



Request for Information (RFI)

August 12, 2010

Instructions for Responses

1. South Carolina Department of Health and Human Services (SCDHHS) would like to receive responses to this RFI by **September 13, 2010**. Please submit your response via e-mail to fbo@scdhhs.gov . The SCDHHS e-mail system does not accept attachments larger than about 15 MB. If your response is near this size or greater, please mail two identical CDs containing your response to:

Replacement MMIS RFI #3
SCDHHS Bureau of Federal Contracts
Attn: Rhonda Morrison
P.O. Box 8206
Columbia, SC 29202

If you use a shipping method that requires a street address, please use the above address replacing the P.O. Box number with **1801 Main St.**

2. SCDHHS may copy your response to other storage media to facilitate review by its staff.
3. Vendors may mark portions of their responses as confidential in accordance with South Carolina Code of Laws and Regulations. Guidance on the proper marking of your response can be found at:

http://www.mmo.sc.gov/MMO/webfiles/MMO_Legal/Documents/FOIA_page.pdf .

While this document is intended for vendor bids, the general guidance and references to statutes and rules are relevant to an RFI response.

4. This RFI is in reference to potential future Requests for Proposals (RFPs) for a Replacement Medicaid Management Information System (MMIS) and related information technology (IT) and business services. This RFI is issued solely for market research, planning, and informational purposes and is not to be construed as a commitment by the State to acquire any product or service or to enter into a contractual agreement.
5. Any costs incurred by a party in preparing or submitting information in response to the RFI are the sole responsibility of the submitting party.

Purpose

The State is seeking feedback on its draft program level acquisition strategy for the Replacement MMIS. This RFI is divided into three sections:

1. Feedback on the Draft Replacement MMIS Program Acquisition Strategy
2. Feedback on potential content of a Common Services Management contract
3. The SCDHHS Medicaid Information Technology Architecture (MITA) State Self-Assessment. This is provided for information only. No feedback is necessary on this document.

The State encourages vendors and other interested parties to provide feedback in response to this RFI. Because of the broad nature of the topics contained in this RFI, parties interested in submitting feedback on only a portion of the State's strategy are still encouraged to respond with such feedback.

This document is not an RFP. The State is not seeking proposals at this time.

1 Draft Replacement MMIS Program Acquisition Strategy

The State published a preliminary strategy in *SCDHHS Replacement MMIS RFI #1*, published in February 2010. The draft acquisition strategy attached to this RFI is a refinement of that strategy with substantial elaboration.

The acquisition strategy document is intended principally as an internal strategy document; however, since vendors play a pivotal role in the program, and since the program is planning to use a relatively uncommon strategy, the State believes that it is in its best interest to obtain timely external feedback on its strategy. This feedback should help the State identify potential weaknesses in its strategy, and it should also serve to assist motivated vendors in planning for potential future procurements.

1.1 Submission Request

The State requests that respondents provide the following information:

1. General feedback on the strategy. Please reference the document section number in your comments to ensure that the State understands to what you are referring.
2. Responses to the questions in Section 1.2 of this RFI.
3. Questions concerning the Draft Replacement MMIS Program Acquisition Strategy. The State plans to publish answers to questions it receives after responses have been submitted. As the subject document is a strategy document, the State requests that vendors not submit questions on detailed aspects of the program, such as the specific content of a proposed solicitation or the planned dates for any proposed solicitations as the State will be unable to answer these questions at this time.

1.2 Questions for Response

1. What weaknesses/risks do you see in this strategy that are not already identified in the document?

2. Does the South Carolina Medicaid Business Process Model, presented in Section 3.3 of the draft acquisition strategy seem reasonable in terms of technical feasibility and the ability of the market to provide solutions?
3. Does the incentive contract concept discussed in Section 3.3.6 seem reasonable? What concerns would you have about using this approach?
4. Does the contract mapping in Figure 3-10 seem reasonable?
5. What do you see as the pros and cons of using a separate Test Management Services vendor?
6. What challenges do you foresee in using a multi-state governance process?
7. What feedback do you have on the Service Oriented Architecture (SOA) vs. Enterprise Application Integration (EAI) concept discussed in Section 7.2?
8. What types and numbers of system environments do you foresee being needed to facilitate an incremental, multi-vendor design, development, and installation (DDI) such as this?
9. What additional opportunities, risks, or issues would you add to the list in Section 12?

2 Potential Common Services Duties and Deliverables

The second attachment to this RFI is a table discussing potential State and vendor duties and deliverables associated with common services (technology, consulting, and operations). The use of a Common Services Management vendor is a key aspect of the State's draft strategy. If not designed properly, such a contract could provide a false sense that the State has fully covered common services. The State is seeking feedback on the content of this document.

2.1 Submission Request

The State requests that respondents provide the following information:

1. Feedback on the proposed duties and deliverables of the various parties for common services. If you believe that these are incomplete or incorrect, please suggest improvements.
2. Feedback on the listed technologies. If you believe that these are incomplete or incorrect, please suggest improvements.
3. Responses to the questions in Section 2.2 of this RFI.
4. Questions concerning the common services duties and deliverables in Attachment 2. The State plans to answer questions it receives after responses have been submitted.

For vendors that publish commercial off-the-shelf tools that are part of the technologies listed in Attachment 2 or that the vendor believes ought to be part of this list, please also provide the following information:

5. A description of your company's tools and any other complimentary tools from your company, other companies, or open source that can provide the capabilities listed in the Common Services Technologies section of the attachment. Please consider including brochures, user guides, and administrator guides.
6. A description of the availability of trial versions of your product(s) for market research.
7. Feedback on whether you would be willing to do onsite or Web-based demonstrations of your product(s) as well as what type of approach would work best (including scheduling lead time).

2.2 Questions for Response

1. What additional technical standards should the State be concerned about?
2. Are there any other common services (technologies, consulting, or operations) that you feel should be added to the list in the appendix?
3. Are there any other common services (technologies, consulting, or operations) that you feel should not be on the list?
4. What are the non-COTS technical services needed to complete a suitable framework for a SOA-based MMIS? The State is concerned that a collection of COTS tools does not, by itself, constitute a suitable, healthcare-domain-aware framework for implementing a SOA-based MMIS. Please provide feedback on other, non-COTS common technical services that you feel would be necessary to achieve success.
5. Are there any specific common services (technologies, consulting, or operations) that you feel should be provided by a 3rd party (not the Common Services Management vendor)?
6. What is the best operational model for a multi-organization call center? The State is concerned about how best to align the duties of the call center with the vendor contracts to avoid having one vendor dump quality issues on another vendor (a potential with purely centralized call center support) or having a frustrating menu tree that requires callers to know whom to talk to when they call (a potential with purely decentralized call center support).
7. What is a good rule of thumb to use when determining the break-even point for a separate high-volume printing capability?
8. What is a good rule of thumb to use when determining the need for a dedicated mail room?
9. Is using a common e-mail/calendaring system for Replacement MMIS program activities worth the investment given that most State/vendor users will also be required to use their own organization's e-mail/calendaring system?
10. Should a separate Business Rules Management System be listed, or should that be a function of the Business Process Management System?

3 SCDHHS MITA State Self-Assessment

Attachment 3 contains the State Self-Assessment that SCDHHS completed in the fall of 2009. The MITA Project team is using this document as a baseline for the “as is” business processes. This document is provided for information only, and the State is not seeking any feedback from respondents concerning it.

Thank you for your interest in the State of South Carolina

Attachment 1

Replacement MMIS Draft Program Acquisition Strategy



**Replacement Medicaid Management Information System Draft
Program Acquisition Strategy**

**Prepared by
South Carolina Department of Health and Human Services**

**Draft for External Review
As of Aug 11, 2010**

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1 Background

The purpose of this document is to express the planned strategy at the program level (all contained projects) for the Medicaid Information Technology Architecture (MITA)/Replacement Medicaid Management Information System (MMIS) program for the South Carolina Department of Health and Human Services (SCDHHS). As a strategy document, it does not contain all relevant details for the program and its projects. Also, while the program team will generally keep the document current and accurate until it no longer serves a useful purpose as a planning document, many potential changes may occur that will not warrant an update to this document.

The State understands that at the time of development of this document, there are still significant unknowns in the program; however, delaying publication of this strategy document to achieve a greater level of perfection does not seem prudent.

1.1 Brief History of MMIS in South Carolina

The MMIS system was developed as a project between the South Carolina Department of Social Services (SCDSS) and Clemson University in the late nineteen seventies with some help with requirements through a request for proposal (RFP) with Touche Ross consultants and utilizing some concepts from Minnesota's MMIS. It was developed on Clemson's mainframe using COBOL and Assembler programming languages, Cullinane's IDMS database management system, and a proprietary online system. In 1981 it achieved federal certification – the first federally certified database oriented MMIS. In the late 1980s, the proprietary online system was replaced with CA-ADS/O.

Over time, SCDHHS has undertaken projects to enhance the functionality of the MMIS and to meet certain external and mandatory requirements.

Today the MMIS, in addition to the mainframe, also includes a real-time Eligibility Verification System (MEVS) developed by Clemson in 2001 using the X12 270/271 transactions. In 2003, as part of the HIPAA remediation done under a contract with EDS, an Electronic Data Interchange (EDI) component for handling HIPAA X12 transactions to/from trading partners and a web application providing claims data entry/submission and eligibility inquiry were added. Claim status inquiry was added to the web application in 2005.

The MMIS also includes new interfaces to contractor-supplied systems that replaced paper-based or other manual processes.

MMIS has seven core subsystems: Recipient, Provider, Reference, Claims Processing, Payment, Management and Administrative Reporting (MARS), and Third Party Liability (TPL). The MMIS has evolved in response to state and federal programs and the overall health care environment.

Through the MMIS, SCDHHS can enroll providers, adjudicate claims, pay providers, report costs and utilization, and enroll recipients in special programs. Providers can verify Medicaid eligibility 24 x 7 and inquire on the status of their claims.

1.2 Brief History of MEDS in South Carolina

The Medicaid Eligibility Determination System (MEDS) system is also managed, operated, and maintained through a contract with Clemson University. The system houses Medicaid eligibility data. In 2002, Clemson replaced the twenty-eight-year-old batch eligibility system operated by the SCDSS with a real-time and batch MEDS system operating on the same mainframe as the MMIS. The database management system is relational IDMS.

Using MEDS, eligibility workers throughout the state take applications from potential beneficiaries and determine their eligibility based on financial and resource data, as well as citizenship, identity, and several other criteria. MEDS interfaces with federal agencies (Social Security Administration—SSA, CMS, etc.) and state agencies (SC State Retirement System--SCSRS, Employment Security Commission—ESC, DSS, etc.) to verify data and assist in determining eligibility. Eligible beneficiary information in MEDS is passed to MMIS for use in claims processing and special Medicaid programs.

1.3 Impetus for Initiating a Replacement MMIS Program

SCDHHS needs to replace its MMIS and MEDS, principally, for the following reasons:

- The State's MMIS is one of the oldest still in operation in the United States. The cost of maintaining the system in an environment of rapid business change is prohibitive. Discussions with the Centers for Medicare and Medicaid Services (CMS) indicate that States making the initial transition from legacy systems to modern systems reap significant savings in administrative costs associated with maintaining the system and from business services relying heavily upon the MMIS.
- The State's MEDS is also mainframe based and still relies on "green screen" user interface technology. While it uses a more modern design approach, the modifications required to meet future requirements are significant enough to warrant acquiring an entirely new system.
- The MITA initiative is driving states towards using a service oriented architecture (SOA) to promote flexibility and reuse.
- Taking full advantage of changes in technology and improved business operations driven by recent legislative changes (e.g., electronic health records) requires a system and technology platform more easily able to perform needed processing and capitalize on greater access to needed information.
- Reducing costs associated with fraud, waste, and abuse requires the ability to rapidly adapt to changing strategies in order to prevent inappropriate payments up front rather than using pay and chase.

1.4 Relationship to MITA

The program is often referred to as the "MITA Project" within SCDHHS because the program goals are so heavily tied to the MITA goals. SCDHHS sees this effort as a MITA pilot or proof of concept. While many states appear to have made significant progress in using MITA to refine their Medicaid operations, true adoption of the MITA principles in building an MMIS does not

yet appear to have taken hold at a large scale. Success on this program can serve both as an example and a foundation for other states' MITA efforts.

While the defining document for MITA is the *Medicaid Information Technology Architecture (MITA) Framework 2.0*, published in March 2006, this document appears to be weighted more heavily towards describing an enterprise architecture than describing an enterprise architecture framework. In initiating planning for the Program, the South Carolina MITA Project team used The Open Group Architecture Framework (TOGAF) to assist in adding more framework elements to MITA to support the program. The team refers to the result as the South Carolina Medicaid Enterprise Architecture Framework (SCMEAF). As SCDHHS has no true enterprise architecture history, this framework is being used principally by the MITA Project team. At this time, the framework is both incomplete as well as relatively immature; however, it is robust enough to provide a structure around which the team can document the agency's enterprise architecture needs in a way that can be translated into competent solicitation documents. The team hopes that success on the Replacement MMIS Program will serve as an accelerant to adoption of enterprise architecture principles throughout the agency.

