment on the Payment Activity page and modify or delete it until it is processed for payment.

The AutoPay page will offer recipients various options to tailor the feature to meet their needs. Recipients can select when they want AutoPay to be in effect, when they want their payments to be made in relation to their due dates, the amount they want paid, and the payment account they want to use.

E-mail Types

OpenBill *Express* will automatically generate various kinds of e-mails to recipients based on certain events. The system will allow the State to determine the text of the e-mails, and text changes can be entered and made effective in real time.

System Administrative Functions

The OpenBill *Express* Administrative application will be equally user-friendly. Critical to a successful online statement service, the Administrative application will put system control and oversight into the State's hands and provide enhanced customer service, system maintenance, reporting, and auditing features.

EDS*PAY for Convenience Pay

In addition to the payment options described thus far, recipients will have the option of a singular payment by telephone (through IVR) or online. Recipients who do not wish to enroll in OpenBill *Express* can still pay their premiums electronically through EDS*PAY. EDS*PAY will provide recipients multiple

payment methods, including payment by electronic check (ACH), credit card and debit cards.

To take advantage of this service, a recipient can simply access the EDS*PAY Web site for the State and provide the account number, payment account information, and amount to pay to complete the transaction. If the credit card option is selected, the recipient will be prompted to enter the credit card account number. The recipient will be presented with a confirmation page, and the ability to make any updates to the data. Once validated, the recipient would select the Accept button to finalize the payment. The recipient can receive a confirmation e-mail by providing an e-mail address.

The EDS*PAY system will update the Replacement MMIS each day and e-mail reports to designated EDS staff.

E-mail Types

EDS*Pay will automatically generate various kinds of e-mails to recipients based on certain events. The system will allow the State to determine the text of the e-mails, and text changes can be entered and made effective in real time.

Returned Checks and/or Adjustments

Checks returned for insufficient funds or closed accounts will be posted to the appropriate account, resulting in reversal of the prior payment. If the rejected payment is for a prior period, all payments subsequently posted will be rolled back so the oldest obligations can be satisfied first. The same process will be used to handle adjustments related to declined credit cards, credit card charge-backs, and rejected ACH transactions.

If the rejected or returned payment was made through OpenBill *Express*, an e-mail will be generated to the recipient who made the payment. Standard e-mails will be available for ACH payment failed, ACH notification of change, and credit card charge-back. For returned checks, a letter will be sent to the recipient documenting the returned payment as past due and notifying the recipient that a returned check fee has been added to the outstanding balance. The returned check will be included with the letter. We will retain a copy of the returned check. We will process returned checks within one business day of receipt.

Premium Refunds/Reimbursements

Occasionally a recipient may make an incorrect payment resulting in an overpayment that needs to be refunded. When overpayments are received on accounts that do not have an outstanding balance, the data will be captured and reported to the State. Expenditures will be entered daily into the Expenditure window of the Replacement MMIS for all overpayments. Refund checks will be created and mailed to the recipient. Refund check data will be maintained and reported to the State for reconciliation purposes.

Notification

Standard written notifications will be sent to recipients based on certain "trigger" events. The following table, Notification Types, shows the notifications from both OpenBill *Express* and EDS*PAY.

Notification Types

Notification	Open Bill *Express*	EDS*PAY
New enrollment/Welcome	X	
Bill ready	X	
ACH payment failed	X	X
ACH notification of change	X	
Credit card declined	X	X
Credit card charge-back	X	X
Credit card refund		X
Payment made	X	X
Password hint	X	
Recipient/user ID request	X	
Feedback	X	

Delinquent Accounts

We will follow up on accounts with past due amounts monthly. We will generate letters notifying these recipients of the past due amounts and the due dates.

We will notify the State of all past due accounts so determinations can be made regarding continuing eligibility for those recipients. If eligibility is ended, the Replacement MMIS will expect an updated transaction from the State's eligibility system. After eligibility has ended, no further notices will be sent.

Technical Proposal BAFO page D-773:

RFP No.	RFP Requirement	EDS Response
40.14.2.33	Fiscal Agent shall produce refunds and adjustments of recipient premiums	Met by customization of interChange and operational processes and procedures. The existing Financial Expenditure Information panel will be updated to include adjustments to meet~~s~~ this requirement, and the EDS Financial team will use this panel to record and issue refunds and adjustments of recipient premiums, as required.
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	Met by and operational processes and procedures. The interChange premium billing capabilities will be updated to include processing recipient premiums, in accordance with GAAP, including payments, refunds, adjustments, collection, processing, tracking, imaging, recording, and reconciliation. Operational processes and procedures will be established to support this activity.
40.14.2.73 (New)	Fiscal Agent shall accept and post recipient payments and issue refunds and adjustments for retroactive, current and future months	Met by interChange, with a portion of the requirement requiring custom code, and operational processes and procedures. The interChange premium billing capabilities will be updated to accept and post recipient payments and issue refunds and adjustments for retroactive, current, and future months. Operational processes will be put in place within the Financial team to perform these activities.
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	Met by interChange with a portion of the requirement requiring custom code and operational processes and procedures. The financial reporting capabilities will be updated to include cash reports that can be used to reconcile to the monthly (or daily) bank statements to include recipient premiums. The Recipient Relations team will be responsible for this monthly reconciliation.
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	Met by interChange, with a portion of the requirement requiring customization code, and operational processes and procedures. The premium payment function will be updated to void checks when they come back as undeliverable. interChange will be customized to allow the reversal of the refund so that the financial system remains balanced.
40.14.2.76 (New)	Fiscal Agent shall update recipient premium payment history online to reflect all payments, refunds and adjustments	Met by interChange with a portion of the requirement requiring customization code, and operational processes and procedures. The premium payment functionality allows the Recipient Relations team to update recipient premium payment history online to reflect payments, refunds, and adjustments.

RFP No.	RFP Requirement	EDS Response
40.14.2.77 (New)	Fiscal Agent shall establish a receipt system to handle cash premium payments and refunds	Met by interChange with a portion of the requirement requiring customization code, and operational processes and procedures. The premium payment function will be updated to handle cash premium payments. Operational processes will be established using a lockbox for depositing any cash payments directly to the appropriate bank account. Premium refunds shall be issued via check for proper recording and tracking of issued funds. And refunds will be done via check.
40.14.2.78 (New)	Fiscal Agent shall deposit funds into a State-owned account as required by State and Federal policy	Met by customization of interChange and operational processes and procedures. While operational processes will be established to make sure funds are deposited into a State-owned account, the interChange financial system will be updated to maintain financial balancing. This provides for a full audit trail of the funds that were deposited, and enables them to be accurately tied to the proper accounts.
40.14.2.79 (New)	Fiscal Agent shall prepare financial statements and expenditure reports and submit them as directed by the State	Met by interChange, with a portion of the requirement requiring customization code and operational processes and procedures. Existing financial statements and expenditure reports will be updated to include the premium payment components. Operational processes will be updated to include the preparation and submission of these reports as directed by the State. It is assumed that they will be created monthly and will be part of the standard financial reporting cycle. Also, the data related to premium payments will be updated in the BIAR database to allow the State to create additional reports as needed.
40.14.2.80 (New)	Fiscal Agent shall accept, at a minimum, cash, check, money order, and credit/debit card for recipient premium payments	Met by customization of interChange and operational processes and procedures. interChange premium payment capabilities currently support cash, check, and money orders. Acceptance of credit/debit card payments will be new functionality added to the application, using our EDS*Pay and OpenBill *Express* service offerings. Operational procedures will include processing cash, checks, and money orders through a lockbox and then updating interChange to reflect the premium payment against the recipient account and to reflect the monies received and posted to the State owned account. The State will cover the costs of the merchant bank fees.

Technical Proposal BAFO page D-785:

RFP No.	RFP Requirement	Metrics for Measurement
40.14.3.54 (Added 7/21/08)	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	Met by operational processes and procedures. EDS will issue a refund to recipients within 15 business days from the time a corresponding entry is made into accounts payable 99.9 percent of the time.

Changes to Statement of Work

The following statement of work (SOW) lists the work necessary to deliver the requirements identified in the RFP, including the requirements set forth in RFP Addenda 4 and 5. The deliverables and/or performance standards are identified for each work item. For easy cross-reference, the SOW number corresponds to the work breakdown structure (WBS) number contained in the project schedule in proposal section 50.2.5.2 Integrated Master Schedule, with the exception of the Operations Section and the Turnover Section, which are not reflected in the DDI project schedule. In order to not repeat information in this SOW, we reference other sections of this proposal containing the details.

STATEMENT OF WORK FORMAT

DDI Section			
SOW Number (WBS Number)	**Work Statement Description**	**Performance Standard**	**RFP References**
1.3	**Project Startup Activities.** The start-up phase confirms a mutual understanding of scope, establishes internal procedures, and organizes the team that will complete the planning activities. The tasks are as follows: • Establish initial project team and internal financial procedures • Review staffing requirements • Set up facilities • Review and debrief final contract • Conduct kickoff meeting • Conduct initial project team orientation • Procure hardware and software • Install interChange hardware and software • Set up iTRACE • Establish initial project environments • Schedule and conduct Multi-Payer Summit • Perform Medicaid accounting system analysis The start-up phase activities are	Performance of these work activities can be measured by State approval of the following deliverables: • Stakeholder analysis • Staffing management plan • Software development and systems engineering methodology • Deployment/rollout plan • EVMS reports • Integrated Master Schedule • Master Test and Quality Assurance Plan • Communication plan • Risk management plan • Change control/configuration management plan • Issue management plan • Security plan • Data accession list • Browser-based project information repository	50.2.5 Section E—Project Management Plan

DDI Section			
SOW Number (WBS Number)	**Work Statement Description**	**Performance Standard**	**RFP References**
	described in detail in the following sections of the Technical Proposal: • 50.2.5.1 Integrated Master Plan • 50.2.5.2 Integrated Master Schedule • 50.2.4.1.2 Software Development • Systems Engineering Methodology **Planning.** In this phase, the EDS project management team will develop the project components discussed in section 50.2.5 Section E—Project Management Plan. The detailed project plan will include the project schedule, quality assurance plan, configuration management plan, communication plan, risk management plan, change control plan, and problem management plan. These plans will be developed in the following activities: • Project deliverables content and format review • Develop stakeholder analysis • Develop staffing management plan • Review cost and budget estimates • Review software development and systems engineering methodology	(iTRACE)	

DDI Section			
SOW Number (WBS Number)	**Work Statement Description**	**Performance Standard**	**RFP References**
	• Develop deployment/rollout plan • Review Earned Value Management System(EVMS) reports • Create project management plan The planning activities are described in the following sections of the Technical Proposal: • 50.2.5 Project Management Plan • 50.2.5.1 Integrated Master Plan • 50.2.5.2 Integrated Master Schedule • 50.2.4.1.2 Software Development and Systems Engineering Methodology		
1.4	**Ongoing Project Management.** We provide comprehensive project management throughout the life of the project. As described in sections 50.2.5 Section E—Project Management Plan, 50.2.5.1 Integrated Master Plan, and 50.2.5.2 Integrated Master Schedule, the project plan and components are living documents constantly being updated to reflect the current status of the project. Project management is described in the following sections of the Technical	Performance of these work activities can be measured by State approval of updates to the following deliverables: • Integrated Master Schedule • Master Test and Quality Assurance Plan • Communication plan • Risk management plan • Change control/configuration management plan • Issue management plan	50.2.5 Section E—Project Management Plan

DDI Section			
SOW Number (WBS Number)	**Work Statement Description**	**Performance Standard**	**RFP References**
	Proposal: • 50.2.5 Project Management Plan • 50.2.5.1 Integrated Master Plan • 50.2.5.2 Integrated Master Schedule	• Security plan • Data accession list This phase also will include State approval of the following deliverables: • Operations management plan • Turnover plan • Business continuity and disaster recovery plan	
1.6.8	**Requirements Validation (RV).** The requirements are validated with the State. Documentation is updated in iTRACE. RV activities are described in the following sections of the Technical Proposal: • 50.2.5 Section E—Project Management Plan • 50.2.5.2 Integrated Master Schedule • 50.2.5.8 Change Management Approach • 50.2.4.1.2 Software Development and Systems Engineering Methodology	Performance of these work activities can be measured by State approval of the following deliverable: • Requirements verification updates in iTRACE	50.2.4 Section D—Proposed Solution Details 50.2.7 Section G—Contract Data Requirements List 50.2.5.3 Master Test Process and Quality Assurance Approach
1.6.16	**Conversion - Analysis, Mapping,**	EDS will provide the State the	50.2.4.1.3 Data

DDI Section			
SOW Number (WBS Number)	**Work Statement Description**	**Performance Standard**	**RFP References**
	Design, Testing and Preliminary Conversion. EDS will begin data conversion activities early in the project. This will include planning and requirements gathering. The State will be able to review preliminary data conversion plans. Conversion activities are described in the following sections of the Technical Proposal: • 50.2.4.1.3 Data Conversion and Migration Approach • G Contract Data Requirements List	following deliverables for approval in this phase: • Data conversion and migration plans for each subject area • Data conversion requirements analysis and mapping • Preliminary data conversion results	Conversion and Migration Approach
1.6.12	**Detail System Design Documentation.** The design process will create a technical level design document. In this phase the technical design documentation is created in iTRACE. This document is the result of incorporating the output of the RV sessions with stakeholders. In addition to a review and analysis of the business processes and workflows that affect a functional area of the system, the initial	Performance of these work activities can be measured by State approval of the following technical design documents: • Recipient management • Provider management • Claims/POS • Third-party liability (TPL) • Prior approval • Automated voice response system (AVRS)	50.2.4 Section D—Proposed Solution Details

DDI Section			
SOW Number (WBS Number)	**Work Statement Description**	**Performance Standard**	**RFP References**
	change orders are generated as a result of the RV sessions and subsequent breakout work groups. The follow-on effort completes the design effort, and iTRACE is the repository for information and data for all stages of technical development. As the technical design matures, the data in iTRACE matures until a change order sign-off is achieved and ready for testing. The technical design will include the following information that will be used to customize the interChange MMIS for the State: • Subsystem narrative overview • Subsystem description • Data model • Data tables • System flow • Subsystem logic: job scripts, programs, browser pages, reports, letters • Internal and external interfaces • Requirements matrix • Change orders • Data element dictionary • Workflow	• Drug rebate • Managed care • Management and Administrative Report (MAR) • Eligibility Verification System (EVS) • Reference • Benefit administration • Financial • Home health—Early Periodic Screening, Diagnosis, Treatment (EPSDT) • Drug Utilization Review (DUR) Pro-DUR/Retro-DUR • Computer-based training (CBT) • Desktop publishing • Single sign-on • Premium Billing	

DDI Section			
SOW Number (WBS Number)	**Work Statement Description**	**Performance Standard**	**RFP References**
	• Supplemental documentation • Applicable business rules • Page-panel specifications • Batch program changes • Database changes • Unit Test plans		
1.6.14	**Construction and Unit Testing.** interChange will be modified and enhanced. Application components will be unit tested to verify that a function or set of functions tested meet North Carolina requirements. Please refer to the subsystem compliance tables within each of the business areas in System Requirements and Operational Requirements.	Performance of these activities can be measured through the PM Toolset on iTRACE (to measure the progress of change orders). Weekly status reports for completed construction tasks and staged delivery inspections, and Earned Value progress reports will provide additional information.	50.2.4 Section D—Proposed Solution Details
1.7	**Testing.** In this phase the following testing activities will occur: • **System Testing—**This testing verifies that the system functions as required based on approved business requirements. • **Inter-System Testing (IST)—**IST verifies that the interfaces between	Performance of these work activities can be measured by State approval of the following deliverables: • Weekly status of system testing results • Inter-system testing (IST) results	50.2.4.1.2 Software Development and Systems Engineering Methodology

DDI Section			
SOW Number (WBS Number)	**Work Statement Description**	**Performance Standard**	**RFP References**
	interChange and external systems function according to requirements. This requires coordination between entities for data test cases and scheduling. • **Staged delivery inspections—** Review of software artifacts. • **Parallel Testing—**This testing will run converted claims through the new system and compare those processing results to the legacy system to see if the claims priced the same and flagged the same errors. Any discrepancies will be investigated to determine which system was correct. • **Volume/Stress Capacity and Performance Testing—**This testing verifies system performance and capacity scalability under full operations. • **Regression Testing—**Regression testing confirms that changes and upgrades to the software product have not resulted in introduction of new defects. • **User Acceptance Test (UAT)—**UAT	• Parallel testing results • Regression testing results • Volume/stress testing results • UAT results • User operational readiness test results	

DDI Section			
SOW Number (WBS Number)	**Work Statement Description**	**Performance Standard**	**RFP References**
	tests interChange components, processes, conditions, and cycles, including conversion and interface software for the complete application with system users. Testing activities are described in the following sections of the Technical Proposal: • 50.2.4.1.2 Software Development and Systems Engineering Methodology • 50.2.5.2 Integrated Master Schedule • 50.2.5.3 Master Test Process and Quality Assurance Approach		
1.8	**DHHS and Provider Training Sessions**. Training plans will be developed for relevant stakeholder groups (target audiences). EDS will develop DHHS and provider training materials. EDS will manage logistics for training delivery. EDS will deliver classroom and CBT training. Training activities are described in the following sections of the Technical Proposal:	Performance of these work activities can be measured by State approval of the following deliverables: • Training plan • Training material and manuals • Completion of training classes • Training activities in weekly status reports	50.2.4.4 Training Approach

DDI Section			
SOW Number (WBS Number)	**Work Statement Description**	**Performance Standard**	**RFP References**
	• 50.2.5.2 Integrated Master Schedule • 50.2.4.4 Training Approach • 40.1.1 General System Requirements: Training subsection • 40.5.1 Provider System Requirements: Training subsection • 40.1.2 General Operational Requirements: Training subsection		
1.10	**System Implementation.** Implementation will involve delivery and modification of Replacement MMIS code to the State and the final data conversion. Final conversion results will be reviewed with the State. Implementation activities are described in the following section of the Technical Proposal: • 50.2.4.1.4 Deployment/Rollout Approach	Performance of these work activities can be measured by State approval of the following deliverables: • Status, progress, and variance reports • Final data conversion results • Notification of readiness to assume fiscal agent functions	50.2.4.1.4 Deployment/Rollout Approach
1.11.2	**Certification.** The critical process in the first year of operations will be the Replacement MMIS' certification by CMS. EDS is familiar with the certification process and the services provided by the	Certification achieved, as validated in approval letter from CMS System certification folders	10.2, bullet 1

DDI Section			
SOW Number (WBS Number)	**Work Statement Description**	**Performance Standard**	**RFP References**
	fiscal agent in support of this critical event. Account Manager Melissa Robinson will appoint a certification manager who will report directly to Melissa. The certification manager will work with account personnel to provide any data or reports required to support certification.		

Operations Section			
SOW Number	**Work Statement Description**	**Performance Standard**	**RFP References**
2.1	**Mail room.** EDS will prepare and process incoming and outgoing mail. Mail is date-stamped with date of receipt. EDS will print and mail or electronically deliver Replacement MMIS State-approved forms. EDS will prepare RAs for mailing or transmitting, electronic funds transfers (EFTs) for transmitting, and checks for release and mailing. Mail room activities are described in the following sections of the Technical	The performance standard is met when: • Mail date-stamped with actual date of receipt within one business day of receipt • Print and mail Replacement MMIS State-approved forms to providers within two business days of receipt of the provider request (at no cost to the provider).	10.10 Life-Cycle Support Objectives 10.12.1 Operations Management CDRL - Operations Management Plan (OMP) 50.2.4.2 Operations 50.2.6 Section F -

	Proposal: • 40.8.1 Claims Processing System Requirements: Mailroom Requirements subsection • 40.8.2 Claims Processing Operational Requirements: Mailroom Requirements subsection		Operations Management Approach These references apply to all parts of the operations section.
2.2	**Data entry/imaging.** EDS will perform data entry of hard-copy claims. EDS will scan hard-copy claims and accompanying documentation. EDS will pre-screen hard-copy claims before entering claims into the system and return those not meeting certain criteria to providers under the Return to Provider (RTP) letter, indicating missing or incorrect information and log returned claims daily. Data entry/imaging activities are described in the following section of the Technical Proposal: • 40.1.1 General System Requirements: Document Management and Correspondence Tracking subsection	The performance standard is met when: • Entry-field accuracy rates are greater than 98 percent. • Every claim and attachment is scanned within one State business day. • Images of checks and written correspondence from or to the provider are indexed for audit purposes throughout the life of the contract.	See SOW Number 2.1 for RFP references for this line.
2.3	**Recipient.** EDS will maintain recipient data and provide access using any combination of recipient ID number or Social Security number (SSN,) name or	The performance standard is met when: • Specified Common Name Data Service (CNDS) data is	See SOW Number 2.1 for RFP references for this line.

	partial name, date of birth (DOB), gender, Medicare Health Insurance Claim Number (HICN), or county. EDS also will provide capability for name and partial-name search through use of a proven phonetic/mnemonic algorithm, such as Soundex or a State-approved solution. Alternatively, recipients can be classified into multiple concurrent eligibility groups by health benefit program and benefit plan. Recipient activities are described in the following sections of the Technical Proposal: • 40.2.1 Recipient System Requirements • 40.2.2 Recipient Operational Requirements	reconciled with the Replacement MMIS each State business day. • Specified State-entity DMA eligibility data is reconciled with Eligibility Information System (EIS) each State business day. • Specified State-entity DMH eligibility data is reconciled with ASC X12N 834 transactions each State business day. • Online access to State entities' eligibility edit/error reports are provided by 7 a.m. Eastern each State business day. • The Replacement MMIS is updated with batch eligibility data from each State entity by 7 a.m. Eastern each State business day. • Each State entity's eligibility data is updated from online processes for State EIS, CNDS, local managing entities (LMEs), and DPH in near real time. • Certificates of Creditable Coverage (COCCs) are generated and the mail date for each COCC mailed is logged. Fiscal agent provides a monthly	

		report with the number of recipients terminated from each health plan and the number of COCC mailed within one month of the termination.	
2.4	**Claims Processing.** EDS will provide online claims resolution, edit override capabilities for each claim type, and online claims adjudication. EDS will provide the capability to sort suspended claims into applicable work queues using K2 workflows. Claims Processing activities are described in the following sections of the Technical Proposal: • 40.8.1 Claims Processing System Requirements • 40.8.2 Claims Processing Operational Requirements	The performance standard is met when: • An internal control number (ICN) is assigned to every claim, attachment, and adjustment within 24 hours of receipt. • Within 24 hours of processing, a notice of teleprocessed electronic claims files received as either accepted or rejected, along with the number of claims, is sent to the submitter. • Ninety percent of clean claims are adjudicated for payment or denial within 30 calendar days of receipt. • Ninety-nine percent of clean claims are adjudicated for payment or denial within 90 calendar days of receipt. • Nonclean claims are adjudicated within 30 calendar days of the date of correction of the condition that caused the	See SOW Number 2.1 for RFP references for this line.

		claim to be unclean. • Correct claims are provided disposition and posted to the appropriate account or, when appropriate, additional information is requested within one State business day of receipt. • Hard-copy claims missing State-specified required data are returned within two State business days of receipt. • The State is notified of any delays in the checkwrite process by 8 a.m. Eastern the next State business day following the checkwrite cycle. • The State is notified immediately upon discovery of any erroneous payments, irrespective of cause, and before initiating appropriate recovery action. • Financial month-end reporting to the State is provided within three days from the last checkwrite of each month. • Payment claims are adjudicated with the date of service in previous fiscal year July through April claims by the	

		last checkwrite in May for payment, and claims for May and June are adjudicated by the last checkwrite in October of the current fiscal year August for payment because of State fiscal year processing of the State monies.	
2.5	**Pharmacy Point of Sale.** EDS will provide an interactive system that accepts NCPCP-compliant pharmacy claims and processes these claims according to policy including the notification to the provider of potential Pro-DUR alerts. EDS will price pharmacy claims incorporating State-approved pricing methodologies, including using the lesser of logic among the available rate types. EDS will then return the appropriate NCPDP response. Pharmacy point-of-sale activities are described in the following sections of the Technical Proposal: • 40.8.1 Claims Processing System Requirements: Pharmacy Point-of-Sale Requirements subsection	The performance standard is met when: • A response is provided in five seconds or less 98 percent of the time, 24 hours a day, 7 days a week, 365 days a year. • POS is available 99.9 percent of the time, 24 hours a day, 7 days a week, 365 days a year, except for scheduled downtimes. • Applicable documentation and successful test data are provided for State approval within 10 State business days before value-added network (VAN) Replacement MMIS implementation.	See SOW Number 2.1 for RFP references for this line.
2.6	**Adjustments.** EDS will receive, scan, and perform optical character recognition (OCR) of adjustments and then process	The performance standard is met when:	See SOW Number 2.1 for RFP references for this line.

	them through the system for adjudication. EDS will direct workload through the K2 workflow engine process. Adjustment activities are described in the following sections of the Technical Proposal: • Adjustment Processing Requirements subsection of 40.8.1 Claims Processing System Requirements • Adjustments Requirements subsection of 40.8.2 Claims Processing Operational Requirements	• Provider-initiated adjustments are processed within 45 calendar days of receipt.	
2.7	**Retrospective Drug Utilization Review.** EDS will provide a file of paid drug claims to the Retro-DUR vendor. EDS also will provide a file of recipient, physician, clinic, hospital, and pharmacy provider data to the Retrospective DUR vendor. Retrospective DUR activities are described in the following sections of the Technical Proposal: • Retrospective DUR Requirements subsection of 40.8.1 Claims Processing System Requirements • Retrospective DUR Requirements subsection of 40.8.2 Claims Processing Operational Requirements • Retrospective DUR Early	The performance standard is met when: • Specified quarterly extract files are provided to the DUR vendor within five State business days of the start of the month following the quarter's end.	See SOW Number 2.1 for RFP references for this line.

	Implementation option in Proposed Early Implementations subsection of 50.2.4.1.1 Overview of System Solution and Solution for DDI		
2.8	**Drug Rebate.** EDS will handle required drug rebate activities, such as issuance of invoices, receipts, entry, handling of disputes and update data on manufacturers with whom rebate agreements exist. Drug Rebate activities are described in the following sections of the Technical Proposal: • 40.12.1 Drug Rebate System Requirements • 40.12.2 Drug Rebate Operational Requirements	The performance standard is met when: • An outstanding rebate balance percentage (that is, more than 45 days) of less than 10 percent of total rebates due for each quarter is maintained, excluding the outstanding balance of Manufacturers' Disputes Accounts Receivable. • Total Medicaid expenditure is provided for multiple source drugs (annually), as well as other drugs (every three years) accurately and consistently 99.9 percent of the time. • Labeler checks received by labeler, check number, amount, date received, date entered into DRS Accounts Receivable file, and date of deposit are logged. The fiscal agent forwards the logs to the State within five business days from the end of the previous month. • The drug rebate accounts	See SOW Number 2.1 for RFP references for this line.

		receivable is updated within two State business days of receipt. • Labeler checks are deposited within one State business day of receipt. • Interest calculation is performed on outstanding drug rebate balances and results are applied to drug rebate accounts receivable 99.9 percent of the time, as directed by the State. • End-of-month drug rebate balancing processes are performed and forwarded to the State for review within five State business days of the end of the previous month. • Drug rebate history data is extracted monthly and moved to the quarterly file within two State business days from the end of the previous month. • Labeler disputes are logged on the date of receipt and forwarded to the State within five business days from the end of the previous month. • Labeler disputes are processed within 10 State business days from the date of receipt.	

		• A Recapitulation Report, which is a revised invoice, is produced for the labeler one State business day after the completion of the dispute resolution. • The Recapitulation Report is sent to State auditor(s) for review and approval by close of business the same day the Recapitulation Report is produced. • The Recapitulation Report is sent to the labeler with a copy of the current summary balance the same day the State auditor's approval is received. • The State will have access to the total expenditures for multiple source drugs (annually) as well as other drugs (every three years) accurately and consistently 99.9 percent of the time, by drug rebate program. • Quarterly invoices for each labeler that has signed a rebate agreement with CMS or the State, as division appropriate, and for Medicaid, are created and forwarded within five State	

		business days from receipt of CMS tape. Fiscal agent electronically transfers required data to CMS and the State as applicable to the drug rebate requirements within five State business days from invoicing. • Online access to five years of historical drug rebate invoices is provided based on criteria provided by the State accurately and consistently 99.9 percent of the time. • The fiscal agent attends CMS-sponsored Drug Rebate Labeler Dispute meetings, as ~~directed~~ required by the State.	
2.9	**Eligibility Verification System.** EDS will provide the capability to receive and process eligibility inquiry and response transactions in real-time and batch transactions. Eligibility Verification System activities are described in the following sections of the Technical Proposal: • 40.3.1 EVS System Requirements • 40.3.2 EVS Operational Requirements	The performance standard is met when: • A response from the EVS is provided in three seconds or less 98 percent of the time, 24 hours a day, 7 days a week, 365 days a year. • EVS is available 99.9 percent of the time, 24 hours a day, 7 days a week, 365 days a year, except for scheduled downtimes. • Applicable documentation and	See SOW Number 2.1 for RFP references for this line.

		successful test data are provided to the State for approval within 10 State business days before VAN Replacement MMIS implementation.	
2.10	**Automated Voice Response System.** EDS will provide toll-free telephone access for providers and Medicaid recipients to access relevant claims, payment, recipient eligibility, and prior approval information from the Replacement MMIS. EDS will provide telephone access in the threshold languages. Automated Voice Response System activities are described in the following sections of the Technical Proposal: • 40.4.1 AVRS System Requirements • 40.4.2 AVRS Operational Requirements	The performance standard is met when: • The daily systems check is performed to verify that the AVRS electronic interface is working properly and the findings are reported monthly. • Transaction analysis occurs by hour of the day, indicating the number of transactions processed, and reports are created monthly. • A response from the AVRS is provided within three seconds or less 98 percent of the time, 24 hours a day, 7 days a week, 365 days a year, except for State-approved scheduled system maintenance. • System checks to the AVRS are executed daily, and the findings are logged. • Monthly AVRS logs are provided within five State	See SOW Number 2.1 for RFP references for this line.

		business days from the end of the previous month. • A Web site for providers and recipients, nurse aides, potential employers of nurse aides, and so on is operated and maintained 24 hours a day, 7 days a week, 365 days a year, except for State-approved scheduled maintenance.	
2.11	**Provider Enrollment.** EDS will enroll eligible providers in a multi-payer environment using a single enrollment strategy. EDS will conduct provider credentialing and source verification of provider participation criteria and requirements and notify providers as needed electronically or by mailing. EDS will provide secure log-on that allows providers to retrieve and update incomplete application or check status of a submitted application. Any paper copies of provider enrollment or required paper copies for retained forms will be scanned and retained in our EDMS solution for easy retrieval and reference. Provider Enrollment activities are described in the following sections of the Technical Proposal:	The performance standard is met when: • Hard-copy provider applications are logged and imaged within one State business day of receipt. • Credentialing and source verification are completed to make sure participation guidelines are met on completed applications within three business days. • Providers who have no negative responses to credentialing requirements are approved within two State business days of receipt of data necessary. • Approval letters and other State-required information are	See SOW Number 2.1 for RFP references for this line.

	• 40.5.1 Provider System Requirements: Provider Enrollment Workflow and Provider Enrollment Requirements subsections • 40.5.2 Provider Operational Requirements: Provider Enrollment, Credentialing, and Verification Requirements • 50.2.4.1.1 Overview of System Solution and Solution for DDI: Provider Enrollment, Credentialing, and Verification Early Implementation option in Proposed Early Implementations subsection	sent within one State business day of provider participation approval. • Denial letters and other State-required information are sent within one State business day of provider participation denial. • Urgent reviews are initiated within one State business day of receipt of any adverse provider information. • Receipt of provider appeal requests is acknowledged within one State business day of receipt. • Appeals are adjudicated within 30 calendar days of receipt unless permission for delay is received from the State. • The State is provided with an extract of the MMIS provider tables each business night. • Online real-time access is provided between EIS, Mental Health Eligibility Inquiry, Medicaid Quality Control, Online Verification, Automated Collection and Tracking System (ACTS), and Health Information System (HIS) and the Replacement MMIS from 7	

		a.m. until 7 p.m. Eastern, Monday through Friday, including non-State business days when EIS is available for online processing, and from 10 a.m. to 5 p.m. Eastern on weekends when EIS is available for batch processing. • Batch access to provider data is provided between EIS and the Replacement MMIS from 5:30 p.m. Eastern Monday through Friday until batch processing is completed. • Initial and ongoing updated e-mail listservs are provided based on initial and ongoing provider enrollments, disenrollments, and change requests on the same day the transaction occurs 99.9 percent of the time. • Monthly system check logs are provided.	
2.12	**Call center.** EDS will operate a Customer Service Call Center. Services will include an automatic telephone attendant that provides a hierarchical, menu-driven capability for directing calls to appropriate Replacement MMIS EDS call center staff. A toll-free telephone number shall be	The performance standard is met when: • The help desk staff is available from 8 a.m. to 5 p.m. Eastern Time on State business days • At least 90 percent of	See SOW Number 2.1 for RFP references for this line.

	provided for receipt of calls. Call Center activities are described in the following sections of the Technical Proposal: • 40.1.1 General System Requirements: Call Center Services subsection • 40.1.2 General Operational Requirements: Call Center Services Requirements subsection • 40.2.2 Recipient Operational Requirements	telephone calls are not on hold for more than 60 seconds before a staff person, not an automated answering device, answers. • Less than 1 percent of telephone calls are abandoned, dropped, or receive a busy signal. • Initial and ongoing capability is provided for recording and tracking communications with providers and recipients during State business days between the hours of 7 a.m. to 11 p.m. Eastern Monday through Friday and from 7 a.m. to 6 p.m. Saturday and Sunday 99.9 percent of the time.	
2.13	**Reference.** EDS will provide online access to authorized users for reference and pricing data. We will initiate reference updates and complete as required and process mass adjustments as required. Correspondence will be scanned, indexed and retained for reference. Reference activities are described in the following sections of the Technical Proposal:	The performance standard is met when: • Online updates occur within two State business days of receipt. • Mass adjustments are completed within two claims cycles. • Before and after images are returned to the originator of the State Memo the same day the	See SOW Number 2.1 for RFP references for this line.

