STATE OF NORTH CAROLINA **Department of Health and Human Services** **Office of Procurement and Contract Services**	**REQUEST FOR INFORMATION NO**. 30-190062-DHB – Medicaid Integrated Modular Solution
	Due Date/Time: **September 27, 2018 at 2:00 PM ET**
Refer ALL Inquiries to: Kimberley Kilpatrick Contract and Compliance Specialist Medicaid.Procurement@dhhs.nc.gov 919-527-7015	Issue Date: **August 16, 2018**
	Commodity: 918 – Consulting Services
E-Mail: Medicaid.Procurement@dhhs.nc.gov	Using Agency: NC Department of Health and Human Services, Division of Health Benefits (DHB)

This Medicaid Integrated Modular Solution Request for Information (RFI) is available electronically on the NC Interactive Purchasing System (IPS) at https://www.ips.state.nc.us/ips/.

The purpose of this RFI is to survey the market for information requested herein and not to award a contract. Submission of a response does not create an offer, and no award will result by submitting a response. The State recognizes that considerable effort may be required in preparing a response to this RFI. However, the Respondent shall bear all costs for preparing and submitting a response. Information obtained through this RFI process may be used to develop a future solicitation.

Responses to this RFI will be received until **2:00 PM ET, September 27, 2018**.

EXECUTION

RESPONDENT NAME:		E-MAIL:	
STREET ADDRESS:		P.O. BOX:	ZIP:
CITY & STATE & ZIP:		TELEPHONE NUMBER:	TOLL FREE TEL. NO:
TYPE OR PRINT NAME & TITLE OF PERSON SIGNING:		FAX NUMBER:	
AUTHORIZED SIGNATURE:		DATE:	

TO SUBMIT A RESPONSE: It is the responsibility of the Respondent to email its response to this RFI to Medicaid.Procurement@dhhs.nc.gov. Responses should clearly note the RFI Number 30-190062-DHB in the subject line of the email.

Section I. Respondent Questions, Response Instructions, and Confidentiality

   A. **Respondent Questions Concerning this RFI**

   1. Submit any questions concerning this RFI by email to the Contract and Compliance Specialist listed on the first page of the RFI by August 30, 2018. Please insert "***Questions RFI 3*0-190062-DHB***"* as the subject of the email. The questions should be submitted in the format below.

RFI Question Reference	Respondent's Question
1. *(example: Section IV, Question 5)*	
2.	

2. The Department intends to prepare responses to written questions submitted by the specified deadline and post an Addendum on IPS with the Department's responses.

B. Instructions for Developing Responses

1. Read and carefully review all Sections of this RFI.

2. Respondents are requested to prepare responses in a straightforward and detailed manner. Responses are to be submitted to the Department according to the instructions found on the cover page of the RFI and this section.

3. Respondents should complete the Execution section on Page 1 of the RFI and provide responses to the questions in Section IV using the space provided. While the Department encourages Respondents to respond to all questions and items within this RFI, there is no obligation to do so. The Department reserves the right to contact any respondent and request additional information.

4. **To facilitate the response process, a MS Word version of this RFI may be requested by sending an email to Medicaid.Procurement@dhhs.nc.gov.**

C. Instructions for Submitting Responses to Section IV: Questions for Respondents

1. Respondent should email its response to this RFI to Medicaid.Procurement@dhhs.nc.gov

2. When submitting a response, include all pages of the RFI, with the EXECUTION SECTION on Page 1 completed and signed and responses added to questions in Section IV.

   The following copies are required to be provided to the Department as part of response to this RFI:

   i. One (1) electronic copy of the signed, original executed response marked *RFI 30-190062-DHB*.

   ii. One (1) electronic copy of the signed, original executed response redacted in accordance with Chapter 132 of the North Carolina General Statutes (NCGS), the Public Records Act, marked *RFI 30-190062-DHB - Redacted*. For the purposes of this RFI, redaction means to edit a document by obscuring or removing information that is considered confidential and proprietary by the Respondent and meets the definition of Confidential Information set forth in G.S. § 132-1.2. Any information removed by the Respondent should be replaced with the word, "Redacted." If the response does not contain Confidential Information, Respondent should submit a signed statement to that effect marked *RFI 30-190062-DHB - Redacted*.