1.5 Relationship of This Document to Other Documents

Just as this document expresses South Carolina's strategy at the program level, individual project acquisition strategy documents will outline the State's approach to the individual business areas within the program (a business area will typically be associated with a vendor contract). Each of these documents will provide additional detail useful to the State in its planning as well as vendors and other interested parties. SCDHHS plans to release these strategy documents for comment prior to initiating development or implementation work on the various projects.

Additionally, SCDHHS plans to use an open requirements development process whereby draft requirements documents (and other related technical information) will be posted to permit vendors, states, and other interested parties to provide feedback prior to finalization of these documents. SCDHHS understands that vendors provide such feedback at their own expense, and the agency will endeavor to carefully consider requests prior to making them. Given the (clearly intended) propensity for states to use other states' requirements documents to "seed" their own efforts, SCDHHS believes that vendor investment in the South Carolina requirements process will pay dividends in the long run via more consistent and reusable requirements for other states.

1.6 Scope of the Program

At the current time, the program consists of:

Requirements and planning for the entire Medicaid enterprise except Program Integrity and decision support/reporting functions associated with a data warehouse. SCDHHS recently completed procurement of a Decision Support System/Surveillance Utilization Review System (DSS/SURS) known as the Business Intelligence System (BIS). While a new MMIS will drive the need for changes to the BIS or the need for a new DSS/SURS, it is too early to lock in the best strategy for this capability. SCDHHS will address the updated DSS/SURS capability in a subsequent APD.

- **Implementation** for the scope contained in the previous bullet except the eligibility portion of Member Management. When the Implementation Advance Planning

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Document (IAPD) for the program was submitted, CMS directed SCDHHS to remove implementation of a new eligibility system from the IAPD so that certain administrative issues could be resolved. SCDHHS believes that the eligibility portion of Member Management will be covered in a separate APD to be submitted later in 2010. This should result in a relatively seamless transition for Member Management from the planning activities conducted under the Replacement MMIS IAPD to the implementation activities under the eligibility APD.

SCDHHS will manage changes to the healthcare landscape driven by Health Information Technology (HIT) legislation and the Patient Protection and Affordable Care Act (PPACA) via this program to the best extent practical; however, immediate implementation needs will generally be handled via separate APDs. Rapid changes in legislation, rules, and market capabilities will undoubtedly result in the inability to achieve all goals during the initial round of Design, Development, and Installation (DDI); however, the flexibility the agency seeks in a new MMIS should provide the ability to better adapt to these changes than is currently possible with the legacy systems.

1.7 Key Definitions

The following definitions serve to clarify key terminology for the program:

Replacement MMIS Program – the collection of all of the projects and related efforts described by this acquisition strategy document, as amended.

MITA Project – this is a synonym for the Replacement MMIS Program. SCDHHS will refrain from using this terminology in contractual documents but uses it frequently in casual conversation and non-contractual documentation.

MITA Business Area – a group of related business processes in the MITA Business Process Model

South Carolina Business Area – a group of related business processes in the South Carolina Medicaid Business Process Model (shown in Section 3.3). If no qualifier is used, the term “business area” means South Carolina Business Area.

Project – a group of activities undertaken to address the scope of one or more South Carolina Business Areas. Outsourced efforts on a single project will normally be accomplished via a single contract.

Enterprise Architecture – Enterprise architecture is a complete expression of the enterprise; a master plan which “acts as a collaboration force” between aspects of business planning such as goals, visions, strategies and governance principles; aspects of business operations such as business terms, organization structures, processes and data; aspects of automation such as information systems and databases; and the enabling technological infrastructure of the business such as computers, operating systems and networks.¹

¹ *Enterprise Architecture Good Practices Guide*, Jaap Schekkerman, 2009, p. 31

1.8 Disclaimers

This acquisition strategy serves only as a planning document and is not an authoritative source for procurement, budget, or APD information. The document and the information contained herein is provided as is and without any warranty. Potential solicitations described in this document may not be published, competitive procurement strategies may be changed, and the State shall not compensate any party for any action taken as a result of the publication of this document or the information contained in it.

2 Program Goals

The Replacement MMIS Program has the following top-level goals:

- **Cost**
 - Use information technology (IT) to improve the efficiency and effectiveness of SCDHHS operations and enable opportunities to reduce the growth in the cost of care provided to Medicaid beneficiaries.
 - Reduce the occurrence of fraud, waste, and abuse in SCDHHS health benefit plans by applying controls more to pre-payment than post-payment, and by integrating information in a way that highlights anomalies
- **Quality of care**
 - Use access to information and efficiencies driven by IT to allow SCDHHS to focus more resources on measuring and improving the quality of care for beneficiaries
 - Position SCDHHS to make full use of the capabilities provided by electronic health records (EHRs), the South Carolina Health Information Exchange (SCHIE), and healthcare quality data from providers.
- **Enterprise architecture**
 - Align SCDHHS business operations, IT, the organization's structure, and vendor outsourcing contracts to simplify the South Carolina Medicaid enterprise, and use MITA to influence this alignment.
 - Make substantial improvements in process maturity associated with MITA
 - Reduce future costs for SCDHHS, the State of South Carolina, and other states by designing for reuse and by minimizing redundancy of services
 - Increase the use of business measurement within SCDHHS
- **Technology**
 - Achieve the MITA technical goals to the greatest extent practical (standards, security, interoperability, adaptability, extensibility, etc.)
 - Replace the legacy MMIS with a modern service oriented architecture (SOA) - based system.

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- Replace the legacy MEDS with a modern SOA-based system that is fully integrated with the functionality typically associated with an MMIS (i.e., a single seamless “system”)
- Reduce or eliminate the need for standalone PC-based applications that currently fill the gaps in MMIS capabilities
- Build the foundations of a multi-payer system to allow for flexibility and growth
- Provide a platform on which other states can build future MMIS’.
- Provide an infrastructure to assist the State in implementing a future health insurance exchange.
- Build a system with a long lifespan in order to minimize future capital investments.
- Reduce the use of paper documents dramatically.

3 Contract Goals and Strategy

3.1 Contracting Goals

The State has the following goals for contracts and the procurement process for the program:

- Attract high quality vendors by providing business opportunities that are fair to all participants, offer reasonable opportunities to make a profit, and that deliver to the State needed services and technologies at acceptable and competitive costs.
- Encourage existing MMIS vendors and non-traditional MMIS vendors to submit bids to program solicitations. To attract new vendors, the State must structure this program differently than is typically done. The cost to enter the classic MMIS fiscal agent market appears to be too high to attract new players.
- Publish as much useful advance information to vendors as practical to permit them to evaluate the business potential of a project and to allow committed vendors to prepare strategies on a more reasonable timeline than just the period from formal solicitation until the proposal due date.
- Create solicitations that offer flexibility where flexibility has value, but that do not arbitrarily leave work scope, terms, and conditions open to definition and interpretation post-award.
- Use contract terms equal to the duration of DDI for that particular contract *plus* five years of operations (some of which will likely be option years). The DDI portion of some contracts could be long enough as to consume over half of the standard five-year maximum on multi-term contracts. SCDHHS believes that the slightly longer contract lengths will result in lower costs because vendors can amortize internal investments over a greater number of years. This approach could result in overall contract terms of between six and eight years (inclusive of options). Such durations will require approval of State procurement officials or the State Budget and Control Board. Should such approval not be obtained, or if the process of obtaining such approval would result in inadvisable delays, the State will reduce the contract term to avoid the need for special approvals. Follow on contracts will be competitively reprocured using five-year terms (with some combination of base and option years). The State hopes to stagger the

reprocurements in a way that avoids the potential for large scale turnover of vendors over a short time span.

- Strongly discourage the vendor practice of “buying in” to the program caused when a vendor intentionally reduces its bid price of DDI below that which can be practically achieved and then attempts to make up the difference via change orders and business operations services. It is in all parties’ best long term interests that contract pricing is rational; related to the products and services being solicited; and supportable by bases of estimates (covered in greater detail in Section 4.2).

3.2 General Contract Strategy

The State plans to use a multi-vendor approach to DDI and subsequent operations. While other states have had concurrent DDI efforts for the MMIS replacement projects, SCDHHS is not aware of any other state that has attempted a full multi-vendor DDI project before. This means that the State must manage risks on this program very aggressively and reflect those mitigation activities in its acquisition strategies and solicitations.

A key element of the multi-vendor strategy is alignment of the IT and business operations services. The duties of building and maintaining a portion of the MMIS and the business operations supported by that system segment generally will be on the same vendor contract (for those services that are outsourced). This should strongly encourage self-policing software quality because a vendor’s efficiency and effectiveness (and thus profit margin) in performing business operations will be directly influenced by the quality and capabilities of the software it creates and continues to maintain.

In response to the *Replacement Medicaid Management Information System RFI #1*, published in February 2010, vendors expressed both support and concern for this strategy. Those expressing concern indicated that the best source for IT services may not be the best source for business operations services. While SCDHHS recognizes this to be true on its face, it appears that the vast majority of states use contracts requiring both IT and business operations services. Even South Carolina, which does not use a classic Fiscal Agent approach to Medicaid operations, generally uses vendors that supply both business operations services as well as IT systems supporting those operations. The State believes that the objective of self-policing software quality is important to the strategy. Interested vendors providing only IT or business operations services will be encouraged to partner with other vendors providing complimentary services in order to compete for program contracts.

SCDHHS currently uses more than a dozen MMIS-related, outsourced contracts to provide needed services to its Medicaid program. These contracts are typically aligned to individual services that were needed at the time of their inception, and the contract structure has generally remained the same over time. The result is that each major SCDHHS business unit (headed by a Deputy Director) is served by multiple vendors, even for individual MITA business processes. For example, significant changes to the Adjudicate Claim/Encounter process could require changes to five or more contracts (not even including the Managed Care Organization contracts) and associated IT systems. This is clearly an unsustainable approach in an era of rapid changes in healthcare insurance. It also places a huge burden on each Deputy Director and his/her associated Bureau Chiefs to integrate the services of multiple, imperfectly aligned vendors. To solve this

problem, SCDHHS must align its IT and business service contracts with its business structure, and it must evaluate its current business structure for effectiveness and continued relevance going forward.

3.3 Contract Structure and Business Alignment

As part of this business structure analysis, SCDHHS modified the MITA business process model to improve alignment with the business. Additionally, vendor responses to *RFI #1* indicated that the MITA business process model used, as is, was not suitable for multi-vendor outsourcing. The MITA business process model is an excellent abstraction of the Medicaid enterprise, but the boundaries between the MITA business areas do not map directly to an application or technical architecture. For example, accounting and finance related processes appear in multiple MITA business areas, but it would clearly be illogical to divide the system's accounting functions among two or three vendors or to build two or three separate accounting systems into the MMIS.

