



REQUEST FOR PROPOSAL

**Care Management Solution
Healthcare IT System**

RFP #1040-J18

June 15, 2018

SUBMISSION DEADLINE DATE: July 16, 2018

Pursuant to General Statutes of North Carolina, Section 143 Article 3 subject to the conditions and specifications herein, Vendors are invited to submit Proposals for Care Management Solution.

Partners Behavioral Health Management and Cardinal Innovations Healthcare reserve the right to modify this RFP to correct any errors or to clarify requirements. Any changes will be posted on our websites at www.partnersbhm.org and www.cardinalinnovations.org and sent to all bidders.

GENERAL INFORMATION

I. PURPOSE OF THE RFP

Partners Behavioral Health Management (Partners) and Cardinal Innovations Healthcare (the ENTITIES) are collaborating to procure a **Care Management Solution**. The goal is to work with a vendor that can provide a platform which makes available the components that fit their needs respectively. The collaboration seeks to share in the economies of scale through pricing, system components, vendor support, shared resources and experiences.

Both entities operate under the same government contracts and must provide the same functions and outcomes required under those contracts. It also must be recognized that there may be unique variations that will require the vendor to be able to work with both organizations closely through the procurement process. Implementation and integration plans may have some unique variations for each organization although both organizations intend to pursue joint learning and collaboration in this procurement process. The timelines in this project are the same; however, there may be distinct needs to specific milestones.

There are two objectives for this RFP:

1. Short Term (Required): Acquire and implement a Health Plan **Care Management Solution**

- Core components which will support all Care Management functions:
 - i. Care Management Administration
 - ii. Utilization Management Administration
 - iii. Enrollee and Provider Portals
 - iv. Population Health
 - v. System Integrator to support other aspects of a Managed Care System (Call Center, Eligibility & Enrollment, Claims Management, Provider Profiles)

2. Long Term (Preferred): Acquire a Managed Care Healthcare Platform

- Solution Enhancement Services: As North Carolina continues to roll out its Medicaid Transformation Plan, other departments will need to upgrade their software solutions to meet new system requirements thus expanding our Managed Care System solutions. As part of this RFP, the vendor is asked to provide or support the integration of System Enhancement Services to expand the scope of the platform, as defined by the Entities to support both Care Management and the following Managed Care Core Administration:

- i. Enrollee profiles - eligibility and enrollment
 - ii. Benefit plans
 - iii. Provider profiles
 - iv. Claims Management and Administration
- Planning, design, development and implementation of solution enhancements may range from moderate to significant in size as defined in the Entities' Managed Care Strategy and scope of work.

II. BACKGROUND

The Care Management Solution is part of the larger initiative to modernize and consolidate various systems used throughout Partners and Cardinal Innovations.

Good care management is the backbone to managing quality healthcare delivery. The business challenge for each entity is how to capture, analyze and report the data and information it needs to make decisions for care management. Without the accurate information based on valid and reliable measures, the organization is unable to truly demonstrate the value that care management/care coordination brings to the organization.

Care management is impacted because care coordinators use multiple information systems. Care coordinators are challenged when they do not receive information in a timely or consistent manner. Dependence on multiple systems is a critical challenge because care coordinators may not be proficient at using all the systems, often spend extra time tracking down information and may have several manual processes in place to share and exchange information with providers.

The current information system is not an electronic health record system and does not allow sharing or exchanging of information with providers or community resources/referrals. Additionally, it does not have an enrollee portal. As a result, information is not provided to care coordinators in real time and clinical information is often missing.

The recommendations to resolve business challenges are:

- Investment in a **Care Management Solution**, including:
 - Enrollee and Provider portals
 - Enrollment/Eligibility
 - Population Health
 - Utilization Management
- Integration with existing or future core administration systems, such as, Call Center, Enrollee Services, Network Management and Contracts/Provider Profiles
- Integration with existing or future Claims Management System
- Integration with external entities (State, Federal, Providers, Institutions etc.)
- Integration with Provider Electronic Health Records (EHR)

- Integration with Health Information Exchange

These recommendations complement each other and a robust Care Management Solution is needed to address them. For example, the Care Management Solution must have the ability to interface with provider electronic health records, exchange of real time information, data and population health analytics and enable enrollees to access their own information and electronically message a care coordinator.

The expectation is that the system will increase care management efficiency and improve enrollee care. The ability to perform predictive analytics and resulting reduction in unnecessary hospitalizations and emergency department visits is essential. Quality of life factors including a safe place to live, improved relationships and the ability to work are often equally important indicators of effective care management.

The Care Management Solution shall impact the organization positively. Staff will have resources and information at their fingertips. Enrollees and families will appreciate the ability to access their own health information and message a member of his/her care team any time of day or night. Exchange of real time information will also strengthen relationships with the care team, including behavioral and physical health providers. The Care Management Solution must support the management of health care delivery with data. Those data must include monitoring and tracking the quality of the care, improving the enrollee's health and reducing costs.

With systemic changes on the horizon, there is an increased need for providers, hospitals and health plans to communicate with one another regarding shared patients. This is particularly essential for programs such as chronic care management and transitions of care management. Lack of communication, consultation and coordination when an individual is being served by multiple health providers often leads to duplication of services, medication errors and poor patient satisfaction.

Integration of patient-centered care management is dependent upon documentation standards and data-sharing requirements. The ability to schedule enrollee appointments through use of technology for discharge from acute services and linkage to care is essential to managed care operations. The solution should have the ability to receive and assign referrals. Referrals may come from both internal and external sources. In addition to receiving referrals, the solution should have the capability of making referrals to internal and external stakeholders.

The main purpose of this RFP is to acquire and implement a Care Management Solution for both Partners and Cardinal Innovations that will support individual and population-based approaches to health management, beginning with care management activities. The intent is to utilize clinically relevant, predictive risk modeling tools and gaps in care analysis of various enrollee populations for early screening, case identification and risk stratification. The Care Management Solution must have the ability to develop, monitor, share and reassess an evidence-based care

plan that ensures clinically appropriate information and services are provided and communicated to improve the health outcomes of Medicaid and uninsured enrollees.

The Care Management Solution will support access to care, coordination of care and management of the care to ensure efficient and effective delivery of health care for enrollees, their providers and community partners. This will be accomplished by removing communication barriers, bridging gaps and exchanging relevant and timely enrollee information. The system will allow for real-time care management analytics and will include the ability to collect multiple sources of data (including hospital census, claims data, pharmacy data, clinical/bio-medical data from providers and social determinants of health data from other systems, such as public health and social services) to identify opportunities that an enrollee or provider can take to improve clinical and financial outcomes. And finally, the solution should provide robust and user-friendly reporting capabilities and Web-based tools necessary to effectively conduct Care Management Programs' strategic planning, quality management and performance management including clinical, utilization and financial changes among intervened populations.