   The electronic copies of the response must not be password protected.

D. Confidentiality

1. As provided for in the North Carolina Administrative code (NCAC), including but not limited to 01 NCAC 05B .0210, 09 NCAC 06B .0103 and 09 NCAC 06B .0302, all information and documentation relative to the development of a contractual document for a proposed procurement or contract shall be deemed confidential in nature, except as deemed necessary to develop a complete contractual document. In accordance with these and other applicable rules and statutes, such material shall remain confidential until the award of a contract or until the need for the procurement no longer exists. Any proprietary or confidential information, which conforms to exclusions from public records as provided by NCGS Chapter 132, **must be clearly marked as such and reflected in the redacted copy submitted on *RFI 30-190062-DHB - Redacted*.** By submitting a redacted copy, the Respondent warrants that it has formed a good faith opinion, having received such necessary or proper review by counsel and other knowledgeable advisors that the portions marked confidential meet the requirements of NCGS Chapter 132. The Respondent must

identify the legal grounds for asserting that the information is confidential, including the citation to state law.

2. Except as provided in Section I.D.1 of this RFI, pursuant to NCGS §132-1, et seq., information or documents provided to the Department in response to this RFI are Public Record and subject to inspection, copy and release to the public unless exempt from disclosure by statute, including, but not limited to, NCGS §132-1.2. Redacted copies provided by Respondents to the Department may be released in response to public record requests without notification to the Respondent.

Section II. Rights and Obligations

A. Rights to Submitted Materials

All responses, inquiries or correspondence relating to or in reference to this RFI, and all documentation submitted by the various Respondents shall become the property of the Department when received. Ideas, approaches, and options presented by Respondents may be used in whole or in part by the State in developing a future solicitation should the Department decide to proceed with a solicitation. Further, combinations of ideas from various Respondents may also become part of a solicitation, based on consideration of various RFI submissions and the needs of the Department, which may differ from any respondent's experience in other places.

B. Obligations of the State

The Department may choose to issue a solicitation for the procurement of a Medicaid Integrated Modular Solution (MIMS). However, this RFI is not a guarantee that a solicitation will be issued for any or all of the modules referenced herein, about which ideas and approaches are being sought. Unless included in the redacted version, information sent in by Respondents for this RFI will remain confidential until after the award of any solicitation or until the State makes a decision not to issue a solicitation.

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Section III. Background

A. Purpose of RFI

In September 2015, the General Assembly enacted Session Law 2015-245,[1] directing the transition of Medicaid from a predominantly fee-for-service structure to a predominantly managed care structure. As the North Carolina Department of Health and Human Services (Department) prepares to transition to Medicaid managed care, it will work with stakeholders and experts to refine program design and implementation approach.

The Department seeks to implement Medicaid managed care in a way that advances high-value care, improves population health, engages and supports beneficiaries and providers, and establishes a sustainable program with predictable costs.

The Department intends to replace its legacy multi-payer Medicaid Management Information System (MMIS) with a suite of solutions that follows the Centers for Medicare and Medicaid Services (CMS) guidance on modular procurement to support enhanced functionality, flexibility, and lower total costs. The purpose of the Medicaid Integrated Modular Solution (MIMS) Request for Information (RFI) is for the Department to solicit feedback from potential vendor partners that may be able to provide a solution to all or some of the identified MIMS modules.

B. Current MMIS Environment

The State's current MMIS, NCTracks, was implemented in July 2013 and includes subsystems to manage Finance, Provider (includes a portal), Recipient (includes a portal), Reference Data, Prior Authorization, Claims – Medical, Managed Care and Pharmacy, e-Commerce, Drug Rebates/Retrospective Drug Utilization Review, Program Integrity, and Third-Party Liability which support business rules for multiple divisions within the Department. NCTracks also includes operations portals and a collaboration portal. In State Fiscal Year 2017, NCTracks processed approximately 232,254,000 claims in support of approximately 2,111,000 recipients. The overall Medicaid expenditures were approximately $14,300,000,000[2]. The NCTracks program also includes the following:
- Technical operations and maintenance support services
- Development services to support the implementation of new functionality
- Business services that support functions including provider management, non-DMA recipient eligibility management, financial services (e.g., payments, recoups), claims inquiries, prior approval, Program Integrity and, Third Party Liability support
- Capability to determine all payers that cover a claim, route to the best payer based on a Department defined hierarchy, and the route to subsequent payers if applicable
- Clinical services that support utilization management, including prior authorizations, claims reviews, and pharmacy support
- Call centers