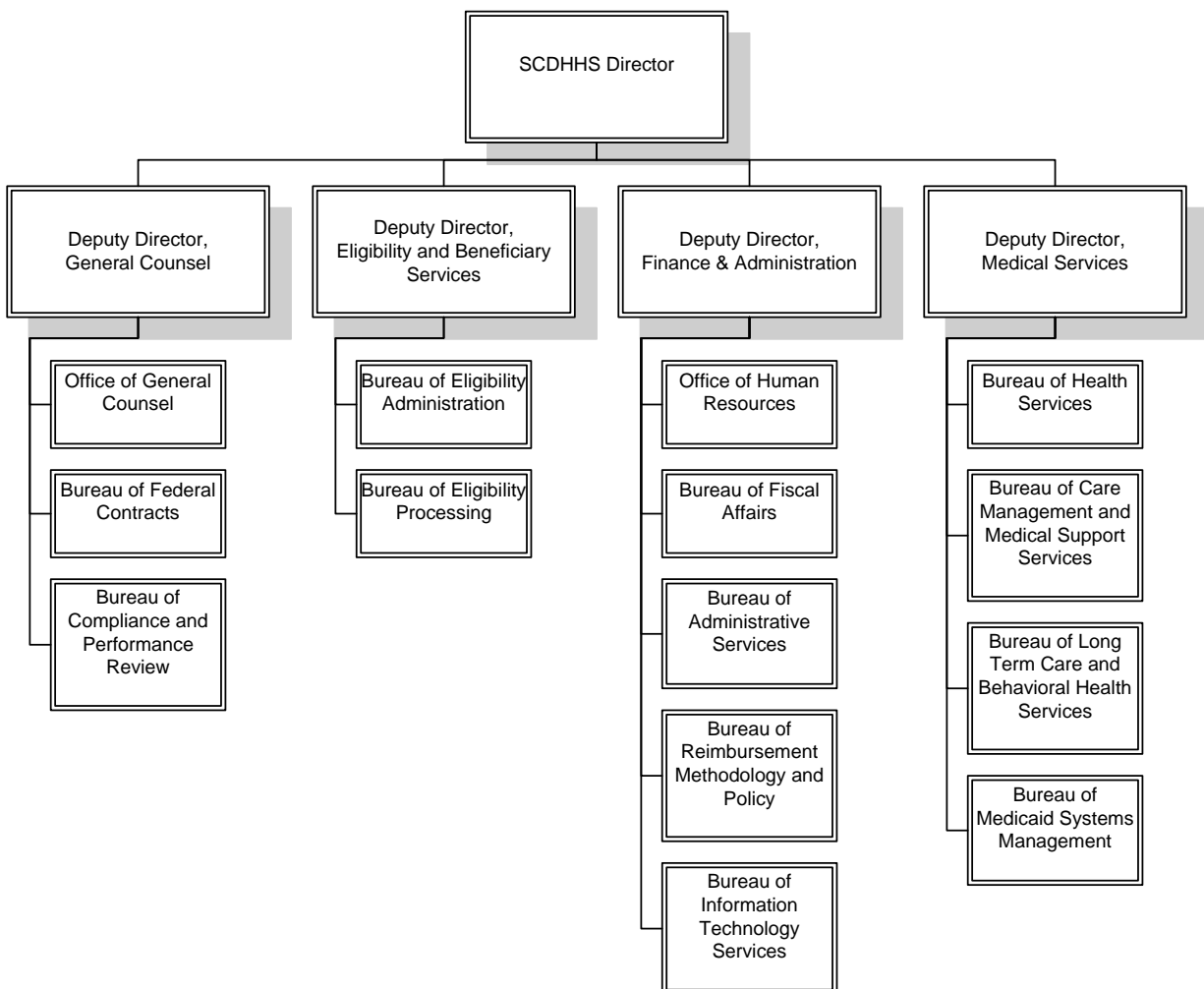


Figure 3-1. SCDHHS Organization Chart

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Figure 3-1 shows the organization chart of SCDHHS and Figure 3-2 shows the South Carolina Medicaid Business Process Model as it currently stands. This model is subject to change as the State refines its understanding of the enterprise requirements and suitable solutions. While the general alignment between the organization structure and the new business process model should be reasonably evident, the business area descriptions in the following subsections will identify the intended connections.

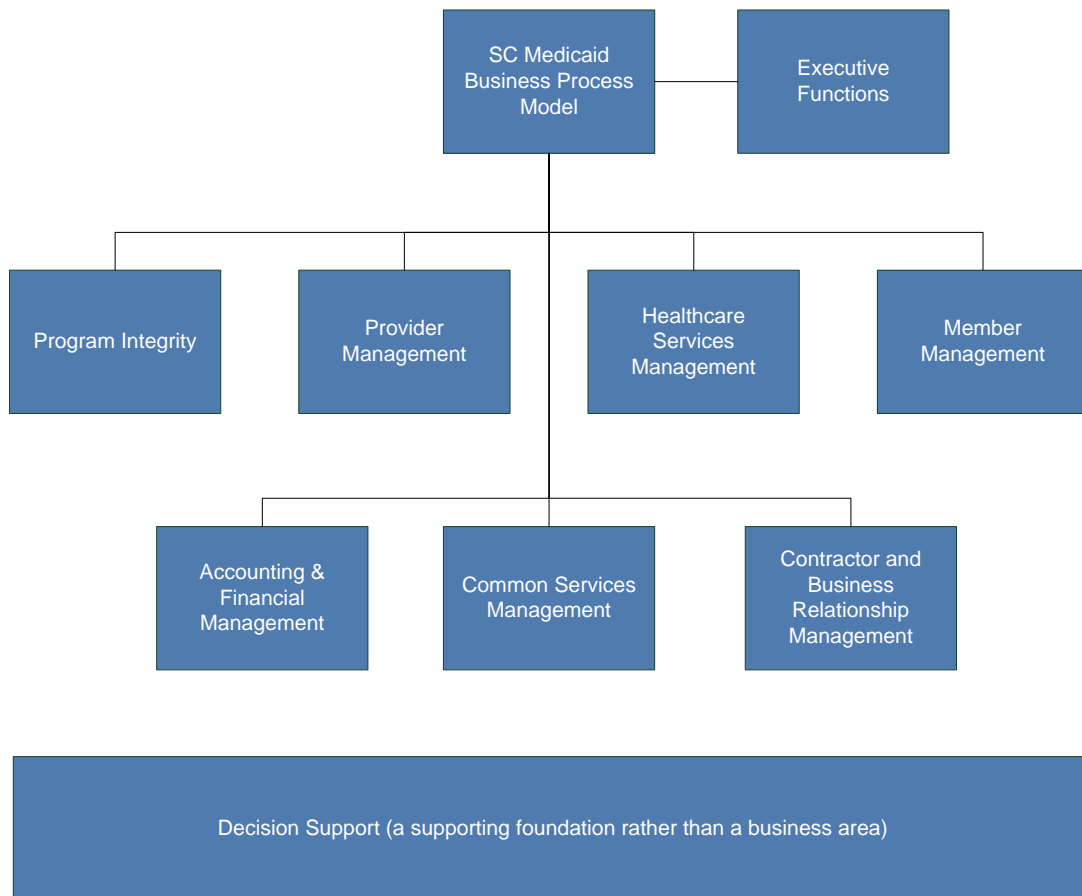


Figure 3-2. SC Medicaid Business Process Model

The subsections below discuss each business area and the State's strategy for satisfying the business needs associated with that business area.

3.3.1 Executive Functions

There are certain processes that, while belonging to the Program Management MITA business area, are typically performed by, or on behalf of, executive management. While these processes will likely use tools that are part of the enterprise solution, they are not logically tied to any one business area. Figure 3-3 indicates those business processes.



Figure 3-3. Executive Functions

3.3.2 Member Management

The Member Management process model is an enhanced version of its MITA equivalent. SCDHHS added the MITA sub-areas of “Capitation and Premium Payment” and “Member Payment Management” because they are member-centric business processes. While they may involve the transfer of funds between the State and other entities, the actual payment is not the principal activity in these processes. The business functions in the Member Management business area are most typically led SCDHHS personnel working under the Deputy Director for Eligibility and Beneficiary Services.

Figure 3-4 shows the updated business process model for Member Management.

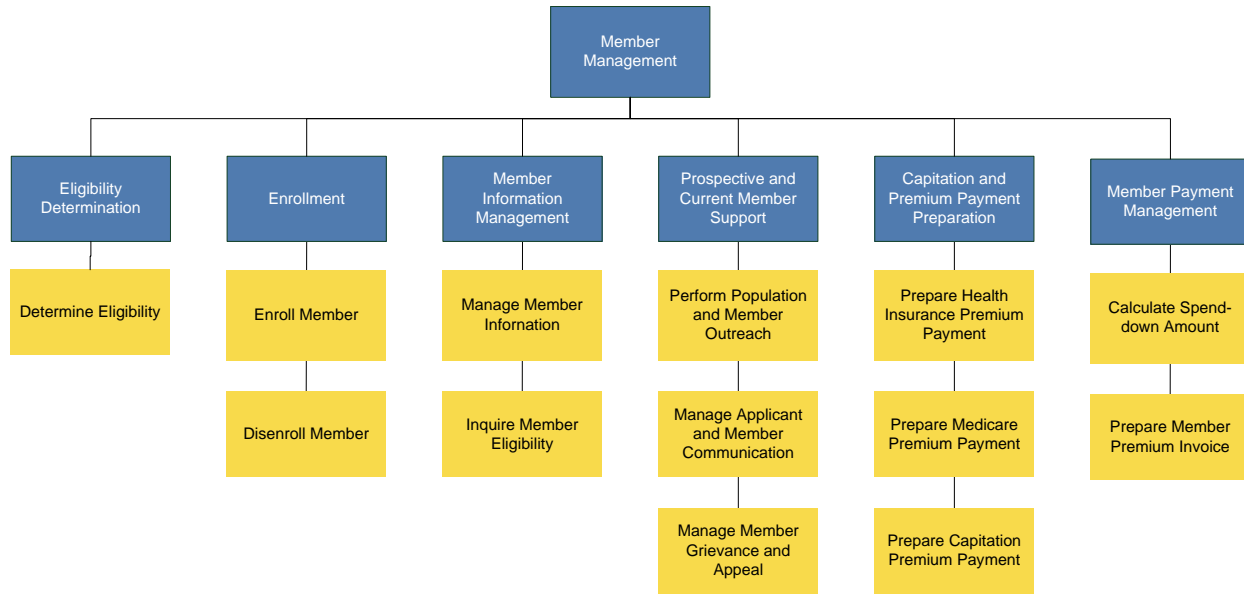


Figure 3-4. Member Management Business Process Model

At this time, the State intends to contract with Clemson University for development of the Member Management it capability. In this role, Clemson University will act as a “vendor.” This assignment has been chosen for the following reasons:

- As developer and maintainer for both the legacy MEDS and MMIS, Clemson is in a unique position of having detailed knowledge of both segments of functionality for Member Management (eligibility and the traditional “recipient” subsystem).
- By not needing a competitive procurement for Member Management, and by making this functionality the first major business capability delivered, SCDHHS can mitigate risks associated with the inevitable “discovery” process on a challenging project of this nature. SCDHHS can engage Clemson to help flesh out system-wide architectural issues even in advance of contracting with any other vendors.
- Decommissioning all/parts of two legacy systems nearly simultaneously will be a challenging process, particularly the first time it is done. Minimizing the number of parties involved will reduce risk.
- Currently, most business operations processes for Member Management are done by State personnel, including SCDHHS employees at county offices and eligibility workers at major inpatient providers. Keeping Member Management “within the State” continues the concept of aligning IT and business operations services with a single entity.

In the future, the State will likely insource managed care enrollment as part of the standard eligibility determination and enrollment processes. This function is currently outsourced.

As mentioned in Section 1.6, SCDHHS has Federal funding approval only for planning activities on Member Management. The agency must address implementation issues via a separate, concurrently-executed APD.

3.3.3 Provider Management

The Provider Management business area contains the same business processes as the original MITA business area. Figure 3-5 repeats this business process model from the MITA Framework. The business functions in the Provider Management business area are most typically led SCDHHS personnel working under the Deputy Director for Medical Services.

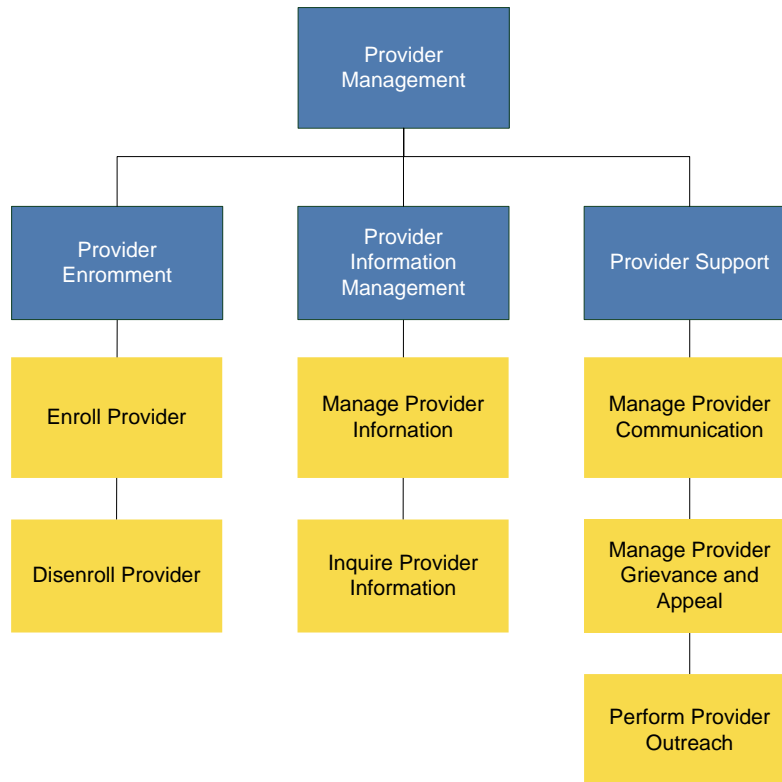


Figure 3-5. Provider Management Business Process Model

The State intends to competitively procure Provider Management services. The scope of the contract is planned to include developing the needed software and performing business services associated with Provider Management, such as provider enrollment and outreach. At the time the Provider Management capability is implemented, incentive payments associated with the meaningful use of electronic health records (EHRs) will still be ongoing. Depending on the State's implementation of its management of meaningful use payments and collection of required healthcare quality data, the Provider Management Services vendor may also provide services related to this activity.