	• 40.6.1 Reference System Requirements • 40.6.2 Reference Operational Requirements	change is made. • Weekly reports for the Contract Monitoring Unit are produced by 7 a.m. Eastern each State business Monday. • The accuracy of file maintenance activities is verified and weekly reports are produced for the Contract Monitoring Unit by 7 a.m. Eastern each Monday following the update activity.	
2.14	**Prior Approvals.** EDS will provide capability to receive and adjudicate prior approval and referral requests and adjustments. The Prior Approval Customer Service Center will support inquiries regarding prior approval, referrals and overrides from physicians, pharmacists, recipients, and other healthcare professionals. Prior Approval activities are described in the following sections of the Technical Proposal: • 40.7.1 Prior Approval System Requirements • 40.7.2 Prior Approval Operational Requirements.	The performance standard is met when: • The prior approval business area is updated with prior approval results received from other entities within 24 hours of receipt from each entity, except Fridays, when the updates will be available by 7 a.m. Eastern on the following Monday. • A decision for non-pharmacy prior approval is rendered within one State business day of the receipt of the required information or research for non-emergency prior approval requests. • Prior approval decisions are	See SOW Number 2.1 for RFP references for this line.

		generated and mailed to appropriate designees within two State business days of rendering a decision. • The State Prior Approval Policy is applied with a 99.9 percent accuracy rate based on the information available when rendering a prior approval decision. • Online inquiry and data entry to the Prior Approval data to providers, Fiscal Agent staff, and State-designated staff is available from 6 a.m. until 11 p.m. Eastern Monday through Friday and 7 a.m. to 7 p.m. on Saturday and Sunday 99.9 percent of the time. • For Non-Medicaid only, online inquiry and data entry to the Prior Approval data to AP/LME staff and State-designated staff is available from 7 a.m. until 7 p.m. Eastern Monday through Friday 99.9 percent of the time. • The Pharmacy Prior Approval Customer Service Center is available from 7 a.m. until 11 p.m. Eastern on State business days Monday through Friday,	

		and from 7 a.m. until 6 p.m. Eastern Saturday and Sunday. • System-generated letters to recipients and providers of the status of prior approval requests are produced within 24 hours of receipt. • Weekly Pharmacy Alerts are produced. • Each complete pharmacy prior approval request is adjudicated within one State business day of receipt. • A response is sent to a requesting provider within one hour for a telephone request for an emergency override. • A quarterly report of the number of prior approval requests received is created. • A weekly batch processing report is created. ~~•A monthly meeting is held with DUR, the State, and Retro-DUR vendors and Community Care Program and minutes from the meeting are included in the biweekly Project Status Report.~~ • All meeting minutes are delivered to the State within	

		five business days following each meeting. • DUR Board agenda and meeting materials are delivered to the State no fewer than 20 State business days prior to the scheduled quarterly meeting.	
2.15	**Managed Care.** EDS will provide online access to recipient, provider, claims, reference, and encounter data related to Managed Care. EDS will provide a call center for call-in inquiries. We will maintain and process Managed Care capitation rates overrides and withholds as required. Managed Care activities are described in the following sections of the Technical Proposal: • 40.9.1 Managed Care System Requirements • 40.9.2 Managed Care Operational Requirements	The performance standard is met when: • Requests for changes to capitation payments and management fees are completed within two State business days from date of request. • Written override approval requests are entered into the system within two State business days from receipt of the request and a decision is provided to the requesting providers within five State business days from receipt of request. • A requesting provider is sent a response within one hour for a telephone request for an emergency override. • The Data Submission Manual for encounter information	See SOW Number 2.1 for RFP references for this line.

		processing is compiled, updated, and distributed to providers within five State business days from State date of approval of change. • Toll-free access and a point of contact for Managed Care providers is available between 8 a.m. and 5 p.m. Eastern each State business day. • Managed Care provider telephone messages are responded to within one State business day of receipt of the message. • The Withhold and Penalty Log is provided within five State business days of the end of the previous month. • The file maintenance log for Managed Care-related transactions is provided within five State business days of the end of the previous month. • Managed Care provider enrollment reports are created and available to providers no later than the first day of each month. • Weekly searches are conducted for "exempt"	

		numbers that are linked to the mandatory program category for a system-generated letter advising the eligible of the potential of primary care provider selection from five providers within a 30-mile range. • ~~The Health Choice file is sent to the North Carolina State Health Plan by the third business day of each month.~~	
2.16	**Health Check.** EDS will maintain the Health Check periodicity schedule. EDS will maintain each Health Check-eligible recipient, the current and historical screening results, referral, diagnosis and treatment, and immunizations, including the provider numbers and dates. EDS will provide this data to the counties as needed through the Web portal and provide support and training as required. Health Check activities are described in the following sections of the Technical Proposal: • 40.10.1 Health Check System Requirements • 40.10.2 Health Check Operational	The performance standard is met when: • The Denied Claims Report for Health Check denials is reviewed and providers are contacted by telephone to educate and schedule provider visits if denial rate is greater than 10 percent. • The Health Check County Option File Master Report is reviewed monthly to make certain that participating counties received Automated Information Notification System (AINS) (or Fiscal Agent equivalent) data and Health Check reports.	See SOW Number 2.1 for RFP references for this line.

	Requirements	• The Health Check Management Fee Option File Master Report is reviewed monthly to verify that Health Check management fee claims were generated correctly. • The monthly FTE Report is submitted to the State. • The Health Check Billing Guide is updated. • Telephone and on-site technical support and training for Health Check Coordinators are provided. • Annual regional Health Check workshops are conducted for participating providers in six separate sites throughout the State.	
2.17	**Third-Party Liability.** EDS will make certain that claims are cost-avoided based on available TPL data supplied through eligibility data. This TPL cost avoidance process will not be applied to preventive pediatric services and prenatal care for pregnant women regardless of other available coverage. Necessary drug invoices for Medicaid will be generated. Claims data extracts will be provided to DMA's TPL vendors for cost recovery efforts. We will handle DPH and ORRCC	The performance standard is met when: • System-generated letters to providers, recipients, and county offices are produced. • Paid Claims History for State-specified TPL recoveries and provider/recipient collections are adjusted within five State business days from end of the previous month.	See SOW Number 2.1 for RFP references for this line.

	TPL recovery processes as required in RFP. TPL activities are described in the following sections of the Technical Proposal: • 40.11.1 TPL System Requirements • 40.11.2 TPL Operational Requirements	• Recoveries or collections are dispositioned accurately and consistently 99.8 percent of the time. • Drug invoices for insurance carriers are produced and billed within five State business days of TPL entry. • Accident inquiry letters are mailed to the identified recipients within five State business days from end of the previous month. • Within two State business days of report notification of death, three copies of an invoice are generated and sent to the ERE representative at the county Department of Social Services, local health departments, Developmental Evaluation Centers/Children's Developmental Services Agencies (DECs/CDSAs), Purchase of Medical Care Services (POMCS), or other local entities. • TPL edit/error report(s) for ACTS (Automated Collection and Tracking System) are provided for State staff access	

		each State business day. • Daily (next business day) transmission logs are created, showing successful transmission of TPL data to Client Services Data Warehouse (CSDW) and to and from ACTS available for State staff access each State business day. • Recipient TPL data transmitted by ACTS is extracted, processed, and transmitted from the electronic Division of Information Resource Management (DIRM) File Cabinet by 7 a.m. • A daily extract of TPL carrier and recipient resource data is produced and sent to DIRM for ACTS, CSDW, and EIS. • A daily extract of updates to TPL recipient resource data is produced and sent to DIRM for ACTS for Medicaid recipients referred to Child Support.	
2.18	**Financial Management and Accounting.** EDS will maintain a full range of financial management and accounting functions and provide the required financial support for the required	The performance standard is met when: • The State is provided with confirmation and validation of	See SOW Number 2.1 for RFP references for this line.

	financial activities/tasks, such as receipt and disposition of cash refunds, timely deposit of funds received through lockbox mechanisms, checkwrite funding communication, and financial reconciliations. Financial Management and Accounting activities are described in the following sections of the Technical Proposal: • 40.14.1 Financial Management and Accounting System Requirements • 40.14.2 Financial Management and Accounting Operational Requirements	accurate file maintenance request transactions 99.9 percent of the time. • Capitation and management fee adjustments are produced 99.9 percent of the time. • Returned monies are deposited the same State business day of receipt. • Capitation payments and management fees are processed accurately in the month-end claims cycle and payment in the first checkwrite of the next month. • HMO withholds and penalties and primary care provider penalties are processed accurately in the next claim cycle after receipt of withholding and penalty requests 99.9 percent of the time. • The planned annual checkwrite schedule is published 60 days before the start of the next calendar year. • The State is notified by 9:30 a.m. Eastern Time on the first State business day following checkwrite of funds required.	

		• The State is notified by close of the State business day of notification from the Controller's Office that funds are in place each day following any delays in check mailings and EFTs. • The State is notified of any delays and reasons in the checkwrite process by 8 a.m. Eastern Time the next State business day following the checkwrite cycle and estimated time frame for completion. • Each checkwrite is balanced accurately 99.9 percent of the time, and any discrepancies are reported to the State immediately. • Check voucher information from the State Controller's Office is accurately processed 99.9 percent of the time and within one State business day of receipt. • Weekly budget reporting is accurate and consistent 99.9 percent of the time. • HMO withholds and penalties and primary care provider penalties are accurately processed in the next claim	

		cycle after receipt of withholding and penalty requests. • Cost settlement activities are performed accurately and consistently 99.9 percent of the time, as directed by the State. • Correct Federal Medical Assistance Percentage (FMAP) is applied to receivables and payables accurately and consistently 99.9 percent of the time within the monthly financial processing cycles. Certain receivables and payables may be subject to prior period FMAP. • Collection and management of accounts receivable/payable occur accurately 99.9 percent of the time. • 1099/W9 earnings reports are produced and mailed no later than January 31 each year and reported to the IRS no later than March 1. • Accounts receivable are removed monthly when a provider record has been terminated for one year. The fiscal agent generates a	

		monthly report of removed accounts receivables. • Program funds paid out and recovered in accordance with State-approved guidelines are accounted for and reported accurately and consistently to the State 99.9 percent of the time. • Each provider's receipts are summarized accurately 99.9 percent of the time for the previous calendar year no later than January 15 of the succeeding year. The summary is provided to the Internal Revenue Service and North Carolina Department of Revenue (NC DOR) by sending a file using file transfer protocol (FTP). • The receipt date of each withholding and penalty request and completion date of withholding or penalty is logged accurately within one State business day of receipt 99.9 percent of the time. • The State is provided a confirmation and validation for each completed date of	

		withholding or penalty on the State business day that the transaction is completed. • IRS regulations are complied with 99.9 percent of the time. • 1099 corrections are issued to providers before March 31 each year. The fiscal agent verifies that corrections are incorporated into the IRS file to report earnings for the prior year accurately 99.9 percent of the time. • Tax identification numbers and tax names are reported accurately 99.9 percent of the time. • Checks received are logged each State business day with disposition denoted, date, time, and individual processing the check accurately 99.9 percent of the time. • Program cash receipts received are deposited into the State-designated State Treasurer's Account each State business day by 1 p.m. and the amount deposited to the NC DHHS Controller is certified by 1:30 p.m.	

		• Other nonprovider checks are processed in accordance with State-approved policies and procedures—such as TPL and drug rebate receipts. The fiscal agent deposits these funds daily into the State-designated State Treasurer's Account 99.9 percent of the time. • Monthly bank account reconciliation is performed and reports are submitted for State approval within 10 State business days of each calendar month. • North Carolina Accounting System (NCAS) account data is received weekly to support checkwrite activity accurately and consistently 99.9 percent of the time. • For Non-Medicaid only, special "timely filing" edits are applied at the end of the State fiscal year for services rendered before May 1 no later than the cutoff for the last payment cycle in June consistently 99.9 percent of the time. • Checkwrite Financial Summary and FPR Reports are	

		completed the day after each checkwrite. • Month-end processing and financial reports are completed, balanced and distributed no later than the fifth business day of the following month. • The system and business reports are produced and maintained as required by the RFP. • Program cash receipts received are logged each State business day in Fiscal Agent/bank-managed lockboxes designated by the State with disposition denoted, date, time, and individual who processed the receipt. • Verification of daily deposit total to receipt logs by an employee who is independent of the lockbox remittance and bank deposit process are provided. • Transactions for program cash receipts received in Fiscal Agent or bank-managed lock boxes designated by the State are processed and posted. • Program cash receipts and adjustments are dispositioned	

		within the month of receipt to the applicable program division, benefit plan, NCAS CAC code and period code, reason code, service, and county code. • An extract of DMH claims data for CDW is produced with each checkwrite. • Refunds are issued to recipients within 15 business days from the time a corresponding entry is made into accounts payable 99.9 percent of the time.	
2.19	**System Availability.** The Replacement MMIS will be consistently accessible to authorized users. System availability standards are described in the following section of the Technical Proposal: • 40.1.1 General System Requirements: System Availability subsection	The performance standard is met when: • The system is available for 99.9 percent of the time annually during production hours of operation, excluding planned system downtime. • 90 percent of transactions occur in four seconds or less. • 95 percent of transactions occur in five seconds or less. • 97 percent of transactions occur in six seconds or less. • 99 percent of transactions occur in seven seconds or less.	See SOW Number 2.1 for RFP references for this line.

Turnover Section			
SOW Number	**Work Statement Description**	**Performance Standard**	**RFP References**
3.1	**Turnover Plan.** The turnover planning process is described in the following sections of the Technical Proposal: • 50.2.9 Section I – Turnover Approach • 50.2.7 Section G – Contract Data Requirements List: The Turnover Plan CDRL	Performance of these work activities can be measured by State approval of the following deliverable: • Turnover Plan	CDRL Turnover Plan p. 254 50.2.9 Section I— Turnover Approach
3.2	**Turnover Roles and Responsibilities.** The Turnover Plan will clearly identify roles and responsibilities for turnover activities. The plan will delineate roles and responsibilities for the turnover account manager, turnover technical director, State, and the new fiscal agent. EDS also provides for a post-turnover support liaison to address issues that might arise and to minimize potential service disruptions. Turnover roles and responsibilities are described in the following section of the Technical Proposal: • 50.2.9 Section I – Turnover Approach: Roles and Responsibilities subsection	Performance of these work activities can be measured by State approval of the following deliverable: • Roles and Responsibilities Section of the Turnover Plan	CDRL Turnover Plan p. 254 50.2.9 Section I— Turnover Approach

3.3	**Turnover of Materials.** The turnover of the Replacement MMIS production data, libraries, and documentation will be included as tasks in the Turnover Plan. The turnover of materials is described in the following section of the Technical Proposal: • 50.2.9 Section I – Turnover Approach: Turning Over Materials subsection	Performance of these work activities can be measured by State approval of the following deliverables: • Inventory of Replacement MMIS System Documentation • Turnover of Materials	10.12.2 Deployment/Rollout and Turnover CDRL Turnover Plan p. 254 50.2.9 Section I— Turnover Approach

Early Implementation Section			
SOW Number (WBS Number)	**Work Statement Description**	**Performance Standard**	**RFP References**
1.5.2~~1~~	**Early takeover and implementation of Provider Enrollment, Credentialing, and Verification.** EDS will take this function over from DHHS. Today, the process of enrolling, credentialing, and verifying provider information is largely manual. EDS will automate this function, using Echo software for the electronic capture of important data. We also will stand up a provider Web portal six months before full system implementation to allow the providers to become acclimated to greater electronic functions.	• Provide updates in the weekly status reports. • Delivery and approval of this option's implementation	10.7 Early Implementation Objectives

	For more information on this Early Implementation Option, please refer to the following section of the Technical Proposal: • 50.2.4.1.1 Overview of System Solution and Solution for DDI: Proposed Early Implementations subsection		
1.5.1~~2~~.4	**Early implementation of Retrospective Drug Utilization Review.** EDS will work with Health Informations Designs to implement Retro-DUR reporting in the DDI phase. The tools made available through this early option will allow the State to identify the recipients, prescribers, and pharmacies that demonstrate the greatest opportunities for cost savings. For more information on this Early Implementation Option, please refer to the following section of the Technical Proposal: • 50.2.4.1.1 Overview of System Solution and Solution for DDI: Proposed Early Implementations subsection	• Provide updates in the weekly status reports. • Delivery and approval of this option's implementation	10.7 Early Implementation Objectives
1.5.4.~~3~~2	**Early implementation of an electronic document management system**	• Provide updates in the weekly status reports.	10.7 Early Implementation

	(EDMS). EDS will implement EDMS as an early option (with the State's approval) for claims and adjustments. This option will provide a refreshed platform for scanning and imaging claims and adjustments for any divisions using the Replacement MMIS. For more information on this Early Implementation Option, please refer to the following section of the Technical Proposal: • 50.2.4.1.1 Overview of System Solution and Solution for DDI: Proposed Early Implementations subsection	• Delivery and approval of this option's implementation	Objectives
1.5.4.12	**Early implementation of a performance dashboard.** EDS is proposing the BusinessObjects Dashboard Manager as a replacement for the current monthly performance spreadsheet reports provided to the State. The Dashboard will maximize the efficiency of managers and professional staff in the processes of accessing, understanding, and presenting performance metrics. For more information on this Early Implementation Option, please refer to the following section of the Technical	• Provide updates in the weekly status reports. • Delivery and approval of this option's implementation	10.7 Early Implementation Objectives

	Proposal: • 50.2.4.1.1 Overview of System Solution and Solution for DDI: Proposed Early Implementations subsection		

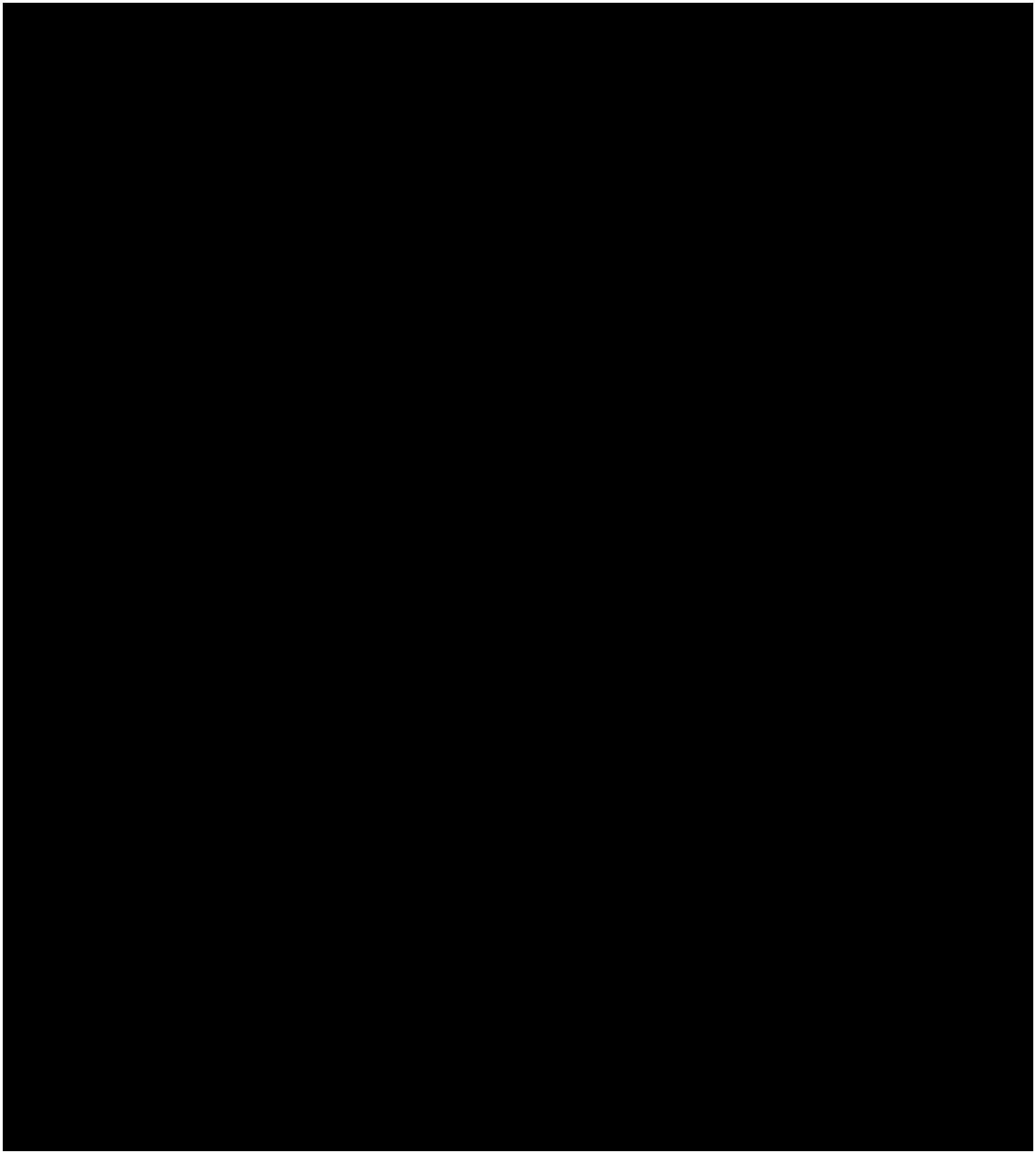
Section E—Project Management Plan

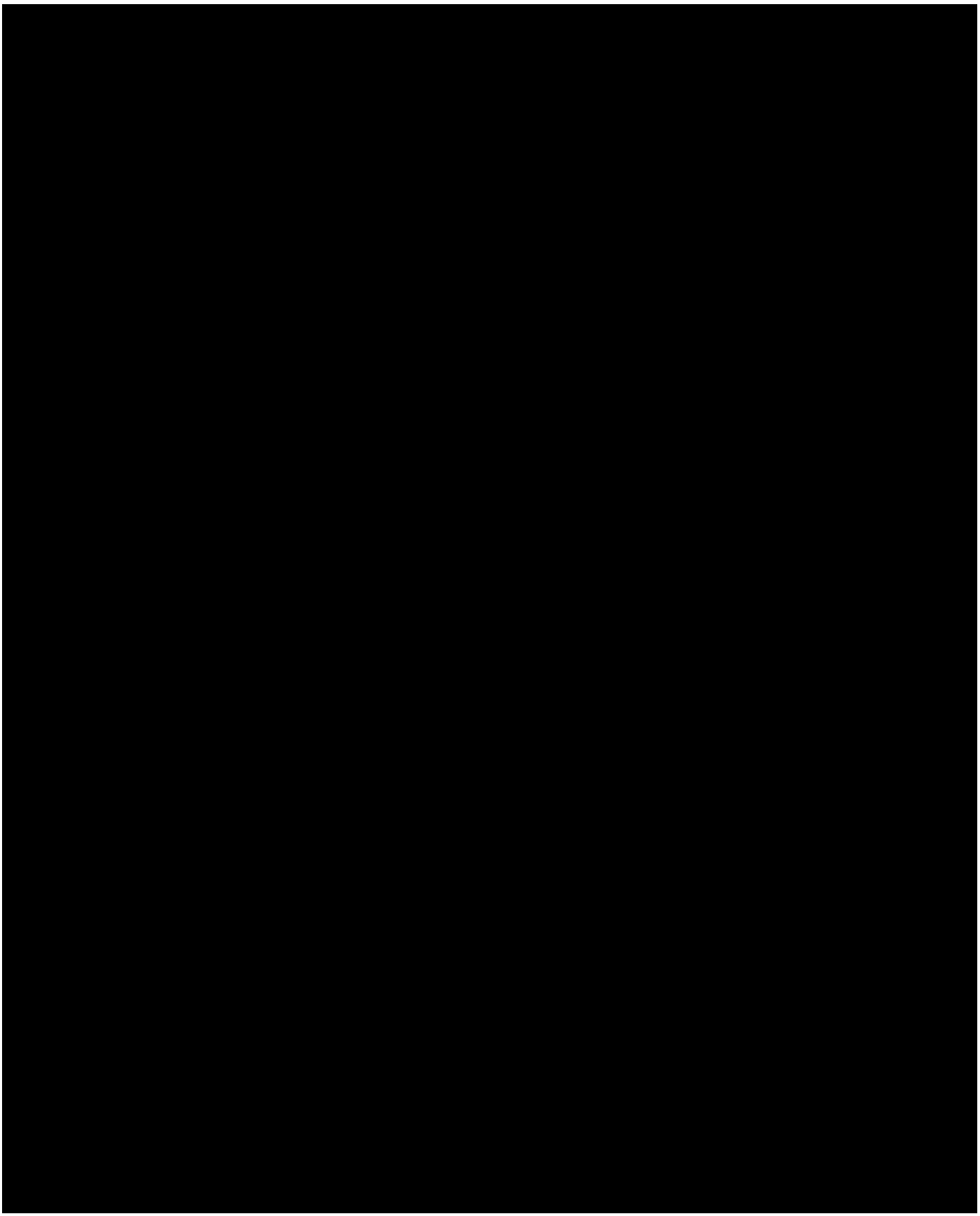
RFP Reference: RFP Addendum 4 – North Carolina Replacement MMIS Updated Requirements

In compliance with the requirements of RFP Addendum 4 – North Carolina Replacement MMIS Updated Requirements, this section of our Technical Proposal Supplement contains the following items:

- Changes to Integrated Master Plan
- Integrated Master Schedule
- Changes to Staffing Approach
- Changes to Initial Risk Assessment

Changes to Integrated Master Plan





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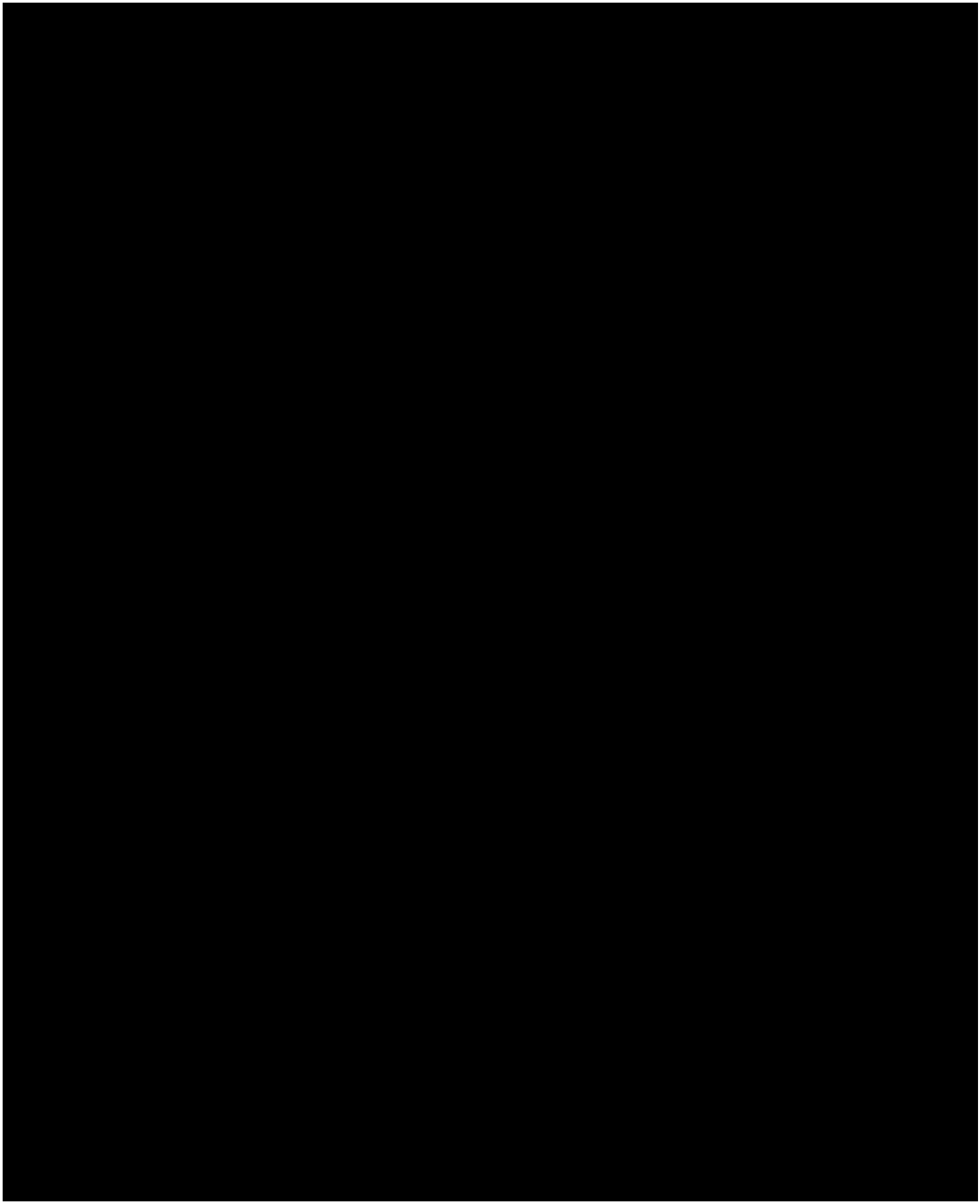

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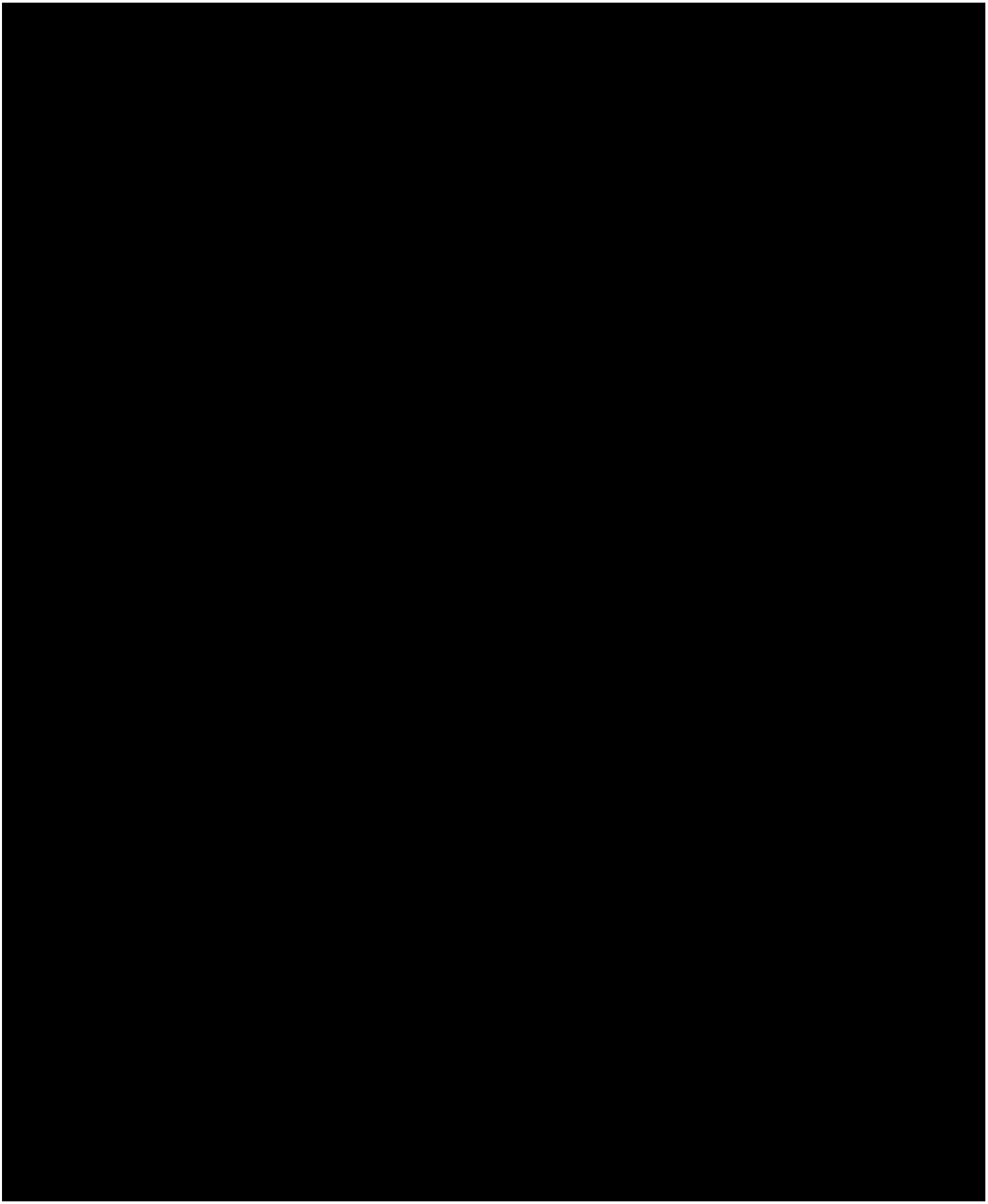