III. ORGANIZATIONAL INTEREST

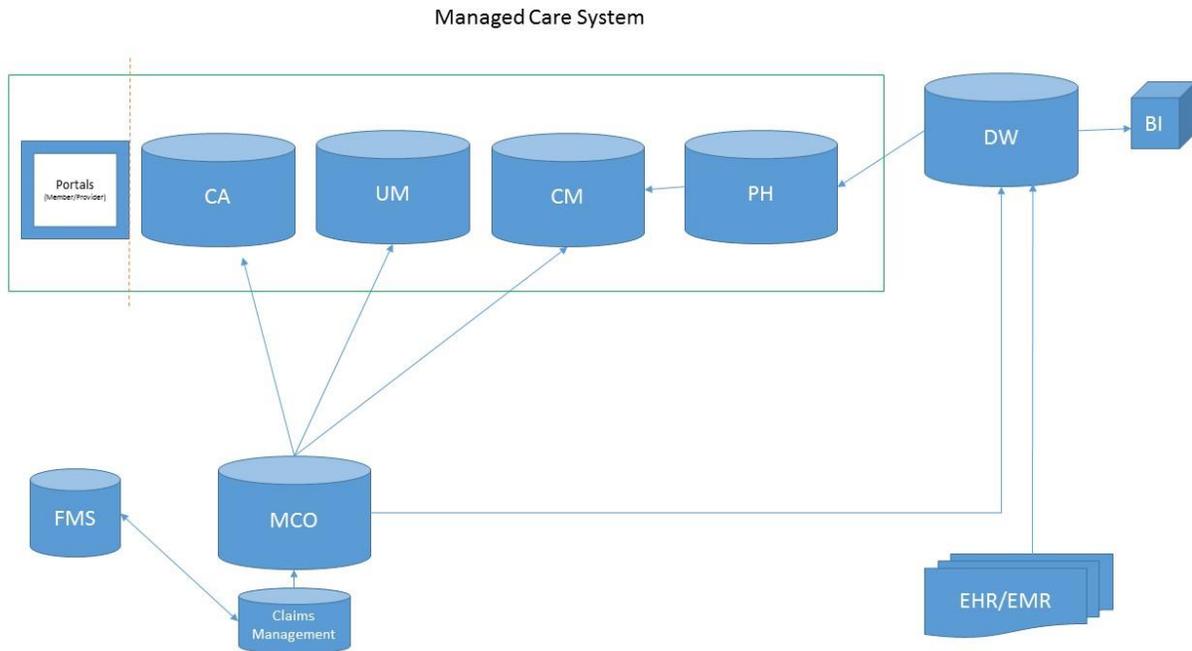
Goal: Secure and implement a platform which provides the following capabilities and meets intended goals

Objectives:

- Allow care coordinators to care for high-risk patients and special healthcare populations across the healthcare system
- Care Plan Development, manage care teams, document contact with patient / providers/ care providers, health risk assessments, task management

Capabilities:

- Care Management
- Population Health
- Portals
- Utilization Management
- Core Administration (Enrollee profiles, call center, eligibility, enrollment, benefit plans, provider profiles)



Legend; CA=Core Administration, UM= Utilization Management, CM=Care Management, PH=Population Health, DW=Data Warehouse, BI=Business Intelligence, FMS=Financial Management System

There must be a meaningful data exchange between the managed care system and the Care Management Solution. Ideally, these modules should all be contained within the Care Management Solution, exchange data seamlessly and provide the ability to integrate with a myriad of external data sources. It is required that the Care Management Solution has these capabilities regardless of when they are integrated.

The Entities expect to have the Care Management Solution in place on April 1, 2019, with noted capabilities installed. The platform will be highly integrated with our existing claims systems within six months of initial implementation. Each module must be tested and staff trained on the new system prior to April 1, 2019.

IV. MINIMUM SYSTEM REQUIREMENTS

Each entity is initiating this Request for Proposal (RFP) to solicit responses from appropriately qualified vendors. The minimum qualifications for the selected vendor are listed below. For relevant project experience, please provide in the technical proposal the entity served, scope of your services, contract start date, contract end date, number of users and number of vendor staff needed to complete project. Bold formatting indicates required experience. Partners and Cardinal Innovations reserve the right to remove from consideration any respondent that does not meet the Minimum Vendor Experience. The vendor shall have:

1. **Demonstrated experience with Care Management solutions successfully installed.**
2. **Provided implementation and support services for all integrated systems for a minimum of three years. Understanding of Managed Care system is required.**
3. **A minimum of three years demonstrated prior experience in the public sector; specifically, with city, county or state health and human services agencies.**
4. **Demonstrated good communications skills, sound judgment, integrity, reliability and a professional reputation of providing high-quality services. This will be evidenced by satisfactory references from three clients, with a minimum of one city, county or state government agency.**
5. **Demonstrated knowledge and experience with Medicaid.**
6. **Demonstrated knowledge of state and federal Care Management Initiatives.**
7. **Demonstrated knowledge of behavioral health care industry-standard protocols for data transfer and demonstrated success in using standard protocols.**
8. **Demonstrated knowledge and experience integrating with EHR/EMR, Health Information Exchange (HIX).**
9. **If the vendor subcontracts any of the system requirements, the subcontractors or third parties must meet the same systems(s) requirements as the vendor. The vendor will be held responsible for errors or noncompliance resulting from the action of a subcontractor or third party. The Entities prefer that the vendor negotiate pricing and manage all subcontractor and third parties' relationships without liability to the Entities.**

V. INNOVATION

Each entity has set forth our planned concept for a Care Management Solution in this RFP. However, we understand that through ongoing work efforts, vendors are rapidly developing innovative solutions. We both welcome RFP responses that meet North Carolina state objectives that rely on innovative concepts outside of our identified framework.

Issuance of an RFI or RFP does not guarantee a financial award nor does it indicate a commitment on the part of the issuer to pursue further contractual relationship.

VI. EXPECTED TIMELINES FOR RFP PROCESS

Expected RFP Schedule	
RFP Posted	June 15, 2018
Letter of Intent & References Due to Partners	June 25, 2018
Vendor Inquiries Due	June 25, 2018
Questions & Answers Posted	July 9, 2018
Vendor RFP Responses Due	July 16, 2018
Demonstrations	July 23-27, 2018

Tentative Award Announcement	August 10, 2018
Contract Start Date	September 10, 2018
Projected Start Date for Initial Implementation	April 1, 2019

No pre-bid conference will be held in conjunction with this RFP.

VII. SUBMISSION PROCESS

Partners will be a single point of contact on behalf of both LME/MCOs.

Access *Request for Proposal* through the link below.

[Click here for RFP #1040-J18](#)

Submit to:

purchasing@partnersbhm.org

or

c/o Purchasing
Partners Behavioral Health Management
901 S. New Hope Road
Gastonia, NC 28054

Questions: Email purchasing@partnersbhm.org

Announcement of Awards: All applicants will receive written notice regarding the outcome of the RFP process within 30 calendar days from the final determination date.

VIII. INQUIRIES

We encourage inquiries regarding this RFP and welcome the opportunity to answer questions from potential applicants. Please direct your questions to purchasing@partnersbhm.org. Please include the words "**RFP: Inquiry**" in the subject line. All inquiries must be submitted in writing no later than **June 25, 2018**.