At this time, the State's provider enrollment process is largely manual and paper-based. SCDHHS has the goal of early implementation of an online provider enrollment capability as soon as practical after contract award. This capability may be enhanced as other portions of this business area are implemented.

3.3.4 Healthcare Services Management

The Healthcare Services Management business area was created as a result of realigning the Operations Management, Program Management, and Care Management MITA business areas. As mentioned previously, SCDHHS created this business area, along with the Accounting & Financial Management business area, in order to align the MITA business process model more closely with the agency's organization and responsibility assignments, as well as to partition the IT requirements in a realistically implementable fashion.

Figure 3-6 shows the business process model associated with Healthcare Services Management. The business functions in the Healthcare Services Management business area are most typically led SCDHHS personnel working under the Deputy Director for Medical Services.

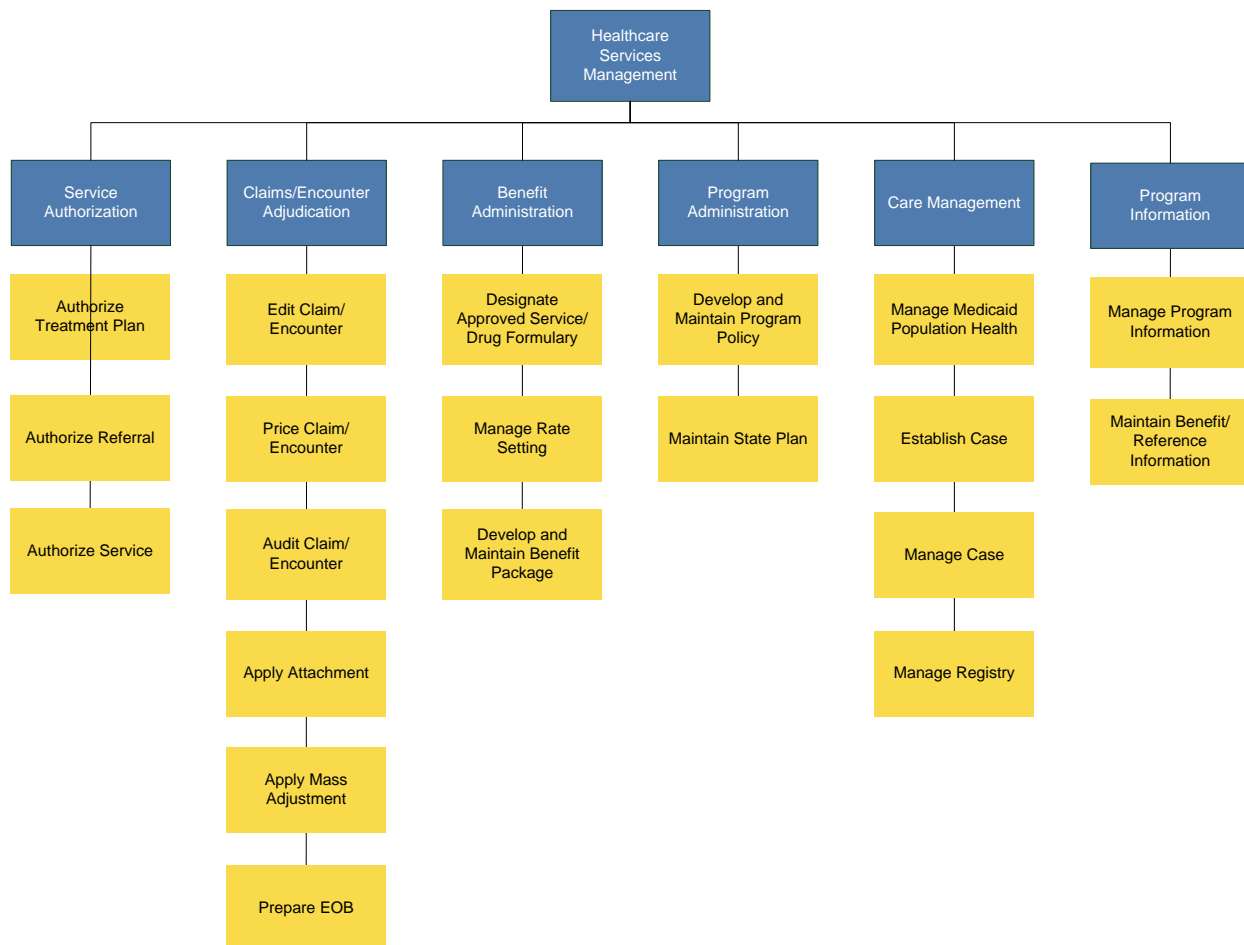


Figure 3-6. Healthcare Services Management Business Process Model

The State intends to competitively procure a Healthcare Services Management solution. The scope of the contract is planned to include developing the needed software and performing business services associated with Healthcare Services Management. Because of the State's history with outsourcing services associated with this business area, Healthcare Services Management is likely to be the contract most intricately woven with SCDHHS internal

processes. SCDHHS will determined the details concerning which processes will be insourced and which will be outsourced at a later date, but in general those activities that are insourced today will remain insourced in the future, and those outsourced today will remain outsourced in the future. Potential exceptions include:

- Outsource some clinical support and coding positions due to systemic hiring challenges.
- Outsource fee schedule updates and improve automation to reduce manual entry errors.
- Outsource the most of the remainder of prior authorizations not already outsourced.
- Insource the conduct of provider training.

While there are a number of potential early implementation opportunities in Healthcare Services Management, this business area tends to have significant dependencies on services provided in other business areas; therefore, many services will have to wait until final MMIS implementation in order to function properly.

3.3.5 Accounting & Financial Management

As with Healthcare Services Management, the Accounting & Financial Management business area was created from a realignment of multiple MITA business areas. Figure 3-7 shows the Accounting & Financial business process model. The business functions in the Accounting & Financial Management business area are most typically led SCDHHS personnel working under the Deputy Director for Finance and Administration.

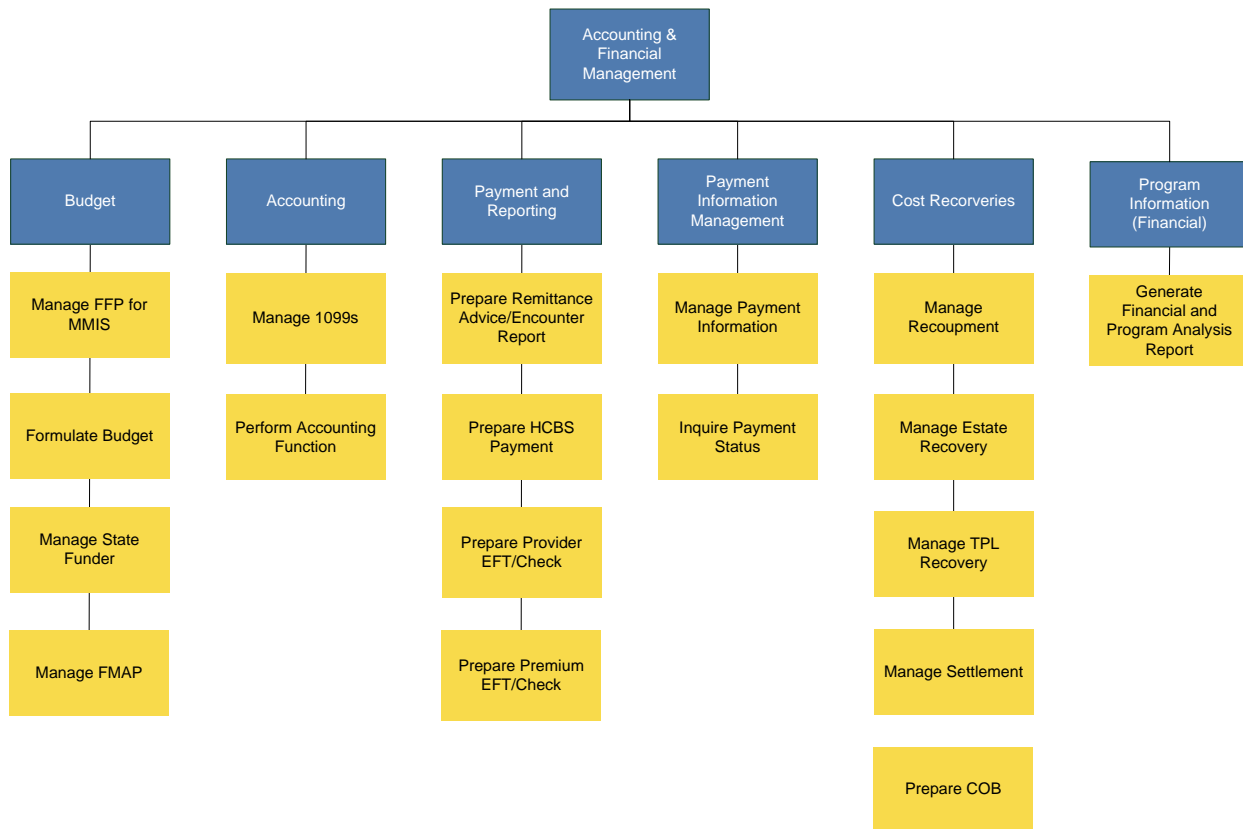


Figure 3-7 Accounting & Financial Management Business Process Model

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Most accounting and financial functions accomplished today are insourced with the exception of cost recoveries (e.g., third party liability). The State is migrating to an SAP-based enterprise resource planning solution known as the South Carolina Enterprise Information System (SCEIS). SCDHHS uses this system for accounting & finance; however, numerous functions required to perform Medicaid fiduciary duties are not present in the initial implementation of SCEIS, so portions of legacy systems are still being used. As part of the program, additional SAP capabilities must be implemented and others modified to meet SCDHHS needs. At this time, SCDHHS does not know which additional existing functions will be migrated to SCEIS, and which will continue to require external support.

The State plans to competitively procure cost recovery services. The scope of the contract is planned to include developing the needed software and performing business services associated with cost recoveries. Additionally, if non-SAP accounting and finance functionality is needed, this functionality will likely be part of the scope of this contract.

3.3.6 Common Services Management

Common Services Management is the most unique business area in the South Carolina Medicaid business process model. It does not have a direct analog in the MITA business process model. The purpose of this business area is to provide common technical and business operations services used by the enterprise with respect to MMIS.

Common Services Management consists of:

- Technologies that support the fulfillment of requirements spanning multiple business areas
- Consulting services to develop, configure, implement, and integrate those technologies
- Technical operations services that manage the common technologies
- Business operations services that provide common “utility” business capabilities

The State has consciously chosen not to designate the vendor performing Common Services Management as the “integrator” even though many duties will involve integration-oriented functions. The reason the State is choosing to do this is because without the privacy of contract offered by a prime vendor/subcontractor relationship, it is difficult to assign performance-based duties to an integrator. While the Department of Defense regularly uses integrators lacking a typical contractual relationship with other participating vendors, the interface boundaries are often more clearly defined and functionality unambiguously allocated (e.g., integrating an infrared camera with an aircraft). In the MMIS domain, the State feels that only it has the ultimate authority required to make and enforce decisions. As such, the Common Services Management vendor will provide integration type services, but the State will retain most decision-making authority. While this adds an element of risk, it simultaneously removes a substantial impediment that could result in an untenable contract.

The specific technical and business operations services provided by the Common Services Management vendor has not yet been finalized, but examples may include (this list is not all-inclusive):

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- Install, configure, and operate common commercial off the shelf (COTS) products such as an enterprise service bus (ESB), business process management system (BPMS), business rules management system (BRMS), enterprise document management system (EDMS), call center technology, data management tools, etc.
- Provide technical and management consultation during development and operations.
- Operate the Medicaid portal
- Support system testing
- Operate the call center (although many calls would generally be routed to another vendor or to the State)

The State plans to competitively procure a Common Services Management solution. This will be the first vendor chosen competitively, and is on the project's critical path. This procurement is further challenged by the need to select a vendor prior to completing all requirements analysis. Because there is a strong possibility that the vendor chosen for this business area will experience significant risk associated with unexpected tasks and problems, the State would like to use some form of incentive contract. At the Federal level, incentive contracts of this type typically take the form of cost plus award fee (CPAF) and cost plus incentive fee (CPIF) contracts². While the South Carolina Procurement Code allows such contracts, there is no existing infrastructure or accounting rules to support such a choice, and the State believes that its ability to hire an individual trained in the financial management of such contracts is limited. Additionally, the use of cost-reimbursable contracts places certain demands on vendor accounting systems that may limit competition.