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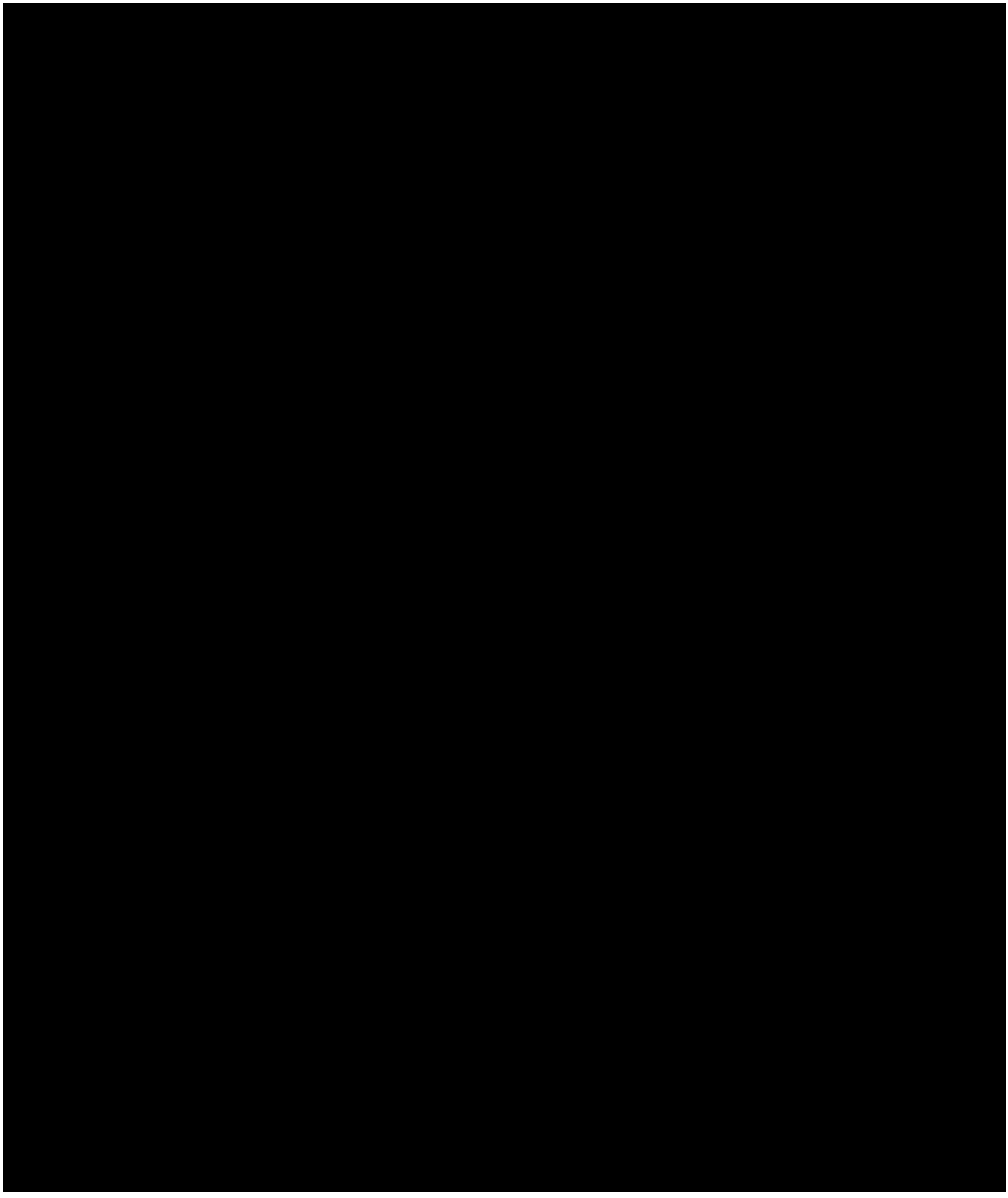

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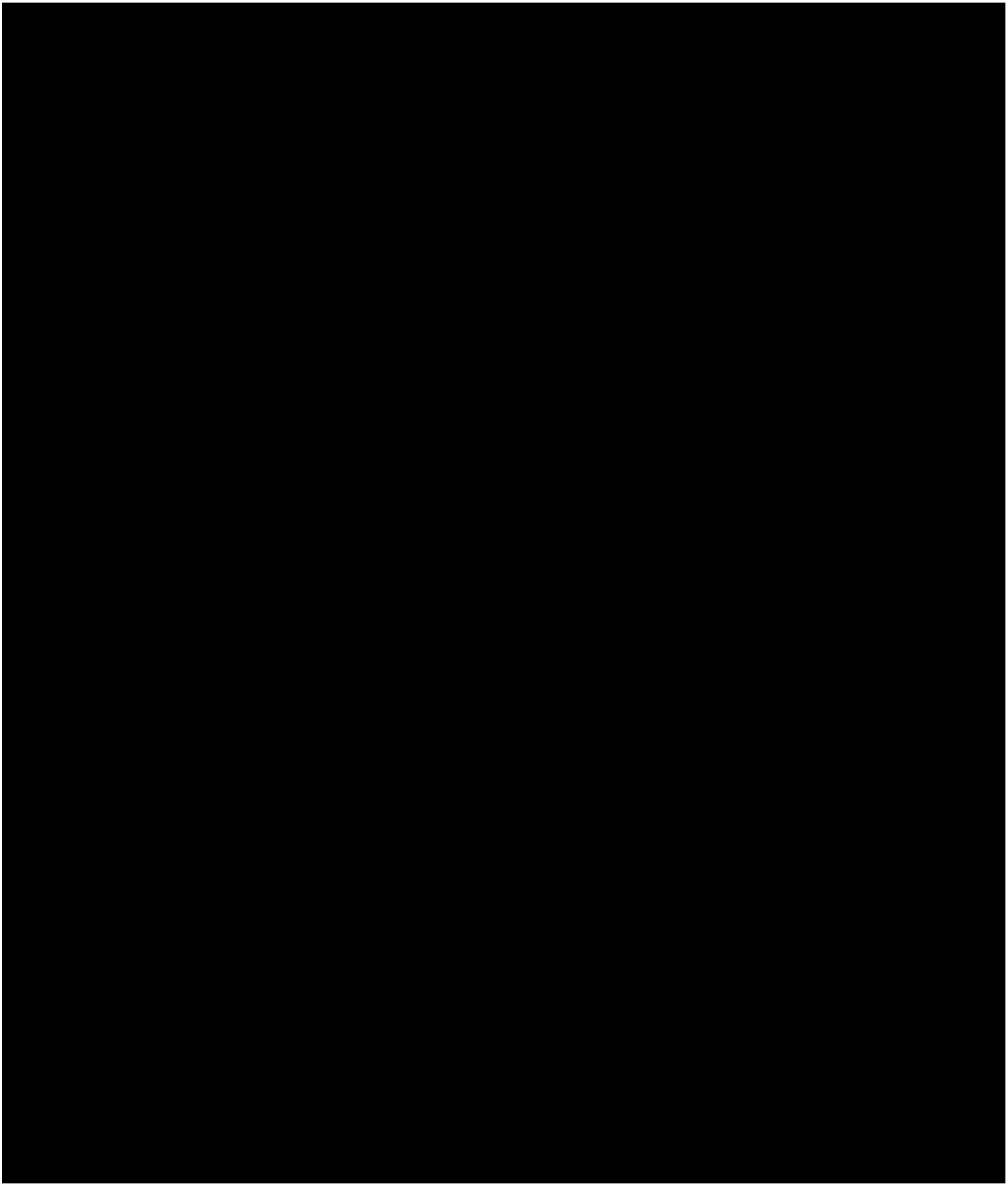

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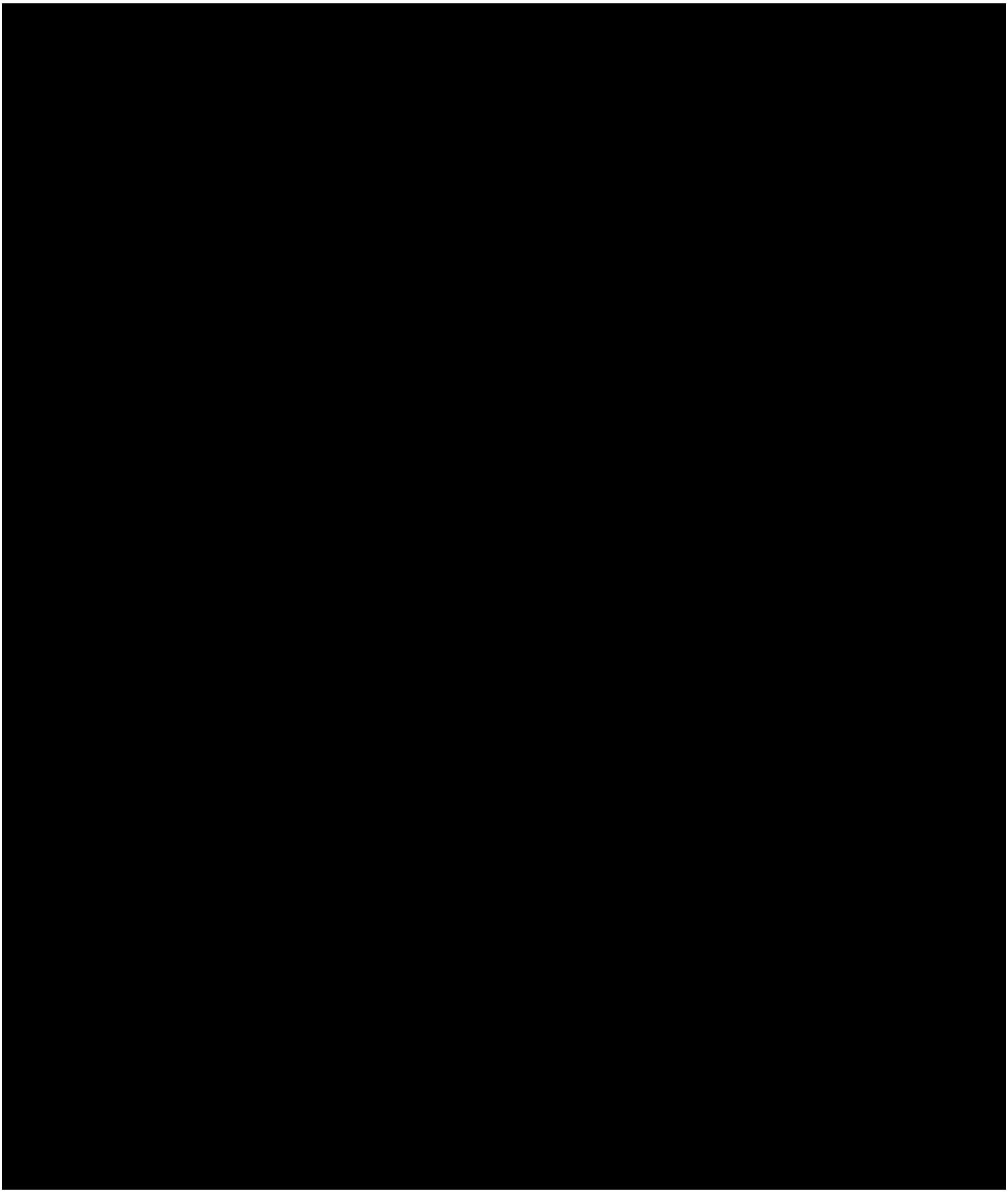

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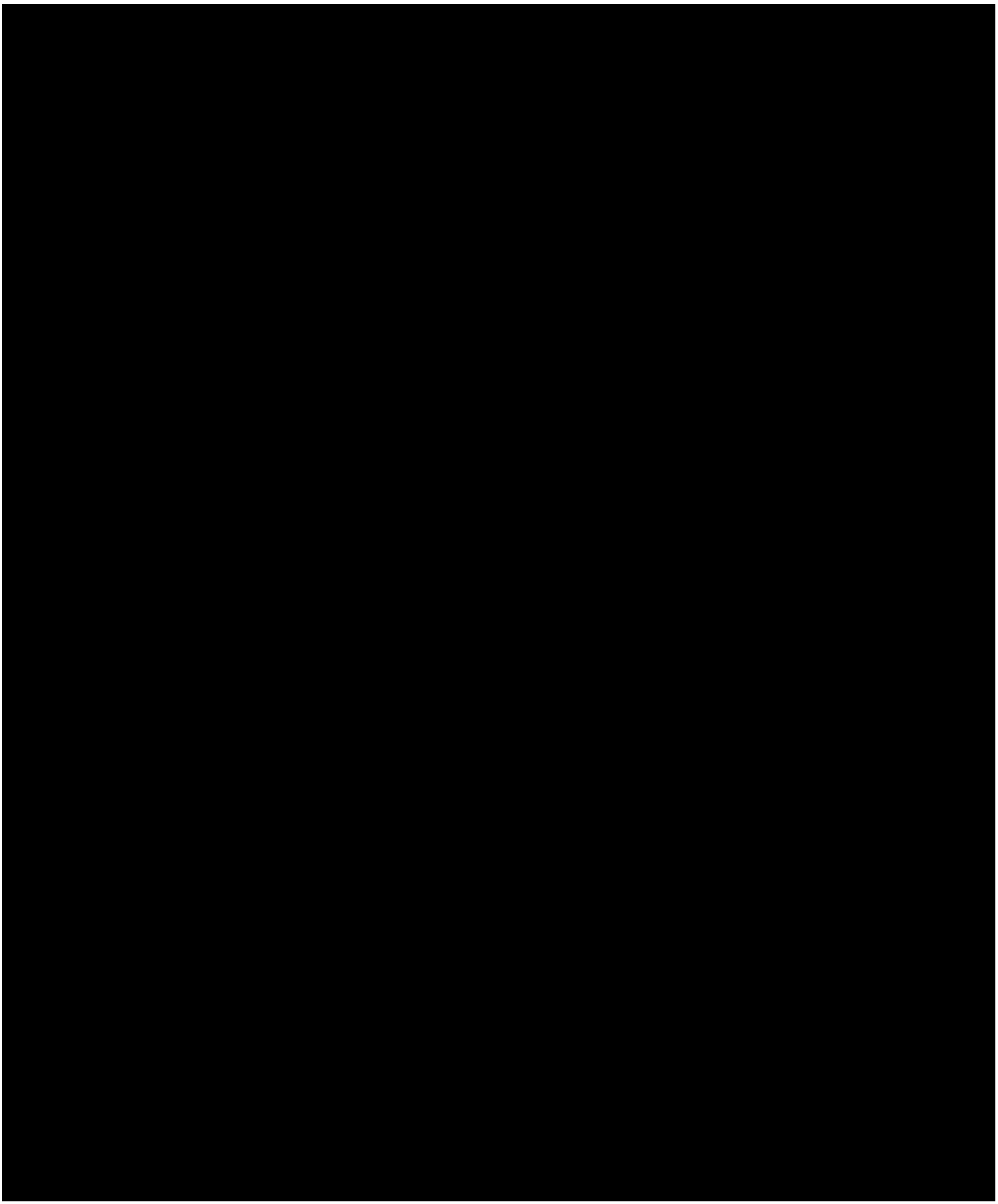

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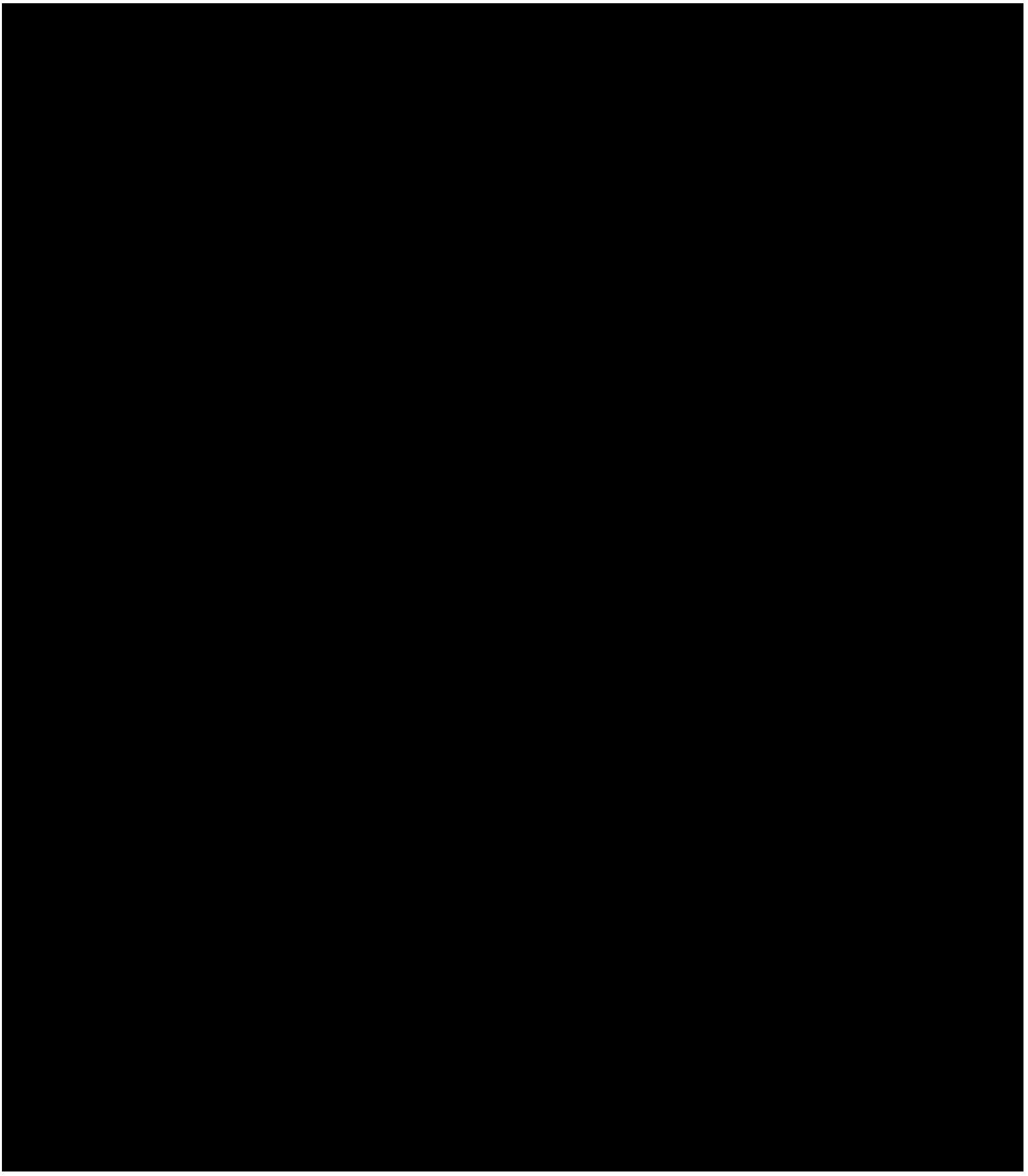

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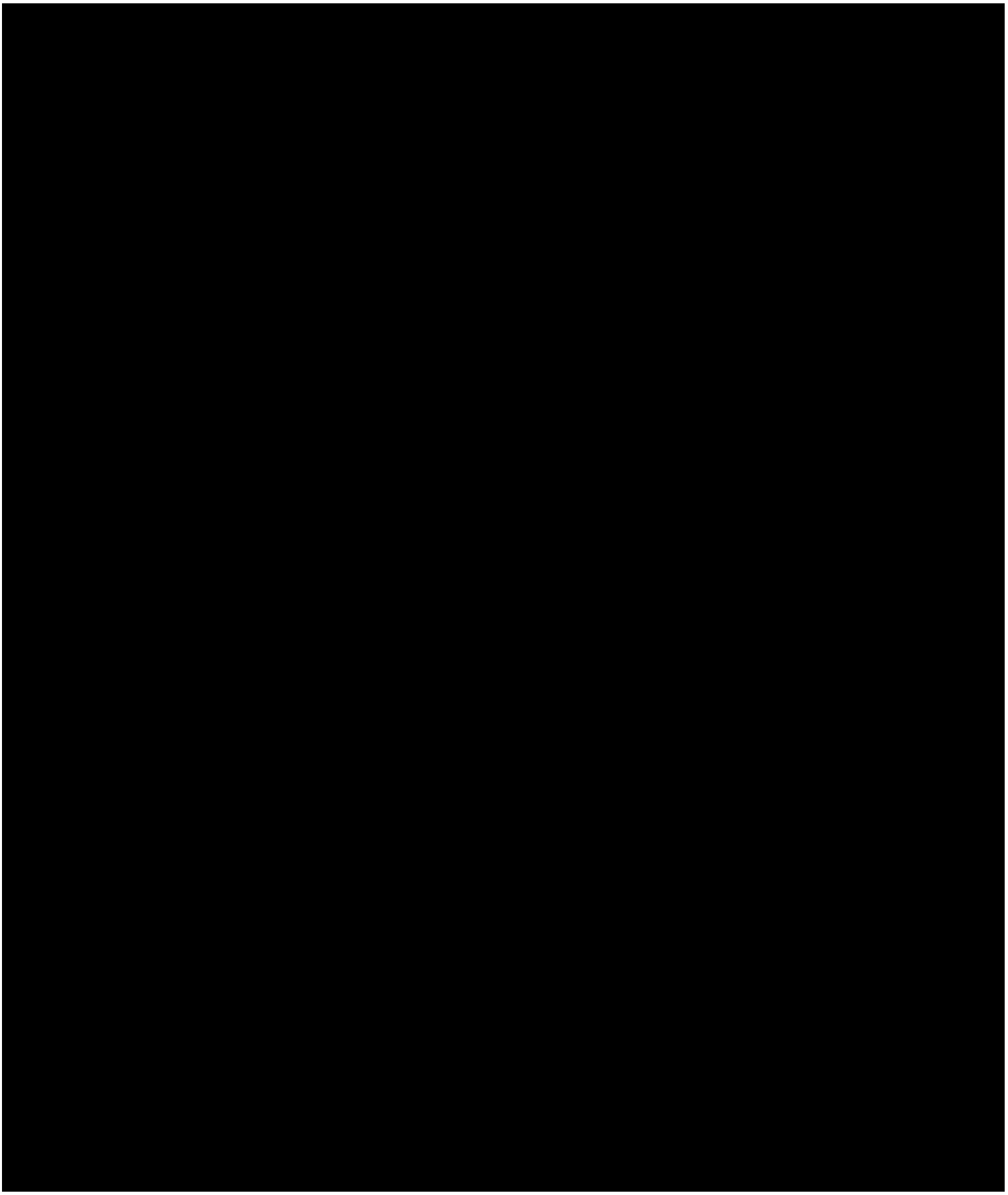

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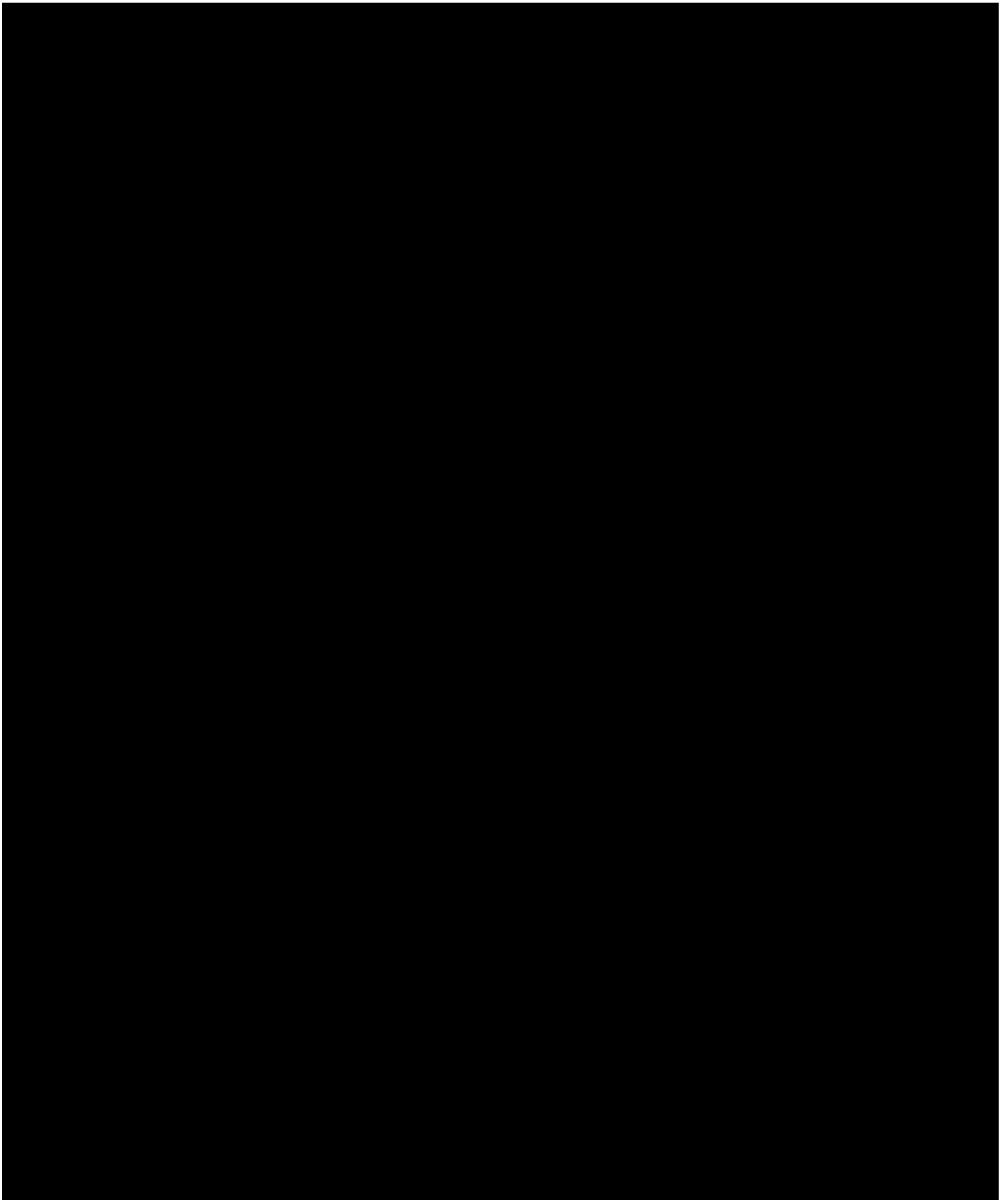

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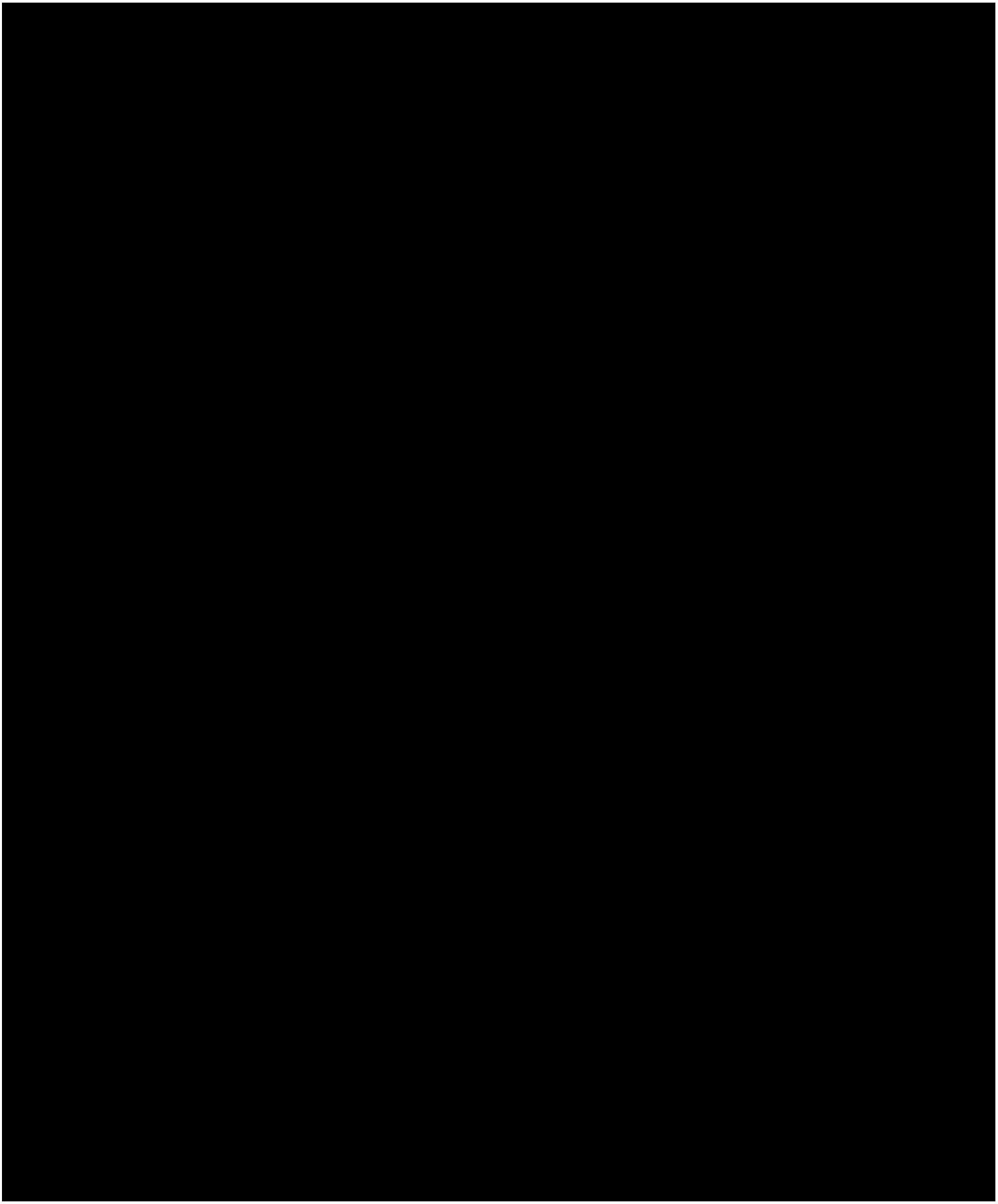

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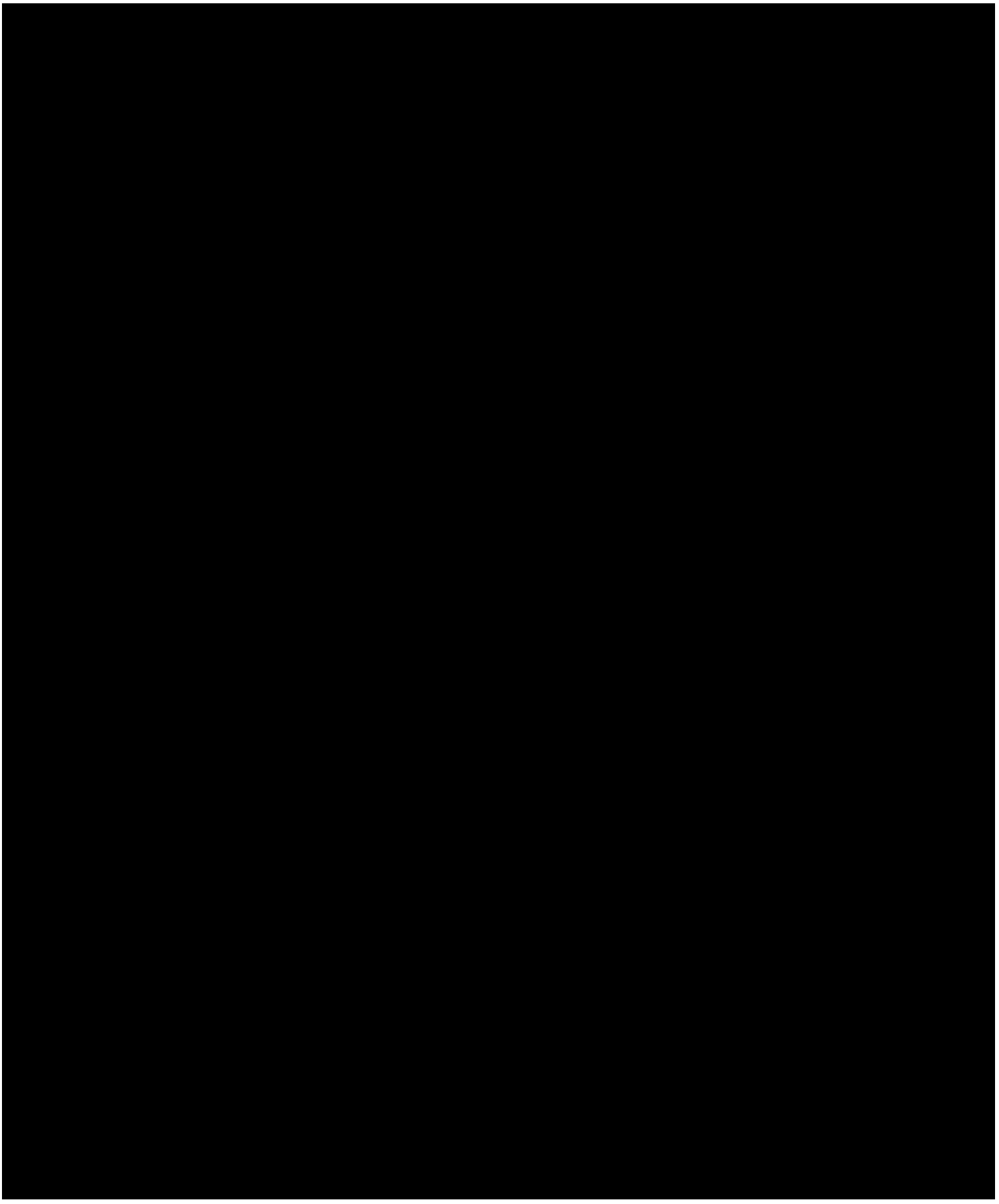