Questions and answers about the RFP will be posted to the Entities' websites no later than **July 9, 2018**. Any objection to the RFP or to any provision of the RFP that is not raised in writing on or before the last day of the questions period is waived. A copy of all questions or comments and responses will be posted on both Entities' websites: www.partnersbhm.org and www.cardinalinnovations.org

IX. GENERAL CONDITIONS

- The Entities are not obligated to any course of action as the result of this RFP. Issuance of this RFP does not constitute a commitment to award any contract.
- The Entities are not responsible for any costs incurred by any vendor or their partners in the RFP response preparation or presentation.
- Information submitted in response to this RFP will become the property of the Entities.
- All responses will be kept private from other vendors.
- The Entities reserve the right to modify this RFP at any time and reserve the right to reject all responses to this RFP, in whole or in part, at any time.
- The Entities reserve the right to reconsider any proposals at any phase of this procurement process.
- The Entities also reserve the right to meet with select vendors at any time to gather additional information.
- The Entities will not be held responsible for the failure of any email delivery service to deliver a proposal response. It is solely the vendor's responsibility to: (1) ascertain that they have all required and necessary information, documents and addenda, prior to submitting a response (2) ensure that the response is delivered to the correct email address on or prior to the date and time listed. Late responses, regardless of delivery means, will not be accepted. Submittals received by hand delivery, telephone or facsimile will not be accepted. (3) The Entities reserve the right to reject all submittals or any portions thereof. The Entities reserve the right to cancel, issue amendments or modify this RFP to correct any errors or to clarify requirements.
- The Entities will post all communication regarding this RFP on their websites <http://www.partnersbhm.org> and <http://www.cardinalinnovations.org>. Any changes, amendments or clarifications will be made in the form of written responses to vendor questions, amendments or addenda issued by the Entities and posted on their websites. Vendors should check the websites frequently for notice of matters affecting the RFP.

RFP REQUIREMENTS

X. LETTER OF INTENT TO RESPOND

The Entities ask that all vendors email a letter of intent declaring their intention to respond to this RFP no later than **6/25/2018**. The e-mail should be sent to purchasing@partnersbhm.org. Please include the words "**RFP: Intent to Respond**" in the subject line.

XI. REFERENCES

The Entities ask that all vendors email a list of at least three references of similar requested work performed by the vendor within the past three years. References should include customers with requirements like those described in this RFP.

Include:

- Client Company Name & Industry
- Client Contact Name
- Client Phone
- Client Email address
- Implementation Date

References should be emailed to purchasing@partnersbhm.org and received no later than **6/25/2018**. Please include the words "**RFP: References**" in the subject line.

XII. SUBMITTAL INSTRUCTIONS

Responses shall be submitted in PDF format and sent using electronic mail. Send your response to: purchasing@partnersbhm.org by the date and time specified above. Receipt will be acknowledged via email. Please include the words "**RFP: Vendor Response**" in the subject line.

Vendors should organize their proposals as defined below to ensure consistency and to facilitate the evaluation of all responses. All the sections listed below must be included in the proposal, in the order presented, with the description listed. The responses shall be submitted in the following format:

XIII. RESPONSE REQUIREMENTS AND FORMAT

Vendor must include the following:

- **Attachment A – Care Management Solution Requirements List**
- **Attachment B - Responses to Integration**

- **Attachment C – Sample Project Management plan**
- **Attachment D – Sample Implementation plan**
- **Attachment E – Total Cost Projections**

Vendors interested in being considered for providing the specified software and services shall submit a response electronically to purchasing@partnersbhm.org.

Responses shall be labeled in Subject Line and in Introductory Letter as:

RFP# 1040-J18 Care Management Solution

When responding to this RFP, please follow all instructions carefully. Proposals must address all the questions and requirements of the RFP in the order and format specified in each section. It is the vendor's responsibility to ensure its proposal is submitted in a manner that enables the Evaluation Team to easily locate all response descriptions and any exhibits or attachments for each requirement of this RFP.

Responders are strongly encouraged to provide information and responses directly into the Requirements Spreadsheet. If the responder is providing attachments, it is important to specify the associated Section letter directly on the attachment.

1. Care Management Solution Requirements:

The vendor must have a comprehensive, automated and integrated managed care system that can meet the requirements listed below and throughout this Agreement and that can provide all the data and information necessary for the Entities to meet Federal and State Medicaid and State/Federal reporting and information regulations.

The vendor's **Care Management Solution** functionality shall include, but not be limited to requirements on **Attachment A - Care Management Solution Requirements List**.

The vendor's Care Management Solution must support the components of the Long-Term Objective, Managed Care System. This will enable the Entities to fully operate effectively and efficiently. The Long-Term Objective includes: Management of Provider Enrollment and Credentialing

- Claims receipt, processing, adjudication and analysis
- Grievance Tracking and Management
- Claims and/or Encounter Submission to DMA/DMH and reconciliation
- Third Party Coverage and Cost Avoidance Management
- Financial Transactions Management and Reporting
- Payment Management (Checks, EFT, Remittance Advices)
- Reporting (Ad hoc and Pre-Defined/Scheduled and On-Demand)
- Enrollee Services/Call Center Management – integration with phone software – call recognition to pull up enrollee data

Specific functionality related to **Long-Term Objective** includes, but is not limited to the following:

- If applicable, the vendor's Claims Processing system must have the capability to process claims consistent with timeliness and accuracy requirements of a federal MMIS system.
- The vendor's Services Authorization system must be integrated with the Claims Processing component
- The vendor must be bi-directionally linked to other operational systems to enable encounter data to be utilized for customizable reports and analytics
- The Care Management Solution must be compliant with the requirements of National Provider Identifier (NPI), and transaction processing, including being able to process electronic data interchange transactions in the Accredited Standards Committee (ASC) 5010 format.
- The Care Management Solution must have the ability to send and receive as needed the HIPAA transaction formats including:
 - 820 – Payment Report
 - 834 – Enrollment Report
 - 835 – Remittance Advice

- 837P – Professional claims
- 837I – Institutional claims
- 270/271 – Eligibility Inquiry and Response
- 276/277- Claim Inquiry and Response
- 278 – Authorization
- 999 - Acknowledgement

Subcontractors or third Parties must meet the same systems(s) requirements as the vendor. The vendor will be held responsible for errors or noncompliance resulting from the action of a subcontractor or third party. The Entities prefer that the vendor negotiate pricing and manage all subcontractor and third parties' relationships without liability to the Entities.

2. Overview of Scope of Requirements

The Entities have a need for the Care Management Solution to provide functionality for current operations, in addition to future operations. The following sections of the overview are to provide narrative context to several of the requirements. This is not an inclusive list of all requirements.

The Vendor must review Attachment A for the full Requirements List.

The Care Management Solution will be part of and integrates with a substantially robust managed care system. The vendors system(s) will be guided by a unified framework that encompasses:

- Coordination of care and disease management for all consumers/members
- Identification and assessment of enrollees of “priority populations” through
 - Care needs screenings
 - Risk scoring and stratification
 - Comprehensive assessment
- Delivery of care management to high-need populations
- Delivery of transitional care management for consumers/members in transition between settings
- Ability to define and add additional priority populations as needed

This section describes the policies that North Carolina has developed to ensure either directly or through delegation with oversight, meet all consumers/members' care management needs.



2.1.1 Care Management

Care management will be focused on populations with significant needs and will have a specific person or designated care management entity responsible for coordinating their services, including follow-up on referrals, coordination across types of providers (e.g., physical and behavioral health, primary care and specialty care) and coordination with community and social support providers.

The Care Management Solution shall provide capability for sharing information with community health workers, social workers or other types of staff, to link consumers/members with the local community resources and social services necessary to meet any identified unmet resource needs related to social determinants of health.

The Care Management Solution must have the ability to inform care managers when an enrollee makes a transition between delivery systems to ensure services are not interrupted during the transition.