The State is investigating an alternative method of exercising an incentive contract that may reduce the administrative burdens while still achieving most of its goals. Such an alternative might have the following structure:

- The vendor would be compensated for billable labor hours at and the purchase of materials specifically intended to be transferred to the State (e.g, software licenses where the State was the end license holder). Labor rates would be fully burdened
- The State would retain a percentage of each invoice as part of an evaluation pool
- Every six months, the State would evaluate the vendor on pre-determined, subjective criteria and assign a percentage of the evaluation pool to be paid to the vendor. The remainder of the pool would be forfeited
- If the vendor overran the target cost of the contract, then a percentage of future invoices would be also forfeited

The resulting contract would be similar to a cost plus award fee/incentive fee (CPAF/IF) from the Federal Acquisition Regulations, but would not require the same administrative accounting burdens.

The SCDHHS plans to seek input on this approach from the Information Technology Management Office (ITMO), CMS, and vendors prior to pursuing this strategy.

² Federal Acquisition Regulations, Part 16

3.3.7 Program Integrity

The Program Integrity business process model remains the same as in the MITA Framework, and is shown in Figure 3-8. The business functions in the Program Integrity business area are most typically led SCDHHS personnel working under the Deputy Director, General Counsel.

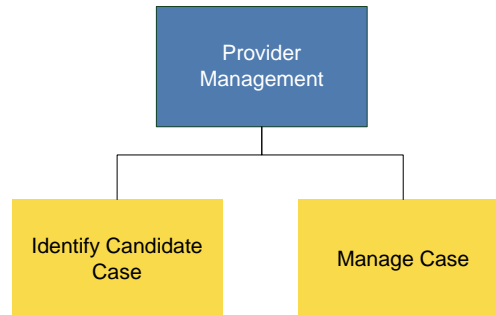


Figure 3-8. Program Integrity Business Process Model

Within the MMIS community, program integrity functionality is usually bundled as part of a DSS/SURS. Since the system for both functions is driven by data warehousing technology, it makes the most sense to package the two functions together. The State intends to continue this model, and plans to competitively procure either a new DSS/SURS or an upgrade to the existing DSS/SURS. Although consolidation of data sources is generally beneficial, this approach does not preclude the use of specialized analytical tools for other purposes within the enterprise.

As discussed in Section 1.6, the entire DSS/SURS project is not currently part of the scope of the program.

3.3.8 Contractor and Business Relationship Management

Because of the similarity between Contract Management and Business Relationship Management, the State is bundling these MITA business areas together. Otherwise, as shown in Figure 3-9, they remain unchanged from the MITA Framework. The business functions in the Contractor Management and Business Relationship Management business area are currently spread across more than one Deputy Director's business unit.

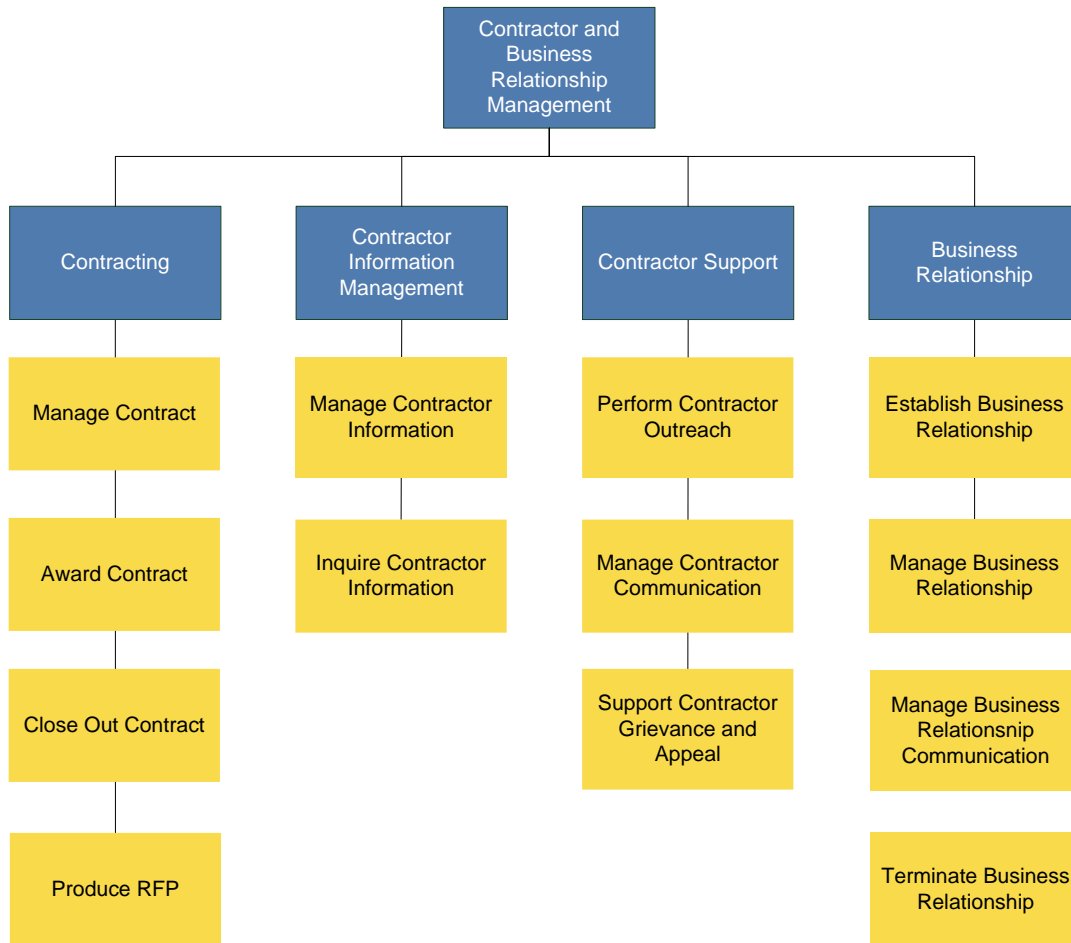


Figure 3-9. Contractor and Business Relationship Management Business Process Model

At this time, the State plans to procure software development for these services as part of the Common Services Management procurement if requirements analysis indicates a strong enough need to incorporate these capabilities in to the Replacement MMIS. Some minor business operations support may also be procured, but the majority of this effort will remain insourced. Note that some of the business processes in Contractor Management are supported by SCEIS. Additionally, the State believes that many of the needed capabilities for this business area could be satisfied with commercial off-the-shelf software.

3.3.9 System Hosting

The State plans to host all, or the majority, of the Replacement MMIS at Clemson via a sole source contract. Additional details concerning this activity are contained in later sections of this document.

3.3.10 Existing Contract to Future Contract Mapping

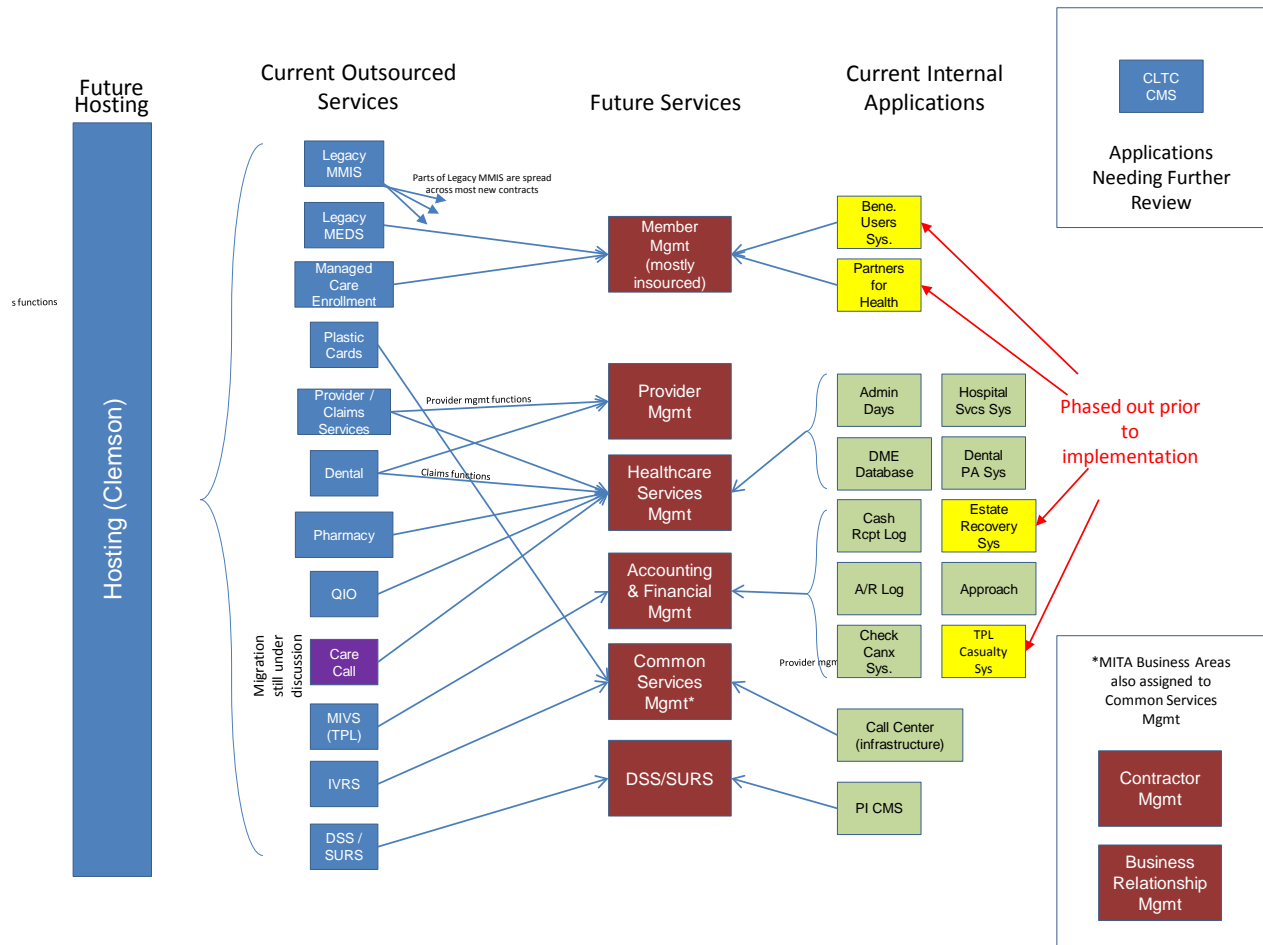


Figure 3-10. Application/Contract Migration

Figure 3-10 shows a conceptual migration from existing contracts and internal applications to future business areas/contracts. Table 3-1 provides additional details concerning this migration. Each of the existing contracts has its own period of performance, and part of the migration is transitioning IT and business operations in a coherent manner that minimizes disruption. For each new business area/contract, the date on which the vendor takes over operations of one or more existing contracts will, in part, drive an incremental implementation approach for the program. SCDHHS is still working the timing details of transition for each of the existing contracts and internal applications.

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Contract	Vendor	Effective Date	Base Year End Date	Option Year End Date	Base Year(s)	Option Year(s)
MMIS	Clemson University	7/1/10	6/30/11	6/30/15	1	4
MEDS	Clemson University	7/1/10	6/30/11	6/30/15	1	4
Medicaid Insurance Verification System (MIVS)	ACS	6/27/06	6/28/08	6/30/11	2	3
Interactive Voice Response System (IVRS)	First Data Government Solutions	1/2/07	1/1/10	1/1/12	3	2
Managed Care Enrollment Counselor	Maximus	4/1/07	3/31/10	3/31/12	3	2
Quality Improvement Organization (QIO)	Alliant (via emergency contract)	8/1/10	2/1/11	As needed until reprocurement completed	N/A	N/A
Care Call	First Data Government Solutions	8/24/07	8/23/10	8/23/12	3	2
Plastic Cards	Blue Cross Blue Shield of South Carolina	1/1/08	12/31/10	12/31/13	3	2
Pharmacy Benefits Management (PBM)	Magellan	3/19/09	3/18/12	3/18/14	3	2
Dental Administrative Services Organization (ASO)	DentaQuest	6/8/09	6/7/12	6/7/14	3	2
Business Intelligence System (BIS) (e.g., DSS/SURS/Medicaid Administrative Reporting System (MARS))	Thomson Reuters	7/20/10	7/19/11	7/19/15	1	4
Medicaid Operations	Blue Cross Blue Shield of South Carolina	6/26/10	6/25/11	6/25/15	1	4

Table 3-1. Existing Contract Information

Some of the contract completion dates are soon enough that the services may be competitively reproced one additional time prior to transition to the MITA Project.

Information on the internal PC-based applications can be found in the *Self-Assessment Report for the Medicaid Information Technology Architecture*.