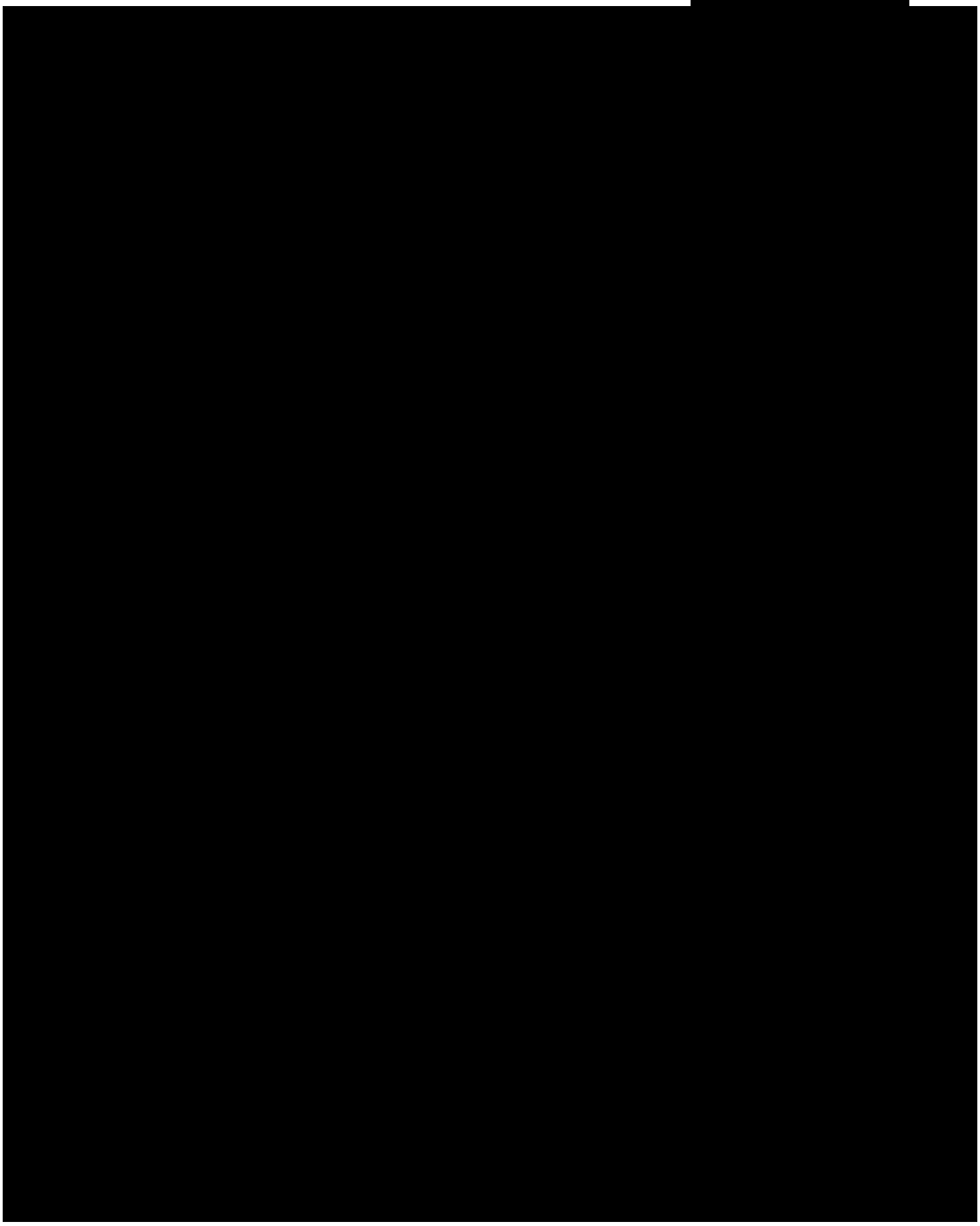

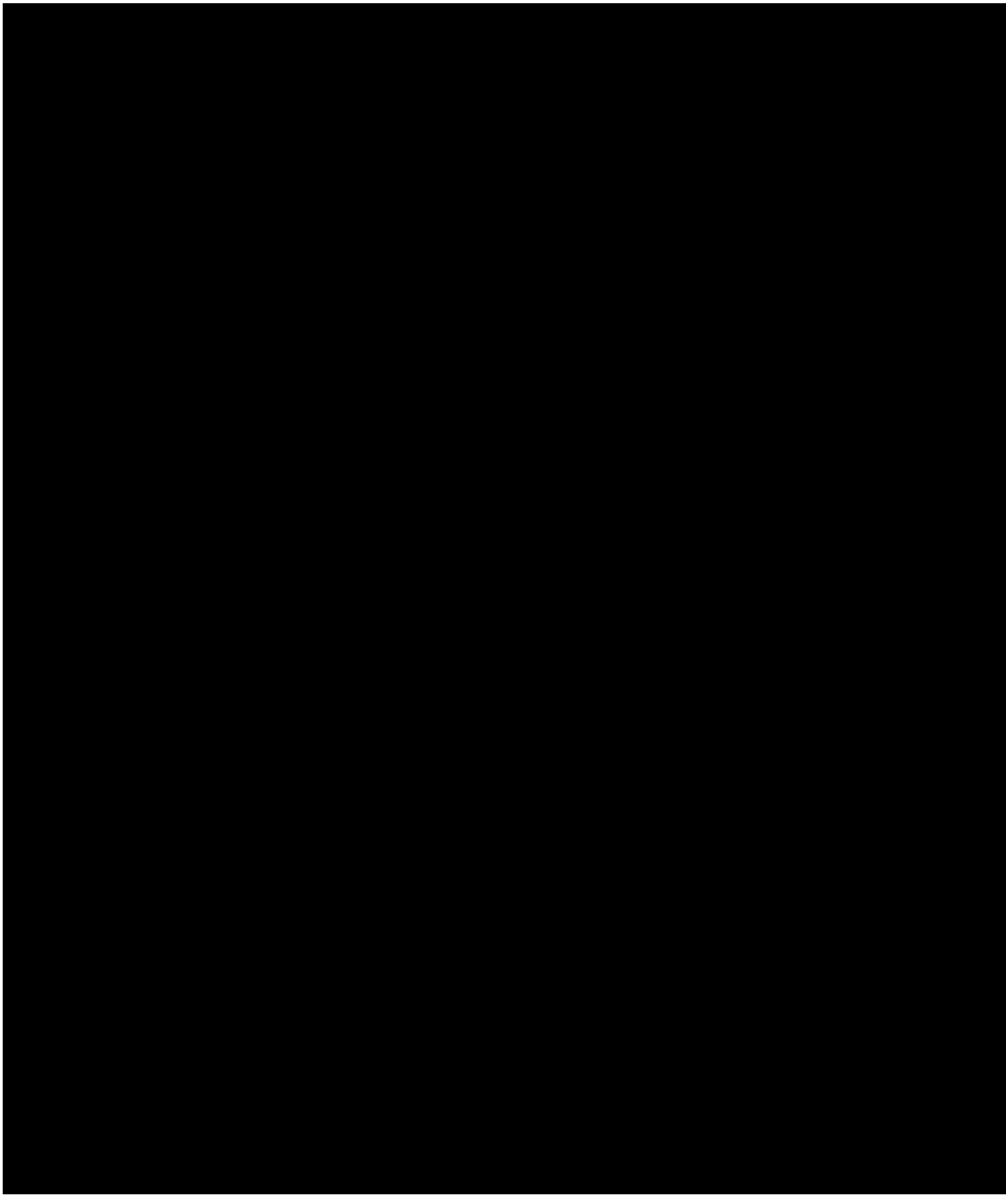

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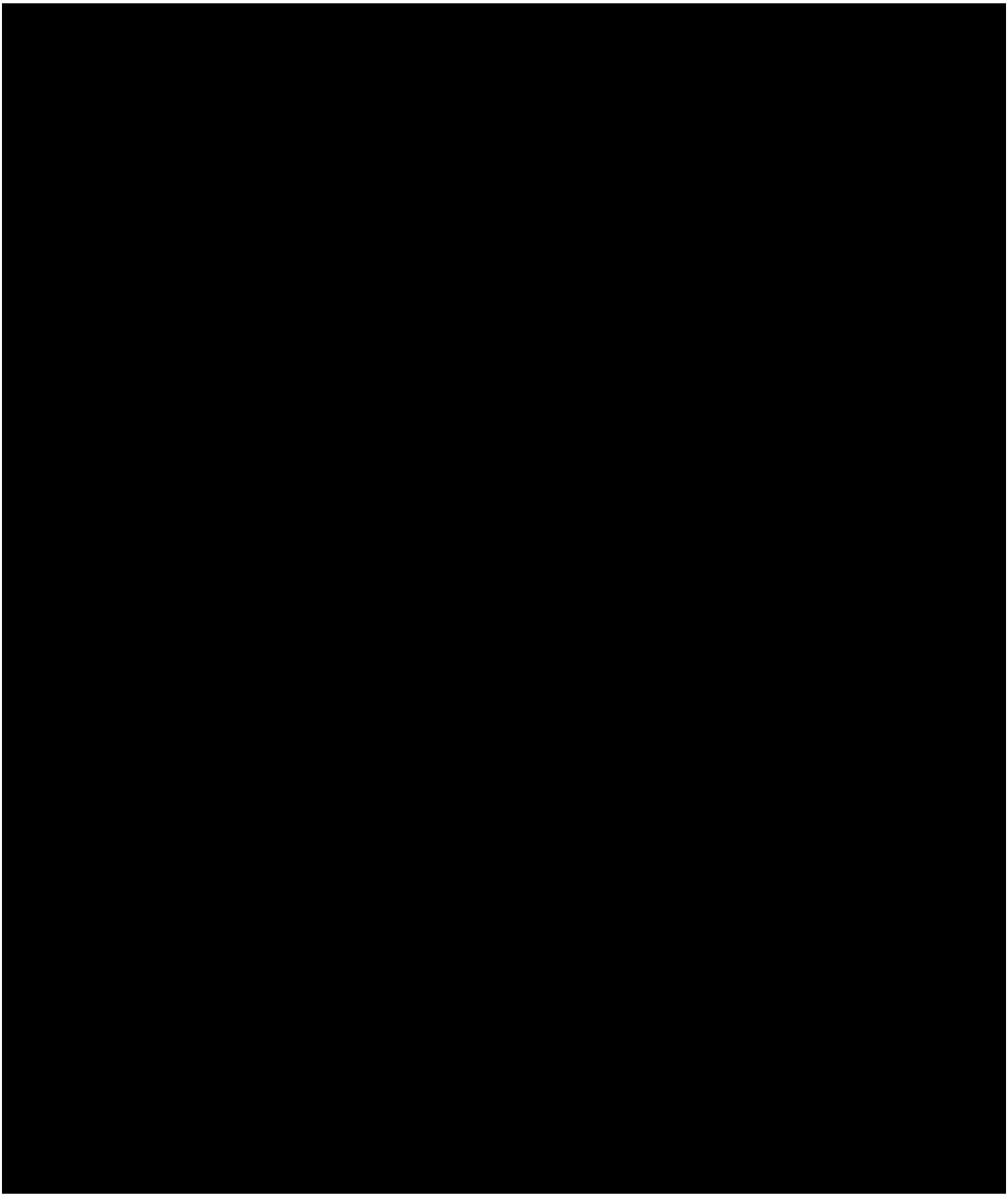

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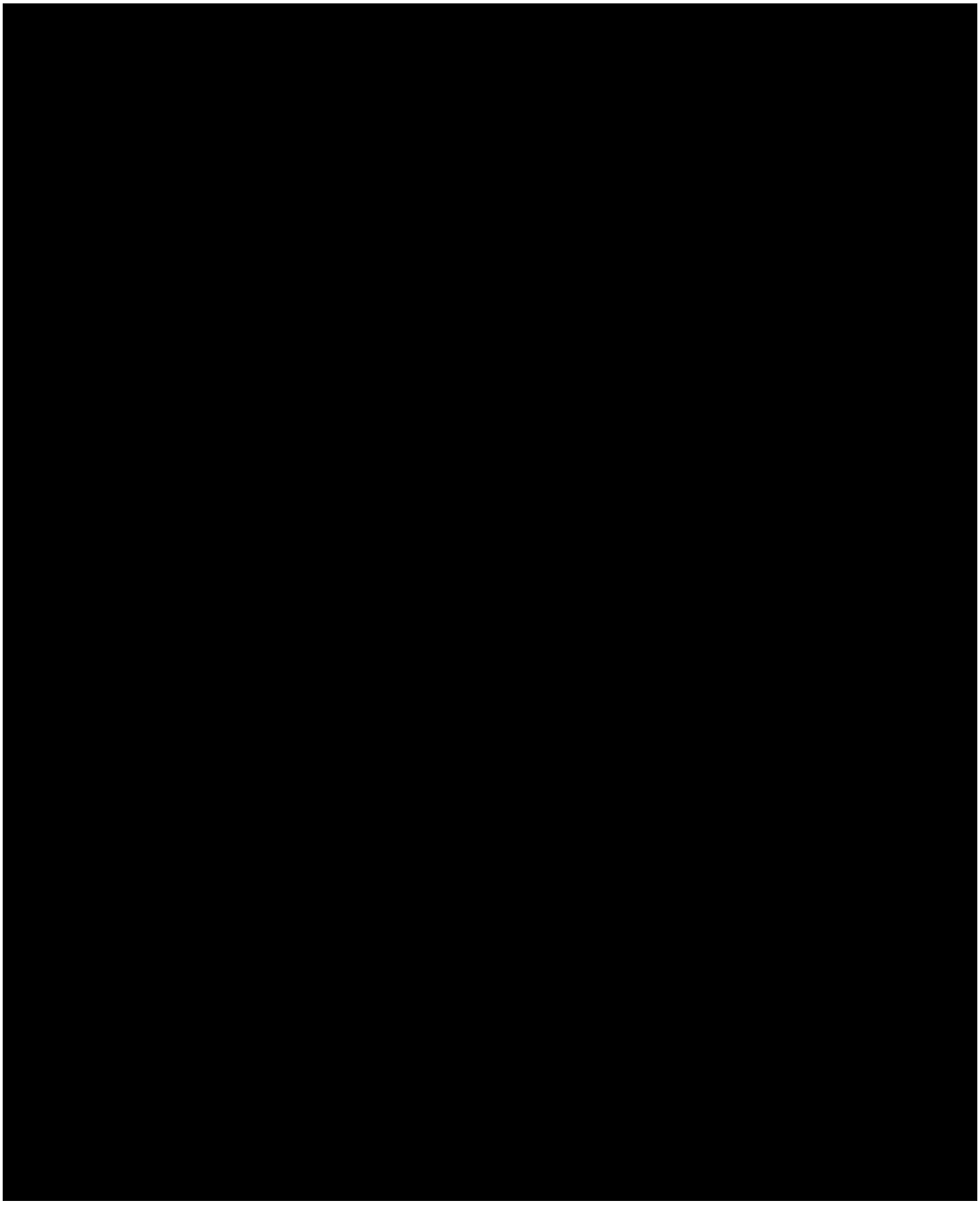

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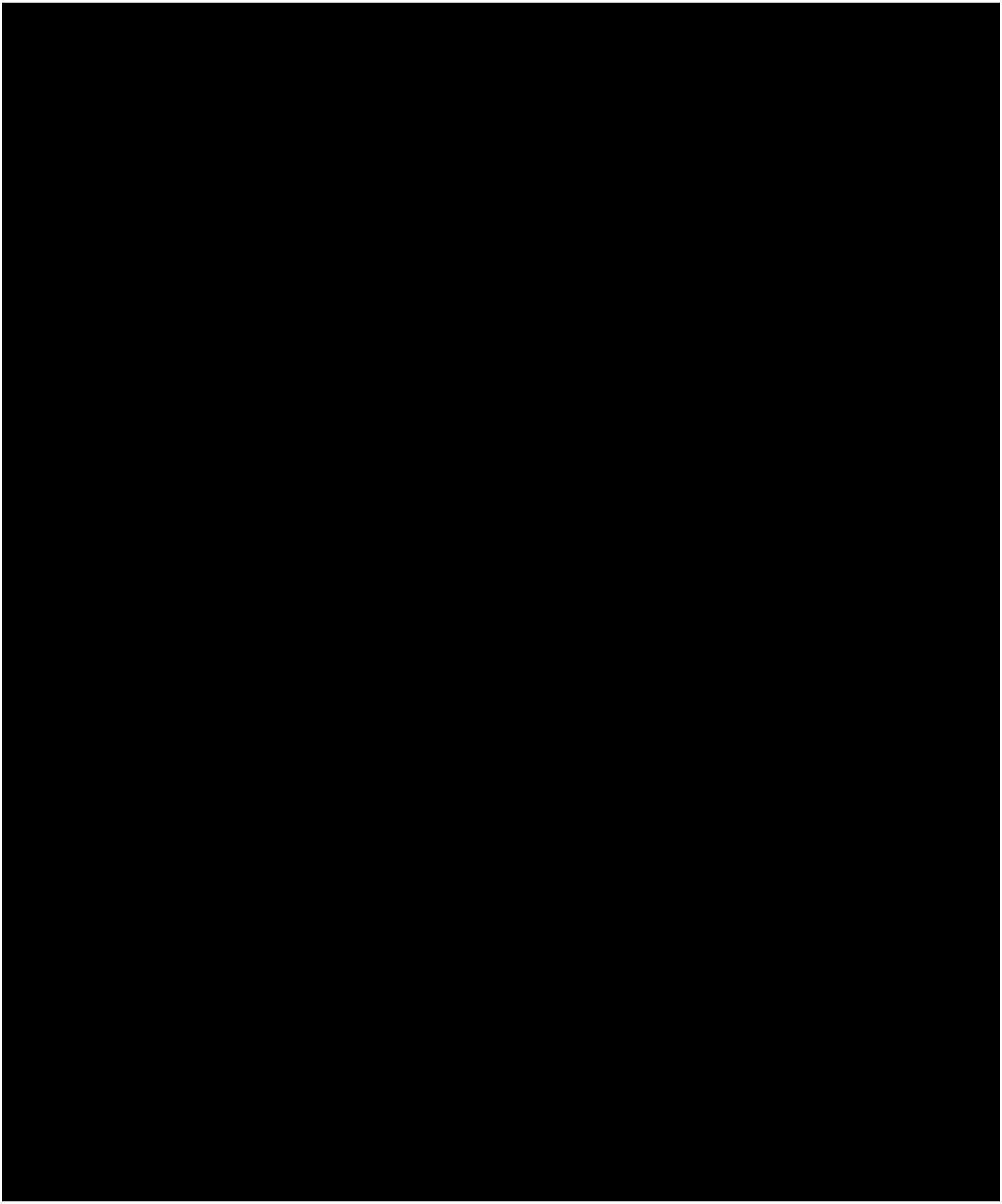

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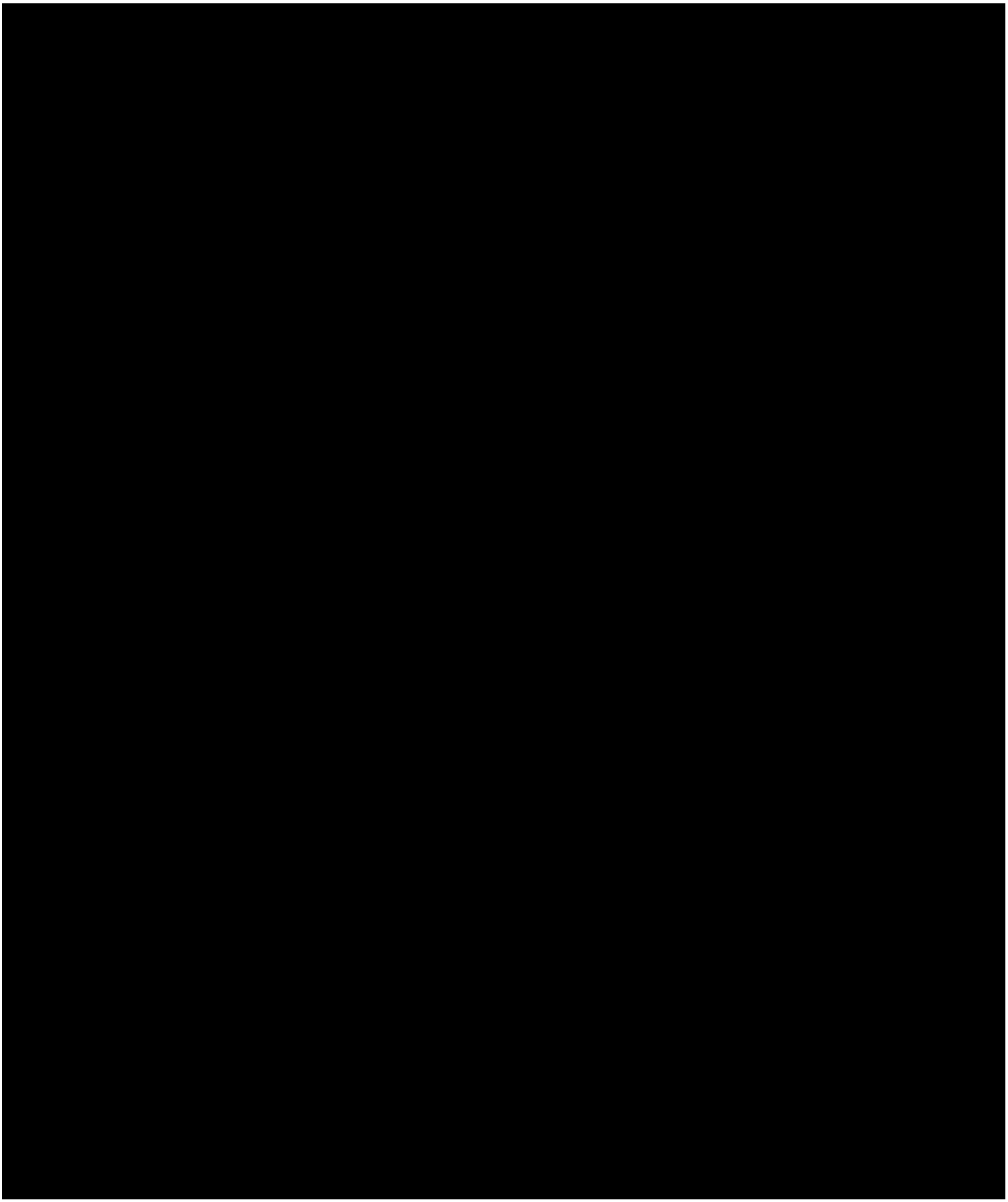

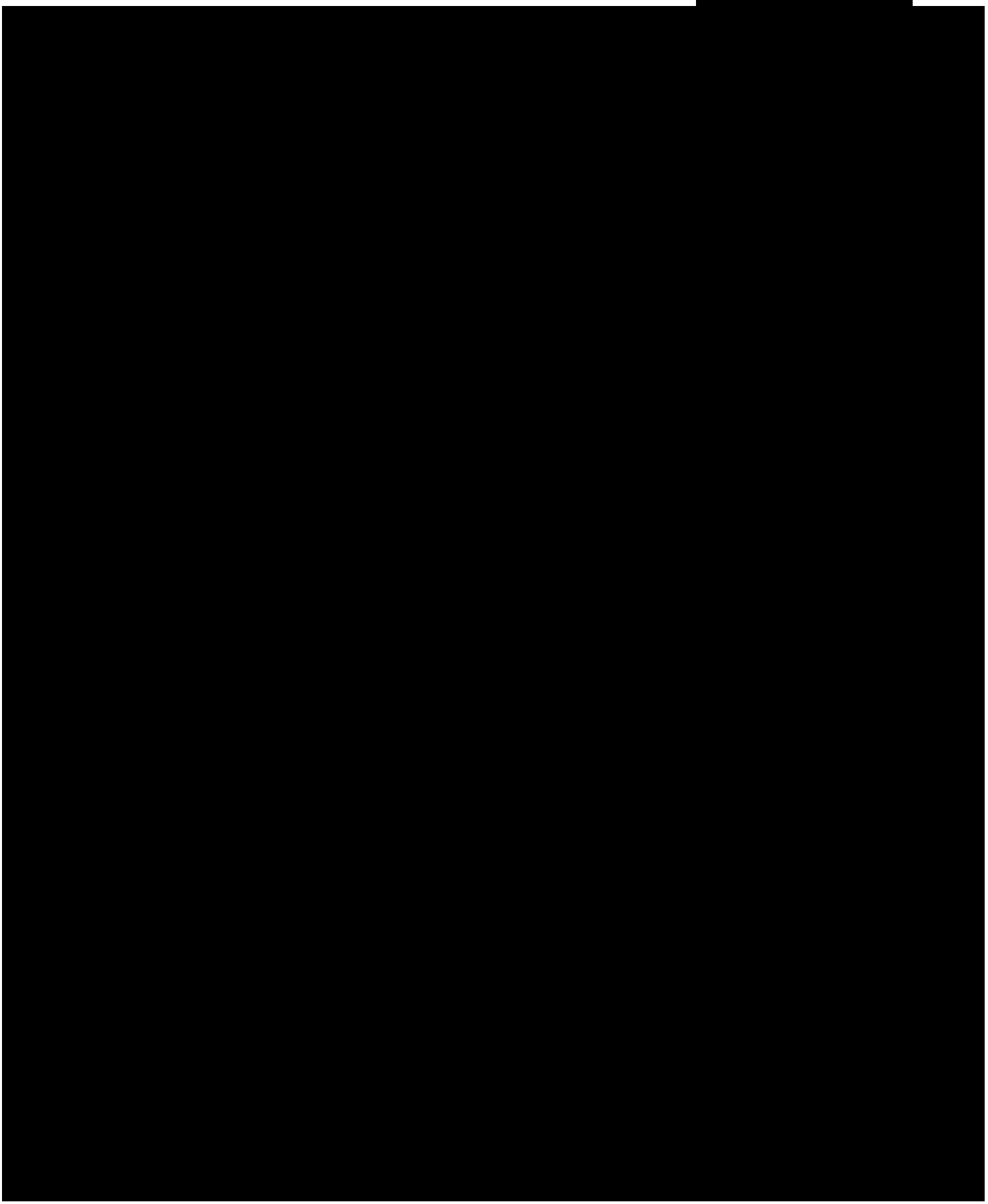

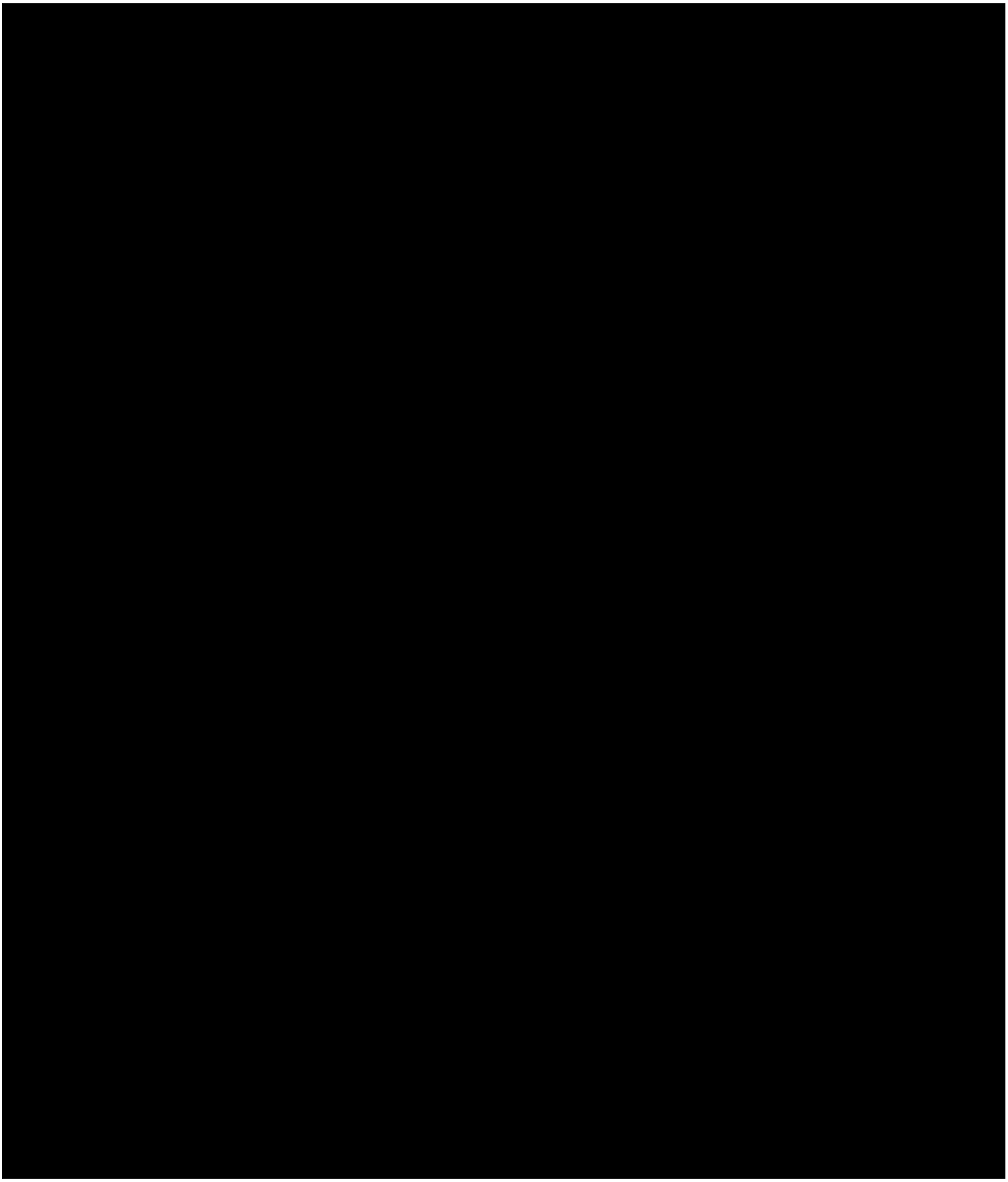

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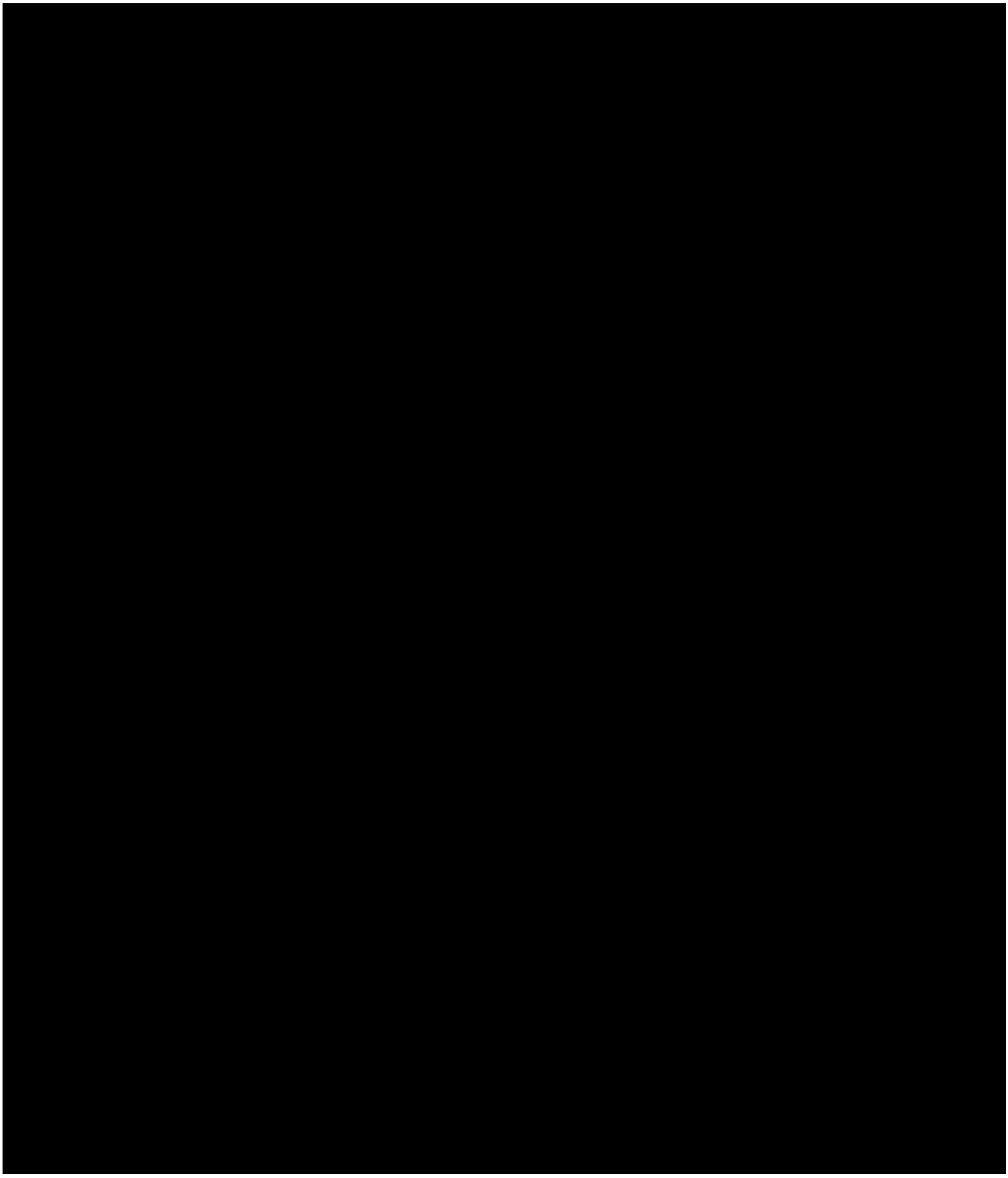