C. MIMS Overview

Based on the desire to have a more modular, interoperable solution, the Department has developed a comprehensive approach for replacing the Department's current MMIS over the next several years.
The Department has identified the following goals for MIMS:

- A customer service-centric environment that gives State users, the State's agents, members, providers, and citizens easy access to healthcare services and information using multiple devices and channels.
- Support of an Agile methodology for implementation and operation.

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[1] Session Law 2015-245 has been amended by Session Law 2016-121, Section 11H.17. (a) of Session Law 2017-57, and Part 4 of Session Law 2017-186.
[2] North Carolina Medicaid and NC Health Choice Annual Report for State Fiscal Year 2017

- A Commercial off the Shelf (COTS) or Software as a Service (SaaS) solution that includes a product with robust functionality and configurability; the solution inherently would have periodic baseline software releases that reflect investments in the Medicaid and healthcare industry's ongoing functional needs and improvements.
- Solution that offers software versions that are continuously enhanced by periodic releases and offer the Department alternatives for configuring the baseline software.
- Solution that manages, or can be expanded to manage, multiple payers for multiple state agencies
- An environment that embraces innovation and change, allowing for better services while maintaining good stewardship of State and Federal resources.
- Partnership that co-manages risks through collaboration between contracted healthcare and technology experts and State Medicaid experts.
- Solutions offered must meet the Federal, State and NC DHHS Privacy and Security requirements.

This RFI is focused on the group of modules that the Department is defining as MIMS in the red box in Figure 1 below.
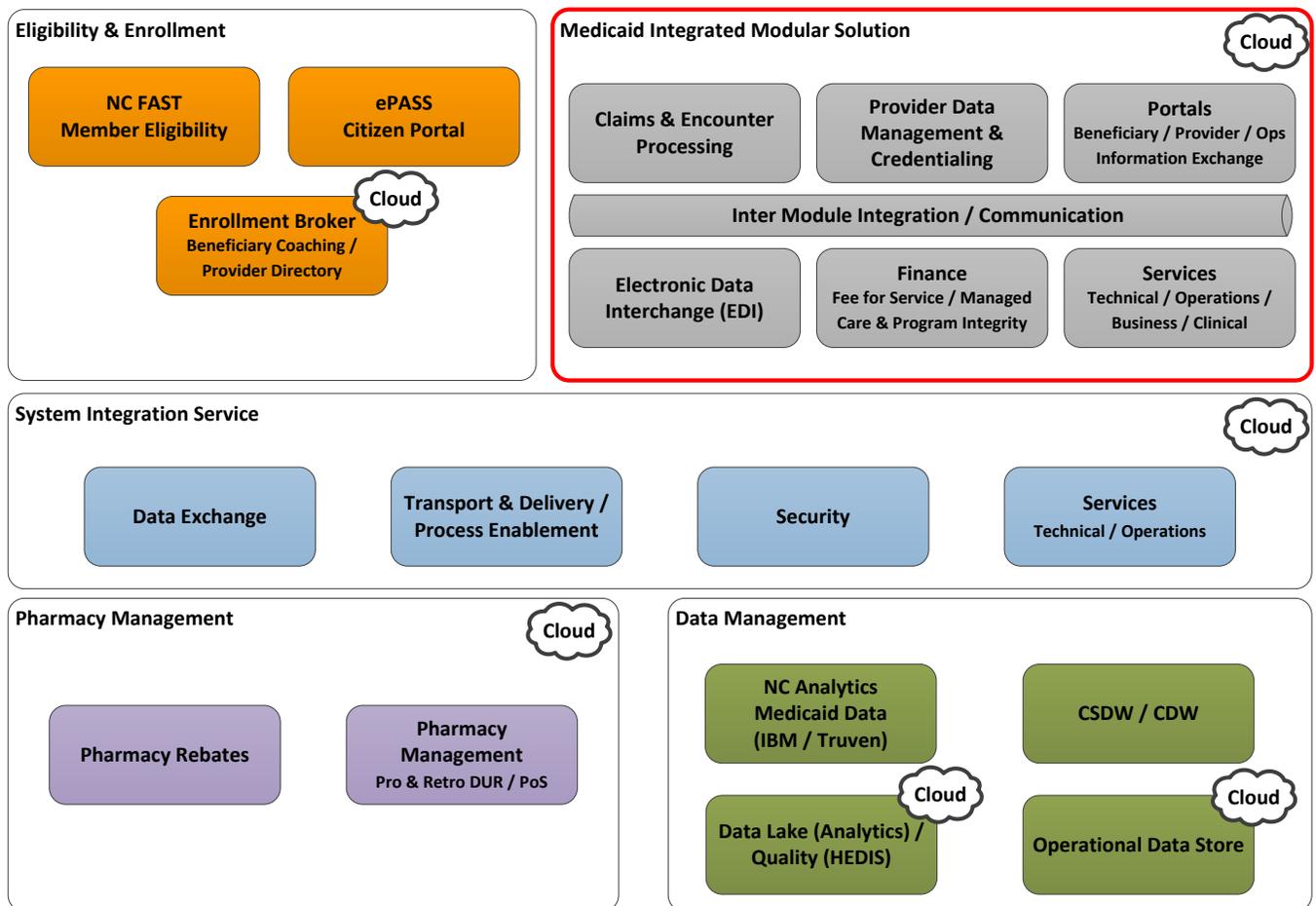
DHHS Medicaid Enterprise System End State