3.3.11 Independent Verification & Validation (IV&V)

As is the norm, CMS has mandated the use of an IV&V vendor to provide feedback on project execution. The State plans to competitively procure these services early in the program. At this point, the State has not determined whether it will use a continuous onsite monitoring approach or a periodic review approach. In either case, the IV&V vendor's duties will generally be limited to oversight with hands-on testing being used only where necessary to verify other results. More details concerning the goals for this effort are discussed in Section 8.

To avoid an unacceptable conflict of interest or appearance thereof, the IV&V vendor will not be allowed to bid on any other contract on the program (including, but not limited to, the Test Management Services contract described below) or be a subcontractor to the prime vendor on any of these contracts.

3.3.12 Test Management Services

The State is considering competitively procuring the services of a test management services vendor. This vendor would augment the State's test team and provide both consulting services concerning testing and quality assurance as well as providing hands-on planning, executing, and reporting on testing activities. Due to the dynamic nature of these services, the State is likely to use a time and materials contract, or other similar approach, for these services.

To avoid an unacceptable conflict of interest or appearance thereof, the Test Management Services vendor will not be allowed to bid on any other contract on the program (including, but not limited to, the IV&V contract described above) or be a subcontractor to the prime vendor on any of these contracts.

The State will likely publish an RFI on this topic as part of its detailed planning and market research activities.

3.3.13 Tool Support

The State will likely need numerous IT tools to support efficient and effective management of the program. Depending on the cost of such tools (from free, open source to high cost), the State will procure those tools in accordance with the South Carolina Procurement Code.

Examples of tools that may be acquired are:

- Requirements management tool
- Data management tools
- BPMS for business process development during planning activities
- Web conferencing and teleconferencing tools
- Project financial management tool
- IT research reports and consultation

3.3.14 Real Estate Lease

To obtain needed office space for the project, SCDHHS will lease space in the Dennis Building, near the South Carolina State House. By using this space, the program is occupying otherwise vacant space, and has obtained a lease rate below that of nearby commercial space. The General

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Services Division (GSD) of the Budget and Control Board is renovating the space on behalf of SCDHHS in advance of the team moving in. GSD should complete renovations by early fall 2010. In the event that SCDHHS needs additional space for the program or other related projects, there is an opportunity to secure space in the nearby Brown Building.

The majority of the office space will be used for cubicles. SCDHHS is obtaining these cubicles from the South Carolina Prison Industries. The agency will procure other related furniture using existing term contracts.

3.3.15 Restrictions on Multiple Contract Awards

To assist in achieving a vendor agnostic solution, the State is likely to place some limits on awarding multiple contracts to a single vendor (or major subcontractor). The State understands that this decision may have a strong impact on vendor participation, but to achieve the program goals, it seems prudent not to concentrate too large a portion of the system with one vendor. The specific restrictions have not yet been determined; however, one restriction likely to be present is that the Common Services Management vendor will not be permitted to be the prime vendor nor a major subcontractor on any other project.

At this time, the State does not expect to enforce these restrictions on product procurements (e.g., COTS software tools).

4 Financial Strategy

4.1 Program Funding

Via the *South Carolina Replacement MMIS Implementation Advance Planning Document*, the State requested Federal Financial Participation (FFP) for this program. Table 4-1 shows the top-level breakout of funds requested for the project and percentage breakout between the State and Federal shares.

Budget Redacted for Procurement Reasons

Table 4-1. Program Funding

4.2 Use of Bases of Estimates in Conjunction with Procurement Activities

A basis of estimate (BOE) is a quantitative description of how costs and prices were estimated for work to be performed and materials to be acquired. While estimates may need varying levels of detail based on the work or material, the level of risk associated with the effort, and method of estimation, a key aspect of completeness is whether or not a reasonably informed person could draw a similar conclusion as the estimator (vendor). This is particularly important for work breakdown structure (WBS) elements whose cost is not intuitive or is not generally known to the marketplace. The cost of software development virtually always falls into the non-intuitive category, and solid BOEs are needed to justify costs and prices of such development.

The State plans to require vendors to submit BOEs for all competitive and sole source procurements, other than procurements for commodity products. The State believes that a vendor's ability to estimate costs correlates strongly with that vendor's ability to successfully perform the intended services. Poor BOEs may indicate high project risk.

Essential elements of BOEs include:

General:

- Assumptions having a significant impact on the estimate
- Method(s) of estimation
- Pertinent actual data and the source(s) of data used (e.g., previous projects, parametric models used, etc.)
- Adjustments made to account for risk (particularly the risk assumed by the vendor on efforts with fixed prices)
- Results of the estimate

Software-related BOEs must address at least:

- Software/configuration sizing in terms of new, modified, reused, and deleted software/configuration
- Other pertinent measurements of the scope of work (e.g., effort associated with the creation of training materials)
- Productivity estimates and how they drive labor estimates
- Derivation of labor quantities and costs
- Derivation of material/non-labor costs (including licensing costs)

Operations-related BOEs must address at least:

- Derivation of labor quantities
- Derivation of labor productivities
- Derivation of material/non-labor costs

4.3 Return on Investment Goals

Replacing and MMIS and eligibility system is an expensive process. Additionally, while computing a return on investment for MMIS administrative costs is reasonably easy, computing a return on investment associated with reducing the cost of care and improving outcomes is substantially more difficult. It may be impossible to measure accurately.

The State would like to achieve a positive administrative return on investment within five years of operating the entire system. It assumes that the majority of the administrative savings will be accrued via lower cost vendor contracts driven by increases in productivity offered by the use of improved IT and consolidation of duplicative services.

5 Schedule Strategy

The State is approaching this program as fundamentally incremental in nature. This incremental approach applies to the timing and spacing of the individual projects as well as incremental deliveries within each project. This approach avoids the “big bang” implementation approach and should allow some elements of iteration to be applied to the program without the cost and schedule uncertainty associated with a true iterative approach. Additionally, by providing increments of functionality on a periodic basis throughout DDI, the State will be able to improve its enterprise capability without having to wait until the end of a particular project or the entire program. Because of the stagger between elements of the program, different contracts could be in different phases of their life-cycle simultaneously (planning, DDI, operations).

5.1 Schedule Assumptions and Constraints

The following assumptions and constraints drive the program schedule:

- The Common Services Management business area is on the critical path. No other business functionality can practically be delivered, nor can serious development occur without identifying the technical services and related standards associated with Common Services Management.
- Member Management must be complete in time to support the State’s approach to a health insurance exchange. At this early date, the State has not identified its strategy for this exchange; however, in the meantime, SCDHHS will proceed assuming that the new Member Management services must be operational in advance of the January 2014 deadline for the health insurance exchange.
- Healthcare Services Management must complete at or near the end of DDI. Functions such as claims processing have system-wide dependencies that must be in place prior to completion of Healthcare Services Management.
- Accounting & Financial Management cannot be completed until at or near the end of DDI for reasons similar to those for Healthcare Services Management. The principal difference with Accounting & Financial Management is that portions of this process can and must be complete prior to the end of DDI. As such, the State is planning to break this business area into two phases: functionality that can be completed and used early in the program and functionality that cannot be completed until later in the program.
- The MITA/Replacement MMIS program will not complete soon enough in order to obviate the need to modify the legacy systems for ASC X12 5010 or ICD-10. The State’s approach for those mandates is likely to involve a minimum implementation on the legacy systems followed by a full implementation on the new system.
- Spacing between the projects must be sufficient to allow for any development that drives inter-project dependencies, documentation needed for follow-on projects/vendors, and

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procurement timelines. This is, by far, the largest schedule challenge for the program, and it drives minimum timeline by which the program can be completed.

- Contract awards between projects with strong predecessor-successor relationships generally must be planned at least six months apart, with a minimum of nine months preferable. This will allow for the predecessor project to publish initial project information (technology choices, project schedule, etc.) in time to be available for vendors submitting proposals on successor projects.
- The exception to the above rule is that Member Management may begin early architecture and design activities in order to help identify needs for the Common Services business area and to perform early identification of utility services that are likely to be useful to all vendors.
- The State believes that it is important to provide bidders with sufficient information and sufficient time to prepare proposals; however, the State expects potential bidders to take advantage the information that the State plans to provide in advance. Vendors waiting to “get smart” until after publication of a Request for Proposals (RFP) will likely find themselves with insufficient time to properly prepare their proposals. The State will be very unlikely to extend published proposal due dates unless a substantial error is discovered in the solicitation documents or procurement library that affects proposal preparation.
- The project should try to release useful functionality at least every six months during DDI, preferably starting no later than January 2012.
- The planned release cycle during the operations phase is likely to be every three months. Note that this does not include changes in business rules or minor changes to workflows or user interface. In order to be responsive to typical user needs, these elements must be easily modifiable over very short time periods.
- Initial project durations are low-fidelity, top-down estimates. The State will refine these schedules based on its own analysis and vendor feedback. Final schedules for each project will be driven by vendor proposals as much as is practical. History has shown that states attempting to define too many corners of the “project management triangle” on MMIS projects usually succeed on none of the corners.
- Program Integrity (along with all of DSS/SURS) is not currently part of this program; however, final system certification will require having a compatible data warehouse and associated tools and reports.

5.2 Top-Level Program Schedule

Figure 5-1 shows the top-level program DDI schedule. At this time, the schedule has a low precision and accuracy. The MITA Project team will publish more detailed schedules as they are developed and validated. Note that planning, solicitation, and evaluation timelines are not included on this graphic.

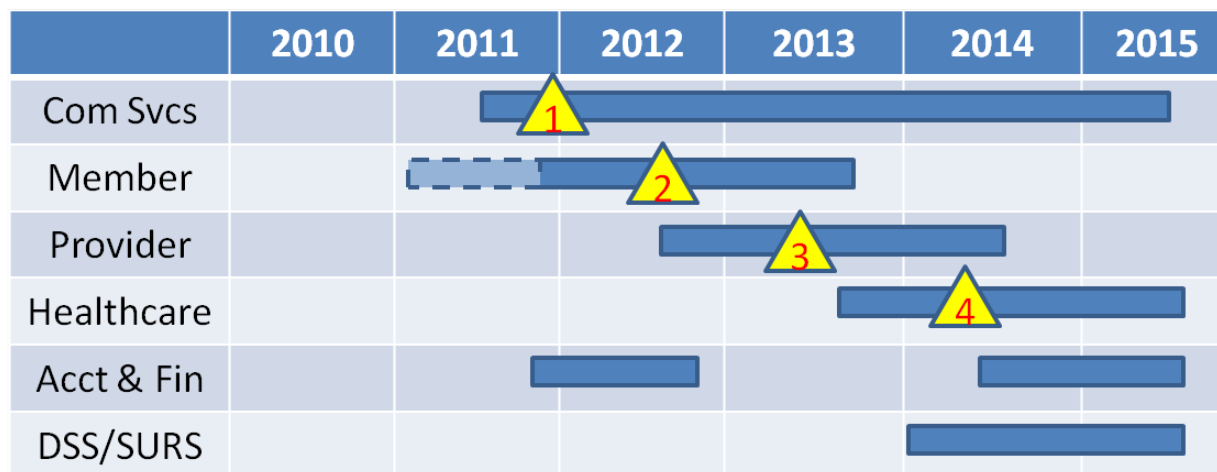


Figure 5-1. Top-Level Program DDI Schedule

The triangles shown in Figure 5-1 are merely placeholders indicating that the State would like to implement some functionality early in each business area. The State will identify candidates for early implementation as part of the requirements development process and agency management discussions. As stated previously, this schedule depiction contains elements that are not currently part of the program.

5.3 Procurement Timelines

As mentioned in Section 5.1, the procurement timelines are the largest schedule challenge on the program. The major schedule drivers for procurement are:

- Creation of the RFP. By using the requirements process to generate RFP-ready documentation, the remaining documentation effort is focused on scope determination; term and conditions; and procurement process information. If an existing acquisition strategy document is in place, the RFP drafting time can be reduced significantly.
- RFP approval time. CMS approvals are required to be completed within 60 days. While CMS strives to beat this timeline, the increased volume of reviews and approvals driven by changes in healthcare legislation are likely to impact CMS throughput for the foreseeable future. The MITA Project team believes that by working closely with State procurement officials, that State approval time can be contained within the CMS approval cycle.
- Proposal preparation time. Depending on the complexity of the procurement, this can range from one to three months.
- Proposal evaluation time. Depending on the complexity of the procurement, this can range from one to many months.
- Award recommendation approval time. As with RFP approval, both State and CMS officials will need to approve our contracts. This can take a similar amount of time as RFP approval.

- Protest waiting period.

The result of these processes is that the time from beginning of the RFP creation process until contract award can range from 5-14 months or 3-10 months from RFP publication to contract award (worst case scenarios could always exceed this time). The MITA Project team believes that if a subsequent procurement depends on its immediate predecessor, it is best to plan for at least nine months between contract awards for the two procurements.