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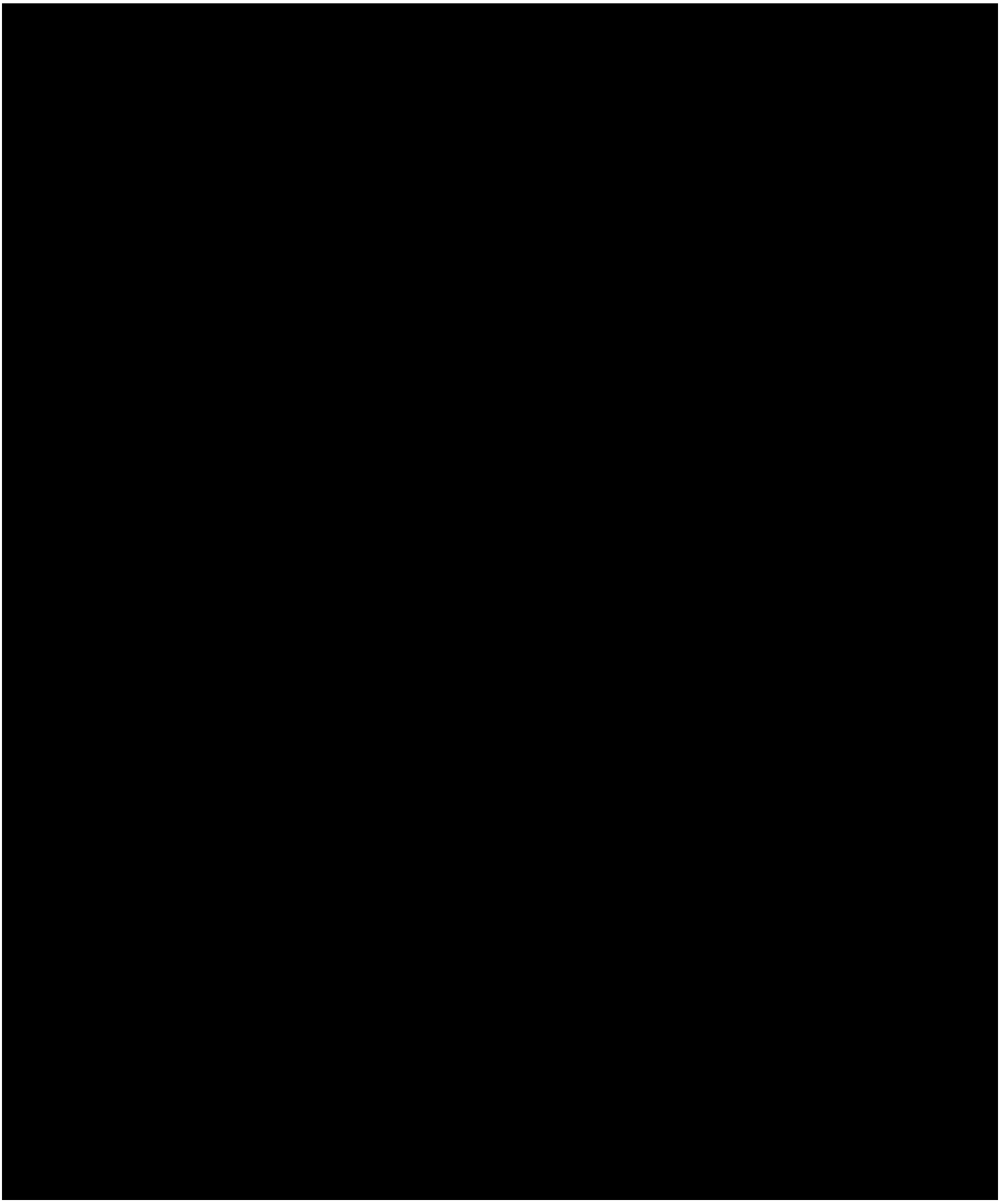

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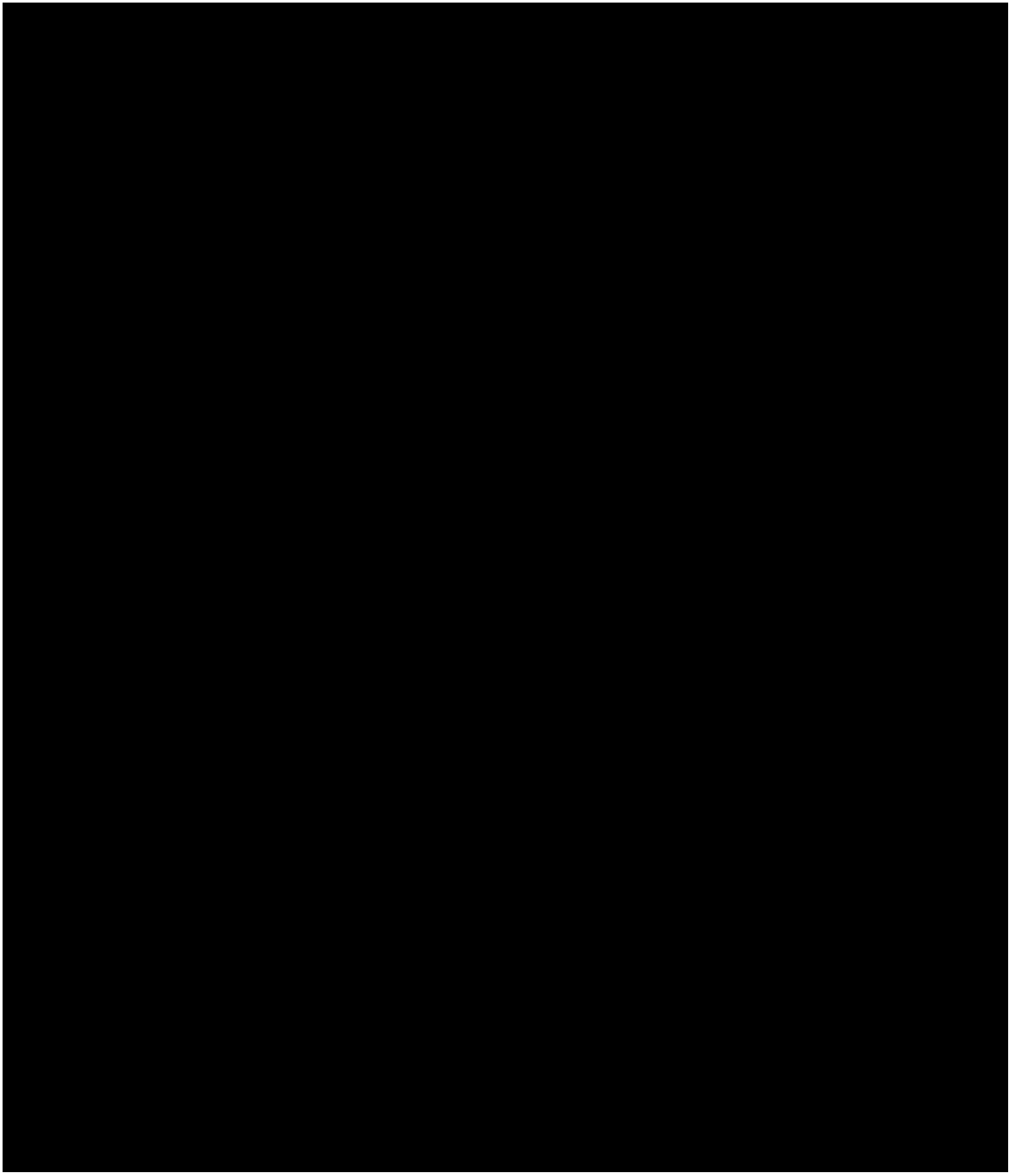

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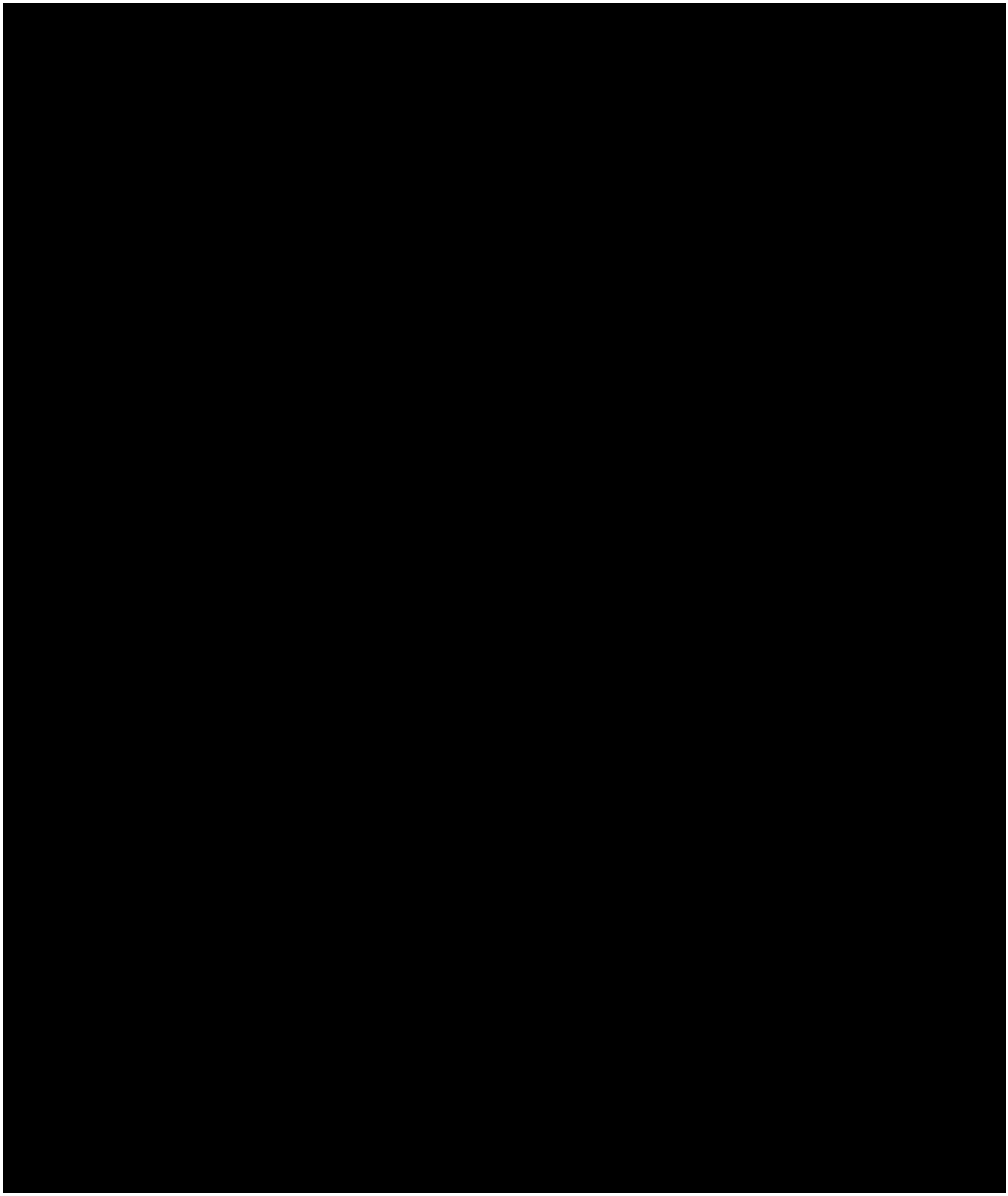

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Integrated Master Schedule

On the following page, we provide our completed Integrated Master Schedule (IMS), which incorporates the additional requirements provided by the State in RFP Addenda 4 and 5. In completing this updated IMS, we followed the same approach that we described on Technical Proposal BAFO pages E-107 to E-117.

This updated IMS shows a revised start date based on the January 21, 2009, award date published in RFP Addendum 5. Please note that the dates in this IMS reflect this new schedule. Unless otherwise noted, the integrity of time lines that appear elsewhere in the Technical Proposal BAFO remains the same and should be adjusted in line with the new IMS.

In accordance with the November 20, 2008, letter titled "RFP 30-DHHS-1228-08 NC Replacement Medicaid Management Information System Confidential and Proprietary Information," we have redacted our Integrated Master Schedule (IMS). This page and the page that follows represent the redacted IMS in its entirety.

[redacted]

Changes to Staffing Approach

In response to RFP Addendum 4, the exhibit on the following page, EDS DDI Phase Organization, replaces the exhibit following Technical Proposal BAFO page E-149.

EDS DDI Phase Organization

Denotes required positions in Appendix 50, Attachment I

* Operations teams indicated here under the Deputy Account Manager ramp up throughout the replacement phase and the roles in each organization are indicated on the operations chart.

Technical Proposal BAFO page E-177:

EDS has identified the following additional staffing positions as critical to the success of the Operations Phase:

- Deputy Account Manager Dennis Vaughan
- Technical Director/Systems Programming Manager Tim Sullivan
- Provider/Recipient Services Manager Chris Ferrell
- Prior Approval Manager Sharlene Bryant
- Financial Services Manager Jamie Herubin
- Senior Technical Analyst and Subject-Matter Expert (SME) for MMIS and Multi-Payer Mike Frost
- Senior Technical Analyst and SME for HIPAA Stacey Barber
- Database Administrator Terry Hensley
- Senior State Business Liaison Anthony Perkins
- Retro-DUR Account Manager John Williams, R.Ph.

Technical Proposal BAFO page E-177:

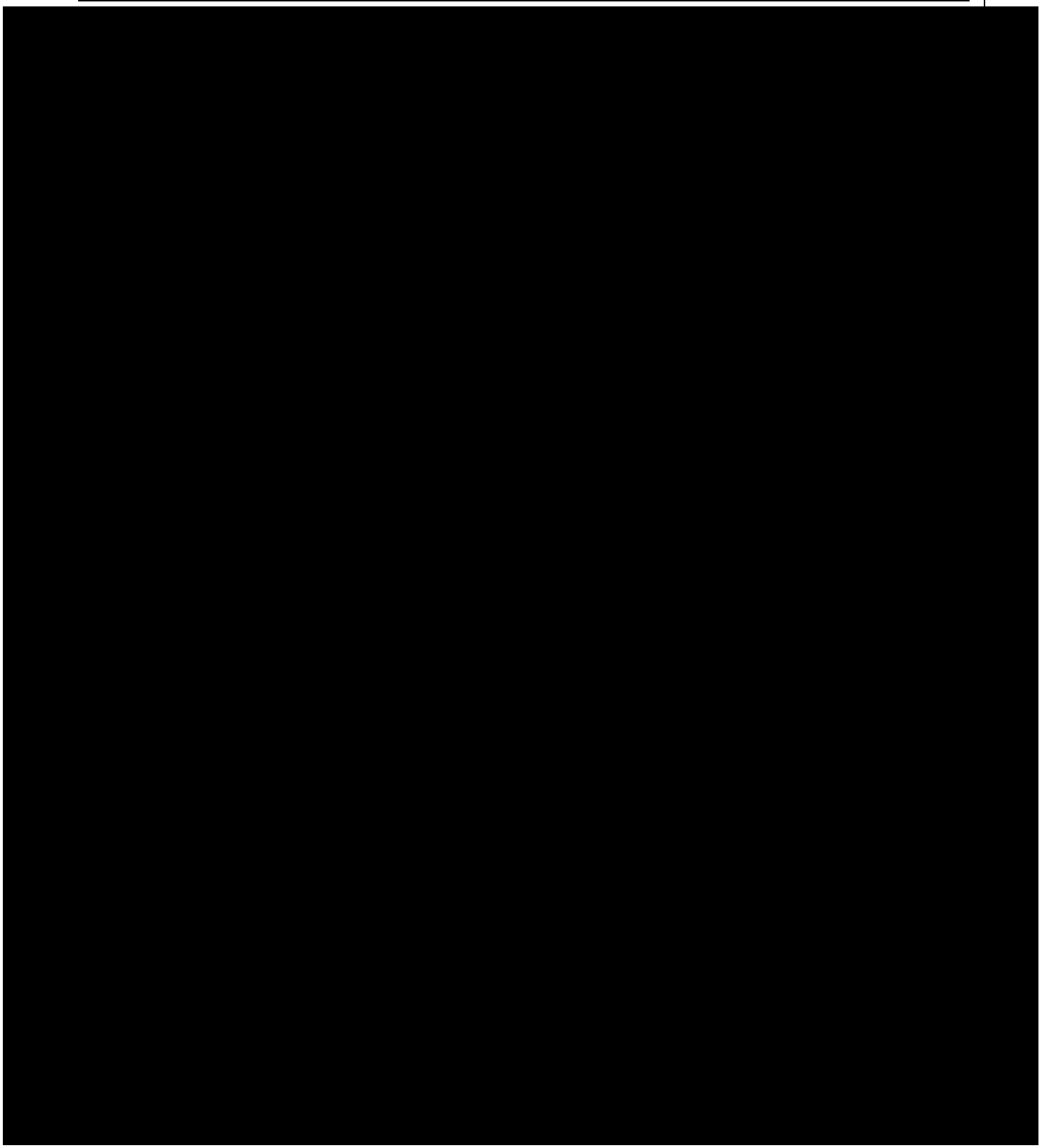
Resumes for Key and Other Operations Personnel

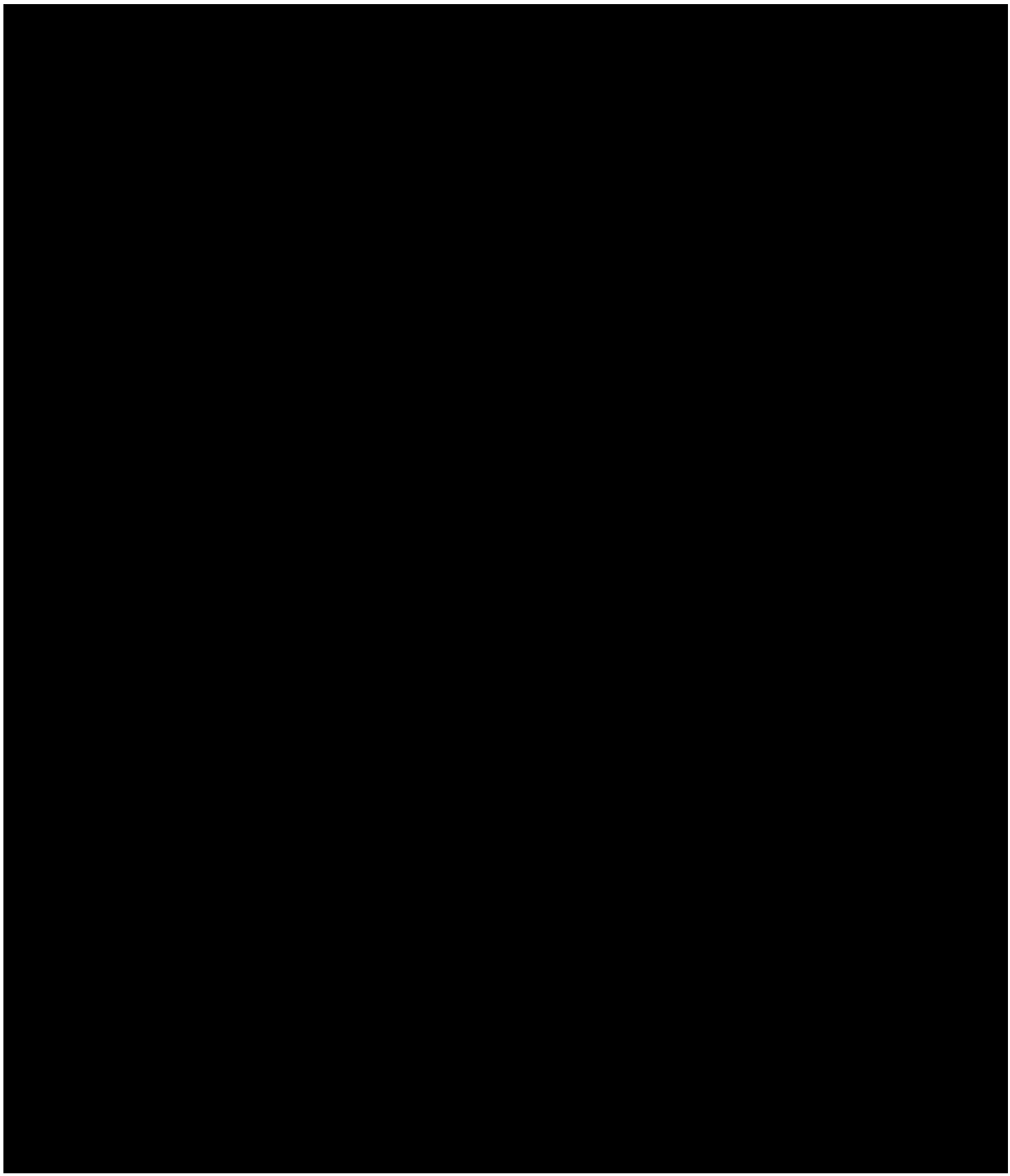
We provide resumes for the following key and other leadership personnel in the Operations Phase:

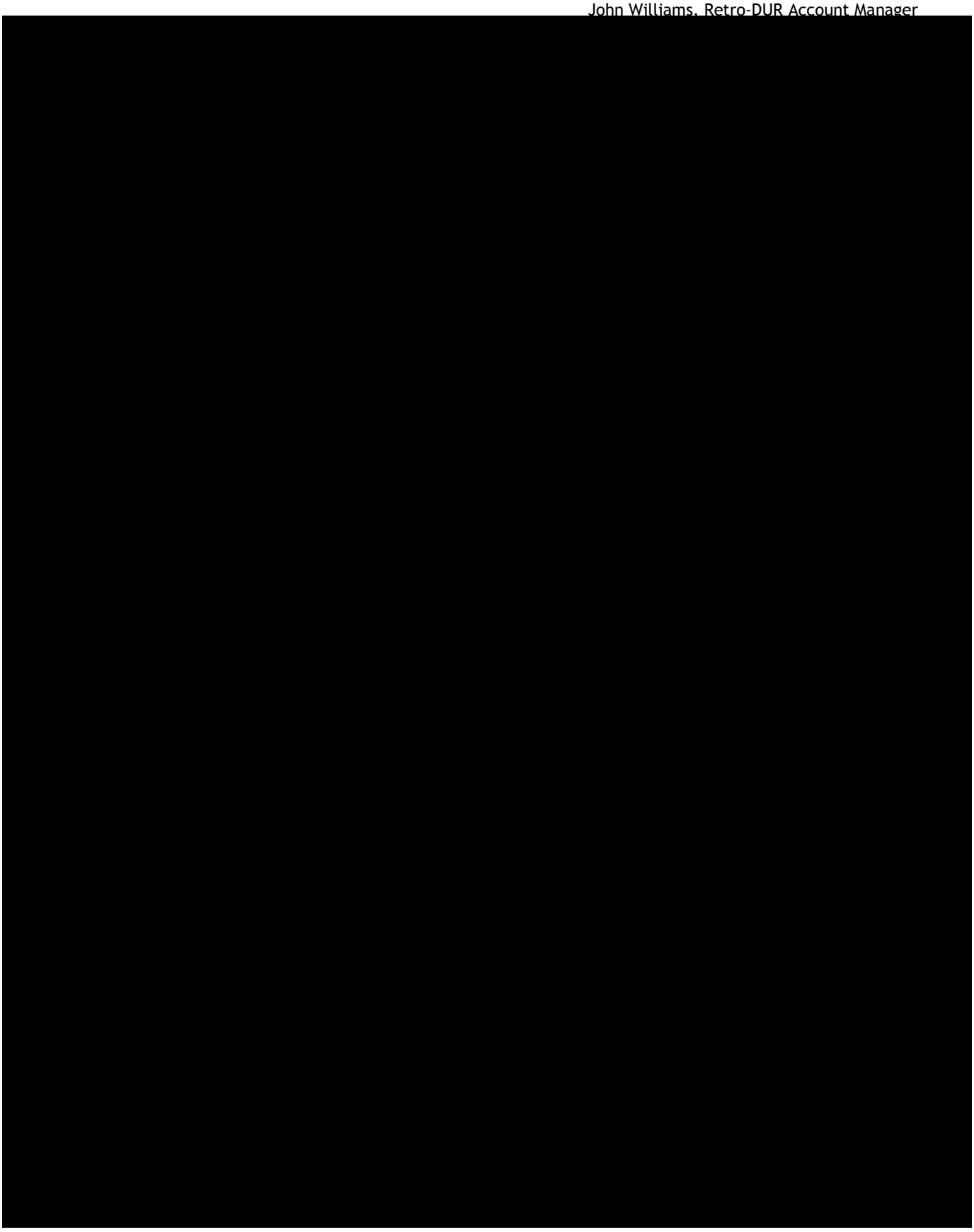
- Account Manager Melissa Robinson (Please refer to Melissa Robinson's resume in the DDI Staffing section.)
- Deputy Account Manager Dennis Vaughan (Please refer to Dennis Vaughan's resume in the DDI Staffing section.)
- Operations and Claims Processing Manager Tammy Wheeler (Please refer to Tammy Wheeler's resume in the DDI Staffing section.)
- Medical Director Dr. Margaret Martin, M.D.
- Pharmacy Director Sharon Greeson, R.Ph.
- Retro-DUR Account Manager John Williams, R.Ph.
- Dental Director Dr. David Brooks, D.D.S., M.S.
- Technical Director/Systems Programming Manager Tim Sullivan

- Provider/Recipient Services Manager Chris Ferrell
- Prior Approval Manager Sharlene Bryant
- Financial Services Manager Jamie Herubin (Please refer to Jamie Herubin's resume in the DDI Staffing section.)
- Senior Technical Analyst and SME for MMIS and Multi-Payer Mike Frost
- Senior Technical Analyst and SME for HIPAA Stacey Barber (Please refer to Stacey Barber's resume in the DDI Staffing section.)
- Database Administrator Terry Hensley (Please refer to Terry Hensley's resume in the DDI Staffing section.)
- Senior State Business Liaison Anthony Perkins (Please refer to Anthony Perkins' resume in the DDI Staffing section.)

John Williams, R.Ph.







In response to RFP Addendum 4, the exhibit on the following page, EDS Operations Phase Organization, replaces the exhibit following Technical Proposal BAFO page E-179.

EDS Operations Phase Organization

[redacted]

Denotes required positions in Appendix 50, Attachment I

Technical Proposal BAFO page E-185, position added after Pharmacy Director position:

Retro-DUR Account Manager

John Williams' primary responsibilities as the Retro-DUR account manager for the Operations Phase comprise the following:

- Assisting the State with selection of criteria for review
- Creating ad hoc reports, provider profiles, and report cards as requested
- Overseeing staff to make sure all provider mailings are tracked for responses and interventions
- Overseeing report creation for the DUR board meetings and the annual report
- Providing assistance with RxExplorer software and database questions
- Polling other states for alternative practices, as requested
- Training personnel in the profile review process

Technical Proposal BAFO page E-186, position added after Financial Manager position:

Financial Supervisor

The primary responsibilities of the financial supervisor for the Operations Phase comprise the following:

- Maintaining quality assurance and check and balance procedures regarding payments from the financial team
- Making sure the financial team's cash application efforts for provider refunds and recipient premium requirements are in accordance with State and federal guidelines, generally accepted accounting principles (GAAP), and approved operating procedures
- Working closely with the State's Financial Directors, DHHS Controller's offices, and other NC financial stakeholders to make sure Replacement MMIS processes align with the established financial requirements of the RFP
- Establishing and maintaining bank and lock box accounts and provide financial reconciliations and reporting as required
- Overseeing the operational readiness activities for assigned financial areas

- Coordinating and designing procedures to support financial management activities
- Making sure financial service levels are met and executed through the Replacement MMIS Operations phase
- Supervising the buy-in team supporting and meeting the buy-in requirements
- Maintaining appropriate staffing levels and mentoring and coaching assigned financial team members
- Reviewing quality reports to assess current operations performance and establish with the EDS PMO office any required corrective action plans
- Conducting weekly status meetings with staff
- Reporting progress on issues to the State
- Overseeing the development of performance standards and reports
- Performing administrative tasks necessary for smooth operation of the team

Technical Proposal BAFO page E-193, position added after Provider/Recipient Service Representatives position:

Recipient Financial Customer Service Representative

The recipient financial customer service representative will perform the following functions:

- Providing first-level support for recipient telephone and written inquiries
- Entering information into the Replacement MMIS' CTMS to track each recipient issue or question
- Researching problem areas and documenting processes used to correct the problem
- Assisting recipients with premium payment questions, validating application to premium balances, and initiating any premium refunds as required

Technical Proposal BAFO page E-206, position added after PA Analyst position:

Pre-Admission Certification PA Analyst

The primary responsibilities of the Pre-Admission Certification PA analyst for the Operations Phase comprise the following:

- Performing preliminary work on pre-admission certification PA requests and reviewing the request according to applicable State policy, available claims, and payment data within the Replacement MMIS
- Obtaining additional physician review or input to determine approval, change in request, or denial of services
- Researching problems and questions Provider Services or other departments may need answered or researched
- Assisting the State and providers with issues regarding pre-admission certification PA requests

Changes to Initial Risk Assessment

This section contains changes to our Technical Proposal BAFO section 50.2.5.7 Initial Risk Assessment (Risk Profile) that resulted from the requirements set forth in RFP Addenda 4 and 5. We present in its entirety each risk that was added or changed.

The following risks did not change as a result of the addenda:

- DDI Risk #1: Expansion of Project Scope Due to Alteration of Requirements
- DDI Risk #5: Dependencies on Other Entity Interfaces
- DDI Risk #8: Deliverable Development and Review Cycle Delays
- DDI Risk #9: Milestone Date Slippage
- DDI Risk #11: Lack of interChange Knowledge on the Existing EDS Account Leadership Team
- DDI Risk #12: Severe Defects
- DDI Risk #16: Delay in Equipment Delivery
- DDI Risk #17: Adapting a System From Another State
- Operational Risk #1: Providers' Inability to Transition to Using a New MMIS
- Operational Risk #2: Hardware Downtime or Lack of Software Reliability
- Operational Risk #3: Disaster Strikes EDS' Raleigh Data Center or Office
- Operational Risk #4: Automated or Manual Workflow Backlogs
- Turnover Risk #1: Attrition of EDS Experienced Staff
- Turnover Risk #2: No System Freeze
- Turnover Risk #3: State and EDS Staff Unavailable
- Turnover Risk #4: New Vendor Failing to Meet Contractual Obligations
- Turnover Risk #5: Lack of Communication Among the New Vendor, the State, and EDS
- Turnover Risk #6: Loss of EDS Institutional Knowledge
- Turnover Risk #7: Claim, Adjustment, and Refund Volume Spikes

Technical Proposal BAFO page E-271:

The section identifies common risks associated with MMIS implementations, with brief descriptions of anticipated actions for mitigation of the risks. These risks apply to the four DHHS divisions represented in the RFP: DMA, DMH, DPH, and ORHCC. Additionally, they include the benefit programs noted in RFP Addendum 4, namely the following:

- North Carolina Health Choice (NCHC), including Kids' Care
- Medicaid Community Alternatives Program for Persons with Mental Retardation or Developmental Disabilities (CAP-MR/DD) and Medicaid Community Alternatives Program for Children (CAP-C) where families pay part of the cost of services
- Health Coverage for Workers with Disabilities (HCWD), a Medicaid program under Ticket to Work-Work Incentives Improvement Act (TWWIIA)

Using the risk analysis methods described in the Quantitative Risk Analysis subsection of proposal section 50.2.5.6 Risk and Issue Management Plan, we have placed these risks in the order of their highest potential probability and impact on the project.