In addition, the Care Management Solution must provide disease management programs to address enrollees' ongoing health needs and those that are in alignment with the North Carolina's Quality Strategy, such as diabetes, asthma, obesity, tobacco use, hypertension management and opioid abuse programs

The Care Management Solution must provide the ability to identify enrollees who will most benefit from it. The platform shall allow for each entity to customize and define its own set of priority populations for care management, including:

- Enrollees with Long Term Services and Support needs
- Adults and children with “special health care needs,” a category that includes consumers/members with HIV/AIDS
- Enrollees at risk, as determined by customizable and defined criteria
- Enrollees with high unmet resource needs related to social determinants of health
- Enrollees with high service utilization
- Any other priority groups identified by the health plan

The Care Management Solution must have the ability to identify enrollees of these priority populations through a combination of screening, analysis and assessment. Additionally, the solution shall provide data support to facilitate efficient startup of care management activities.

- **Care Needs Screening:** The Care Management Solution must have the ability to customize screening tools. Aligning with federal regulations, care managers are required to make best efforts (at least two contact attempts) to screen all enrollees for their care needs within 90 days of enrollment. While we will use own tools to perform screenings, the DHHS will define standard questions relating to core social determinants of health. Screening is also required during all calls to the Access call center to triage immediate needs utilizing standardized tools.
- **Risk Scoring and Stratification:** The Care Management Solution shall have the ability and methodologies by which we can identify consumers/members at risk, using a combination of claims analysis and clinical, screening and other data. Typically, such methodologies will feed a proprietary risk stratification and scoring system. The vendor will be responsible for using our methodologies to identify enrollees of these priority populations. While the methodologies and tools will predominantly be designed by us, DHHS will monitor them to ensure that priority populations are being adequately identified.
- **Comprehensive Assessment & Care Plan/ISP:** The most intensive stage of the identification and assessment process is the comprehensive assessment. Within 30 days of an enrollee being identified as part of a priority population, we will be required to perform this assessment to identify whether care management is required and, if so, the enrollee's needs. Enrollees with LTSS needs and those requiring higher levels of care management for behavioral health needs (potential - mental health, substance use, and/or intellectual/developmental disabilities) will automatically be determined as requiring ongoing care management.

Following an assessment, tasks are then assigned to care management and receive prompts and reminders of due dates. For example, within 30 days of the comprehensive assessment, the care manager will complete a care plan identifying the services and supports that the enrollee requires, identify and coordinate with the enrollee's care team and initiate care management to ensure that the enrollee accesses needed services.

The Care Management Solution shall allow for the assessment and care plan to be updated when an enrollee's circumstances or needs change significantly, or at the enrollee's request. Should the care team determine based on the re-assessment that the enrollee no longer requires a course of treatment or regular care monitoring, we will develop processes to close out care management, including a clear enrollee notification process.

- **Transitional Care Management:** While care management is individualized, DHHS will require that all care managers conduct medication reconciliation, follow-up on referrals, peer support, training on self-management and any transitional care management required for a high-need enrollee. Alerts & Notifications for transition periods prevent unplanned or unnecessary readmissions, emergency department visits or adverse outcomes.

Certain higher-risk transitions— such as a discharge from an inpatient stay of more than two weeks, discharge from inpatient behavioral health services or discharge from the neonatal intensive care unit—will trigger higher-touch transitional care management. Alerts and notifications to care manager or need for care management assignment when a transition from one setting to another, such as from the hospital back to the community. Coordination during transitions will include facilitation of clinical handoffs, medication reconciliation, confirmation that follow-up visits are scheduled and occur, and contact with the assigned care manager within 48 hours of discharge

- **Multiple types of care management programs/groups:** For example, high-needs care management must include interventions targeted toward addressing an enrollees' unmet resource needs, such as by ensuring enrollees receive in-person assistance to secure health-related services like food or transportation, connecting homeless consumers/members to housing specialists or ensuring access to medical-legal partnerships to address legal issues adversely affecting health. Acquiring a care management system, within a managed care system, is a key component of our ability to move the dial on delivery of high-quality care. Notably, when we are held accountable for outcomes, they, in turn, work to strengthen care management programs and provider to ensure that outcomes can be improved. The importance of this broader continuous quality improvement mechanism places emphasis on ensuring that these systems have appropriate accountability at all levels.

2.1.2 Utilization Management

The Entities will need flexibility to implement and manage utilization management policies, procedures and criteria. These are predicated on having specific lines of accountability for tracking implementation of utilization policies and procedures and for individual medical necessity determinations. Being able to identify provider utilization patterns and the ability to track the status of utilization management reviews will help to improve care and reduce costs.

Several processes must be in place to support the accountability and tracking:

- Processes used to determine which services require prior authorization and how often these requirements will be re-evaluated; processes for enrollees requiring services from non- participating providers

- Prior authorization processes for enrollees who require expedited prior authorization review and determination due to conditions that threaten the enrollee's life or health
- Processes to ensure consistent application of criteria by individual clinical reviewers inclusive of clinical practice guidelines
- Process for emergency department or other identified services utilization review and identification of enrollees with high utilization
- Processes of assuring the appropriateness of inpatient care
- Processes for assigning incoming service reviews to appropriate clinical staff, with second level reviews as needed for denial or appeal decisions

2.1.3 Core Administration

Core Administration is the foundation which provides flexibility as a payor to meet our business requirements.

- Benefit Plan administration
- Claims/Encounter Data
- Diagnosis codes
- Enrollment activities
- Enrollee data
- Enrollee eligibility
- Procedures codes
- Provider data
- Service Matrix
- Treatment History data

2.1.4 Portals

The vendor will include web access for use by and support to enrolled providers and enrollee. The vendor will create secure web access for Medicaid providers and enrollees to access case-specific information. The vendor shall manage provider and enrollee access to the system; providing for the applicable secure access management, password, and PIN communication and operational services necessary to assist providers and enrollees with gaining access and utilizing the web portal. The services shall be provided at no cost to the provider or enrollee. All costs associated with the development, security and maintenance of these websites shall be the responsibility of the vendor and should be incorporated into the bid price.

Support Performance Standards will include:

- Email inquiries – one business day response
- New information posted within one business day of receipt
- Monthly maintenance

- Standard reports regarding portal usage such as hits per month by providers/enrollees, number, and types of inquiries and requests, and email response statistics as well as maintenance reports
- Website User interfaces will be ADA compliant

2.1.5 Population Health

Population health provides a comprehensive framework for assessing and improving the health and well-being of a defined population by improving the quality of care and outcomes, and managing costs for a defined group of people. The defined group of people and the health management interventions can be identified by demographic differences, health needs such as chronic physical and mental health diseases and social determinants of health.

The Entities Population Health Solution will support the following functions:

- Data Aggregation- Population Health Data Aggregation is the process in which information is gathered from multiple entities in the enrollee's continuum of care for purposes of statistical analysis and improving the health of the population
- Care Coordination which can be defined is a set of activities designed to assist patients and their support systems in managing their medical and psychosocial conditions more effectively.
- A clinical Registry provides information to health care professionals to improve the quality and safety of patient care.
- Analytics is the leverage of data enabling context specific insight that is actionable.
- Risk Stratification is the act of identifying and predicting patients that possess or are at risk of developing high risk health problems.
- Data Reporting – collecting and submitting data
 - This includes the reporting and dash boarding capacity of the software
 - Visualization layer part of the software

The Vendors solution will have the following features:

- Care Coordinators/managers will be primary End users. All others secondary
- Communications facilitated with secondary end users.
- Flexible levels of user access based on functional roles
- Registry robustness
- Robust care plan integration with EHR/EMR and other data sources
- Strong end-user usability

2.1.6 Predictive Health Analytics

The vendor shall provide a system or integrate with an existing third-party solution to collaboratively and inventively test advanced analytical practices, different data sources, integration techniques and processing methods.