Figure 1: DHHS Medicaid Enterprise System End State Vision

A high-level description of each MIMS module is provided for potential Respondents to get a general understanding of the functionality and capabilities that the State is seeking in each module.

1. **General Overview**

All MIMS modules should have the following capabilities:

- All modules should be built using a loosely coupled approach to data exchanges. They should have the ability to exchange data via real time, asynchronous, file based, and message-based data exchanges.
- The solution should include the ability to capture eligibility. Medicaid eligibility is determined in a separate system however there may be other programs that need to capture eligibility status.
- The solution should include truly modular components that can stand on their own, easily integrate with other modules, and that can be replaced with modules (including those provided by other vendors) that support the same functionality.
- All modules should support self-service for the end users where applicable.
- All modules should provide configurable reporting capabilities including ad hoc reporting, scheduled reporting (with distribution capabilities), and integrated reporting (inter module per MECT requirements).
- All MIMS modules must meet Federal HHS CMS Medicaid Information Technology Architecture (MITA) and State privacy and security regulations and must follow NC DHHS Privacy and Security policies Medicaid IT standard definitions of modular.
- All modules should support business rules specific to each payer within the Department currently supported by the current MMIS.
- All modules should provide configurable business rules minimizing the need for customization.

2. **Claims & Encounter Processing**

The claims and encounter processing module should include functionality to support the following:

- Claims Processing – Capability to intake and adjudicate all claims specific to the Fee for Service business for multiple payers within the Department. This includes new claims and updates to existing claims (adjustments, voids, updates, etc.) based on each payer's preferred process. Claims Processing should also manage claim history data to support program audits and utilization review. The Claims module should support also include the ability to support multiple, unique sets of rules and edits to allow for multiple payers within the module. The claims module may also include financial capabilities as described below in the Finance module section.
- Peripheral Claims Modules – Reference data management, including covered services and pricing, should support the business rules for each payer. Prior Authorization should support batch and online requests for multiple payers. Business rules for pre and post payment recovery for third party payments should also be included.
- Encounter Processing – The Encounter Processing System (EPS) should include the functionality to validate and verify all encounters for multiple payers in a Managed Care system. The payers include: NC Medicaid, NC Division of Public Health, NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. This includes data certification via Workgroup for Electronic Data Interchange Strategic National Implementation Process (SNIP 5-7) as well as business specific edits / audits. The EPS should include the ability to enrich the data as encounters are processed and include the capability for submitters to review errors in submission online through a portal and remediate files that are not compliant with the specific formats (EDI x12), NCPDP.
- Appropriately identify and pay from multiple payor funding sources.