Technical Proposal BAFO page E-273:

Risk Description	Exposure	Management of Risk
DDI Risk #17: Adapting a system from another state	Low	Determining the specific requirements for the State and configuring the Replacement MMIS to meet them
DDI Risk #18: Lack of an effective solution for recipient-submitted claims	Medium	Using a combination of configuration, minor enhancements, and manual processes to meet the requirements
Operational Risk #1: Providers' inability to transition to using a new MMIS	Medium	Developing and implementing provider education opportunities to encourage use and minimize transition fears

Technical Proposal BAFO page E-273:

Risk Description	Exposure	Management of Risk
Operational Risk #4: Automated or manual workflow backlogs	Low	Monitoring operational workflows and initiating staffing remediation, when necessary
Operational Risk #5: Incomplete or inaccurate claims submitted by recipients	Medium	Designing forms and processes to enable complete and accurate data
Turnover Risk #1: Attrition of EDS experienced staff	High	Identifying key staff and encouraging continuity of employment; initiating staffing remediation, when necessary

DDI Risk #2: Limited Access to, and Participation from, State Stakeholders and SMEs	
Risk Description	The project requires active participation from stakeholders to share knowledge and reveal information so that business functions can be understood. It is critical that the appropriate staff members are available at the appropriate time to stay on schedule. The deliverables must be completed by all parties according to the schedule, including sign-off.
Risk Owner	Implementation Manager Dean Taunton
Status	Active
Root Cause	Stakeholders will not be 100 percent dedicated to the DDI; however, a significant portion of their time will be essential during certain phases of the project. If this is not built into their calendars and responsibilities, they may not be able to dedicate the necessary time to the DDI effort.
Risk Probability	4: High probability of occurring in current project development phase (about 75 percent probability)
Impact if Risk Occurs	5: The project's ability to support the required operational capabilities (functions and availability) is at risk of a very serious impact due to a major project component not being available. Limited availability of the appropriate State staff members, with the necessary decision-making authority to provide thorough and timely review of project deliverables and make decisions regarding project scope and requirements, could negatively affect the implementation schedule or create cost overruns. This is especially important during the NCHC and Kids' Care data conversion and benefit plan administration configuration because EDS will be reliant on support from the teams that support these programs today.
Exposure	High
Risk Mitigation	The State and EDS will identify the State participants from the four divisions and other stakeholders as part of the start-up process and determine who has authority to make binding decisions on business processes, requirements, and designs. EDS will work with the State and its divisions to identify the personnel needed and the knowledge required for particular evolutions of the solution. The IMS will drive a master calendar which will be used to coordinate and communicate all the RV sessions, review sessions, staged delivery inspections, and other activities well in advance so that the stakeholders can plan their schedules accordingly. In developing the IMS, we took the following steps into consideration for incorporating the State SME staff: • Staggering the timing of the RV sessions to lessen any conflict in the reviews for key personnel that may span multiple functional areas • Aligning the data mapping and review sessions to reduce any conflicts • Staging the review cycles for deliverables to account for different durations required for "Complex" and "Other" (small/medium) deliverables to make sure the review periods are an integral component of the schedule and are realistic • Using iTRACE to provide project information to State and EDS team members' desktops for real-time information and updates regarding project deliverables • Holding status meetings to review and identify potential threats to the work plan before they affect the dates, cost, and resources • Distributing agenda for key meetings and following up with minutes, sent to participants, to document discussions on key aspects of the project

DDI Risk #3: Inability to Staff the Project with Experienced Personnel	
Risk Description	The project requires technical and operational staff that have experience with interChange and with specific North Carolina business understanding. This balance of technical and business expertise is essential for the success of a project of this importance. If this staff is unavailable at the time that they are planned for in the project schedule, there could be impacts to the schedule and the ability to meet milestones.
Risk Owner	Account Manager Melissa Robinson and Implementation Manager Dean Taunton
Status	Active
Root Cause	The root cause of this issue is resource availability and the ability to balance resource needs.
Risk Probability	2: Low probability of occurring in current project development phase (about 25 percent probability)
Impact if Risk Occurs	5: The project's ability to support the required operational capabilities (functions and availability) is at risk of a very serious impact due to a major project component not being available. If EDS and the State are unable to staff the project with experienced people, it may take longer to translate North Carolina benefit plan nomenclature and business functions into interChange.
Exposure	High
Risk Mitigation	The completion of many MMIS DDI efforts in 2008 will make available knowledgeable staff in ~~the fourth quarter of 2008,~~ 2009~~,~~ and beyond for the North Carolina DDI effort. Additionally, we will use our corporate knowledge and resources, including the following: • EDS interChange resource staff • EDS product teams • Our product development business analyst team led by Angie Casey • Deputy Account Manager Dennis Vaughan • Retro-DUR Account Manager John Williams • The existing North Carolina account team • Cathy Bennett, with a technical and Medicaid and Mental Health background

DDI Risk #4: Conflicting Definitions of a Multi-Payer Environment	
Risk Description	Incorporating different health programs and payers into one system is a new approach to reimbursing providers for healthcare services. Each program brings its own service coverage and compensation policies, which must be accurately translated into the Replacement MMIS.
Risk Owner	Implementation Manager Dean Taunton
Status	Active
Root Cause	Healthcare programs are unique to recipient eligibility, provider enrollment, covered services, and provider reimbursement.
Risk Probability	~~3~~4: Medium probability of occurring in current project development phase (about ~~50~~ 75 percent probability)
Impact if Risk Occurs	5: The project's ability to support the required operational capabilities (functions and availability) is at risk of a very serious impact due to a major project component not being available. If EDS and the divisions have conflicting definitions of a multi-payer environment, additional time may be needed to agree on a common approach. Adding new programs into the scope for the initial implementation requires obtaining buy-in from additional stakeholders during DDI.
Exposure	High
Risk Mitigation	The interChange base system provides a multi-payer capability. During the DDI phase, EDS and the State will work through the potential issues of combining multiple divisions and programs into one application and come to a unified definition of multi-payer for North Carolina. Our multi-payer experience will be strengthened by the following: • Our current work with the DMA and DMH and NCHC for children ages zero - five, CAP MR/DD, and CAP-C • The Multi-Payer Summit, a planned week-long forum for discussion regarding multi-payer business processes, business rules, and finalizing criteria with the State stakeholders, and DDI PMs and TFALs • The interChange multi-payer design based on industry trends and direction • The PMO providing an unified approach for all stakeholders • Work patterns for RV, design, development, and test consider multi-payer interactions or interdependencies • Bring up instance of interChange core product, so each of the Divisions can see a working version of interChange during RV sessions

DDI Risk #6: No System Freeze	
Risk Description	System enhancements required to the Legacy MMIS+ application or other legacy applications during the last three to six months of DDI, prior to the Targeted Operational Start date.
Risk Owner	Implementation Manager Dean Taunton and Technical Manager Tim Sullivan
Status	Active
Root Cause	System modifications required by program or legislative mandate—or otherwise deemed critical by the State—that must be implemented during the last six months of the DDI may require making the same changes to the Legacy MMIS+, DPH, ~~and~~ ORHCC, BCBSNC, and MEDCO applications. These required changes increase costs, consume technical resources, and complicate DDI efforts.
Risk Probability	3: Medium probability of occurring in current project development phase (about 50 percent probability)
Impact if Risk Occurs	4: The project's ability to support the required operational capabilities (functions and availability) is at risk of a serious impact due to part of a major project component not being available. If changes need to be made to the Legacy applications and addressed during DDI, the State can incur additional expense of implementing the change in multiple locations. Additionally, the change in the Replacement MMIS may cause schedule impacts.
Exposure	Medium
Risk Mitigation	Working with the State to manage State Legislative specific changes, such that these changes can be deferred until after the DDI is complete. Developing a process with the State and CMS to determine if federal legislative changes can be postponed until after the completion of the DDI. The PMO functions as the gatekeeper, working with the stakeholders to confirm that the changes are controlled and managed accordingly. The management functions include the following: • Evaluating impacts to the scope, schedule, budget, and system quality through the change control process, which will be coordinated between the legacy applications and the Replacement MMIS for consistency in the change • Deferring the development of nonessential changes to the system to facilitate completion of DDI scope, at the State's direction • Continuing to support the Legacy MMIS+ and implementing changes required in conjunction with changes to be made to the Replacement MMIS by the current EDS team • Coordinating system changes with DPH, ORHCC, BCBSNC, and MEDCO to make sure there are no impacts to the data conversion process • Logging system modifications in coordination with the State • Tracking CSRs in iTRACE for work after the Replacement MMIS goes live

DDI Risk #7: Inaccurate Estimates for Enhancements	
Risk Description	The potential for under-scoping resource usage when documenting application enhancement requests can cause potential issues in its development, such as increased costs or time usage.
Risk Owner	Implementation Manager Dean Taunton
Status	Active
Root Cause	Lack of a clear understanding of business requirements
Risk Probability	3: Medium probability of occurring in current project development phase (about 50 percent probability)
Impact if Risk Occurs	4: The project's ability to support the required operational capabilities (functions and availability) is at risk of a serious impact due to part of a major project component not being available. If there are inaccurate estimates for enhancements, implementation delays may result.
Exposure	Medium
Risk Mitigation	The ability to gather actual metrics of multiple implemented MMIS solutions in Alabama, Connecticut, Kentucky, and Pennsylvania has helped forecast the duration and efforts required for the Replacement MMIS project. We found the metrics gathered from each project to be consistent, so the risk of parametric estimation providing an inaccurate projection is minimized. The DDI team verifies the anticipated effort to the planned effort and adjusts accordingly for CSRs created during the Technical Design phase. We use this process in our ongoing project management to minimize estimated to actual usage variations. Our approach also relies on the following: • Leveraging the strong business knowledge of the EDS North Carolina team • Including experienced business analysts on our team to help translate the NCHC and Kids' Care program specifics for the benefit plans not currently supported within the Legacy MMIS+ • Managing business requirement changes through the control change process • Balancing the North Carolina program knowledge with the product team application knowledge • Refining estimates based on business and technical design, which allows for adjustments and management of the Integrated Master Schedule during DDI

DDI Risk #10: Data Conversion Issues	
Risk Description	Data conversions are typically complex when migrating from an aging legacy application to a new application. This complexity is amplified by the inclusion of data from the four divisions: DMA, DMH, DPH, and ORHC. The NCHC and Kids' Care programs will require additional data conversions from external systems.
Risk Owner	Implementation Manager Dean Taunton
Status	Active
Root Cause	Data conversion is critical to the successful implementation of any project that entails replacing a legacy application. Issues typically arise when there is a lack of knowledge about the data being converted or about the use of the data in the replacement application.
Risk Probability	2: Low probability of occurring in current project development phase (about 25 percent probability) This is typically a high probability when conducting a major data conversion. However, because EDS currently manages the DMA and DMH data, we have resident SMEs who can help us resolve data issues or discrepancies quickly. This risk is not completely eliminated because we do not have experience with the DPH or ORHCC or NCHC data that is resident at BCBSNC and MEDCO.
Impact if Risk Occurs	4: The project's ability to support the required operational capabilities (functions and availability) is at risk of a serious impact due to part of a major project component not being available. Delays in data conversion, or the inability to quickly resolve issues related to data mapping, will have significant impact on the project schedule and success. The iterative user acceptance testing (UAT) will depend on having a minimal set of good data; however, a full set of clean, converted data is required for full UAT and operational readiness testing (ORT).
Exposure	Medium
Risk Mitigation	EDS currently manages the data for DMA and DMH and understand the data that requires conversion. We have identified SMEs for these programs who will assist in the data mapping to the Replacement MMIS. The interChange data conversion manager will be the single point of contact for managing this effort. He or she will work closely with OMMIS and the data conversion team to verify the successful completion of the data conversion. To further mitigate this risk, we will take the following actions: • Conduct extensive analysis at the data element level to normalize the data model, confirm valid values, check data element integrity, validate business and technical rules, and determine field-level distinct values • Analyze data content within key fields across records within the same file and records across different files and work with the State to identify and resolve key elements not accounted for in the source data • Perform a gap analysis between the source data and the Replacement MMIS to determine data compatibility, looking at source-to-target and target-to-source mapping • Identify and resolve differences in field-level data contents, valid values, field lengths, and field formats • Match critical and key data elements from the source data to the Replacement MMIS and document elements for which a clear match is not identified • Conduct parallel testing of claims processing, comparing claims payment results in the existing system to payment and disposition results in the new system

DDI Risk #13: Resistance to Critical Business Process Reengineering Changes	
Risk Description	State and program stakeholders may undermine project success by resisting critical business process reengineering changes designed to maximize the State's investment in new technology.
Risk Owner	Account Manager Melissa Robinson
Status	Active
Root Cause	Some business processes have become embedded into the daily activities of the stakeholders; therefore, changing these may cause anxiety or uncertainty, which can lead to resisting change.
Risk Probability	2: Low probability of occurring in current project development phase (about 25 percent probability)
Impact if Risk Occurs	3: The project's ability to support the required operational capabilities (functions and availability) is at risk of a moderate impact due to a small part (one-tenth) of a major project component not being available. When resistance to change occurs, it typically manifests itself in additional customization to the application to meet current business practices, even if the business practice is no longer required within the Replacement MMIS. This leads to project delays, cost overruns, and unhappy stakeholders.
Exposure	Low
Risk Mitigation	The State and EDS will mitigate this risk by using cultural business change management practices. The plan will support the cultural business change organization by achieving the following: • Involving leaders from stakeholder organizations in the project to help stakeholders share a common vision of the future and promote active, visible sponsorship • Creating and executing training programs that highlight the benefits of the changes that come with using the Replacement MMIS, emphasizing the positive impacts that this will have on their daily activities and showing how to gain the maximum efficiencies through using interChange and the new processes and procedures • Leading by example, with our EDS Operations team being excited and ready for changes that will make them more efficient and effective at serving the needs of the State's stakeholders, providers, and recipients and our senior business analysts being dedicated to each of the programs to maintain consistency and continuity in our communication and assimilation of each program into the Replacement MMIS • Employing a strong team of EDS and program stakeholders to perform a gap analysis between the current cultural environment and the future environment, with team members responsible for particular program areas using their knowledge of existing business processes and interChange features to document new procedures and develop customized training materials • Addressing ongoing organizational and cultural issues and concerns with frequent two-way communication to set appropriate expectations • Establishing clear objectives and metrics for project success to enable us to objectively measure and communicate project success to the stakeholders

DDI Risk #14: Hardware Downtime or Lack of Software Reliability	
Risk Description	The system cannot process claims and encounters through the Replacement MMIS because of unanticipated hardware downtime or lack of hardware reliability.
Risk Owner	Implementation Manager Dean Taunton and Senior System Architect Scott Lowry
Status	Active
Root Cause	Hardware or software that is defective when delivered to EDS, installed, or configured incorrectly can cause downtime or unreliability.
Risk Probability	1: Very low probability of occurring in current project development phase (about 10 percent probability)
Impact if Risk Occurs	5: The project's ability to support the required operational capabilities (functions and availability) is at risk of a very serious impact due to a major project component not being available. If hardware or software failures occur, delays in construction and testing may occur.
Exposure	Low
Risk Mitigation	We have 14 years of experience with the hardware platforms and software integration with interChange. We have a superior relationship with EDS partners, EDS preferred software and hardware partners, and Agility Alliance partners to expedite or escalate assistance. We evaluated the number of claims being processed for all the programs, considering expected growth in the programs, and sized the hardware and software environment accordingly. We monitor systems to initiate immediate problem resolution during development, testing, and production. Risks are mitigated by thorough testing of patches and upgrades and maintaining current operating system patches and firmware. Platform configuration can be modified to enable critical task processing in a different server domain. Desktop procedures for infrastructure management will be used with a global business continuity and disaster recovery plan to mitigate potential impact from service outages. We incorporate solid design of the development and testing environments based on prior large MMIS implementation experience. We will perform daily incremental backups of the development and model office environments. Full backups of the development and model office environments will be performed weekly, and we will store these backup files off-site. EDS also offers years of experience using the processing platform, regular backups, solid and proven procedures, and extensive security supporting the platform. For example, our Pennsylvania interChange application is running at 99.5 percent uptime. If hardware or software failures occur, we first would rely on our Business Continuity Plan to continue service without interruption. If necessary, we will purchase different software or engage technical support from our vendors to rectify the problem.

DDI Risk #15: Understanding Complex Business Rules and Processing Requirements	
Risk Description	The time required for a Replacement MMIS vendor to get up to speed to understand North Carolina's complex healthcare processing needs may put the entire project schedule in jeopardy.
Risk Owner	Account Manager Melissa Robinson and Implementation Manager Dean Taunton
Status	Active
Root Cause	In-depth knowledge of the specific North Carolina healthcare is limited to the State, the stakeholders, and the current EDS fiscal agent and technical support staff.
Risk Probability	1: Very low probability of occurring in current project development phase (about 10 percent probability)
Impact if Risk Occurs	5: The project's ability to support the required operational capabilities (functions and availability) is at risk of a very serious impact due to a major project component not being available. The learning curve and knowledge transfer would be significantly more complex and require more time to successfully complete. This typically results in requirement ambiguities, schedule delays, cost and schedule overruns, and potential quality impacts.
Exposure	Low
Risk Mitigation	EDS has been supporting DMA since 1977 and DMH since 2001. We have also supported CAP-C and CAP-MR programs, and a portion of the NCHC program recipients. We have experienced staff members in place who understand the business needs of these divisions and continue to provide service excellence to them every day. Our extensive experience with these two divisions allows us to quickly identify requirements and any needed system modifications for DPH, ~~and~~ ORHCC, and NCHC. No other bidder can make such a claim. Additionally, we will incorporate the information learned from the participants at the multi-payer summit and the multi-payer checkpoints established throughout DDI. Our leaders—Melissa Robinson, Tim Sullivan, Jamie Herubin, Mike Frost, Sharon Greeson, Tammy Wheeler, Dean Taunton, and Scott Lowry—understand the State's business. Dean and Scott recently led and completed a successful interChange implementation in Kentucky. The business analyst team, led by Angie Casey, and the product team bring a significant level of experience and knowledge to the project. We also have a significant pool of business analysts, developers, database administrators, and testers available to work on the Replacement MMIS DDI who will have completed interChange implementations for other states. We will include the current staff in the RV sessions and data mapping sessions to share the business knowledge between the DDI team and current account team.

DDI Risk #18: Lack of an Effective Solution for Recipient-Submitted Claims	
Risk Description	Processing recipient-submitted claims represents a conceptual change to the standard system and operational processes of interChange. The risk is addressed by making sure the scope of the MMIS changes for recipient-based claims are identified and solutioned appropriately for the small volume of claims to process.
Risk Owner	Account Manager Melissa Robinson and Implementation Manager Dean Taunton
Status	Active
Root Cause	The base interChange MMIS is designed as a provider payer system and will require modification to reimburse recipients.
Risk Probability	4: High probability of occurring in current project development phase (about 75 percent probability)
Impact if Risk Occurs	2: The scope of the solution could increase and cause schedule delays to the overall solution.
Exposure	Medium
Risk Mitigation	EDS will have a project manager focused on the recipient-based claims processing to make sure the solution remains balanced between processing these claims efficiently and accurately. EDS will have a business analyst responsible for the complete set of application and operational procedure touch points to have a unified view of the requirements, design, and ultimate solution for recipient-based claims. We will have a comprehensive cross-functional review of the affected functional areas to mitigate the system application risk as well as the design of the operational procedures.

Operational Risk #5: Incomplete or Inaccurate Claims Submitted by Recipients	
Risk Description	Incomplete or inaccurate claims submitted by a recipient will result in manual intervention and possible delays in the payment of those claims. If the forms or process is overly complex, there will be increased call volumes of questions from the recipient population submitting these forms.
Risk Owner	Account Manager Melissa Robinson, Claims Manager Tammy Wheeler, and Finance Manager Jamie Herubin
Status	Active
Root Cause	The policy within state health programs enables the recipients to receive reimbursement for out-of-pocket claims. Payment of claims requires accurate and complete information, which, given the complexity of insurance claim forms, is not an easy task for recipients. Typically, trained office professionals are responsible for submitting claims.
Risk Probability	4: High probability of occurring in current project development phase (about 75 percent probability)
Impact if Risk Occurs	2: The estimated volume of recipients who will submit claims for out-of-pocket expenses or other reasons is very low, making issue resolution and throughput concerns minor. However, if a significant number of paper claims were submitted with a high degree of errors or incomplete data, there would be a drain on the staff and a delay in processing those claims.
Exposure	Medium
Risk Mitigation	EDS will have a business analyst responsible for the complete set of application and operational procedure touch points to have a unified view of the requirements, design, and ultimate solution for recipient-based claims. While using the existing claims forms as a baseline, EDS will work with the State to standardize as much information and format on the claims as possible, including defaulting some common fields. The claims forms will contain detailed instructions and FAQs that will help the recipient complete the form. It also will state that receipts and/or itemized statements from the provider must be included along with the claim. These instructions and forms will be readily available on the Recipient Web Portal for ease of access and reference.

Section G—Contract Data Requirements List

RFP Reference: RFP Addendum 4 – North Carolina Replacement MMIS Updated Requirements

This section contains changes to our Technical Proposal BAFO section 50.2.7 Section G—Contract Data Requirements List that resulted from the requirements set forth in RFP Addenda 4 and 5. We present in its entirety each CDRL item that was added, removed, or changed.

The following CDRL items did not change as a result of the addenda:

- Integrated Master Plan (IMP)
- Project Management Plan
- Integrated Master Schedule (IMS)
- Earned Value Management System (EVMS) Reports
- Risk and Issue Management Plan (RIMP)
- Software Development and Systems Engineering Methodology
- Turnover Plan
- SAS 70 Audit
- Hardware/Software Inventory
- Escrow Updates

Technical Proposal BAFO page G-2:

CDRL	RFP Section 40.15	EDS Work Plan
Provider User Manuals		X
North Carolina Health Choice Recipient Benefits Booklets		X
Provider Handbooks		X

Technical Proposal BAFO page G-3:

CDRL	RFP Section 40.15	EDS Work Plan
Financial Technical Design		X
Premium Billing Technical Design		X
Health Check – Early and Periodic Screening, Diagnosis, and Treatment (DPSDT) Technical Design		X

Technical Proposal BAFO page G-6:

CDRL	Review Complexity
Provider Handbooks	Complex
North Carolina Health Choice Recipient Benefits Booklets	Complex
MMIS Updated/Revised System Documentation	Complex

Technical Proposal BAFO page G-6:

CDRL	Review Complexity
Financial Technical Design	Complex
Premium Billing Technical Design	Complex
Health Check – Early and Periodic Screening, Diagnosis, and Treatment (DPSDT) Technical Design	Complex

Project Management

TITLE	Integrated Master Schedule (IMS) – Post Requirements Validation (RV)		
VENDOR	EDS		
TYPE OF DATA	Planning/Execution	DATA RIGHTS	State Material
FREQUENCY DUE	NA	1ST SUBMISSION DATE	~~10/21/2009~~02/02/2010
METHOD OF DELIVERY	Electronic—Microsoft Project		
EDS DESCRIPTION	Though EDS will present an updated IMS as a part of regular status reports, EDS expects significant changes to the IMS after the team achieves certain project milestones.		

TITLE	Integrated Master Schedule (IMS) – Post Detailed System Design (DSD)		
VENDOR	EDS		
TYPE OF DATA	Planning/Execution	DATA RIGHTS	State Material
FREQUENCY DUE	NA	1ST SUBMISSION DATE	~~04/02/2010~~07/13/2010
METHOD OF DELIVERY	Electronic—Microsoft Project		
EDS DESCRIPTION	Though EDS will present an updated IMS as a part of regular status reports, EDS expects significant changes to the IMS after the team achieves certain project milestones.		

TITLE	Integrated Master Schedule (IMS) – Post Construction		
VENDOR	EDS		
TYPE OF DATA	Planning/Execution	DATA RIGHTS	State Material
FREQUENCY DUE	NA	1ST SUBMISSION DATE	~~06/17/2010~~09/17/2010
METHOD OF DELIVERY	Electronic—Microsoft Project		
EDS DESCRIPTION	EDS will use this version of the IMS as an input into project reviews after completion of the DDI phase. The final IMS also will serve as an input into planning for future projects.		

TITLE	Joint DDI Communications Plan		
VENDOR	EDS		
TYPE OF DATA	Planning/Execution	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1ST SUBMISSION DATE	~~12/29/2008~~ 03/25/2009
METHOD OF DELIVERY	Electronic—iTRACE		
DESCRIPTION	This document will define the methodology for sharing project-specific communications among project stakeholders during the DDI Phase. It will describe the processes to facilitate timely and appropriate generation, collection, dissemination, storage, and ultimate disposition of project information. It must include, but is not limited to: ❑ Information communications ❑ Information communication requirements/needs ❑ How, where, and when communications will occur ❑ Who will provide/receive the communication ❑ Meeting protocol procedures-noting when minutes are taken, and so on ❑ Provider communications approach—to include interactions among the State, Vendor, and providers; the Vendor's approach to provider awareness following Contract award; and the facilitation of ongoing project status communications ❑ Incident reporting and escalation—to include reporting of security incidents The State and Vendor will develop a mutually acceptable Joint DDI Communications Plan after Contract award. Updates or changes to the Joint DDI Communication Plan, as mutually agreed, will occur as needed.		

TITLE	Stakeholder Analysis		
VENDOR	EDS		
TYPE OF DATA	Planning/Execution	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1ST SUBMISSION DATE	~~11/07/2008~~02/06/2009
METHOD OF DELIVERY	Electronic—iTRACE		
EDS DESCRIPTION	This document is a subsection of the EDS Communications plan. EDS will detail State and EDS stakeholders and document their role in the DDI and Operations phases for the Replacement MMIS project. The analysis will allow project team leaders to determine security levels, communication types and frequency, Change Control Board participation, escalation paths, and more.		

TITLE	Staffing Management Plan		
VENDOR	EDS		
TYPE OF DATA	Planning/Execution	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1ST SUBMISSION DATE	~~01/16/2009~~04/10/2009
METHOD OF DELIVERY	Electronic—iTRACE		
EDS DESCRIPTION	This document will detail EDS' staff management approach and describe the DDI organization for the Replacement MMIS. At a minimum, this document will include the following information: ❑ DDI Organizational Chart ❑ Description of DDI Organization ❑ Proposed Key DDI Personnel ❑ Job Descriptions and Resumes for Key DDI Personnel		

TITLE	Quality Assurance Plan		
VENDOR	EDS		
TYPE OF DATA	Planning/Execution	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1ST SUBMISSION DATE	~~08/07/2009~~10/30/2009
METHOD OF DELIVERY	Electronic – iTRACE		
EDS DESCRIPTION	This plan will contain information on the approach, process, and metrics related to the EDS QA methodology that will be used for the Replacement MMIS implementation. At a minimum, EDS will conduct quality reviews of the work products and the deliverables being provided. EDS' quality review process includes the following: ❑ Establishing project quality standards and procedures for each project phase, including documentation, design, and code ❑ Aligning quality standards appropriately to the Replacement MMIS project objectives ❑ Defining roles and responsibilities of EDS team members to conduct quality assurance (QA) reviews and audits ❑ Creating and maintaining a project QA plan ❑ Using templates or processes to validate conformance by work product type ❑ Having a State-approved project QA plan ❑ Defining, collecting, and evaluating metrics to verify that the project is progressing as expected and that the QA processes are being used as designed and with the intended quality results If QA reviews result in the identification of any issues for resolution, EDS will promptly respond. Our QA procedures will include the ability to track the identification and resolution of issues and the action items arising from those issues. The QA processes and execution will be monitored by the PMO organization.		

TITLE	Identification, Analysis & Response Plan		
VENDOR	EDS		
TYPE OF DATA	Planning/Execution	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1ST SUBMISSION DATE	~~12/17/2008~~03/17/2009
METHOD OF DELIVERY	Electronic—iTRACE		
EDS DESCRIPTION	This document details the results of risk analysis activities. The Replacement MMIS team will determine the following for each identified risk: ❑ Probability of occurrence ❑ Impact of occurrence ❑ Mitigation response		

TITLE	Change/Configuration Management Plan (CMP)		
VENDOR	EDS		
TYPE OF DATA	Planning/Execution	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1ST SUBMISSION DATE	~~12/01/2008~~02/27/2009
METHOD OF DELIVERY	Electronic—iTRACE		
DESCRIPTION	This document describes the process, roles, responsibilities, and documentation required to manage change within the project and subsequent operations. The plan should describe the operation of the Change Control Board both during the DDI and Operations phases. Changes managed with this process include both those that result in contract changes and those that do not require contract changes. The process described in this plan should manage changes to any baselined artifact. A baselined artifact is one that has been completed or signed off in its current version (that is, it is complete for its current use even if the Vendor or State plans to change it again in the future for a different purpose). Artifacts can include plans, software, data, or any other items over which management control is necessary. The CMP also shall contain information describing configuration management information necessary for the Vendor's daily artifact control that is at a level of detail lower than needs to be managed by the joint State/Vendor team (for example, source code management during construction). The Vendor's entire configuration management process is not required in this document.		

TITLE	Security Plan		
VENDOR	EDS		
TYPE OF DATA	Planning/Execution	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1ST SUBMISSION DATE	~~07/01/2009~~09/24/2009
METHOD OF DELIVERY	Electronic—iTRACE		
DESCRIPTION	This document describes the DDI and operations processes and the system features that will make certain that the Vendor meets the Contract requirements for security. The plan shall describe how the Fiscal Agent intends to use current industry, State, and federal standards during the DDI Phase and within the Operations Phase to address the following: ❑ Security features inherent in the system design and operation ❑ Entity-wide security program planning and management, including risk management, data protection assurance, staff responsibilities, performance assessment and audit, and reporting ❑ Access controls for the system and the facility and assurance of system availability and performance ❑ Management of application development and change controls (with respect to security) ❑ Controls for protecting, managing, and monitoring the technical environment ❑ Controls for continuing services and access to information during and after minor to disastrous interruptions (by reference to the Business Continuity/Disaster Recover Plan) ❑ Responses to attacks on security and actual breaches of security		

TITLE	Training Plan		
VENDOR	EDS		
TYPE OF DATA	Planning/Execution	DATA RIGHTS:	State Material
FREQUENCY DUE	Annually or more frequently	1ST SUBMISSION DATE	~~03/29/2010~~07/13/2010
METHOD OF DELIVERY	Electronic—iTRACE		
DESCRIPTION	This document describes the Vendor's cohesive and responsive training program to make certain that users can be efficient and effective while using the system, including the Vendor's staff, State staff, and external users-such as the providers. It should reflect the relative lead-time for developing training materials before conducting training classes (including training testing participants and training before implementation); how users' skills will remain current throughout the operations phase; and how the Vendor will build and maintain the training environment. Additionally, it must specify the planned duration of the implementation training rollout, including development of Desk Procedures for use in the Operations Phase. The document will specify the delivery media to be used for each training activity and the accessibility of training materials and training news before, during, and after training. It should describe the process to identify and track training needs and to evaluate trainee feedback to improve course materials and methods. The Training Plan will be updated annually to address specific training activities for the upcoming year and shall be completed at least 90 days before the beginning of the contract year.		

TITLE	Provider User Manuals		
VENDOR	EDS		
TYPE OF DATA	Planning/Execution	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1ST SUBMISSION DATE	~~02/08/2010~~05/17/2010
METHOD OF DELIVERY	Electronic – iTRACE		
DESCRIPTION			
EDS DESCRIPTION	This document will available to providers by Web or mail if needed. It will contain information for providers who are interested in becoming Medicaid providers and instructive information for current Medicaid providers regarding things such as filing claims and using the Provider Web Portal. Combined with a complementary CBT, providers will have the information they need to maximize the benefit of the new system.		

TITLE	Provider Handbooks		
VENDOR	EDS		
TYPE OF DATA	Planning/Execution	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1ST SUBMISSION DATE	~~04/06/2010~~07/14/2010
METHOD OF DELIVERY	Electronic – iTRACE		
DESCRIPTION			
EDS DESCRIPTION	This document will contain specific information for filing various claim types, specify required fields for HIPAA compliance, and provide information on filing claims and contact information for support. The document also will contain information on checking status of claims, eligibility, and so forth, through the Provider Web Portal and AVRS.		

TITLE	North Carolina Health Choice Recipient Benefits Booklets		
VENDOR	EDS		
TYPE OF DATA	Other	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1ST SUBMISSION DATE	04/28/2011
METHOD OF DELIVERY	Electronic and paper		
DESCRIPTION	The purpose of these documents is to describe benefits and standard processes applicable to recipients. Because recipients are the target audience for this information, the document must be written in terms that can be understood by a layperson. Three related benefits booklets must be created and maintained. The NCHC Handbook must cover topics including: ❑ Privacy rights ❑ Identification cards ❑ Description of coverage and benefits limitations ❑ Cost sharing ❑ Procedures for receiving medical, mental health, and dental services and supplies ❑ Prior approval requirements ❑ Non-covered services and supplies ❑ Filing claims ❑ Fraud ❑ Appeals ❑ Contact information for the fiscal agent and State, as applicable The NCHC Emergency Respite Care booklet must cover topics including: ❑ Definitions describing special needs and respite care ❑ Approval procedures ❑ Locating respite care providers ❑ Service limitations ❑ Tips to recipients on how to promote successful respite care ❑ Information resources The NCHC Information for Children with Special Care Needs and Their Families booklet must contain topics including: ❑ Description of benefits ❑ Certification of special needs ❑ Prior approval ❑ Expedited reviews ❑ Additional information resources		

	EDS DESCRIPTION	This document will be available to recipients by Web or mail if needed. It will contain information for recipients who are eligible to participate in Medicaid programs and instructive information regarding things such as available services and using the Web portal.

TITLE	MMIS Updated/Revised System Documentation		
VENDOR	EDS		
TYPE OF DATA	Planning/Execution	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1ST SUBMISSION DATE	~~01/11/2011~~04/13/2011
METHOD OF DELIVERY	Electronic – iTRACE		
EDS DESCRIPTION	iTRACE will be updated with the latest design information as a part of normal processes. Per the master plan, a snapshot of that data will be reviewed as the updated DSD.		

TITLE	Deployment/Rollout Plan		
VENDOR	EDS		
TYPE OF DATA	Planning/Execution	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1ST SUBMISSION DATE	~~04/02/2009~~07/09/2009
METHOD OF DELIVERY	Electronic—iTRACE		
DESCRIPTION	This document will describe the detailed plan for implementing the Replacement MMIS (including any future integration with Reporting and Analytics or DHSR Division of Health Service Regulation (DHSR). It will include the processes and planning activities, roles and responsibilities, and schedule for activities related to cutover from the Legacy MMIS+ to the Replacement MMIS without impacting system processing. It will establish success criteria and provide for a Post-Implementation Evaluation, including metrics for measurement of successful implementation. Other considerations for inclusion are as follows: ❑ Communication of the plan ❑ Disaster recovery and backup procedures ❑ Training manuals ❑ System documentation ❑ Back-out plan ❑ Software support (help desk and break fix) ❑ Monitoring system performance		

TITLE	Business Continuity/Disaster Recovery Plan		
VENDOR	EDS		
TYPE OF DATA	Planning/Execution	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1ST SUBMISSION DATE	~~04/28/2009~~07/21/2009
METHOD OF DELIVERY	Electronic—iTRACE		
DESCRIPTION	This document describes the processes required to facilitate the continuation of critical business processes and the information systems and services supporting them if a disruption of the system itself, the loss of key personnel, or the loss of facilities housing the Fiscal Agent's operations occurs. Plans and processes documented in this plan shall be consistent with those identified in the requirements and its referenced documents: ❑ Roles and responsibilities of participants ❑ Processes that address preparation and planning ❑ Awareness and recognition training ❑ Business service and process relocation ❑ Notification and communication ❑ Testing and auditing processes for verifying the currency of the plan ❑ Response plans for epidemiological disasters that may result in prolonged work force absence from the Fiscal Agency location ❑ This document shall also describe additional processes associated with disaster recovery to include: ❑ Recovery priority for critical resources, including the recovery point objective (RPO) and recovery time objective (RTO) ❑ Processes for data relocation and recovery		

TITLE	Data Accession List (DAL)		
VENDOR	EDS		
TYPE OF DATA	Other	DATA RIGHTS	State Material
FREQUENCY DUE	Monthly	1ST SUBMISSION DATE	~~12/03/2008~~03/03/2009
METHOD OF DELIVERY	Electronic—iTRACE		
DESCRIPTION	This document shall list the data (to include software) and documents that are not part of the CDR that are created under this Contract. The DAL will include the data or document title, a reasonable description, the in-house release date, and the data rights associated with the item. Note: Any data required for proper operation and maintenance of the system and for proper conduct of the Fiscal Agent operations shall be identified in the CDRL rather than the DAL. Monthly delivery of the DAL will continue through contract term. The following items will be included in the DAL: ❑ Adobe Professional ❑ AutoSys ❑ BizTalk 2006 Enterprise ❑ BusinessObjects XI ❑ Captivate ❑ Content Server (Index Server Bundled) ❑ DOC1 ❑ EDIFECS HIPAA Translator ❑ Geostan Bundled Price ❑ inRule ❑ Intervoice AVRS Software ❑ K2 Workflow Engine ❑ SQL Server 2005 Enterprise Edition ❑ Windows 2003 R2 Server Enterprise User ❑ OTSort ❑ Photoshop ❑ ServiceDesk ❑ Sitescope ❑ Snag It ❑ Toad for Oracle ❑ Vault ❑ Veritas Storage Foundation		

	❑ Visual Build Pro ❑ VMware Infrastructure 3 Enterprise ❑ Websphere MQ ❑ WS-FTP ❑ interChange .NET source code (all subsystems) ❑ interChange C source code (all subsystems) ❑ interChange scripts and utilities ❑ i-TRACE source code and scripts

Technical Design

TITLE	Performance Dashboard Detailed System Design		
VENDOR	EDS		
TYPE OF DATA	Planning/Execution	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1ST SUBMISSION DATE	~~08/31/2009~~12/29/2009
METHOD OF DELIVERY	Electronic		
EDS DESCRIPTION	This document will detail the logical design of the Performance Dashboard, including hardware, system interfaces, networks, operating systems, databases, and storage.		