6 Management Goals and Strategy

6.1 Management Goals

The primary management goals for the program are:

- Achieve program success by the proper application of the management functions of planning, organizing, staffing, leading, and controlling.
- Ensure the transparency of management actions and program/project results so that all parties remain properly informed.

6.2 Project Management Strategy

6.2.1 Integration

The purpose of integration is to ensure a unified coherent approach to management and technical functions and across projects and contracts and to ensure that various technical solutions work properly together to achieve the intended program results. As stated in Section 3.3.6, the State will retain the formal duties of integration with assistance from the Common Services Management vendor and other vendors. Because of the breadth of technology across the system, the State is likely to assume greater duties in project management integration activities than in technical integration activities.

Proper application of SOA principles to design and build an integrated system requires all parties to work together towards a common goal and to share information freely. To help ensure that vendors are able to cooperate with legal protections in place, the State will require all vendors to execute Associate Contractor Agreements (ACAs) with the other participating vendors. The purpose of an ACA is to provide a formal agreement between the parties to cooperate and share information while providing for the protection of proprietary information. Other terms and conditions may also be added, as the parties agree. The State is not a party to such agreements, but as a third party beneficiary, it has a strong interest in ensuring that these agreements are in place. To assist vendors in establishing ACAs, the State may consider creating a framework as a starting point for vendors.

The State will make reasonable efforts to avoid placing an unreasonable burden to perform unexpected duties on vendors; however, given the nature of DDI on this program, vendors must recognize that the scope of work for each contract must include responding to challenges common to this type of program. The State cannot practically respond to requests for equitable adjustment from vendors every time another vendor's services do not work perfectly the first time.

6.2.2 Vendor Location During DDI

All else equal, co-located teams are often more productive than geographically-separated teams. The State understands, however, that vendors often have development or operations groups whose services are not easy to relocate without a loss in skill sets or experience. In response to *RFI #1*, vendors suggested a range of opinions from mandatory co-location of as many personnel as possible to a minimal, commute-oriented vendor presence.

The following principles will serve as a guide to vendor location during DDI:

- True co-location requires physical presence in the same building or building complex. Due to real estate investment costs, the incremental nature of the program, and uncertainty about the size of the complete State-vendor team at any given time, the State has determined that large scale co-location during DDI is not practical.
- Small scale co-location of specific personnel, either at a State office or at a vendor's office, is realistic, and will likely be useful. The most useful personnel to co-locate are those needing high interaction, such as for integration purposes.
- Vendor location in the Columbia, SC area (or Clemson, SC area, as applicable) is highly desirable.
 - Vendors should locate an element of senior project/account management in the Columbia area at all times. The State prefers consistency of management personnel rather than rotating managers frequently.
 - Vendors should locate an element of senior technical management in the Columbia area at all times. Like with project/account management, the State prefers personnel consistency.
 - Vendors must perform activities requiring significant interaction with the State in the Columbia area.
 - Personnel involved heavily in system level testing and regression testing should be located in the Columbia area. With a multi-vendor approach, test driven development becomes almost mandatory, and stationing vendor personnel in the same area should dramatically increase the speed with which problems can be identified and resolved.
 - During a source selection, the State will likely show preference to a vendor that commits to locating a greater percentage of its team in the Columbia area assuming that the vendor is responsive and responsible to the solicitation.
 - Each RFP may have a different set of requirements for duties to be mandatorily performed in the Columbia area.

6.2.3 Planning, Processes, Reporting, and Metrics

This program will be challenging to manage in a coherent fashion due to its complexity and the number of participating organizations. While the State prefers to give vendors substantial flexibility in the way they operate and report achievements, allowing each vendor to use different processes and reporting formats would substantially complicate integration efforts. As such, certain aspects of project management will likely have a fair amount of standardization.

Areas likely to require standardization include:

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- Project planning methodology and tools. The State plans to host an instance of Microsoft Project Server to manage the Integrated Master Schedule (IMS). While vendors will be allowed to use the project management tool of their choice for internal purposes, the official IMS must be managed using a single tool.
- Risk/issue/opportunity management.
- Release management.
- Financial reporting.
- Earned value management reporting (as applicable per contract)
- Deliverable review processes (discussed further in Section 8.1)
- Periodic project reporting processes and formats
- Periodic project management reviews
- Rate of change/maturity metrics

Areas likely to remain unique per contract include:

- Financial reporting for unique price-based, unit-based, cost-based charges, etc.
- Other project unique processes and metrics

6.3 Operations Management Strategy

6.3.1 Integration

As with DDI, the State will serve as the primary integrator of business operations. For specific areas, such as call center operations, the State is likely to contract greater integration duties with the Common Services Management vendor.

The State plans to host the majority of the MMIS at Clemson University. Exceptions may include the use of commercially-available or commodity services.

6.3.2 Vendor Location During Operations

To a greater extent than DDI, the State prefers that vendor business operations services be performed locally. While there are clearly certain commoditized services that can be performed more cost-effectively from a centralized location, the use of employees who are easily available to meet with the State and providers, and who are culturally sensitive to the needs of the citizens of South Carolina is important in the success of the Medicaid enterprise.

The State may evaluate the possibility of co-locating the majority of State and vendor MMIS operations personnel in a single facility during operations. Iowa has implemented this approach successfully, and discussions with Iowa representatives indicate that they believe that co-location has had a significant influence on the success of their multi-vendor operations model. If the State does not choose to co-locate to a single facility, strong Columbia (or Clemson, as applicable) presence by vendors is likely to improve coordination of business functions.

Software maintenance and upgrades during operations will likely be managed similarly to software development during DDI.

For those situations where significant vendor personnel are not located in the Columbia area, the same general principles for co-location from DDI apply to operations, as well.

6.3.3 Planning, Processes, Reporting, and Metrics

Managing Medicaid operations is likely to require a greater diversity of approaches than during DDI. While general project planning will likely remain largely the same as during DDI, measuring and reporting on key performance indicators and service level agreements will likely differ from contract to contract. Additional details on this area are deferred to the project acquisition strategy documents.

6.4 Change Management and Governance

Responses to *RFI#1* indicated that governance would be one of the greatest challenges for the project. The MITA Project team concurs with that assessment.

6.4.1 What Falls Under Governance

The following list contains examples of documents and artifacts that would come under control of the governance process:

- Project-oriented documents. This would include project management, technical, contractual, and other similar documents that define the project. Once baselined, future changes will be controlled.
- Enterprise-oriented documents. These would include organizational structure, business processes, business data models/metadata, organizational change management, etc.
- Requirements, architecture, and program-level design documents
- Configurable items such as business rules and workflows
- Interfaces
- Source code and other detailed implementation artifacts. Note that during development and maintenance activities, management of these items would largely fall under a vendor's configuration management processes. Once delivered, changes would fall under the program release management and other governance processes.
- Security procedures (system, physical, etc.)

6.4.2 Roles

With exception of the configuration management processes executed by each vendor, the State owns the governance processes for the entire program. While vendors will support these processes to a great degree, the State will retain decision-making authority.

Detailed, broad spectrum, enterprise level governance is new to SCDHHS, and it is likely to grow in importance and influence as the program progresses. The State's governance process will be structured around a three-tier organization. At the strategic level, the Steering Committee will be made up of the senior executives of SCDHHS and the Clemson University Chief Information Officer (CIO). At the operational level, the Business Owners Group will be made up of the SCDHHS Bureau Chiefs and the Executive Director of Computing, Systems, and Operation from Clemson. This organization will be supported by the Technical Advisory Group that provides input on the information architecture and technical architecture during the operations phase of the program. Additionally, the Change Control Board for the legacy systems currently is a superset of the Bureau Chiefs that includes the SCDHHS Deputy Directors, and is

assisted by other technical and management staff. For the foreseeable future, SCDHHS will operate with that construct as an adjunct to the Business Owners Group. At the tactical level, the User Advisory Group will be made up of subject matter experts from throughout SCDHHS.

For project level and program level governance, the MITA Project team will exercise authority over governance with the consent from the Steering Committee, and as necessary, the Business Owners Group.

The Common Services Management vendor will assist the State in performing its governance functions by evaluating governance proposals and change requests; identifying flaws and inconsistencies in the documents and artifacts being governed, coordinating release management under the direction of the State; and by performing administrative duties associated with governance.

All vendors will perform configuration management on parts of the MMIS that they develop and maintain, work with the State on governing other project level documents and artifacts, and participate in program level and enterprise level governance activities as they apply to their specific contract.

6.4.3 Multi-State Governance

One of the flaws of the current MMIS model, nationally, is that changes made to “transfer” systems used in multiple states are not inherently managed by a universal governance process. While individual vendors may manage certain aspects of their baseline systems and states sometimes share in major modification costs, the lack of coherent multi-state governance processes results in fragmented code bases across the states driving up costs for states and the Federal government when responding to changes.

One of the principal merits of SOA-based systems is reduced modification costs through flexibility and reuse, but those advantages are drastically impacted if states do not truly reuse other states’ services. The MITA Project team is proposing that, to the best extent practical, states and vendors wishing to transfer the South Carolina MMIS be required to participate in a multi-state governance process in order to secure the rights to use this system or its component services.

The principal objectives of this governance process are:

- Reduce the cost of changes by sharing changes to the baseline services in a way that promotes compatibility with all participants’ systems.
- Ensure backwards compatibility, wherever practical, when one or more states modify an existing service, so that the likelihood of a significant fork in the code base is minimized.

An importance assumption of this strategy is that user interfaces, business rules, and workflows, are external from the services. Each state is likely to change those aspects of the system to meet its specific needs. If properly designed, the State hopes that the underlying services will be robust enough to remain reasonably stable from state to state.

In the long run, if a multi-state governance process is successful, and if it is to survive properly, CMS must lead the process. The State has initiated conversations with CMS on this topic, and the organizations appear to agree on this concept.

6.5 Communication

Given the number of entities whose participation is crucial to this program, excellent communication is paramount. Due to the flexibility inherent in asynchronous communications methods (e-mail, Web postings, etc.), this approach will be used extensively. For stakeholders with a higher volume of communications (vendors, SCDHHS personnel, provider representatives, etc.), face-to-face communication will also be greatly used.

The MITA Project team plans to create a program communications plan and individual project communications plans. As such, this section will provide only an overview of the strategy.

In the following subsections, communications are broken down by category of stakeholder.

6.5.1 Internal Communications

The MITA Project team plans to use the following principal methods when communicating with internal SCDHHS/Clemson University stakeholders:

Purpose of Communication	Intended Audience	Potential Methods of Communicating
Program Status	SCDHHS and Clemson University MITA Project team	<ul style="list-style-type: none"> • Presentations at governance meetings • Newsletter/listserv • Web site • Direct e-mail • Internal wiki • Daily management “standup”
Elicit ideas and requirements	SCDHHS staff	<ul style="list-style-type: none"> • Face-to-face meetings • Direct e-mail • MITA Ideas e-mail account • Internal wiki
Training	SCDHHS staff	<ul style="list-style-type: none"> • Face-to-face sessions • Web site • Multimedia and computer-based methods • Internal wiki
Testing and other hands on activities		<ul style="list-style-type: none"> • Direct e-mail • Face-to-face meetings • Web site

Table 6-1. Communications Methods to be Used Internally

6.5.2 Provider Communications

Given the tens of thousands of providers in the State, communication with this stakeholder group will be adjusted based on the intended purpose. Table 6-2 shows likely methods of addressing providers.

Purpose of Communication	Intended Audience	Potential Methods of Communicating
Outreach (including provider bulletins related to the program)	All providers	<ul style="list-style-type: none"> • Newsletter/listserv • Web site • Provider associations' facilitation
Program Status	All providers	<ul style="list-style-type: none"> • Newsletter/listserv • Web site
Requirements, Design, and Testing Feedback	Targeted volunteer professional and institutional providers	<ul style="list-style-type: none"> • E-mail • Face-to-face meetings • Web site • Provider associations as proxy
Soliciting Ideas (broad)	All providers	<ul style="list-style-type: none"> • Newsletter/listserv • Web site
Soliciting Ideas (focused)	Targeted volunteer professional and institutional providers	<ul style="list-style-type: none"> • E-mail • Face-to-face meetings • Web site • Provider associations' facilitation
Training	All providers	<ul style="list-style-type: none"> • Web site (general information, pre-packaged training, simple computer-based training) • Face-to-face at various locations throughout South Carolina

Table 6-2. Communication Methods to be Used with Providers

6.5.3 Member Communication

MITA Project communication with members is substantially more complex because of the volume of members, the wide variation on member perspectives, availability of members to serve as representatives of this stakeholder group (this is not a business venture for members as it is with most other stakeholders), and privacy concerns.

The principal method by which the MITA Project team will communicate with members is via a program Web site, or via beneficiary newsletters. The team may also be able to use proxy

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organizations such as the Department of Social Services (DSS), the Department of Juvenile Justice (DJJ) the South Carolina Department of Corrections (SCDC), the Medical Care Advisory Council (MCAC), and agencies that support the homeless.