3. **Provider Data Management (PDM) & Credentialing Verification Organization (CVO)**

The Provider Data Management and Credentialing Verification Organization module should include functionality to support the following:

- Provider Data Management
  - The PDM should support all provider data management functions including data intake, data management, enrollment, credentialing, data sharing, and data archiving based on each individual payer's rules.
  - The PDM should have the capability to manage all aspects of provider data at both intake as well as maintenance throughout the provider life cycle. This includes functions such as data verification and cleansing (at intake), self-service and administrator-based data updates such as new locations or NPIs, ongoing data validation, provider enrollment, temporal location data, temporal credentialing data, event-based push and outreach capabilities for events such as upcoming re-credentialing, configurable workflow, batch enrollment, as well as other functions.
  - The PDM should manage provider data, such as program eligibility in one or many payer programs and taxonomy, for a service location.
  - The PDM should manage change of ownership data without losing historical information specific to the NPI and tax identification.
  - The PDM should integrate to the CVO in a way that allows a non-disruptive CVO change if required (listed below).
  - The PDM should include both backend administrative screens and capabilities, but also portals for intake and data maintenance.
  - The PDM should support the provider sanction and penalty information required for financial processing.
  - The PDM should track and report on provider data management activities, including but limited to provider information requests and data update plans/schedules.
- Provider Enrollment
  - Provider Enrollment should support multiple types of provider applications and workflows supporting the business rules for multiple payers.
  - Provider Enrollment should allow providers to re-enroll and dis-enroll in or out of the health plans or programs within multiple payers.
  - Provider Enrollment should trigger financial process for collection of applicable enrollment fees and EFT data management.
  - Provider Enrollment should integrate to the CVO in a way that facilitates a non-disruptive CVO change if required (listed below).
  - Provider Enrollment should track and report on provider enrollment activities and inventory.
- Credentialing Verification Organization
  - The CVO should verify all provider data captured as part of the application though the PDM.
  - The CVO should integrate with Department systems as needed and inclusion of the data in the overall verification process.
  - The CVO should track and report on credential verification activities, including but not limited to backlog aging reports, credential verification success/failures, provider information request backlog aging reports. The CVO should have an approach to timeliness and quality.
  - The CVO should be able to proactive and prospectively identify providers whose accreditation is nearing expiration as well as perform periodic checks of credentials to identify any changes in a provider's status.
  - The CVO should comply with credentialing standards such as NCQA as well as federal regulations.
  - The CVO should have the capability to exchange data with the PDM securely and in real time.

o The CVO should include out of the box configurable functions such as lists, forms, repositories and wikis.

4. **Portals**

The portals module should support the following general and specific functionality:

- General
    - o Capability to support complex authorization including role and group-based security by payer.
    - o Capability to integrate to external Identity and Access Management Services such as North Carolina Identity (NCID). Additional information is available at https://it.nc.gov/services/service-directory/core-services/nc-identity-management-ncid/ncid/ncid-integration-forms. The vendor should also include their ability to support multi factor authentication
    - o Capability to extend the functionality within the portal beyond the modules included in the MIMS. For example, the portal should be able to integrate to external systems to allow all information required by a specific stakeholder group to be housed in a single portal.
    - o Capability for secure presentation and integration layers.
    - o Capability for compliance with all accessibility rules and guidelines (WCAG 2.0 compliance).
    - o Capability to support configurable notifications.
- Operations Portal
    - o Dashboards on overall system and program performance (configurable)
    - o Access to view and configure beneficiaries, claims, encounters, reference data, provider data, finance data, etc.
    - o Document repository and collaboration
- Information Exchange Portal
    - o Capability for collaboration-based portal that enables the secure exchange of information between the State and stakeholders (two way) in real-time, near-real time, deferred processing modes.
    - o Support multiple methods (e.g., push, pull, subscriber, etc.)
    - o Capability to be developed on a folder-based or metadata driven hierarchy
    - o Capability to support data exchanges with internal systems to enable machine generated and delivered reports to be outed to users.
- Beneficiary
    - o Capability to enable operations and actions related to beneficiaries.
    - o Capability to integrate to backend systems as needed.
- Provider
    - o Capability to enable all provider data management operations including enrollment, application, AMH attestation, and data management in a secured environment.
    - o Capability to manage communications and reporting, such as a proprietary remittance and Medicaid bulletin announcements.
    - o Capability to submit and manage FFS claims for Medicaid as well as other State payers.
    - o For the fee for service Medicaid business, as well as other State payer business, may also include capabilities for business functions such as beneficiary eligibility verification, PA, payment status, etc.