Partners' and Cardinal Innovations' aim is to increase their organizations' ability to improve enrollee health outcomes and operational efficiencies using data-driven support tools. It will give each organization the ability to integrate and analyze massive amounts of information, transitioning the business from simply understanding "what happened" to uncovering "why it happened," with a focus on predicting and recommending actions that positively affect future performance outcomes.

The vendor shall provide technologies and support that will allow the organization to securely execute and manage the entire data science process.

2.1.7 Reports and Data Access

The vendor shall provide each entity with system reporting capabilities that shall include access to pre-designed and agreed upon scheduled reports, as well as the ability to execute queries to support data and information needs.

The inclusion of an ad-hoc reporting tool allowing the organization to create, save and execute reports from the combined database without vendor involvement is required. In addition to an ad-hoc reporting tool, structured access via API or other interface to the detailed data is necessary for the entity to integrate into our Enterprise Data Warehouse.

2.1.8 Integration

Data transmissions from/to the organization/entity will include, but not be limited to the following

- Beneficiary claim and encounter data including paid, denied, adjustment transactions
- Financial Transaction data
- Enrollee Benefit Plan Enrollment Data
- Premium payment data
- Provider Extract (Bi-weekly on occurrence or Daily Update of inpatient admissions/discharges, emergency department visits, authorization submissions, and appointment status and Bi-Weekly of healthcare information, such as assessments and outcome measures related to care coordination functions)
- Transmissions related to authorization requests inclusive of supporting documentation, and decision notification in real time
- Enrollee Eligibility
- Enrollee Refresh Data Extract
- Third Party Coverage Data

2.1.9 Implementation

The vendor shall follow the industry standard SDLC processes, including the creation of the following deliverables, for each system integration and/or enhancement. For system modifications, each entity will provide guidance on what work products they expect from the vendor as less complex modifications may require fewer work products.

Requirements

The vendor will provide detailed functional and technical requirements, which must then be approved by Partners and Cardinal Innovations before implementation begins. Requirements shall meet the following standards. Partners and Cardinal Innovations will monitor compliance with these standards and act to address consistently poor performance.

- On-time submission of specifications in relation to timeline agreed to by the Entities and the vendor
- Consistency in formatting and content
- Reasonable accuracy in relation to user-defined requests

Change Management / Configuration Documents

The vendor will be responsible for the maintenance of Care Management system configuration documents. Documents will be updated by the vendor when configurations are approved and migrated to the production environment. The vendor will be responsible for document version control. Copies of original configuration documents will be provided during the transfer of support to go-live. Configuration documents shall meet the following standards. Partners and Cardinal Innovations will monitor compliance with these standards and act to address consistently poor performance.

- On-time submission of updates to documents in relation to when modifications are migrated to production
- Consistency in formatting and version control
- Accuracy of information

Testing

Vendor shall conduct unit, system, interface, performance, regression, and user testing per vendor policy and procedures approved by Partners and Cardinal Innovations testing responsibilities include, but are not limited to:

- Comply with entity testing standards
- Provide integration testing that is designed to ensure that all components, data feeds, identity management solutions, etc., work together properly and meet the business and functional requirements of the system
- Provide component integration testing that shall include the development and use of automated system test scripts to validate that the system operates in accordance with the design specification, for example:

- User roles are performing properly
 - Authentication performs properly
 - Workflows perform properly.
 - Data flows perform properly
- For User Acceptance Testing (UAT), the vendor shall schedule and facilitate Partners Behavioral Health Management and Cardinal Innovations-selected users to complete UAT, track their results, and present to each entity for review prior to requesting authorization for production releases.
 - Conduct testing and ensure that the modification or enhancements are completed with 100% positive results, and receive approval from the organization's designee(s) before activating any modifications or enhancements. If there are minor issues (i.e., resulting in less than 100% positive results), the organization may choose to approve modification or enhancement release. In those situations, the vendor will be responsible for resolving issues on an approved timeline post release.

2.1.10 Project Methodology

The vendor will use a demonstrated and proven methodology for project management. The vendor will have project team staff both experienced and trained in their methodology and in their product(s).

Project Leader Ensures contract compliance and contract quality assurance. Oversees overall project planning and execution. At least three years of experience on public sector projects. At least one year of experience with a health and human services agency. At least two years of executive experience with enterprise system oversight. Documented experience with Medicaid Behavioral Health Based Services programs is preferred. At least two years of experience with system implementation, maintenance, and operations. Knowledge of case management systems is preferred. Strong written and communication skills.

Project Manager - Responsible for coordinating the overall project tasks, including project planning, scheduling and staffing. Serves as the primary day-to-day contact for contract services and issues resolution. Ensures service level agreements; At least one year of experience with a health and human services agency. At least two years of experience with system implementation, maintenance, and operations. Knowledge of case management systems is preferred. At least four years of project management experience. Experience with the principles of the Project Management Body of Knowledge are sustained and deliverables are submitted on timely basis. (PMBOK®). Current certification as a Project Management Professional (PMP) by the Project Management Institute (PMI) preferred. Strong written and communication skills.

Support Manager - Manages the Support services team and ensures the service level agreements are sustained. Ensures the deliverables required as a part of this contract are completed on a timely basis and to the satisfaction of the Entities. At least two years of experience managing the maintenance, operation, and enhancements of systems of a similar size and complexity to the Care Management system. Knowledge of care management systems is preferred. Project management experience. Strong written and communication skills.

Systems Integration Manager - Manages the Systems Integration Services team and ensures the service level agreements are sustained. Ensures the services and deliverables required as a part of this contract are completed in a timely basis and to the satisfaction of the Entities. At least two years of experience managing the integrations of systems of a similar size and complexity to the Care Management system. Strong technical background and at least two years of experience with System Development Life Cycle Processes for system design, development and implementations of a similar size and complexity to the Care Management system. Knowledge of care management systems is preferred. Project management experience. Strong written and communication skills.

Deployment Manager - Manages the planning, design build, configuration and testing of all software to create the release package for the delivery of enhancements or changes to the Care Management system. Ensures the service level agreements are sustained. Ensures the services and deliverables required as a part of the System deployment duties of this contract are completed in a timely basis and to the satisfaction of the State. Strong technical background and at least two years of experience with System Development Life Cycle Processes for system design, development, and implementations of a similar size and complexity to the Care Management system. Strong knowledge of all aspects of the end-to-end release process. Knowledge of case management systems is preferred. Project management experience. Strong written and communication skills.