TITLE	Performance Dashboard Business Process Requirements		
VENDOR	EDS		
TYPE OF DATA	Planning/Execution	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1ST SUBMISSION DATE	~~03/12/2009~~07/06/2009
METHOD OF DELIVERY	Electronic – iTRACE		
DESCRIPTION	The State favors methods that provide “dashboard-like” reporting capabilities and trend analyses with online access for management staff.		
EDS DESCRIPTION	This document will detail the business process requirements determined from the requirements validation session for the Performance Dashboard solution.		

TITLE	Electronic Document Management System (EDMS) Technical Design		
VENDOR	EDS		
TYPE OF DATA	Planning/Execution	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1ST SUBMISSION DATE	~~09/1/2009~~12/13/2009
METHOD OF DELIVERY	Electronic – iTRACE		
EDS DESCRIPTION	This document will detail the logical design of the EDMS, including hardware, system interfaces, networks, operating systems, databases, and storage.		

TITLE	EDMS Business Process Requirements		
VENDOR	EDS		
TYPE OF DATA	Planning/Execution	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1ST SUBMISSION DATE	~~03/13/2009~~07/08/2009
METHOD OF DELIVERY	Electronic – iTRACE		
EDS DESCRIPTION	This document will detail the business process requirements determined from the requirements validation session for the EDMS functionality for early implementation.		

TITLE	EDMS (Data Entry) Technical Design		
VENDOR	EDS		
TYPE OF DATA	Planning/Execution	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1ST SUBMISSION DATE	~~09/01/2009~~12/31/2009
METHOD OF DELIVERY	Electronic – iTRACE		
EDS DESCRIPTION	This document will detail the logical design of the Data Entry system, including hardware, system interfaces, networks, operating systems, databases, and storage.		

TITLE	EDMS (Data Entry) Business Process Requirements		
VENDOR	EDS		
TYPE OF DATA	Planning/Execution	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1ST SUBMISSION DATE	~~03/13/2009~~07/08/2009
METHOD OF DELIVERY	Electronic – iTRACE		
EDS DESCRIPTION	This document will detail the business process requirements determined from the requirements validation session for the Data Entry functionality for early implementation.		

TITLE	Requirements Analysis Document		
VENDOR	EDS		
TYPE OF DATA	Planning/Execution	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1ST SUBMISSION DATE	Various per the IMS
METHOD OF DELIVERY	Electronic – iTRACE		
EDS DESCRIPTION	This document will detail results of the requirements validation (RV) sessions, including business process flows, business requirements, business rules, system interfaces, databases, and storage. A document will be prepared for each functional area as follows: ❑ Benefit Administration Requirements Analysis ❑ General System Requirements Analysis ❑ Recipient Business Process Requirements Analysis ❑ Provider Business Process Requirements ❑ Claims/POS Requirements Analysis ❑ TPL Requirements Analysis ❑ Prior Approval Requirements Analysis ❑ Automated Voice Response Requirements Analysis ❑ Drug Rebate Requirements Analysis ❑ Managed Care Requirements Analysis ❑ MARS Requirements Analysis ❑ R&A Requirements Analysis ❑ Data Entry Requirements Analysis ❑ EVS Requirements Analysis ❑ Reference Requirements Analysis ❑ Financial Requirements Analysis ❑ Premium Billing Requirements Analysis ❑ EPSDT Requirements Analysis ❑ EIS Requirements Analysis ❑ DUR Requirements Analysis		

TITLE	General Technical Requirement Design		
VENDOR	EDS		
TYPE OF DATA	Technical	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1ST SUBMISSION DATE	~~12/31/2009~~04/12/2010
METHOD OF DELIVERY	Electronic—iTRACE		
EDS DESCRIPTION	This document will detail the logical design of the interChange MMIS including hardware, system interfaces, networks, operating systems, databases, and storage.		

TITLE	System-wide Architecture Technical Design		
VENDOR	EDS		
TYPE OF DATA	Technical	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1ST SUBMISSION DATE	~~11/16/2009~~ 03/01/2010
METHOD OF DELIVERY	Electronic—iTRACE		
EDS DESCRIPTION	This document will detail the technical design of the interChange MMIS hardware, system interfaces, networks, operating systems, databases, and storage.		

TITLE	Recipient Technical Design		
VENDOR	EDS		
TYPE OF DATA	Technical	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1ST SUBMISSION DATE	~~08/04/2009~~11/11/2009
METHOD OF DELIVERY	Electronic—iTRACE		
EDS DESCRIPTION	This document describes the design of the interChange Recipient feature for the State, which comprises the following: ❑ Interface with other systems to receive and store recipient data and allow direct entry of recipient and entitlement data from authorized staff or departments ❑ Apply appropriate business rules to accurately merge the data from the distinct systems in accordance with State policy ❑ Set rules for benefit plans for enrolling recipients ❑ Enroll recipients in the appropriate benefit plans ❑ Support accurate buy-in processing of dual eligibles ❑ Support Medicare data exchanges, including beneficiary data exchange (BENDEX), the Medicare Modernization Act (MMA), and eligibility database (EDB) files ❑ Support lock-in and lock-out control of recipient service utilization ❑ Support recipient linking and unlinking activities and reporting ❑ Enable recipient premium payment, refund processing and invoicing activities, and reporting ❑ Support cost-sharing activities ❑ Generate Certificate of Credible Coverage (COCC) letters, as appropriate ❑ Inform, initiate, and track follow-up of early and periodic screening, diagnosis, and treatment (EPSDT) eligibles ❑ Provide access to the same Health Insurance Portability and Accountability Act (HIPAA)-compliant recipient information across multiple channels, including the Web, automated voice response system (AVRS), and electronic data interchange (EDI) ❑ Provide a contact center for identification (ID) card requests, notices, and recipient communication, including recipient premium and claims submission ❑ Support North Carolina Health Choice (the State's implementation of the State Children's Health Insurance Program) to include Kids Care ❑ Support Healthcare for Workers with Disabilities (HCWD), also known as Ticket to Work ❑ Support Community Alternatives Program for Persons with Mental Retardation/Developmental Disabilities (CAP-MR/DD) and CAP for Children (CAP-C) programs This document is the result of incorporating the output of the Requirements Validation (RV) sessions with stakeholders. In addition to a review and analysis		

	of the business processes and workflows that affect a functional area of the system, the initial change orders are generated as a result of the RV sessions and subsequent breakout work groups, but the follow-on effort completes the design effort, and iTRACE is the repository for information and data for all stages of technical development. As the technical design matures, the data in iTRACE matures until a change order sign-off is achieved and ready for testing. The technical design will include the following information that will be used to customize the interChange MMIS for the State: ❑ Subsystem Narrative Overview ❑ Subsystem Description ❑ Data Model ❑ Data Tables ❑ System Flow ❑ Subsystem Logic: Job Scripts, Programs, Browser Pages, Reports, Letters ❑ Internal and External Interfaces ❑ Requirements Matrix ❑ Change Orders ❑ Data Element Dictionary ❑ Workflow ❑ Supplemental Documentation ❑ Applicable Business Rules

TITLE	Eligibility Verification System (EVS) Technical Design		
VENDOR	EDS		
TYPE OF DATA	Technical	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1ST SUBMISSION DATE	~~08/05/2009~~11/11/2009
METHOD OF DELIVERY	Electronic—iTRACE		
EDS DESCRIPTION	This document describes the design of the interChange EVS capability for the State. Besides the verification of individual recipient's eligibility, the interChange EVS also will comprise the following features: ❑ Multipayer capability ❑ Access to real-time information through multiple access channels ❑ Automatic validity, format, and consistency edits before allowing a transaction to update interChange ❑ Tracking, reporting, and status of interfaces This document is the result of incorporating the output of the RV sessions with stakeholders. In addition to a review and analysis of the business processes and workflows that affect a functional area of the system, the initial change orders		

	are generated as a result of the RV sessions and subsequent breakout work groups, but the follow-on effort completes the design effort, and iTRACE is the repository for information and data for all stages of technical development. As the technical design matures, the data in iTRACE matures until a change order sign-off is achieved and ready for testing. The technical design will include the following information that will be used to customize the interChange MMIS for the State: ❑ Subsystem Narrative Overview ❑ Subsystem Description ❑ Data Model ❑ Data Tables ❑ System Flow ❑ Subsystem Logic: Job Scripts, Programs, Browser Pages, Reports, Letters ❑ Internal and External Interfaces ❑ Requirements Matrix ❑ Change Orders ❑ Data Element Dictionary ❑ Workflow ❑ Supplemental Documentation ❑ Applicable Business Rules

TITLE	Benefit Administration Technical Design		
VENDOR	EDS		
TYPE OF DATA	Technical	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1ST SUBMISSION DATE	~~07/17/2009~~10/26/2009
METHOD OF DELIVERY	Electronic—iTRACE		
EDS DESCRIPTION	This document describes the design of the interChange Benefit Administration capability for the State. Benefit Administration is a broad set functional capability that includes, but is not limited to, the following features: ❑ Benefit package assignment ❑ Benefit package processing ❑ Unlimited pricing and eligibility segments ❑ Online access to historical data ❑ Integrated rules allowing users to change benefit eligibility criteria ❑ System flexibility allowing users to customize benefit package reference data, such as audit limitations, service authorizations, and rates		

	❑ Consolidation of redundant systems ❑ Direct methods of claims processing for different payers and benefit plans ❑ True multipayer functions capable of supporting State plans outside Medicaid ❑ Service and coverage limitations ❑ Level of care required ❑ Assistance category ❑ Waiver program enrollment ❑ Provider restriction This document is the result of incorporating the output of the RV sessions with stakeholders. In addition to a review and analysis of the business processes and workflows that affect a functional area of the system, the initial change orders are generated as a result of the RV sessions and subsequent breakout work groups, but the follow-on effort completes the design effort, and iTRACE is the repository for information and data for all stages of technical development. As the technical design matures, the data in iTRACE matures until a change order sign-off is achieved and ready for testing. The technical design will include the following information that will be used to customize the interChange MMIS for the State: ❑ Subsystem Narrative Overview ❑ Subsystem Description ❑ Data Model ❑ Data Tables ❑ System Flow ❑ Subsystem Logic: Job Scripts, Programs, Browser Pages, Reports, Letters ❑ Internal and External Interfaces ❑ Requirements Matrix ❑ Change Orders ❑ Data Element Dictionary ❑ Workflow ❑ Supplemental Documentation ❑ Applicable Business Rules

TITLE	Provider Technical Design		
VENDOR	EDS		
TYPE OF DATA	Technical	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1ST SUBMISSION DATE	~~07/22/2009~~10/28/2009
METHOD OF DELIVERY	Electronic—iTRACE		
EDS DESCRIPTION	This document describes the design of the interChange Provider functions for the Replacement MMIS. The interChange Provider module will offer the following features that will be customized for the State: ❑ Provider enrollment ❑ Provider maintenance and management ❑ Provider access by mail, telephone, and Web portal ❑ Workflow ❑ Data organized in tables using a relational database structure so that an update automatically populates the appropriate fields when a user accesses a new page for the same provider This document is the result of incorporating the output of the RV sessions with stakeholders. In addition to a review and analysis of the business processes and workflows that affect a functional area of the system, the initial change orders are generated as a result of the RV sessions and subsequent breakout work groups, but the follow-on effort completes the design effort, and iTRACE is the repository for information and data for all stages of technical development. As the technical design matures, the data in iTRACE matures until a change order sign-off is achieved and ready for testing. The technical design will include the following information that will be used to customize the interChange MMIS for the State: ❑ Subsystem Narrative Overview ❑ Subsystem Description ❑ Data Model ❑ Data Tables ❑ System Flow ❑ Subsystem Logic: Job Scripts, Programs, Browser Pages, Reports, Letters ❑ Internal and External Interfaces ❑ Requirements Matrix ❑ Change Orders ❑ Data Element Dictionary ❑ Workflow ❑ Supplemental Documentation ❑ Applicable Business Rules		

TITLE	Claims/Point of Sale Technical Design		
VENDOR	EDS		
TYPE OF DATA	Technical	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1ST SUBMISSION DATE	~~09/30/2009~~12/07/2009
METHOD OF DELIVERY	Electronic—iTRACE		
EDS DESCRIPTION	This document describes the design of the interChange Claims module that will allow North Carolina to perform the following functions: ❑ Capture ❑ Process ❑ Control ❑ Editing ❑ Auditing ❑ Final disposition This document is the result of incorporating the output of the RV sessions with stakeholders. In addition to a review and analysis of the business processes and workflows that affect a functional area of the system, the initial change orders are generated as a result of the RV sessions and subsequent breakout work groups, but the follow-on effort completes the design effort, and iTRACE is the repository for information and data for all stages of technical development. As the technical design matures, the data in iTRACE matures until a change order sign-off is achieved and ready for testing. The technical design will include the following information that will be used to customize the interChange MMIS for the State: ❑ Subsystem Narrative Overview ❑ Subsystem Description ❑ Data Model ❑ Data Tables ❑ System Flow ❑ Subsystem Logic: Job Scripts, Programs, Browser Pages, Reports, Letters ❑ Internal and External Interfaces ❑ Requirements Matrix ❑ Change Orders ❑ Data Element Dictionary ❑ Workflow ❑ Supplemental Documentation ❑ Applicable Business Rules		

TITLE	Third-Party Liability (TPL) Technical Design		
VENDOR	EDS		
TYPE OF DATA	Technical	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1ST SUBMISSION DATE	~~11/04/2009~~02/17/2010
METHOD OF DELIVERY	Electronic—iTRACE		
EDS DESCRIPTION	This document details the TPL functions of interChange. The TPL module provides the following to make certain that Medicaid is the payer of last resort: ❑ Private health ❑ Medicare ❑ Other third-party resources This includes the flexibility to configure and optimize third-party coverage data through easy-to-use browser pages, real-time access to information, and the automation of tasks including the following: ❑ Policy maintenance ❑ Accounts receivable (A/R) posting ❑ Rebilling, recovery notices ❑ Non-covered services bypass logic This document is the result of incorporating the output of the RV sessions with stakeholders. In addition to a review and analysis of the business processes and workflows that affect a functional area of the system, the initial change orders are generated as a result of the RV sessions and subsequent breakout work groups, but the follow-on effort completes the design effort, and iTRACE is the repository for information and data for all stages of technical development. As the technical design matures, the data in iTRACE matures until a change order sign-off is achieved and ready for testing. The technical design will include the following information that will be used to customize interChange for the State: ❑ Subsystem Narrative Overview and Description ❑ Data Model ❑ Data Tables ❑ System Flow ❑ Subsystem Logic: Job Scripts, Programs, Browser Pages, Reports, Letters ❑ Internal and External Interfaces ❑ Requirements Matrix ❑ Change Orders ❑ Data Element Dictionary ❑ Workflow ❑ Supplemental Documentation ❑ Applicable Business Rules		

TITLE	Prior Approval (PA) Technical Design		
VENDOR	EDS		
TYPE OF DATA	Technical	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1ST SUBMISSION DATE	~~10/21/2009~~02/02/2010
METHOD OF DELIVERY	Electronic—iTRACE		
EDS DESCRIPTION	This document details the technical design of the PA functions within interChange. The PA module will provide the following capabilities: ❑ Process the PA request by validating member eligibility, provider eligibility, and service coverage based on predefined rules ❑ Generate PA records for pharmacy-related claims that meet customized rules related to the recipient ❑ Receive and process PA transactions from multiple input sources including pre-admission certification ❑ Allow providers to initiate PA requests through the Internet and inquire on PA requests to learn the decision status and the authorized units or dollar amounts ❑ Generate provider and recipient notification letters using combinations of fixed, variable, and free-text formats that are automatically triggered ❑ Treat letters containing protected health information (PHI) as secure documents ❑ Use Web pages to give authorized users various levels of access depending on their security levels ❑ Enable changes because of administrative review or appeals This document is the result of incorporating the output of the RV sessions with stakeholders. In addition to a review and analysis of the business processes and flows that affect a functional area of the system, the initial change orders are generated as a result of the RV sessions and subsequent breakout work groups, but the follow-on effort completes the design effort, and iTRACE is the repository for information and data for all stages of technical development. As the technical design matures, the data in iTRACE matures until a change order sign-off is achieved and ready for testing. The technical design will include the following information that will be used to customize the interChange MMIS for the State: ❑ Subsystem Narrative Overview ❑ Subsystem Description ❑ Data Model ❑ Data Tables ❑ System Flow ❑ Subsystem Logic: Job Scripts, Programs, Browser Pages, Reports, Letters ❑ Internal and External Interfaces ❑ Requirements Matrix		

	❑ Change Orders ❑ Data Element Dictionary ❑ Workflow ❑ Supplemental Documentation ❑ Applicable Business Rules

TITLE	Automated Voice Response System Technical Design		
VENDOR	EDS		
TYPE OF DATA	Technical	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1ST SUBMISSION DATE	~~11/06/2009~~02/19/2010
METHOD OF DELIVERY	Electronic—iTRACE		
EDS DESCRIPTION	This document describes the technical design of the interChange AVRS that will provide North Carolina with the following capabilities: ❑ Provider and recipient toll-free telephone numbers to access the MMIS ❑ Automated access to the MMIS data This document is the result of incorporating the output of the RV sessions with stakeholders. In addition to a review and analysis of the business processes and flows that affect a functional area of the system, the initial change orders are generated as a result of the RV sessions and subsequent breakout work groups, but the follow-on effort completes the design effort, and iTRACE is the repository for information and data for all stages of technical development. As the technical design matures, the data in iTRACE matures until a change order sign-off is achieved and ready for testing. The technical design will include the following information that will be used to customize the interChange MMIS for the State: ❑ Subsystem Narrative Overview ❑ Subsystem Description ❑ Data Model ❑ Data Tables ❑ System Flow ❑ Subsystem Logic: Job Scripts, Programs, Browser Pages, Reports, Letters ❑ Internal and External Interfaces ❑ Requirements Matrix ❑ Change Orders ❑ Data Element Dictionary ❑ Workflow ❑ Supplemental Documentation ❑ Applicable Business Rules		

TITLE	Managed Care Technical Design		
VENDOR	EDS		
TYPE OF DATA	Technical	DATA RIGHTS	State Material
FREQUENCY DUE	Technical	1ST SUBMISSION DATE	~~08/25/2009~~12/04/2009
METHOD OF DELIVERY	Electronic—iTRACE		
EDS DESCRIPTION	This document describes the technical design of the interChange Managed Care module that will provide the State with capabilities that include, but are not limited to, the following: ❑ Online access to all recipient, provider, claims, and reference data related to Managed Care ❑ Process financial transactions regarding managed care ❑ Apply edit and audits to managed care cases ❑ Case notes tracking ❑ Track Managed Care statistics ❑ Auto-generate notices This document is the result of incorporating the output of the RV sessions with stakeholders. In addition to a review and analysis of the business processes and flows that affect a functional area of the system, the initial change orders are generated as a result of the RV sessions and subsequent breakout work groups, but the follow-on effort completes the design effort, and iTRACE is the repository for information and data for all stages of technical development. As the technical design matures, the data in iTRACE matures until a change order sign-off is achieved and ready for testing. The technical design will include the following information that will be used to customize the interChange MMIS for the State: ❑ Subsystem Narrative Overview ❑ Subsystem Description ❑ Data Model ❑ Data Tables ❑ System Flow ❑ Subsystem Logic: Job Scripts, Programs, Browser Pages, Reports, Letters ❑ Internal and External Interfaces ❑ Requirements Matrix ❑ Change Orders ❑ Data Element Dictionary ❑ Workflow ❑ Supplemental Documentation ❑ Applicable Business Rules		

TITLE	Management and Administrative Reporting System (MARS) Technical Design		
VENDOR	EDS		
TYPE OF DATA	Technical	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1ST SUBMISSION DATE	~~12/04/2009~~03/17/2010
METHOD OF DELIVERY	Electronic—iTRACE		
EDS DESCRIPTION	This document describes the technical design of the interChange Managed Care module that will provide the State with capabilities that include, but are not limited to, the following: ❑ Extract data monthly from other functions of the MMIS and create extract files used to produce the monthly, quarterly, and annual MAR reports ❑ Summarize and maintain information from other functions for reporting data for current and historical time periods ❑ Run batch report jobs to create State and Centers for Medicare & Medicaid Services (CMS) reports ❑ Verify the accuracy of MAR reports through balancing processes ❑ Offer flexible desktop inquiry and reporting through parameter-driven Web pages This document is the result of incorporating the output of the RV sessions with stakeholders. In addition to a review and analysis of the business processes and flows that affect a functional area of the system, the initial change orders are generated as a result of the RV sessions and subsequent breakout work groups, but the follow-on effort completes the design effort, and iTRACE is the repository for information and data for all stages of technical development. As the technical design matures, the data in iTRACE matures until a change order sign-off is achieved and ready for testing. The technical design will include the following information that will be used to customize the interChange MMIS for North Carolina: ❑ Subsystem Narrative Overview and Description ❑ Data Model ❑ Data Tables ❑ System Flow ❑ Subsystem Logic: Job Scripts, Programs, Browser Pages, Reports, Letters ❑ Internal and External Interfaces ❑ Requirements Matrix ❑ Change Orders ❑ Data Element Dictionary ❑ Workflow ❑ Supplemental Documentation ❑ Applicable Business Rules		

TITLE	Data Entry Technical Design		
VENDOR	EDS		
TYPE OF DATA	Technical	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1ST SUBMISSION DATE	~~12/11/2009~~03/24/2010
METHOD OF DELIVERY	Electronic—iTRACE		
EDS DESCRIPTION	This document describes the technical design for managing data in the Replacement MMIS that includes, but is not limited to, the following capabilities: ❑ Capture ❑ Categorization ❑ Storage and retrieval ❑ Tracking ❑ Linking ❑ Printing and faxing This document is the result of incorporating the output of the RV sessions with stakeholders. In addition to a review and analysis of the business processes and flows that affect a functional area of the system, the initial change orders are generated as a result of the RV sessions and subsequent breakout work groups, but the follow-on effort completes the design effort, and iTRACE is the repository for information and data for all stages of technical development. As the technical design matures, the data in iTRACE matures until a change order sign-off is achieved and ready for testing. The technical design will include the following information that will be used to customize the interChange MMIS for the State: ❑ Subsystem Narrative Overview ❑ Subsystem Description ❑ Data Model ❑ Data Tables ❑ System Flow ❑ Subsystem Logic: Job Scripts, Programs, Browser Pages, Reports, Letters ❑ Internal and External Interfaces ❑ Requirements Matrix ❑ Change Orders ❑ Data Element Dictionary ❑ Workflow ❑ Supplemental Documentation ❑ Applicable Business Rules		

TITLE	Reference Technical Design		
VENDOR	EDS		
TYPE OF DATA	Technical	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1ST SUBMISSION DATE	~~09/23/2009~~01/06/2010
METHOD OF DELIVERY	Electronic - iTRACE		
EDS DESCRIPTION	This document describes the design of the interChange Reference Data Maintenance System. This capability allows maintenance of data used by the MMIS to execute the following functions: ❑ Claims and adjustment processing ❑ Service ❑ PA ❑ TPL processing ❑ Reporting The Reference Data Maintenance System maintains the following logical data groupings: ❑ Benefit plan ❑ Diagnosis ❑ Drug ❑ Edit/Audit Criteria ❑ ICD-9-CM Procedure (Because ICD-10 is not fully defined, it is not listed as a portion of the reference design. For ICD-10 to be included in the design of the Replacement MMIS, two steps are required. First, the final specifications will need to be published. Second, EDS will need to work closely with the State to determine how the divisions intend to apply ICD-10 to their business from a policy standpoint. The ICD-10 design will be included in the technical design document if the ICD-10 specifications are approved and available before the scheduled time for the delivery of the technical design for the reference subsystem.) ❑ Modifier ❑ Procedure This document is the result of incorporating the output of the RV sessions with stakeholders. In addition to a review and analysis of the business processes and flows that affect a functional area of the system, the initial change orders are generated as a result of the RV sessions and subsequent breakout work groups, but the follow-on effort completes the design effort, and iTRACE is the repository for information and data for all stages of technical development. As the technical design matures, the data in iTRACE matures until a change order sign-off is achieved and ready for testing. The technical design will include the following information that will be used to customize the interChange MMIS for the State: ❑ Subsystem Narrative Overview ❑ Subsystem Description		

	❑ Data Model ❑ Data Tables ❑ System Flow ❑ Subsystem Logic: Job Scripts, Programs, Browser Pages, Reports, Letters ❑ Internal and External Interfaces ❑ Requirements Matrix ❑ Change Orders ❑ Data Element Dictionary ❑ Workflow ❑ Supplemental Documentation ❑ Applicable Business Rules

TITLE	Financial Technical Design		
VENDOR	EDS		
TYPE OF DATA	Technical	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1ST SUBMISSION DATE	~~10/07/2009~~03/24/2010
METHOD OF DELIVERY	Electronic—iTRACE		
EDS DESCRIPTION	This document describes the technical design of the interChange Financial modules that will provide the Replacement MMIS with the following capabilities: ❑ Funding Sources ❑ State Program Funding ❑ Payment Estimation Reporting ❑ Payment Holds ❑ Provider Payments ❑ Remittance Advice ❑ Liens/Levies ❑ Accounts Receivable (A/R) ❑ Returned Checks and Provider Refunds ❑ Financial Transactions ❑ Financial Cycle Balancing This document is the result of incorporating the output of the RV sessions with stakeholders. In addition to a review and analysis of the business processes and flows that affect a functional area of the system, the initial change orders are generated as a result of the RV sessions and subsequent breakout work groups, but the follow-on effort completes the design effort, and iTRACE is the repository for information and data for all stages of technical development. As the technical design matures, the data in iTRACE matures until a change order sign-off is achieved and ready for testing. The technical design will include the following information that will be used to customize the interChange MMIS for the State: ❑ Subsystem Narrative Overview ❑ Subsystem Description ❑ Data Model ❑ Data Tables ❑ System Flow ❑ Subsystem Logic: Job Scripts, Programs, Browser Pages, Reports, Letters ❑ Internal and External Interfaces ❑ Requirements Matrix ❑ Change Orders ❑ Data Element Dictionary		

	❑ Workflow ❑ Supplemental Documentation ❑ Applicable Business Rules

TITLE	Premium Billing Technical Design		
VENDOR	EDS		
TYPE OF DATA	Technical	DATA RIGHTS	State Material
FREQUENCY DUE	Technical	1ST SUBMISSION DATE	03/08/2010
METHOD OF DELIVERY	Electronic—iTRACE		
EDS DESCRIPTION	This document describes the technical design of the interChange premium billing module that will provide the State with capabilities that include, but are not limited to, the following: ❑ 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 ❑ Process financial transactions regarding premium collections, billing, and payment transactions ❑ Apply premium policy for benefit plans to the programs listed above This document is the result of incorporating the output of the RV sessions with stakeholders. In addition to a review and analysis of the business processes and flows that affect a functional area of the system, the initial change orders are generated as a result of the RV sessions and subsequent breakout work groups, but the follow-on effort completes the design effort, and iTRACE is the repository for information and data for all stages of technical development. As the technical design matures, the data in iTRACE matures until a change order sign-off is achieved and ready for testing. The technical design will include the following information that will be used to customize the interChange MMIS for the State: ❑ Subsystem Narrative Overview ❑ Subsystem Description ❑ Data Model ❑ Data Tables ❑ System Flow ❑ Subsystem Logic: Job Scripts, Programs, Browser Pages, Reports, Letters ❑ Internal and External Interfaces ❑ Requirements Matrix ❑ Change Orders ❑ Data Element Dictionary ❑ Workflow ❑ Supplemental Documentation ❑ Applicable Business Rules		

TITLE	Health Check – Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Technical Design		
VENDOR	EDS		
TYPE OF DATA	Technical	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1ST SUBMISSION DATE	~~12/29/2009~~04/07/2010
METHOD OF DELIVERY	Electronic—iTRACE		
EDS DESCRIPTION	This document describes the design of the Health Check functions for the Replacement MMIS. This feature provides the following capabilities: ❑ Maintain the Health Check periodicity schedule ❑ Maintain online inquiry to all Health Check data with access by recipient ID and provider number ❑ Maintain each Health Check-eligible recipient, the current and historical screening results, referral, diagnosis and treatment, and immunizations, including the provider numbers and dates ❑ Identify paid and denied screening claims ❑ Identify abnormal conditions by screening date and whether the condition was treated or referred for treatment ❑ Update recipient Health Check data with screening results and dates and referral information ❑ Provide online, updateable letter templates for Health Check monthly notifications, standardized letters, and inserts ❑ Generate automatic monthly notifications to case heads for next screenings, screenings missed, and abnormal conditions not treated based on State criteria ❑ Maintain all notices sent, identifying case and recipient and date the notice was sent ❑ Maintain an online audit trail of all updates to Health Check data ❑ Web-based Health Check application that allows for the creation, update, and management of: Health Check information notifications, Monthly Accounting Activities Reports (MAAR) information, County Options Change Request (COCR) information, full-time equivalency (FTE) information, and Health Check recipient data ❑ Maintain an online audit trail of updates to Health Check data ❑ Perform the following functions using the Web-based application: search recipient data, enter comments, update notification suppression, send standardized notifications ❑ Calculate and system-generate Health Check Coordinator management fees ❑ Generate a monthly FTE report based on information received on the MAAR and COCR This document is the result of incorporating the output of the RV sessions with stakeholders. In addition to a review and analysis of the business processes and		

	flows that affect a functional area of the system, the initial change orders are generated as a result of the RV sessions and subsequent breakout work groups, but the follow-on effort completes the design effort, and iTRACE is the repository for information and data for all stages of technical development. As the technical design matures, the data in iTRACE matures until a change order sign-off is achieved and ready for testing. The technical design will include the following information that will be used to customize the interChange MMIS for the State: ❑ Subsystem Narrative Overview ❑ Subsystem Description ❑ Data Model ❑ Data Tables ❑ System Flow ❑ Subsystem Logic: Job Scripts, Programs, Browser Pages, Reports, Letters ❑ Internal and External Interfaces ❑ Requirements Matrix ❑ Change Orders ❑ Data Element Dictionary ❑ Workflow ❑ Supplemental Documentation ❑ Applicable Business Rules

TITLE	Reporting and Analytics (BIAR) Detailed System Design		
VENDOR	EDS		
TYPE OF DATA	Planning/Execution	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1ST SUBMISSION DATE	~~11/25/2009~~03/10/2010
METHOD OF DELIVERY	Electronic – iTRACE		
EDS DESCRIPTION	This document will detail the logical design of the BIAR subsystem, including hardware, system interfaces, networks, operating systems, databases, and storage.		

TITLE	Drug Rebate Technical Design		
VENDOR	EDS		
TYPE OF DATA	Technical	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1ST SUBMISSION DATE	~~11/04/2009~~02/17/2010
METHOD OF DELIVERY	Electronic—iTRACE		
EDS DESCRIPTION	This document describes the design of the interChange Drug Rebate feature for the Replacement MMIS. This feature allows the State to maximize collections and create a flexible and effective process through the following features: ❑ Process CMS quarterly drug rebate tape and produce drug rebate invoices ❑ Maintain manufacturer contact information ❑ Post drug rebate payments ❑ Perform drug rebate dispute resolution ❑ Provide drug rebate reporting, collections, and follow-up ❑ Access drug rebate accounting and interest This document is the result of incorporating the output of the RV sessions with stakeholders. In addition to a review and analysis of the business processes and flows that affect a functional area of the system, the initial change orders are generated as a result of the RV sessions and subsequent breakout work groups, but the follow-on effort completes the design effort, and iTRACE is the repository for information and data for all stages of technical development. As the technical design matures, the data in iTRACE matures until a change order sign-off is achieved and ready for testing. The technical design will include the following information that will be used to customize the interChange MMIS for the State: ❑ Subsystem Narrative Overview ❑ Subsystem Description ❑ Data Model ❑ Data Tables ❑ System Flow ❑ Subsystem Logic: Job Scripts, Programs, Browser Pages, Reports, Letters ❑ Internal and External Interfaces ❑ Requirements Matrix ❑ Change Orders ❑ Data Element Dictionary ❑ Workflow ❑ Supplemental Documentation ❑ Applicable Business Rules		

TITLE	Drug Utilization Review (DUR) Technical Design		
VENDOR	EDS		
TYPE OF DATA	Technical	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1ST SUBMISSION DATE	~~12/22/2009~~04/02/2010
METHOD OF DELIVERY	Electronic—iTRACE		
EDS DESCRIPTION	This document describes the design of interChange DUR, Pro-DUR, and Retro-DUR for the Replacement MMIS. This feature provides the State with the following capabilities: ❑ Base information ❑ Grandfathering ❑ Age ❑ Primary diagnosis ❑ Secondary diagnosis ❑ Full taxonomy/specialty ❑ First/second line drug therapy ❑ Co-morbid diagnosis ❑ Linking This document is the result of incorporating the output of the RV sessions with stakeholders. In addition to a review and analysis of the business processes and flows that affect a functional area of the system, the initial change orders are generated as a result of the RV sessions and subsequent breakout work groups, but the follow-on effort completes the design effort, and iTRACE is the repository for information and data for all stages of technical development. As the technical design matures, the data in iTRACE matures until a change order sign-off is achieved and ready for testing. The technical design will include the following information that will be used to customize interChange for the State: ❑ Subsystem Narrative Overview and Description ❑ Data Model ❑ Data Tables ❑ System Flow ❑ Subsystem Logic: Job Scripts, Programs, Browser Pages, Reports, Letters ❑ Internal and External Interfaces ❑ Requirements Matrix ❑ Change Orders ❑ Data Element Dictionary ❑ Workflow ❑ Supplemental Documentation ❑ Applicable Business Rules		

TITLE	Enterprise Integration Services (EIS) Technical Design		
VENDOR	EDS		
TYPE OF DATA	Technical	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1ST SUBMISSION DATE	~~12/22/2009~~04/02/2010
METHOD OF DELIVERY	Electronic—iTRACE		
EDS DESCRIPTION	This document describes the design of the EIS necessary to deliver a smooth user experience for the Replacement MMIS. EDS will use the BizTalk Server 2006 because of its ability to support various protocols and message formats. BizTalk Server 2006 provides the following adapters: ❑ Simple Object Access Protocol (SOAP) adapter ❑ BizTalk Message Queuing adapter ❑ File adapter ❑ HTTP adapter ❑ Simple Mail Transfer Protocol (SMTP) adapter ❑ Structured query language (SQL) adapter ❑ Base electronic data interchange (EDI) adapter ❑ FTP adapter This document is the result of incorporating the output of the RV sessions with stakeholders. In addition to a review and analysis of the business processes and flows that affect a functional area of the system, the initial change orders are generated as a result of the RV sessions and subsequent breakout work groups, but the follow-on effort completes the design effort, and iTRACE is the repository for information and data for all stages of technical development. As the technical design matures, the data in iTRACE matures until a change order sign-off is achieved and ready for testing. The technical design will include the following information that will be used to customize interChange for the State: ❑ Subsystem Narrative Overview and Description ❑ Data Model ❑ Data Tables ❑ System Flow ❑ Subsystem Logic: Job Scripts, Programs, Browser Pages, Reports, Letters ❑ Internal and External Interfaces ❑ Requirements Matrix ❑ Change Orders ❑ Data Element Dictionary ❑ Workflow ❑ Supplemental Documentation ❑ Applicable Business Rules		

Transition

TITLE	MMIS System Documentation		
VENDOR	EDS		
TYPE OF DATA	Planning/Execution	DATA RIGHTS:	State Material
FREQUENCY DUE	When Changed	1ST SUBMISSION DATE	~~06/16/2010~~09/16/2010
METHOD OF DELIVERY	Electronic—iTRACE		
EDS DESCRIPTION	These documents detail the specifications for each of the interChange modules including, but not limited to, recipient, eligibility verification, provider, claims, PA, Health Check, and more.		