5. **Inter Module Integration / Communication**
- Capability for modules to integrate and seamlessly communicate between each other.

6. **Electronic Data Interchange (EDI)**
   The EDI module should include the following functionality:

   - The EDI should include the ability to enrich the data as encounters are processed and include the capability for submitters to review errors in submission online through a portal and remediate files that are not compliant.
   - Capability to provide EDI translation to and from a flat file, real time interface, or message to an EDI format.
   - Capability to support multiple file types.
   - Capability to support all mandated X12.org transaction types and NCPDP transaction types.
   - Capability to include minimum SNIP editing of types 1-4 (1-7 preferred) and describe method in which edits are configured.).
   - Capability to return TA1, 999, and 277-CA transactions as appropriate

7. **Finance**
   It is anticipated that the Finance module will be heavily integrated with the other modules (including Finance). The following is the functionality that should be included:
   - Capability to adhere to the North Carolina Cash Management policy.
   - Capability to include all functionality for both managed care payments (including calculating withholds, liquidated damages, kick payments, management fees, etc.), multiple unique per member per month payment configurations, as well as all functionality required for paying adjudicated claims for multiple payers.
   - Capability to integrate with the State's financial system, North Carolina Accounting System (NCAS) for multiple payers.
   - Capability to manage accounts receivables, accounts payables and cash receipts for a provider across multiple state payers.
   - Capability to produce data to support the generation of 835 and 820 transaction files.
   - Capability to generate checks and EFTs for multiple payers.
   - Capability to produce CMS 64 and other relevant financial reports.
   - Ability to appropriate differentiate and account for multiple payer funding sources.

8. **Technical, Operational, Business, Clinical Services**
   In addition to the technology modules detailed above, the Department is also seeking services to support both the technical and business capabilities needed to operate the system. The following provides additional details:

   - *Technical and Operational Services* – The Department is seeking the capability to provide both technical implementation services as well as technical operations support. The operational support includes all aspects of technical operations including operations and maintenance support around the operations of the modules as well as new development, updates, upgrades, release management, operational and technical monitoring and event response (24x7), infrastructure management, batch operations and management, maintenance of existing integrations, implementation of new integrations, and technical issue resolution with the State and the State's vendors. The Department may add additional tasks to the scope of the technical and operational services as needed and the State welcomes the vendors input to how they have provisioned and managed this scope of services for other clients.

- *Business Services* – The Department is also seeking support for business services for program. These services are synonymous with the traditional Fiscal Agent role and includes business services such as provider management, encounter management, issue analysis and resolution, financial management including payment for both fee for service claims and capitation payments for managed care recipients as well as other services and tasks defined by the Department. It would be anticipated that these services can be obtained through a call center. These services may be expanded to other areas and become further defined during any future solicitation.

- *Clinical Services* – Clinical Services include tasks related to utilization management including prior authorizations, claims reviews, management of third party liability, input to program integrity, and other services and tasks that may be defined by the Department.

The implementation of these services will likely be phased. The Department is anticipating the technical services and some business services will be needed for Phase 1 of Managed Care, and other technical and business services required for the management of the State's fee for service business will be phased in as those programs transition from the State's current MMIS platform and Fiscal Agent to the new MIMS platform. The scheduling of this phasing is currently being developed and may be shared during any future solicitation.

Overall, the Department's modular strategy is in alignment with the CMS goal of moving away from a large, tightly-coupled MMIS environment to a more loosely-coupled service-oriented architecture (SOA) environment and meets MITA requirements.

The Department is certain that this undertaking will require the skills and talents of multiple stakeholders to achieve a successful outcome. We look forward to the potential opportunity to partner with the contractor community to better serve the State's most vulnerable citizens.

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Section IV. Questions for Respondents

Respondents are requested to respond to the questions in the table below in the gray-shaded boxes below each question.