They shall provide the following reports in the format and timeframe as agreed upon with the Entities:

- Weekly Status Report - The vendor will provide the Entities' Project Team(s) with a weekly status report due by 5 pm each Tuesday on the general health of the project including:
 - Activities completed in the past week
 - Activities planned in the next four weeks
- Milestone dates for on-going development activities
- Planned system release and bug fixes
- Project risks and mitigation strategies
- If the Tuesday is on a state holiday, the report will be due the next business day
- Monthly Service Level Agreement Report

- Quarterly Performance Report – Report detailing deviations to SLAs for the past quarter and reasons for the deviations
- Annual Summary Reports – Annual reports for the previous year’s performance will be due by the end of the first month in the new year. If that day is on a weekend or holiday, the report will be due the next business day.
- Incident Reporting and Tracking
- Staff Utilization Report – In addition to all invoices, the vendor shall provide a project team utilization report that outlines the employee name, classification, and hours invoiced for all maintenance and operations and enhancement projects
- Other Reports and Documentation – Other reports and documentation will be due as determined by the Entities

2.1.11 Training, User Manual, and Process Documents

At contract commencement, the Entities will already have train-the-trainer training materials developed by the vendor. Additionally, staff training content for that release will have been developed by an experienced trainer.

As new releases are rolled out, the vendor will be responsible for developing training content for train-the-trainer materials and conducting those trainings. The Entities will engage a contracted training vendor to create training courses for the overall staff and provide those staff trainings. After that initial roll-out and training for the new release, the vendor shall be responsible for updating the training content to reflect any minor modifications and enhancements.

- The vendor shall be responsible for updating the training content to reflect any modifications and enhancement.
- The vendor shall, as required but no more than twice a year, provide refresher training for new and select incumbent staff, including updates for deployed components based on minor modifications and enhancements to the system
- The vendor shall create leave-behind video training for organization users
- The vendor shall conduct a quarterly analysis of support tickets, and create additional training to address any areas of frequent inquiries/issues

The vendor will be responsible for the maintenance of Care Management / Managed Care System user manuals, training materials and process documents. Manuals will be updated to reflect changes or additions to functionality as they are approved and migrated to production. The vendor will be responsible for updating the SCORM compliant training content. The vendor will be responsible for version control of all subject documents. User manuals shall meet the following standards. The Entities will monitor compliance with these standards and act to address consistently poor performance.

- On time completion of updates to documents in relation to when modifications are migrated to production.
- Consistency in formatting and version control.
- Accuracy of information.

2.1.12 Performance and Support

Vendor system(s) capability will include, but not be limited to the following:

- 24x7x365, except for scheduled maintenance
- Provider Network Connectivity
- Documented scheduled down time and maintenance windows as agreed upon with the Entities
- The Entities on-line access to all components comprising and supporting the system
- The Entities access to User Acceptance Test environment
- Documented instructions and user manuals for each component
- Secure Access

Systems operations and support will include, but not be limited to the following:

- 24x7x365 operating support, except for scheduled maintenance
- On-Call procedures and contacts
- Job Scheduling and failure notification documentation secure data transmission methodology
- Interface acknowledgements and error reporting
- Technical Issue Escalation Procedures
- Business and Customer Notification
- Change Control Management
- Assistance with User Acceptance testing and implementation coordination
- Documented data interface specifications – data imported and extracts exported including database mapping specifications.
- Disaster Recovery and Business Continuity Plan

2.1.13 Service Level Agreements

Service Levels Overview

Failure by the vendor to meet Service Level Agreements (SLAs) may cause the Entities to incur economic damages and losses, including but not limited to:

- State penalties
- Lost Federal/State match funding if certain implementation deadlines are missed
- Staff productivity losses due to downtime/poor response times
- Costs incurred due to any overtime necessitated
- Applicant time lost if interface is partially or completely down
- Impact on other State systems due to downtime or other processing issues
- Negative project impact and/or risk of negative audit findings due to lack of proper documentation or improper procedures
- Impact to timeline/budget due to unavailability of key staff resources and/or adequate resources on site

As such, compensation to the vendor will be tied to these SLAs. The vendor will provide periodic (monthly and quarterly) updates on its performance in relation to these SLAs. The Entities will hold the vendor accountable to these SLAs and failure to meet SLAs on a consistent basis could have a significant impact resulting in termination of contract. The Entities reserve the right to implement additional SLAs.

3.1.1 Ownership and Access to Systems and Data

Systems enhancements and data accumulated remain the property of the Entities. Source code developed shall remain the property of the Entities. All data accumulated shall remain the property of the Entities and upon termination of the contract the data will be electronically transmitted to the Entities in a format and schedule prescribed by the Entities. The vendor shall not destroy or purge the Entities' data unless directed to or agreed to in writing by the Entities. The vendor shall archive data only on a schedule agreed upon by the Entities and the data archive process shall not modify the data composition of the source records. All the Entities archived data shall be retrievable for review and or reporting by the Entities sent in the timeframe set forth by the State.

3.1.2 Security

The system supports the delivery of critical medical services to enrollees and reimbursement to providers, and as such contingency plans must be developed and tested to ensure continuous operation of the system.

The vendor is responsible for hosting the system at the vendor's data center, and providing for adequate redundancy, disaster recovery and business continuity such that in the event of any catastrophic incident, system availability is restored the Entities within 24 hours of incident onset.

The vendor shall ensure that the hardware and software supporting the system, and the Entities' data, data processing and data repositories are securely segregated from any other account or project, and are under configuration management and change management governed through and in support of the Entities' project.

Vendor will manage all processes related to properly archiving and processing files including maintaining logs and appropriate history files. Archiving processes should not modify the data composition of the Entities' records, and archived data must be retrievable at the request of the Entities. Archiving shall be conducted at intervals agreed upon between the vendor and the Entities.

- The system must be able to accept, process and generate HIPAA compliant electronic transactions as requested, transmitted between Providers, provider billing agents/clearinghouse, or the Entities and the vendor.
- At the beginning of each the Entities Fiscal Year, the vendor must submit the following documents and corresponding checklists for the Entities review and approval:
 - Disaster Recovery Plan;
 - Business Continuity Plan;
 - Security Plan

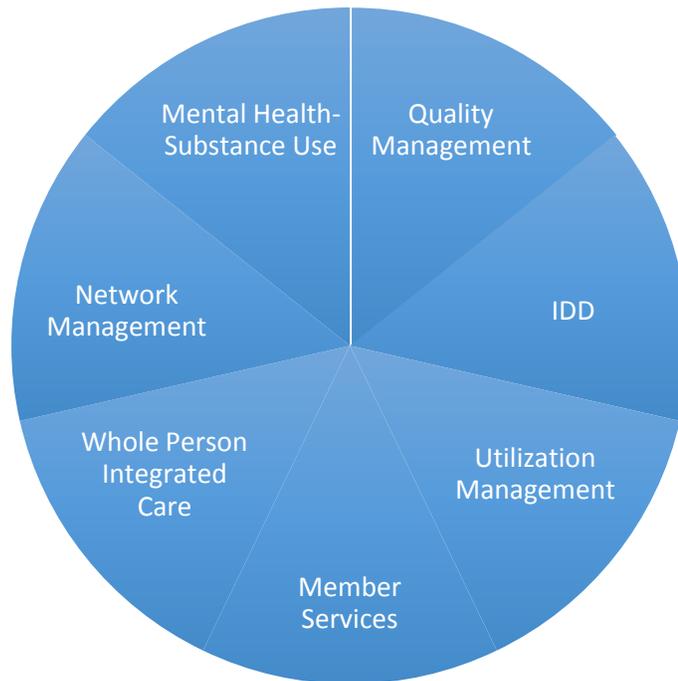
The vendor must provide the following documents. If after the original documents are submitted, the vendor modifies any of them, the revised documents and corresponding checklists must be submitted to the Entities for review and approval:

- Joint Interface Plan
- Risk Management Plan
- Systems Quality Assurance Plan
- Confirmation of 5010 compliance and Companion Guides
- Approach to implementation of ICD-10

ORGANIZATIONAL OVERVIEW and STATE LANDSCAPE
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**XIV. PARTNERS BEHAVIORAL HEALTH MANAGEMENT
ORGANIZATIONAL OVERVIEW**

Improving Lives and Strengthening Communities



Partners is recognized as a strong Managed Care Organization in North Carolina with responsibility for Medicaid and Uninsured populations within an eight-county region. Our passion for development and administration of health care and social service programs is designed to enhance and improve quality of life for residents within this region. Our organization is divided into several divisions, each responsible for supporting specific assigned functions and some of which serve distinct populations.