TITLE	Training Materials/Manuals		
VENDOR	EDS		
TYPE OF DATA	Planning/Execution	DATA RIGHTS:	State Material
FREQUENCY DUE	When Changed	1ST SUBMISSION DATE	~~08/12/2010~~11/19/2010
METHOD OF DELIVERY	Electronic—iTRACE		
EDS DESCRIPTION	Most training materials will be in the form of computer-based training (CBT) that will be managed within the interChange product itself.		

TITLE	Provider Documentation		
VENDOR	EDS		
TYPE OF DATA	Planning/Execution	DATA RIGHTS:	State Material
FREQUENCY DUE	When Changed	1ST SUBMISSION DATE	~~03/09/2011~~05/17/2010
METHOD OF DELIVERY	Electronic – Web Portal		
EDS DESCRIPTION	Provider documentation will be available through a provider Web portal. This documentation will provide guidance for interChange functions including, but not limited to, the following: ❑ Provider Enrollment ❑ Provider Maintenance and Management ❑ Claims Management		

TITLE	MMIS Certification Documentation and Presentation Materials		
VENDOR	EDS		
TYPE OF DATA	Planning/Execution	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1ST SUBMISSION DATE	~~08/19/2011~~11/18/2011
METHOD OF DELIVERY	Electronic—iTRACE		
EDS DESCRIPTION	EDS will lead generation, consolidation, and production of the documents and presentation materials necessary to obtain CMS certification for the Replacement MMIS.		

TITLE	Operations Management Plan (OMP)		
VENDOR	EDS		
TYPE OF DATA	Planning/Execution	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1ST SUBMISSION DATE	~~04/09/2009~~07/16/2009
METHOD OF DELIVERY	Electronic—iTRACE		
EDS DESCRIPTION	The Operations Management Plan strategically describes how the Fiscal Agent will successfully deliver and support operational services. The plan should clearly document the Vendor's approach to operations and communicate an understanding of how it operates a Medicaid Fiscal Agent Contract. Roles and responsibilities of the Fiscal Agent and the State should be clearly delineated. The following areas should be included in an Operations Management Plan, either by incorporating the topic in the document or referring to other standalone documents (duplication of information is not necessary): ❑ Strategic Plan for Operations ❑ Process Improvement ❑ Quality Management ❑ Performance Metrics ❑ Operations Management Reviews ❑ Change and Configuration Management ❑ Risk and Issue Management Plan ❑ Resource Management ❑ Security Plan ❑ Disaster Recover/Continuity of Operations Plan ❑ Training Plan ❑ Communications Process and Procedures (between Fiscal Agent, the State, providers, and citizens)		

TITLE	Operations Manuals		
VENDOR	EDS		
TYPE OF DATA	Planning/Execution	DATA RIGHTS:	State Material
FREQUENCY DUE	Annually or more frequently	1ST SUBMISSION DATE	~~04/08/2010~~12/08/2010
METHOD OF DELIVERY	Electronic—iTRACE		
EDS DESCRIPTION	This document details the regularly scheduled operational processes, escalation procedures, and contact information for partners and vendors. The document comprises the following sections: ❑ **Systems Operating Procedures Manual Overview—**Provides a brief overview of the System Operating Procedures manual and includes a description of the intended audience for this manual ❑ **Processing Schedules—**Provides details on the daily, weekly, quarterly and monthly processing schedule ❑ **Operational Processes—**Explains the regular operational processes, including EDI, cycle balancing, and cycle reports ❑ **Problem Escalation Procedures—**Explains incident and emergency response procedures ❑ **Trading Partners List—**Lists trading partners working with EDS on the Replacement MMIS project ❑ **Vendor Interface Connection Listing—**Lists vendor interfaces for the Replacement MMIS		

TITLE	Special Contingency Plan		
VENDOR	EDS		
TYPE OF DATA	Planning/Execution	DATA RIGHTS	State Material
FREQUENCY DUE	When Changed	1ST SUBMISSION DATE	~~04/13/2010~~07/08/2010
METHOD OF DELIVERY	Electronic—iTRACE		
EDS DESCRIPTION	Given the extensive system, user acceptance, parallel, and operation readiness testing that interChange has undergone, the probability of systems issues serious enough to require a reversion to the Legacy system are extremely small. Close attention will be paid to production interChange results by comparing them to expectations established during the "Large Parallel" testing. If interChange operates within these tolerances, any minor systems issues will be addressed in the interChange environment. In the unlikely event that North Carolina decides to revert to the Legacy MMIS+, this deliverable documents the steps required to execute this contingency. The action items for each of the following MMIS components are detailed: ❑ Communications ❑ Mainframe ❑ Paper claims ❑ Member ❑ Provider ❑ Claims ❑ BBS ❑ Prior Authorization (PA) ❑ Interim Decision Support System (DSS) ❑ EDS ❑ Desktop PC As a part of the special contingency plan, a Microsoft Project schedule estimates the level of effort required for each task.		

Testing

TITLE	Master Test and Quality Assurance Plan (MTQAP)		
VENDOR	EDS		
TYPE OF DATA	Planning/Execution	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1ST SUBMISSION DATE	~~11/10/2008~~02/09/2009
METHOD OF DELIVERY	Electronic—iTRACE		
DESCRIPTION	This plan applies the processes for testing and quality assurance from the Software Development and Systems Engineering Methodology to this project to include specific test and quality assurance activities and results required for success. The plan should identify key events and their objectives, along with roles, responsibilities, and resources needed for these events to be successful. The MTQAP adds detail to items in the IMP related to testing and quality assurance.		

TITLE	User Acceptance Test Plan		
VENDOR	EDS		
TYPE OF DATA	Planning/Execution	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1ST SUBMISSION DATE	~~03/29/2010~~07/13/2010
METHOD OF DELIVERY	Electronic – iTRACE		
EDS DESCRIPTION	A plan will be developed to describe the approach and methodologies planned for the User Acceptance Testing (UAT) Phase. UAT is formal testing conducted to allow the State or other authorized entity to determine whether a system satisfies its acceptance criteria and whether to accept a system or component of a system. This testing will be performed after the successful completion of Systems Integration Testing. UAT is performed jointly by EDS and the State. This level of testing will give the State the chance to validate the test cases that were submitted by the EDS testers or submit additional, new test cases. UAT builds on the testing performed in Integrated System Testing to make sure all subsystems function as specified in the DSDs. This type of testing is similar in nature to System Module/Subsystem/Function Testing and Integrated System Testing. The UAT environment will be populated with converted North Carolina production data from the Legacy MMIS+. This plan will describe roles and responsibilities, defect reporting, and additional testing processes.		

TITLE	Final Structured Test Results		
VENDOR	EDS		
TYPE OF DATA	Planning/Execution	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1ST SUBMISSION DATE	~~10/19/2010~~01/25/2011
METHOD OF DELIVERY	Electronic – iTRACE		
EDS DESCRIPTION	EDS provides testing notebooks, test cases, and test results from System Module/ Subsystem/Function and System Integration testing to the State for acceptance before the UAT Phase. Walkthroughs and joint reviews of System Module/Subsystem/Function and System Integration test results are an integral part of our quality approach during design and development. Walkthroughs of the System Module/ Subsystem/Function and System Integration Test results serve the State by doing the following: ❑ Facilitating understanding, answering questions, and expediting the deliverable approval process ❑ Determining the State's satisfaction or concern with the output The Integrated Master Schedule details our approach to providing walkthroughs of the deliverables. The work plan also details our communication with the State for the review of system test deliverables.		

TITLE	Regression Test Results		
VENDOR	EDS		
TYPE OF DATA	Planning/Execution	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1ST SUBMISSION DATE	~~01/28/2011~~04/29/2011
METHOD OF DELIVERY	Electronic – iTRACE		
EDS DESCRIPTION	This document will detail the business process requirements determined from the requirements validation session for the Data Entry functionality for early implementation.		

TITLE	Completed Operational Readiness Test		
VENDOR	EDS		
TYPE OF DATA	Planning/Execution	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1ST SUBMISSION DATE	~~04/18/2011~~07/19/2011
METHOD OF DELIVERY	Electronic – iTRACE		
EDS DESCRIPTION	This document will detail the results of the operational readiness testing. Results of test cases, test cycles, and demonstration of business operations will be included in the document for review by the State.		

TITLE	Integrated Structured Testing (IST) Results		
VENDOR	EDS		
TYPE OF DATA	Technical	DATA RIGHTS	State Material
FREQUENCY DUE	When Changed	1ST SUBMISSION DATE	~~01/04/2011~~04/06/2011
METHOD OF DELIVERY	Electronic—iTRACE		
EDS DESCRIPTION	This document summarizes and details the results of integrated system tests run against the systems within the Replacement MMIS.		

TITLE	Parallel Test Results		
VENDOR	EDS		
TYPE OF DATA	Technical	DATA RIGHTS	State Material
FREQUENCY DUE	When Changed	1ST SUBMISSION DATE	~~02/02/2011~~05/04/2011
METHOD OF DELIVERY	Electronic—iTRACE		
EDS DESCRIPTION	This document summarizes and details the results of parallel system tests run against the Legacy MMIS+ and Replacement MMIS.		

TITLE	Volume/Stress Test Results		
VENDOR	EDS		
TYPE OF DATA	Technical	DATA RIGHTS	State Material
FREQUENCY DUE	When Changed	1ST SUBMISSION DATE	~~01/13/2011~~04/15/2011
METHOD OF DELIVERY	Electronic—iTRACE		
EDS DESCRIPTION	This document summarizes and details the results of volume stress tests run against the Replacement MMIS. For example, this test will run many claims against the Replacement MMIS to determine its performance.		

Conversion

TITLE	Create Outline for Conversion Plan Deliverable		
VENDOR	EDS		
TYPE OF DATA	Planning/Execution	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1ST SUBMISSION DATE	~~12/04/2008~~03/04/2009
METHOD OF DELIVERY	Electronic – iTRACE		
EDS DESCRIPTION	This document will detail the business process requirements determined from the requirements validation session for the Data Entry functionality for early implementation.		

TITLE	Data Conversion Requirements Analysis		
VENDOR	EDS		
TYPE OF DATA	Planning/Execution	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1ST SUBMISSION DATE	Various per the IMS
METHOD OF DELIVERY	Electronic – iTRACE		
EDS DESCRIPTION	The EDS team will identify detailed conversion requirements and sources of data for functional areas necessary to meet functional specifications in the RFP. Extract and data analysis is the first and most critical step of the conversion activity. Essential to this step is the participation of State business and technical subject-matter experts who work with our team to identify and understand the source and target data structures, and data element content. Data analysis tools will be used to quickly and efficiently perform a complete analysis of source data. Detailed knowledge of the values and anomalies in the data are identified early in the conversion cycle and used to help prevent unexpected results later in the process. During the analysis phase, we perform the following activities: ❑ Conduct extensive analysis at the data element level to normalize the data model, validate valid values, check data element integrity, validate business and technical rules, and determine field-level distinct values ❑ Analyze data content within key fields across records within the same file and records across different files ❑ Perform gap analysis between the source data and interChange to determine data compatibility ❑ Identify and resolve differences in field-level data contents, valid values, field lengths, and field formats ❑ Match critical and key data elements from the source data to interChange and document those for which a clear match is not identified		

	❑ Review the functional DSD documents for changes in the business function or data model that would impact the conversion ❑ Identify and resolve with the State any key elements not accounted for in the source data During the analysis process, files that will be linked to the system as interfaces will be identified. The interfaces will be managed through the functional area in which they are used. For example, an eligibility file from an external entity would be managed and documented by the recipient functional area. An analysis for each functional will be prepared for all functional areas requiring conversion. The list of functional areas that will be considered is as follows: ❑ Baseline Provider Data Conversion Requirements Analysis ❑ Baseline DMA Reference Data Conversion Requirements Analysis ❑ Baseline DMA Recipient Data Conversion Requirements Analysis ❑ Baseline Provider Data Conversion Requirements Analysis ❑ Baseline DMH Reference Data Conversion Requirements Analysis ❑ Baseline DMH Recipient Data Conversion Requirements Analysis ❑ Baseline Provider Data Conversion Requirements Analysis ❑ Baseline DPH Reference Data Conversion Requirements Analysis ❑ Baseline DPH Recipient Data Conversion Requirements Analysis ❑ Baseline Provider Data Conversion Requirements Analysis ❑ Baseline ORHCC Reference Data Conversion Requirements Analysis ❑ Baseline ORHCC Recipient Data Conversion Requirements Analysis ❑ DMA Claims Data Conversion Requirements Analysis ❑ DMA Provider Data Conversion Requirements Analysis ❑ DMA Managed Care Data Conversion Requirements Analysis ❑ DMA PA Data Conversion Requirements Analysis ❑ DMA Reference Data Conversion Requirements Analysis ❑ DMA TPL Data Conversion Requirements Analysis ❑ DMA Health Check Tracking (EPSDT) Data Conversion Requirements Analysis ❑ DMA Financial Data Conversion Requirements Analysis ❑ DMA Recipient Data Conversion Requirements Analysis ❑ DMA Drug Rebate Data Conversion Requirements Analysis ❑ DMH Claims Data Conversion Requirements Analysis ❑ DMH Provider Data Conversion Requirements Analysis ❑ DMH PA Data Conversion Requirements Analysis ❑ DMH Reference Data Conversion Requirements Analysis ❑ DMH Financial Data Conversion Requirements Analysis ❑ DMH Recipient Data Conversion Requirements Analysis

	❑ DPH Claims Data Conversion Requirements Analysis ❑ DPH Provider Data Conversion Requirements Analysis ❑ DPH PA Data Conversion Requirements Analysis ❑ DPH Reference Data Conversion Requirements Analysis ❑ DPH TPL Data Conversion Requirements Analysis ❑ DPH Financial Data Conversion Requirements Analysis ❑ DPH Recipient Data Conversion Requirements Analysis ❑ DPH Enrollment Data Conversion Requirements Analysis ❑ ORHCC Claims Data Conversion Requirements Analysis ❑ ORHCC Provider Data Conversion Requirements Analysis ❑ ORHCC Managed Care Data Conversion Requirements Analysis ❑ ORHCC PA Data Conversion Requirements Analysis ❑ ORHCC Reference Data Conversion Requirements Analysis ❑ ORHCC TPL Data Conversion Requirements Analysis ❑ ORHCC Health Check Tracking Data Conversion Requirements Analysis ❑ ORHCC Financial Data Conversion Requirements Analysis ❑ ORHCC Recipient Data Conversion Requirements Analysis ❑ NCHC Claims Data Conversion Requirements Analysis

TITLE	Data Conversion Technical Design		
VENDOR	EDS		
TYPE OF DATA	Planning/Execution	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1ST SUBMISSION DATE	Various per the IMS
METHOD OF DELIVERY	Electronic – iTRACE		
EDS DESCRIPTION	During conversion development and testing, our team will construct programs that facilitate the transformation for each data element from each input source file to the associated interChange system target table and column. We will design input and output record counts into each conversion program. Statistics reports that track the number of records read, number of records considered for conversion, and the number of records converted will be part of each input source file. Counts for the number of records read and loaded into each interChange system target table will also be available. These balance counts will be our initial mechanism to account for records within each source file input into the conversion process. The conversion programs will include error reports that track the number of records with errors that prevented the record's conversion. The key identifying information for the unconverted record and an associated error condition message also will be part of this report. Data validation methods also will be		

	included in the programs. These validation methods may include such things as determining expected counts and valid value editing. Validations may also need to be performed between files (cross-validation relationships validation). Unit testing will validate that each conversion program accounted for the data elements and transformation logic for those data elements. We will conduct unit testing using a sample of actual source data separately for each individual conversion program. Unit testing will be stand-alone testing, intended to demonstrate that each individual conversion program functions as expected, independent of other conversion programs. A design for the following areas will be considered during DDI: ❑ Baseline DMA Provider Data Conversion Technical Design ❑ Baseline DMA Reference Data Conversion Technical Design ❑ Baseline DMA Recipient Data Conversion Technical Design ❑ Baseline DMH Provider Data Conversion Technical Design ❑ Baseline DMH Reference Data Conversion Technical Design ❑ Baseline DMH Recipient Data Conversion Technical Design ❑ Baseline DPH Provider Data Conversion Technical Design ❑ Baseline DPH Reference Data Conversion Technical Design ❑ Baseline DPH Recipient Data Conversion Technical Design ❑ Baseline ORHCC Provider Data Conversion Technical Design ❑ Baseline ORHCC Reference Data Conversion Technical Design ❑ Baseline ORHCC Recipient Data Conversion Technical Design ❑ DMA Claims Data Conversion Technical Design ❑ DMA Provider Data Conversion Technical Design ❑ DMA Managed Care Data Conversion Technical Design ❑ DMA PA Data Conversion Technical Design ❑ DMA Reference Data Conversion Technical Design ❑ DMA TPL Data Conversion Technical Design ❑ DMA Health Check Tracking (EPSDT) Data Conversion Technical Design ❑ DMA Financial Data Conversion Technical Design ❑ DMA Recipient Data Conversion Technical Design ❑ DMA Drug Rebate Data Conversion Technical Design ❑ DMH Claims Data Conversion Technical Design ❑ DMH Provider Data Conversion Technical Design ❑ DMH PA Data Conversion Technical Design ❑ DMH Reference Data Conversion Technical Design ❑ DMH Financial Data Conversion Technical Design ❑ DMH Recipient Data Conversion Technical Design ❑ DPH Claims Data Conversion Technical Design

	❑ DPH Provider Data Conversion Technical Design ❑ DPH PA Data Conversion Technical Design ❑ DPH Reference Data Conversion Technical Design ❑ DPH TPL Data Conversion Technical Design ❑ DPH Financial Data Conversion Technical Design ❑ DPH Recipient Data Conversion Technical Design ❑ DPH Enrollment Data Conversion Technical Design ❑ ORHCC Claims Data Conversion Technical Design ❑ ORHCC Provider Data Conversion Technical Design ❑ ORHCC Managed Care Data Conversion Technical Design ❑ ORHCC PA Data Conversion Technical Design ❑ ORHCC Reference Data Conversion Technical Design ❑ ORHCC TPL Data Conversion Technical Design ❑ ORHCC Health Check Tracking Data Conversion Technical Design ❑ ORHCC Financial Data Conversion Technical Design ❑ ORHCC Recipient Data Conversion Technical Design ❑ NCHC Data Conversion Technical Design

TITLE	Data Conversion and Migration Plan		
VENDOR	EDS		
TYPE OF DATA	Planning/Execution	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1ST SUBMISSION DATE	~~12/12/2008~~04/29/2009
METHOD OF DELIVERY	Electronic—iTRACE		
DESCRIPTION	This document describes a comprehensive plan to convert and migrate all required data from the Legacy MMIS+ to the Replacement MMIS. It must include strategies and activities required to support development, testing, certification, and long-term operations. The plan must document processes and activities to include analysis of the conversion and migration requirements; design and construction of solutions; testing of these solutions; identification of documentation required to support conversion and migration activities; and the processes that will actually be used to convert and migrate the data. The plan must clearly identify the data to be converted, the specific methods to be applied to these data (both automatic and manual), data cleansing and validation, data security, and the strategy to make certain that the data are converted and migrated in a timely fashion to support testing and implementation. Additionally, the plan shall describe the roles and responsibilities of the parties involved in these activities. The IMP shall identify key events, accomplishments, and criteria for data conversion and migration that are supported by this plan.		
EDS DESCRIPTION	This document will outline the procedures and standards that will apply to conversion data. The Global Conversion Plan will comprise the following information: ❑ Conversion objectives ❑ Roles and responsibilities ❑ Description of the conversion process, including process and environment diagrams ❑ Status reporting standards ❑ Statistical and error-reporting standards ❑ Procedures for notification, tracking, and correcting conversion problems ❑ Conversion preparation task outline ❑ Procedures for verifying the integrity and accuracy of the converted files, including quality control and sampling verifications ❑ A narrative and plan for the management of the conversion effort, including strategies for dealing with delays, a backup plan, backup personnel, and any significant issues ❑ Conversion support requirements, including use of the system, policy issues, and hardware ❑ List of conversion tools		

	❑ Procedures to handle manual conversion and data-cleanup activities ❑ Conversion data volume considerations, including the size of the database and the amount of data to be converted ❑ Development schedule ❑ User work and delivery schedules and time frame for reports ❑ Conversion deliverable outlines

TITLE	Detail Data Conversion Plan		
VENDOR	EDS		
TYPE OF DATA	Planning/Execution	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1ST SUBMISSION DATE	~~03/23/09~~07/15/2009
METHOD OF DELIVERY	Electronic – iTRACE		
DESCRIPTION	This document describes a comprehensive plan to convert and migrate all required data from the Legacy MMIS+ to the Replacement MMIS. It must include strategies and activities required to support development, testing, certification, and long-term operations. The plan must document processes and activities to include analysis of the conversion and migration requirements; design and construction of solutions; testing of these solutions; identification of documentation required to support conversion and migration activities; and the processes that will actually be used to convert and migrate the data. The plan must clearly identify the data to be converted, the specific methods to be applied to these data (both automatic and manual), data cleansing and validation, data security, and the strategy to make certain that the data are converted and migrated in a timely fashion to support testing and implementation. Additionally, the plan shall describe the roles and responsibilities of the parties involved in these activities. The IMP shall identify key events, accomplishments, and criteria for data conversion and migration that are supported by this plan.		
EDS DESCRIPTION	The data conversion plan will document how data required by the Replacement MMIS will get populated. It also will identify unused data items from the current system and how that data will be handled. The detailed conversion requirements will primarily reside in iTRACE and Data Explorer software, as described in the preceding Conversion Tools subsection. Additionally, the conversion functional area test plans will be determined in this phase. The data conversion plan for each subsystem will include the following: ❑ A description of files to be converted and whether it will be a manual conversion, an automated conversion, or a combination of the two ❑ An understanding of the function of the data in the old system and the determination of whether the use will be the same or different in the new system ❑ An understanding of the order in which data is processed in the old system and how that affects the integrity of the data in the new system ❑ Data element mapping cross-walks (including values) of source-to-target and target-to-source, including unmapped source fields and default target values will be included. ❑ Normalization of data from the old system into the new relational model ❑ Data transformation logic comprising special logic or functions needed to transfer the data into the Replacement MMIS ❑ Configuration and code table data cross-walks, such as provider type and		

	specialty ❑ A function-specific plan for testing and verifying conversion programs and procedures to accommodate differences in functional areas ❑ Approach for organizing and presenting the conversion test results, including type of results to be provided ❑ Approach for handling obsolete or unused data that is not converted, to be archived subject to the retention periods specified

TITLE	Preliminary Conversion Test Results		
VENDOR	EDS		
TYPE OF DATA	Planning/Execution	DATA RIGHTS	State Material
FREQUENCY DUE	When changed	1ST SUBMISSION DATE	~~02/18/2011~~05/13/2011
METHOD OF DELIVERY	Electronic—iTRACE		
EDS DESCRIPTION	After creating a detailed conversion plan, EDS tests the plan on non-production data and analyzes the results. The detailed conversion plan will be updated as necessary. The Preliminary Conversion Test Results is comprised of the following: **Overall Findings and Recommendations:** ❑ Summary of the conversion plan results and status of the conversion software ❑ Identification of any significant outstanding deficiencies or limitations ❑ Effect of any outstanding deficiency on the remainder of the conversion schedule and recommended solutions for correcting the deficiency ❑ Assessment of how the test environment may differ from the operational environment and how this may affect the test results ❑ Recommendations for improving the design, operation, or testing of conversion software **Detailed Test Results** ❑ Results of the conversion testing formatted as defined in the conversion plan and approved by the State ❑ Completion status of each test case of the testing plan ❑ Identification of test cases where the result was not as expected, an explanation of the problem that occurred, and the procedure in which the problem occurred ❑ Chronological record of the testing covered by the conversion test results report, including dates, times, and locations of testing ❑ Identification of the hardware and software configurations used for testing ❑ Log of dates and times of testing activity, including the individual performing the testing Before final conversion, the State will approve conversion for each functional area. State sign-off will indicate that the test plan and preliminary conversion for a specific functional area are complete and accurate. This will be documented in the sign-off section of the status report.		

TITLE	Final Conversion Test Results		
VENDOR	EDS		
TYPE OF DATA	Planning/Execution	DATA RIGHTS	State Material
FREQUENCY DUE	When Changed	1ST SUBMISSION DATE	~~05/02/2011~~08/02/2011
METHOD OF DELIVERY	Electronic—iTRACE		
EDS DESCRIPTION	This document will provide the following information post-conversion: **Detailed Test Results** ❑ Results of the conversion formatted as defined in the conversion plan and approved by the State ❑ Completion status of each conversion case of the conversion plan ❑ Identification of conversion cases where the result was not as expected, an explanation of the problem that occurred, and the procedure in which the problem occurred ❑ Chronological record of the conversion results report, including dates, times, and locations of conversion ❑ Identification of the hardware and software configurations used for conversion ❑ Log of dates and times of conversion activity		

Operations

TITLE	Performance Reports		
VENDOR	EDS		
TYPE OF DATA	Operations	DATA RIGHTS	State Material
FREQUENCY DUE	Monthly	1ST SUBMISSION DATE	~~5/30/2011~~08/03/2011
METHOD OF DELIVERY	Electronic – iTRACE		
EDS DESCRIPTION	Through the performance dashboard, critical performance standards will be reported, and other operational performance standards will be reported as required.		

TITLE	Invoice		
VENDOR	EDS		
TYPE OF DATA	Operations	DATA RIGHTS	State Material
FREQUENCY DUE	Monthly	1ST SUBMISSION DATE	~~5/30/2011~~08/03/2011
METHOD OF DELIVERY	Electronic – iTRACE		
EDS DESCRIPTION	Invoices will be generated monthly and submitted to the State for payment. Documentation supporting billable transactions will be provided to support invoice detail.		

TITLE	Turnover Activities Status Report		
VENDOR	EDS		
TYPE OF DATA	Operations	DATA RIGHTS	State Material
FREQUENCY DUE	Monthly	1ST SUBMISSION DATE	~~5/30/2015~~ 08/03/2015 (or 2016 with option year)
METHOD OF DELIVERY	Electronic – iTRACE		
EDS DESCRIPTION	Report of turnover activities will provide the current status of related activities, such as providing claims data files for conversion, financial bank statements, and reconciliations.		

TITLE	Replacement MMIS Marketing Plan		
VENDOR	EDS		
TYPE OF DATA	Operations	DATA RIGHTS	State Material
FREQUENCY DUE	Annual	1ST SUBMISSION DATE	~~5/30/2012~~08/03/2012
METHOD OF DELIVERY	Electronic – iTRACE		
EDS DESCRIPTION	The marketing plan will be created to reflect the efforts of provider and other stakeholder outreach necessary to communicate and encourage participation in the Medicaid program in the most efficient and effective manner.		

TITLE	Organization Chart and Staffing Reports		
VENDOR	EDS		
TYPE OF DATA	Operations	DATA RIGHTS	State Material
FREQUENCY DUE	Monthly	1ST SUBMISSION DATE	~~5/30/2011~~08/03/2011
METHOD OF DELIVERY	Electronic		
EDS DESCRIPTION	Reports reflecting staffing and organization data will be updated monthly as needed and provided to the State.		

Section J—Corporate Capabilities

RFP Reference: RFP Addendum 4 – North Carolina Replacement MMIS Updated Requirements

Changes to Relevant Experience

Technical Proposal BAFO page J-11, following first full paragraph, add:

S-CHIP Programs

EDS brings experience with S-CHIP programs in North Carolina and nationwide. For North Carolina's S-CHIP program, EDS has been processing claims for children up to five years of age since early 2006. We modified the Legacy MMIS+ to support Medicaid processing for these S-CHIP recipients and currently process more than 200,000 claims each month. The EDS fiscal agent team provides all services related to processing prior approval and associated notification of prior approvals (when necessary) and claims resolution for pended claims. Financial reports capture and account for these recipient costs.

In addition to this recent experience in North Carolina, EDS also brings experience with the S-CHIP programs in California, Wisconsin, Arkansas, Kansas, and Delaware. In California, EDS supported the Healthy Families Program (California's CHIP) by processing more than 140 million healthcare transactions for more than 660,000 children. On behalf of these children, EDS worked with 20,000 providers representing 29 health plans and four dental plans, billing and collecting payments on 4 million premium bills annually, and responded to 5,000 telephone inquiries per week.

Technical Proposal BAFO page J-15, following "EDS Fiscal Agent Experience" exhibit:

EDS also brings experience in many other functions that are required of the Replacement MMIS, including the following:

- **Premium billing and collections—**EDS provides premium billing and collections services for various state healthcare programs nationally. For the Oklahoma Individual Plan (IP), EDS receives applications for the Insure Oklahoma (Premium Assistance Medicaid Waiver) program and determines eligibility. Individuals apply for the IP and pay a premium to EDS to receive a limited package of Medicaid-funded services. EDS determines eligibility, sends an invoice to the subscriber, and obtains a

bank file of subscriber payments received in the lockbox. For the Indiana Health Coverage Programs (IHCP), EDS processes premium payments for two programs, Hoosier Healthwise Package C (CHIP) and Medicaid for Employees with Disabilities. We manage premium processing for an average of more than 14,000 program members each month, many of these through automatic payments. For Tennessee's Medicaid program (TennCare), EDS manages the premium billing and collections process for TennCare-managed care plans that provide services for the uninsured or uninsurable. We provide comprehensive support for monthly premium billing and invoices by electronic lockbox processes and manual posting of premium receipts. We mail an average of 15,500 premium statements each month for the TennCare program.

- **Recipient call centers—**Until recently, responding to inquiries from program recipients has typically been a state function. In recent years, however, EDS fiscal agent account teams across the country have implemented recipient call centers in Alabama, Arkansas, California, Florida, Indiana, Kansas, Oklahoma, and Wisconsin. For Medi-Cal, California's Medicaid program, our staff responds to more than 18,000 recipient calls each month on such topics as general program information, co-payments, and eligibility. For the Alabama Medicaid program, EDS operates a recipient call center that responds to more than 29,000 recipient calls each month on such topics as requests to change a primary care physician, whether the caller is responsible for payment, requests to reissue a lost ID card, and requests for non-emergency transportation (NET).
- **Retrospective drug utilization review (Retro-DUR)—**EDS brings experience with Retro-DUR functions in seven states: Arkansas, Connecticut, Delaware, Kansas, Florida, Rhode Island, and Wisconsin. In most of these states, EDS is supported by Health Information Designs, Inc. (HID) to provide retrospective drug utilization services. HID is the most experienced and qualified provider of DUR and pharmacy benefit management services in the county. For 28 years, HID has worked to improve the quality and cost-effectiveness of healthcare through clinically rational use of prescription medication. Their clients include public and private healthcare plans throughout the United States, with a combined total of more than 11 million covered lives. In Rhode Island, HID has supported quarterly DUR board meetings for four years and more recently has provided an enhanced lock-in program. Each month, the Rhode Island MMIS provides HID with a file of current drug and claim data. HID uses the MMIS data to perform analyses for DUR and lock-in program reviews. HID performs algorithms against the MMIS data to identify recipients who meet the review criteria or who may be at risk for clinical overuse or abuse.

RFP 30-DHHS-1228-08 NC Replacement Medicaid Management Information System Confidential and Proprietary Information," we have redacted the slides from our February 11, 2008, Oral Presentation. This page and the page that follows represent the redacted presentation in its entirety.