Company Overview		
1.	Please provide an overview of your company's history, scope of products and services offered, and locations of operation.	

| 2. | Please select in the table below the modules that your company could provide and indicate if your company would directly provide the module or use subcontractors to provide the module. | |

MIMS Module	Can Provide? (Yes / No)	Who Provides? (Company / Subcontractor)
Claims & Encounter Processing		
Provider Data Management & Credentialing Verification Organization		
Portals		
Inter Module Integration / Communication		
Electronic Data Interchange		
Finance		
Technical, Operational, Business, Clinical Services		

3.	Please describe your company's experience in providing solutions within each of the applicable MIMS modules defined in this RFI. Please include Customer Name, Contract Start and End Date, Description of Scope of Work, and Implementation Duration. Please describe partnerships you have developed to provide solutions within each of the applicable modules defined in this RFI.
4.	Please provide lessons learned from working with other states to implement and operate solutions within each of the applicable MIMS modules defined in this RFI.
5.	In addition to the MIMS modules previously described, please discuss any additional Medicaid-related capabilities that your company may offer in the MES space.
6.	Please describe your company's ability to specifically provide Systems Integration Services as shown in Figure 1: DHHS Medicaid Enterprise System End State Vision.
7.	Please describe your experience working with system integrators to implement Medicaid or multi-payer solutions.
8.	Although not in the scope of this RFI, please describe your company's experience working as a System Integrator for similar projects.
9.	Please provide the name, title, email address, and phone number for the best person in your organization for the Department to contact if any additional information is needed regarding your response to this RFI.

Implementation Approach
10.	CMS recommends a modular approach to modernizing MMIS functionality. Please describe how your solution and strategy support a modular implementation approach? Describe any advantages and disadvantages you perceive with a modular approach.

11.	The Department prefers vendors who leverage an Agile methodology when implementing their technology. Please describe how your development and implementation methodology utilizes an Agile or similar framework.
12.	Based on the MIMS modules described in this RFI, please provide your estimated timeline to implement each module and include any major assumptions behind estimated timelines. In addition, please indicate your suggested order to implement the MIMS modules.
13.	Please describe your approach to implementing a system that supports multiple payers.
14.	Please describe your staffing resources needed to support each MIMS module you provide.
15.	Please describe your capabilities to provide training support for implemented MIMS modules.
CMS Experience	
16.	Please describe how your solutions are MITA certified in other states and describe your company's knowledge of the CMS MECT / MECL requirements. In addition, please describe your company's familiarity with R1, R2, R3 processes.
17.	Please describe how you support states in engaging with CMS and gaining CMS approval of submitted contracts.
18.	Please indicate if your company participated in any of the CMS precertification pilots and if so, the outcome of the pilots.
Services & Service Level Agreements	
19.	Please provide your experiences around meeting SLAs around availability, transaction time, storage, and performance.
20.	Please provide your experience in supporting your solutions in other states, including technical operations, clinical operations (PA, claims review, etc.), and Provider Data Management.
21.	Please provide recommended Service Level Agreements that would help monitor and manage solution provider's performance during the contract.
22.	Please describe your experience working in a multi-vendor environment from a Service Level and Operating Level perspective.
23.	Please provide any KPIs that would assist in accommodating future changes and growth strategy.
Pricing	
24.	Please describe pricing approaches for each of the applicable MIMS modules defined in this RFI, including implementation and ongoing operations. Please include details on any transaction-based pricing approaches.
25.	Please describe potential value-based payment models that could be used to align the solution provider and Department's incentives to achieve the Department's targeted objectives
Solution Details	
26.	Please describe your solution to the MIMS modules described in this RFI (COTS, SaaS or ASO offering). The Department prefers a hosted solution, so please include your current approach to hosting the modules.