Mental Health/Substance Use Care Coordination

MHSU Care Coordination activities include the identification, coordination and monitoring of, linkage to behavioral health treatment services, rehabilitative and/or facilitative services and supports depending on the enrollee's individual needs and funding source. These promote...

- Recovery in the least restrictive environment and community integration.
- Collaborate with individuals, providers, and natural supports for crisis planning.
- Impact hospital admissions through reducing/mitigating barriers to discharge and connecting to community providers.
- Foster whole person care.

Intellectual/Developmental Disabilities

Coordination of care for highly vulnerable enrollees with intellectual and developmental disabilities, many with co-occurring medical and mental health conditions, who are enrolled in

the NC Innovations Waiver. Care Coordinators complete risk/support needs assessment using standardized template, develop plans of care and monitor implementation of those plans to ensure enrollee health/safety, enrollee satisfaction and quality care. Contact with enrollees is frequent, with a combination of telephonic and face to face contacts. The NC Innovations Waiver is very prescriptive and includes specific monitoring/contact requirements and timelines.

Slots within the NC Innovations Waiver must be managed (each slot has a designated # and slot type to which enrollees are assigned per waiver year) and a waiting list is maintained for services not available at the time of request.

Enrollee Services

Enrollee Services consists of three basic components:

- Access to Care – 24/7 call center available to assist in scheduling crisis appointments, sending out mobile crisis workers within the community, scheduling urgent, walk-in appointments and routine appointments for those who have mental health issues, substance use disorder or intellectual and/or developmental disabilities(I/DD). Referrals for state hospitals is also managed by the Access to Care staff.
- Eligibility and Enrollment – Enters all enrollees who are eligible for receiving state funds to pay for their services. Staff members maintain updated enrollee information and manage the scheduling and management of forensic and multi-disciplinary evaluations.
- Consumer Relations – supports the enrollee and Family Advisory Committee and seeks enrollee feedback on pertinent behavioral health and I/DD issues. Also, housing and employment opportunities are often available for enrollees actively involved in services. Specifically, HUD permanent housing grants are available for qualified homeless individuals and their families as well as assistance with shelters and crisis agencies.

Network Management

Partners has a Provider Network with a comprehensive array of Providers who are:

- Accessible to the local citizens who need their assistance
- Focused in providing high quality, results-oriented care to those in need
- Dedicated to achieving measurable and desired outcomes for enrollees
- Partners expects its Provider Network participants to be categorically accountable to
 - Comply with all regulatory rules and standard
 - Fully comply with terms and conditions of the contract with Partners and all related information contained in this manual
 - Serve enrollees in a way that is enrollee-led and results in the achievement of the treatment goals desired by those being served.

The Provider Network Department at Partners is responsible for assessing the network needs, identifying providers who may fill those needs, credentialing the providers as they come into the

network initially, at re-credentialing and monitoring regularly and servings as technical support to the providers to assure they are able to navigate the system.

Quality Management

Quality Management is made up of four teams:

- Assurance: Internal Audits, External Review Coordination, Accreditation & Report submission compliance
- Improvement: Quality Improvement Activities, Track internal initiatives, Monitoring of NC TOPPS, Division of Health Service Regulation (DHSR) reports & Back up Staffing incidents
- Reports: Track all external reporting, Submission and analysis of state reports, Report Validation & Management of ad hoc data request and reporting, lead for Super Measure reporting
- Monitoring: Provider monitoring- Routine & Targeted, Incident monitoring & tracking, Health & Safety provider monitoring

Utilization Management

The Utilization Management (UM) Department serves multiple purposes within the Managed Care Organization (MCO). The UM process ensures that consumers/members have equitable access to appropriate care across the eight counties in the Partners catchment area. UM provides technical assistance for the Network to support quality services through compliance with clinical guidelines identified in this plan.

UM's process results in consumers/members receiving services that:

- Support recovery
- Reflect enrollee preferences
- Are efficient and cost effective
- Occur in the most appropriate and least restrictive setting
- Are consistent with medical necessity criteria; and
- Promote evidence-based practices

Whole Person Care/Social Determinants of Health/Population Health

Integrated Care Centers (ICC) - Partners has worked collaboratively with its behavioral health providers and partnered with local physical health providers to establish Integrated Care Centers. The ICC is a community based facility that provides enrollees a place to access whole person care. The foundation of Whole Person Integrated Care is an adapted Collaborative Care Model and Collective Impact.

Social Determinants of Health (SDOH) – Partners is committed to working in tandem with our local communities and statewide organizations to address social determinants. Partners has strong connections and relationships with community organizations and local stakeholders. Partners has invested Medicaid Savings to address SDOH and making a positive impact on each of the local communities.

Population Health – Partners is taking a Whole Person Care approach to population health, using data analytics, community initiatives, and grant opportunities. Risk stratification and predictive analytics are tools necessary to improve health of larger groups within its enrollee population. Partners is also developing value based performance contracts to address population health needs.

XV. CARDINAL INNOVATIONS HEALTHCARE ORGANIZATIONAL OVERVIEW

Cardinal Innovations provides access to Medicaid and state-funded benefits, providers and supports for more than 850,000 individuals with complex needs across 20 counties in North Carolina. Long recognized for operational excellence, innovative solutions and superior outcomes for members, as well as accuracy and speed of payments to providers, Cardinal Innovations is a leading managed care organization proud to serve North Carolina’s most vulnerable citizens.

Using a community-based model of care management, Cardinal Innovations seeks to improve the health and wellness of its members through collaboration and community partnerships. Our frontline staff interfaces with members and families, as well as service providers and community stakeholders to ensure the best possible outcomes for individuals who need services.

Cardinal Innovations member- and community-engaged staff includes:

Community Operations, comprised of three units: Community Relations (providing collaboration and partnership with community leaders); Community Engagement (participating in community activities in collaboration with local stakeholders); Member/Consumer Engagement (working directly with members and families as advocates, helping to navigate the system and providing support in the community).

Care Coordination, comprised of four units: *MHSUD Care Coordination* (working directly with members who need services for mental health or substance use disorders by identifying, coordinating and monitoring services, as well as supporting whole-person wellness); *IDD Care Coordination* (working to ensure care in the least restrictive environment for members with intellectual and/or developmental disabilities, including conducting assessments, developing care plans and monitoring implementation of those plans); *Integrated Health* (ensuring that the

individuals health concerns are addressed from a holistic approach to achieve optimum health); *Transitions to Community Living* (assisting individuals who meet the requirements and desire to move from adult care homes to their own homes in the community of their choice).

Other departments providing administration support and functions to enhance the member experience are:

Access, providing 24-hour, toll-free call center service to assist in resolving a crisis, scheduling appointments and providing referrals.

Network Operations, identifying and maintaining a closed network of providers who specialize in evidence-based practices. The Cardinal Innovations network of providers are among the best in the state, and provide a large array of services including walk-in clinics, urgent care and specialized treatment options. Network Specialists are assigned groups of providers to ensure members/consumers and families receive the highest quality of care.

Quality Management, performing audits and reviews, implementing quality improvement activities, and reporting and monitoring to the organization and the state to ensure members/consumers receive the best care.

Utilization Management, ensuring that members/consumers have access to high quality care across the Cardinal Innovations service area beginning with the initial enrollment to completion of services. UM reviews and monitors service requests to ensure the member/consumer receives appropriate services at the right time, in the right setting and in the right amount.

XVI. STATE OF NORTH CAROLINA LANDSCAPE

Anticipated Transformation in North Carolina Medicaid Healthcare System

The North Carolina Department of Health and Human Services (DHHS) is dedicated to designing a comprehensive Medicaid managed care program that optimizes health and well-being for all North Carolinians. Central to these efforts is a commitment to the delivery of high-quality health care through the development of a data-driven, outcomes-based, continuous quality improvement process that focuses on rigorous measurement against relevant targets, and appropriately rewards contracted health plans for advancing quality goals.

As North Carolina transitions to a managed care structure for its Medicaid and NC Health Choice programs, DHHS seeks to advance high-value care, improve population health, engage and support providers, and establish a sustainable program with predictable costs. Their goal is to improve the health of North Carolinians through an innovative, whole-person centered and well-coordinated system of care, which addresses both medical and non-medical drivers of health.

In July 2019, most Medicaid beneficiaries will begin transitioning to Prepaid Health Plans (PHPs)—integrated managed care products providing physical and behavioral health services, long-term services and supports (LTSS), pharmacy and addressing health-related resource needs. Working with the General Assembly, the Department has proposed to create distinct types of PHPs, which will be customized to the populations they serve:

- Standard plans will launch in the first year of managed care and will serve the clear majority of Medicaid beneficiaries.
- Behavioral health and intellectual and developmental disability tailored plans (BH I/DD TPs) will launch in the third year of managed care and focus on the specialized needs of individuals with behavioral health disorders such as severe persistent mental illness, severe emotional disturbance or substance use disorder, intellectual and developmental disabilities, and traumatic brain injury (TBI).

North Carolina begins the Medicaid managed care transition with a history of commitment to measuring quality and improving health outcomes. As North Carolina transitions to managed care, the Department will work with PHPs and providers to develop a data-driven, outcomes-based, continuous quality improvement process that will build on this history and focus on rigorous outcome measurement against relevant targets and benchmarks, promote equity through reduction or elimination of health disparities, and appropriately reward PHPs and, in turn, providers for advancing quality goals and health outcomes.

Attachment A – System & Vendor Requirements List

Attachment B – Responses to Integration

Examples of functionality needed to meet specific North Carolina State requirements. Describe how your system would be able to integrate these data sources, locations of data within modules or systems, and what tools, inherent or 3rd party, would be required.

1. Global Eligibility File (GEF)

The Global Eligibility File (GEF) is an EDI file generated daily by NC DHHS for Medicaid enrollees. The file containing enrollment and disenrollment dates, Coordination of Benefits (COB), Special population, enrollee/responsible party address, and responsible MCO data. The file is in a custom format, and contains information on any Medicaid enrollee whose information has changed in the NCTracks system since the last GEF was generated. The files are designed to be loaded in a sequential order as they contain full history for enrollees with updates since the last file.

Data extracted from the GEF are used for the following:

Medicaid enrollment and disenrollment dates (including retroactive), county of eligibility, program code and details. Utilized to determine proper Benefit Plan, Service Matrix, Dates for Service Authorization eligibility, Claims Adjudication, Performance Measure population definition. Dates and program code are used in conjunction with 834 and 820 files to validate and reconcile PMPM payments.

Enrollee and Responsible Party Address information is used as official mailing address for all correspondence.

Third Party Coverage information used to determine primary liability when reviewing and authorizing SARs, used for coordination of benefits master when adjudicating claims and validating prior coverage has been billed for services.

2. Consumer Data Warehouse (CDW)

CDW is the NC DHHS data repository for demographic and clinical data for the non-Medicaid enrollees served by MH/DD/SU managed care organizations (MCO).

The data collection and reporting for the non-Medicaid enrollee population is maintained and reported to NC DHHS in a very different manner from the Medicaid population. NC DHHS requires the Entities to report all non-Medicaid enrollment and disenrollment for service via custom EDI files. Creation of new enrollee records is performed by the Enrollee Services department when a call is received and an enrollment is performed or by the approval of a provider submitted enrollment. These enrollments can be either a new enrollee or an enrollee

who has been discharged and has re-entered service. Data is extracted from the patient record and sent weekly as well as on demand for new entries, changes to existing data, and discharges from services.

3. NC Tracks Benefit Plans

NC DHHS requires the Entities to assign each non-Medicaid enrollee receiving services into one or more funding source categories based on age, services needed, and/or special groupings as defined by the state. These categories are referred to as NC Tracks Benefit Plans which are utilized by the state to determine payment to the MCO. Benefit Plans are requested by the Service Providers using the Provider Portal and approved by the Entity following review of the request.

Data is extracted from the enrollee record and sent daily for any enrollment and disenrollment activity which has occurred since the prior EDI submission. Benefit Plan data is utilized to determine proper Benefit Plan, Service Matrix, Dates for Service Authorization eligibility, Claims Adjudication, Performance Measure population definition.

4. Service/Treatment Authorization Requests (SAR/TAR)

The Utilization Management Department is responsible for managing and tracking the receipt, review, documentation, and decisions on Service/Treatment Authorization Requests (SAR/TAR). The SAR/TAR process contains several very prescriptive activities and timelines which must be followed, documented, and reported.

Most of SAR/TARs are entered by the requesting Provider into the Provider Portal. The SAR/TAR is electronically delivered to the Utilization Review Department upon submission by the Provider.

Decisions (Approve/Deny) on routine SAR/TARs must be made within 14 days. Decisions on expedited SAR/TARs are required with 3 days of receipt of a completed SAR/TAR.

A Denial Decision can only be made by a MD or PHD and must be documented with reason(s) for denial and any internal/external peer review notes, reasons, and Clinical Coverage Policy

If any portion of a SAR/TAR is denied, a letter is produced within one day of the decision notifying the enrollee and provider of the decision and explaining their right for appeal. The letter is generated by the system with contents merged from the system into the templates provided by NC DHHS. The timeline for appeal is monitored and tracked with all contacts and decision points recorded. The appeal process can contain up to three appeals levels. Trigger points, dates, decisions, and correspondence must be tracked at each level and decision.

Attachment C – Project Plan

Examples of project plan methodology needed to meet specific requirements.

Attachment D – Implementation Plan

Examples of implementation plan needed to meet specific Entities' requirements.

Attachment E – Cost Proposal

Provide a table with summarized proposal costs. A detailed breakdown itemizing all the costs by category should be provided. It is assumed that any requirement that you answered, “Fully or Partial” to is included in your proposal. Please make sure all costs are accounted for.