27.	Please describe the level of changes required for each solution to meet the CMS Modular MMIS certification process.
28.	Please describe the technical platform and application components of your company's solution to the indicated MIMS scope.
29.	Please describe the availability and recoverability of your solution. How is business continuity implemented and managed? Please include uptime of your solution, RPOs and RTOs, and scalability approach for performance management.
30.	Please describe the security principles built into the solution and how that architecture protects the data in the system. This also includes how user security is implemented.
31.	Please describe your approach to reference data management.
32.	Please describe your solution's workflow management capabilities.
33.	Please describe how your solution has pre-configured rules to determine Recipient Eligibility Management?
34.	Please describe the architectural configuration of your modules. How are the modules built using standards such as APIs that are interoperable with modules from other vendors without significant custom integration? Also, please describe how independently each module can operate from one another including any published API catalogues.
35.	Please describe how your claims processing solution is flexible and scalable. Please describe flexibility and scalability in terms of claims volumes, ability to process Medicaid and non-Medicaid claims, incorporation of additional business processes, multi-payer capabilities, etc. Please also describe the details of how the system generates and adjudicates both Fee for Service and Managed Care Payments, and the system's check write and accounting processes.
36.	Please describe your solution's rules engine for processing different types of claims or encounters. Please describe the functionality of your rules engine and your company's definition of a rules engine. Also describe the ease of adding new rules to (including typical development or configuration timelines) support a new program or type of claim and how your solution manages multi-payer capabilities.
37.	To determine how your system treats Fee for Service (FFS) claim adjudication versus processing of Managed Care Organization (MCO) encounter data, please answer the following questions: a) How does your system process both FFS claims and encounter data claims? Please indicate if it is one application that processes both or are there separate applications. Do they share any components (e.g., rules engine, edits, ASC X12)? b) How does your system perform validity checks on MCO encounter data claims? Please describe the level of validation performed. c) Please describe your system's capability to report encounter data and FFS equivalent reimbursement.

38.	With most of the NC Medicaid member population currently enrolled in FFS, DHHS policy and program leaders already understand the variety and complexity of service delivery models that can be offered as benefits. With the focus on improving the service delivery and health outcomes of the incoming Managed Care population, a robust solution that supports rapid, cost effective change and allows for oversight is essential. Discuss the configurability of your company's solution for claims processing. Describe configuration scenarios for the following: • Addition of a new member benefit package (e.g., a new Medicaid program) • Addition of a new claim type • Addition of a new procedure or diagnosis code Please describe any claims processing scenarios that would need customizations within your solution. Also, please describe how your solution can handle multiple payers.
39.	Please describe the capabilities of your solution's EDI module. To what extent does the solution include the ability to apply SNIP editing in 837 (I, p, d) and NCPDP transactions?
40.	Please describe how your Encounter Processing module allows for self-service reporting and remediation on failed encounter submissions.
41.	What out of the box edits does your company's Encounter Processing module include? Please explain the process for developing new edits, including the design, development and testing of a new edit. Also, please give an example of a new edit developed for a customer, including timeframe to design, develop and test.
42.	Please describe your solution's approach to Provider Data Management & Credentialing Verification Organization.
43.	Please describe if each module leverages an independent database, or if all modules are interconnected through a single database. If they are independent, how do the modules interact (e.g., APIs, Operational Data Store)? How is reference data stored and shared?
44.	Please describe how each of the modules supports reporting and what is the standard report output format (e.g., Excel, PDF). How does self-service reporting work in each module? Please describe if the reporting capability is a separate module or if it is integrated into each of the standalone modules. Please describe how multi-payer reporting is or can be addressed.
45.	Please describe how your solution supports financial reporting such as CMS 64 reporting. Also, please describe how you would handle financial reporting for multiple payers.
46.	Please describe how your solution integrate both administrative and clinical information to support reporting such as HEDIS.
47.	Please describe how your solution can receive clinical data that can be incorporated into HEDIS reporting.
48.	Please describe your overall approach to portals. Please indicate if each of the modules includes a separate portal specific to that module. How do the portals interact with other modules? Also, please indicate if the portal solution is a separately licensed module. Please include an explanation of how security is handled, especially as it relates to users for multiple payers accessing the same portals.

49.	What are the business functions or sub-systems included in your claims solution (e.g., Provider, Member, Prior Authorization, Fund Management, Third Party Payer, Reference Data)?
50.	Does your solution include Mobile Applications? How do the Mobile Applications support submission of transactions and/or checking of status?
51.	Please describe your approach to operational monitoring such as performance monitoring availability and uptime, etc. Please also describe how current and historical information is accessed.
Additional Information	
52.	Respondents may provide any additional information that is relative to the scope of this RFI in the space below.
53.	Describe your approach to share and reconcile data with the data warehouse solutions. Include out of the box integration with large warehouse and business intelligence solutions.