6.5.4 Vendor Communication

Table 6-3 shows the types of typical communications the State will use with vendors.

Purpose of Communication	Intended Audience	Potential Methods of Communicating
Pre-solicitation	All vendors	<ul style="list-style-type: none">• Requests for Information and vendor responses• MITA Repository for program artifacts and vendor feedback on postings• SCDHHS Web site• Federal Business Opportunities (FedBizOpps)• South Carolina Business Opportunities
Post-Solicitation/Pre-Award	All vendors	<ul style="list-style-type: none">• South Carolina Enterprise Information System (SCEIS)• SCDHHS Web site• MITA Repository (likely to hold the procurement library)• FedBizOpps (as a notification tool only. Do not plan to use it as a solicitation management tool due to SCEIS)
Post-Award Formal (selected vendors)	Vendors with whom the State has a contract	<ul style="list-style-type: none">• Contracts letters from an authorized State representative
Post-Award Informal (selected vendors)	Vendors with whom the State has a contract	<ul style="list-style-type: none">• Similar methods as identified in the Internal Communications subsection• Project management tools
Transition/collaboration	Vendors with whom SCDHHS or its selected vendors have a non-contractual business relationship or with whom a different state agency has a contract Current vendors supporting legacy systems	<ul style="list-style-type: none">• Formal letters, where appropriate• Informal methods, where appropriate

Table 6-3. Communication Methods to be Used with Vendors

6.5.5 Communication with Other Organizations

CMS and other Federal agencies. The State provides monthly written and telephonic reports to the CMS Atlanta Regional Office. These reports include unofficial funding and expenditure

status. SCDHHS provides a Quarterly Expense Report to CMS that is the agency's official report of funding and expenditure; however, this document is not broken out by APD. The State communicates informally with the Atlanta Regional Office on a frequent basis, and generally confers with CMS personnel concerning all major program decisions.

The agency/program will communicate with other Federal agencies on an as-needed basis.

Other States. SCDHHS communicates with other states via monthly teleconferences for the Southeast Region hosted by CMS and via other formal and informal working groups associated with Health Information Technology (HIT) and other related activities. The MITA Project team has already contacted a few other states requesting feedback and advice on their MMIS implementation experiences, and the team plans to accelerate these contacts throughout the rest of 2010 and into 2011. These contacts may include site visits where valuable and when the travel costs can be properly justified.

6.6 System Certification

Per the State Medicaid Manual and the Code of Federal Regulations, the Replacement MMIS must be certified after completion of DDI. At this time, guidance on certification can be found in the *Medicaid Enterprise Certification Toolkit (MECT)*, published by CMS.

The key unique aspect of certification for this program is that an incrementally developed system will require an incremental (modular) certification in order to provide timely receipt of retrospective FFP. This approach to certification is contained in the approved IAPD.

To provide confidence that the overall system remains certifiable throughout the deployment process, each increment of certification may include a "regression certification" for previously completed functional areas. Additionally, since the certification checklists do not precisely align with MITA, and since the business process model to be used by the State does not precisely align either with MITA or the certification checklists, the State and CMS will have to tailor the checklists significantly in order to complete incremental certification smoothly.

7 Technical Goals and Strategy

7.1 Technical Goals

The key, top level technical goals on the project are (this list is abridged for clarity):

- **Data**
 - Exploit the ubiquity of relatively cheap storage to maximize the amount of historical data maintained online and immediately available to users.
 - Maintain very high data quality and integrity.
 - Convert data from multiple legacy systems while maintaining the integrity of the data and retaining the meaning of the data from its original context.
 - Provide data that is timely, accurate, usable, and easily accessible to support analysis and decision making for health care management and program administration.
- **Standards and Openness**

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- Minimize the use of proprietary technologies other than true commercial off-the-shelf.
- Move towards the use of commodity hardware and eliminate the use of mainframe computers for the Replacement MMIS.
- Design the system to increase the likelihood of reuse by other states.

- **Software architecture**

- Implement a system that follows SOA principles to the extent that they achieve the SOA goals and benefits³ of:
 - Increased intrinsic interoperability
 - Increased federation
 - Increased vendor diversification options
 - Increased business and technology domain alignment
 - Increased return on investment
 - Increased organizational agility
 - Reduced IT burden

Note: the State does not envision that “wrapping” the existing mainframe code in Web services is a viable solution for the Replacement MMIS other than temporarily for transition/migration purposes, if needed.

- Improve flexibility and visibility by using business rules management, business process management, and business activity monitoring tools where practical.
 - Drive the cost of minor changes to the user interface, business rules, and business processes to be so cheap as to nearly be “disposable.” (Note that this is intended to encourage agility, not lack of discipline.)
 - Consolidate IT capabilities, where appropriate, into the MMIS that are currently provided by PC applications and outsourced vendors, and Incorporate the MEDS functionality into the MMIS.
 - Provide access to enterprise-wide information to authorized users from a single sign-on.
 - Maintain very high system availability.
 - Improve agency communications and rapid adoption of new ideas by incorporating staff collaboration tools.
 - Allow users to establish and break relationships between records/entities/items such that they can create meaningful data relationships that do not require case-by-case custom programming.
 - Ensure that the architecture supports basic multi-payer concepts.
 - Use an architecture that can scale gracefully.
- **Security**
 - Meet all HIPAA and other State/Federal privacy and security requirements.

³ SOA: *Principles of Service Design*, Thomas Erl, Prentice-Hall, 2008, p. 55

7.2 The Concept of SOA vs. Enterprise Application Integration (EAI)

Based on responses to *RFI #1*, the MITA Project team sensed a pattern of vendors promoting either their own or third party applications as components or starting points for the Replacement MMIS. The State is concerned that simply selecting the “best of breed” applications and integrating them via Web services using an enterprise service bus will not achieve many of the intended goals of a SOA-based system, and may result in a “ransom note” effect (disjointed pieces without consistency and coherency). The State does not have a goal to build an MMIS from the ground up; however, achieving the goals of a SOA-based system may require existing, off-the-shelf capabilities to be rewritten, larger applications to be decomposed, or when necessary, new capabilities to be written “from scratch.”

The desire for “pure” SOA is rigid. There are clearly situations where using existing applications, in part or in whole, may substantially benefit the program. The following information reflects the State’s philosophy on mitigating circumstances for easing SOA requirements.

The following definitions apply to this Section and may be adjusted in different contexts:

- **Service** – capability/functionality with exposed interfaces and that is composable and has externalized business rules, orchestration/workflow, and user interface. A service assumes those elements will be provided by common services within the system. Note that a service having user interface or other non-SOA interfaces for administration purposes could still fall under this definition.
- **Application** – capability/functionality packaged with business rules, orchestration/workflow, and a user interface. Note that even if the application externalizes these elements, the key attribute of an application is that it expects users to use its own business rules, orchestrations/workflows, and user interface rather than those supplied by external controllers.
- **Service oriented architecture** – a system composed of services using standardized messaging mechanism as communication methods.
- **Enterprise application integration** – a system composed of applications integrated through common communications methods and standards. Note that for the purposes of this paper, integrating *applications* (as “applications” are defined in this paper) using service-oriented methodologies is still considered EAI, because the applications are used as applications, not as services (as “services” are defined in this Section).
- **Point-to-point integration** – a system using services or applications that do not use common/centralized communications methods and standards. Each service/application manages communication with other services/applications individually.
- **Commercial off-the-shelf**– the State will likely use a definition similar to that used by the DoD or from the Federal Acquisition Regulation (FAR). A version of this definition is an item “... that is sold, leased, or licensed to the general public; offered by a vendor trying to profit from it; supported and evolved by the vendor who retains the intellectual

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property rights; available in multiple, identical copies; and used without modification of the internals.⁴

Table 7-1 indicates the relative acceptability of using EAI or point-to-point integration rather than SOA.


Factor	EAI/Point-to-Point More Acceptable	EAI/Point-to-Point Less Acceptable
		
Control - does the State have any control over the service or do IP restrictions or regulatory authority limit control?	Low control	High control
State use vs. vendor use - is the service used principally by the vendor with small or non-existent State/stakeholder use or is it used by large numbers of State/stakeholder users?	Low state/stakeholder use	High State/stakeholder use
Breadth of functionality - does the capability serve a narrow or broad focus?	Narrow scope	Wide scope
Return on Investment - will the investment in creating a service or group of services have a positive ROI in a reasonable period (preferably within five years)?	Low or negative ROI	High ROI
Life span - is the planned lifespan of the service or group of services so short that creating a new service would miss the window of need or never have any ability to achieve a positive ROI (note that this factor is similar to the ROI factor).	Short life span	Long life span
Risk - does the particular capability have a high rate of failure or substantial problems in other similar projects?	High risk	Low risk
COTS - is the capability available in true COTS (particularly if it is commoditized) or is it more often found in custom or semi-custom implementations?	Significant COTS presence	Minimal COTS presence
Need date - is the required need date so soon that the only reasonable choice is to use existing capabilities even if they do not conform to the desired architecture?	Very short term/immediate need date	Distant need date
Performance - can the necessary performance practically be achieved using a SOA approach, or does the solution need an optimized approach to meet requirements?	Performance unattainable with SOA	Performance easily obtainable with SOA
Transparency - is an application architected such that it achieves most of the goals of a SOA-based system without being SOA based? Note that this needs to be evaluated on a system basis, not a function-by-function basis.	Application demonstrates SOA attributes (to include externalization of UI, business rules, workflows, etc.)	Application demonstrates few SOA attributes
External considerations - are there any external considerations (other existing State users, procurement issues, legislative issues, etc.) that make acquiring a non-SOA application preferable?	Strong conflicting external considerations	Few or no conflicting external considerations

Table 7-1. EAI vs. SOA Considerations

⁴ “Commercial Item Acquisition: Considerations and Lessons Learned,” Department of Defense, 2000

7.3 Requirements Process and Documentation

The State's principal goals for the requirements elicitation and management effort are to accurately and completely identify the users' requirements, and to document them more thoroughly than is typically done. In particular, the State hopes to document:

- Functional requirements
- Non-functional requirements
- Business process models
- Business data models
- Business rules
- Use cases, as appropriate
- User interface mockups/prototypes/wireframes

In response to *RFI #1*, multiple vendors responded with concern that the State might use the requirements process to overly constrain the potential solutions. This is clearly not the State's intent as the purpose of the additional documentation is to reduce risk on the program by thoroughly exploring the users' needs, reduce vendor proposed costs/prices on the program because of this reduction in risk, establishing consistency across the various project/contracts, and to shorten the overall schedule by reducing the relative percentage of time spent during vendor DDI on requirements development. The State has essentially moved a substantial percentage of the requirements development effort normally allocated to post-contract award and placed it pre-contract award (thus minimizing the problem of "developing the requirements twice"). The State will need to work with vendors to accelerate the knowledge transfer than typically happens during a vendor requirements development phase.

There is a possibility that the State will not achieve its goals for requirements development. To help mitigate this risk, the State plans to publish draft requirements on the MITA Repository in order to allow vendors and other interested parties to participate in the review process near-simultaneously with internal reviews. The State understands that vendors do this review at their own expense; however, as described in Section 1.5, this investment is likely to be beneficial to all parties if a reasonably large percentage of the resulting requirements are able to be reused by other states.

7.4 Technical Roles

The following list describes the general technical roles of the key stakeholders:

- State
 - Define the architecture and architectural standards
 - Perform oversight of vendors' design, development and testing activities
 - Define the entrance/exit criteria for each phase of DDI
 - Define UAT criteria
 - Develop a data conversion plan
 - Perform the following data conversion processes:
 - Data discovery of all source data
 - Define data requirements for all to-be business processes

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- Data cleansing
- Perform the extraction of data from existing sources and interfaces
- Define the transformation rules
- Perform the data transformation between source and transition data store (the transition data store is envisioned as a tool to assist in interfacing new capabilities with the legacy systems and to assist in the data migration and conversion process)
- Define the data governance policies and procedures
- Produce service design templates
- Working with the Common Services Management vendor and other vendors, identify the services that will serve as the connections to/from specific business areas
- Define service granularity based on requirements
- Evaluate vendor software for compatibility with defined service needs
- Common Services Management vendor
 - Propose and integrate the common technical services
 - Architect, design and build, and test framework components and common services
 - Establish detailed technical standards
 - Maintain service catalog and service registry
 - Coordinate technical integration, test, and problem resolutions with all other vendors and with the State
 - For data stores that will be created and maintained by the Common Services Management vendor, develop and execute data conversion load processes in accordance with the state-defined data conversion plan
 - Conform to established standards for interfaces
- Other project vendors
 - Architect, design, construct, unit test specific services
 - Participate in integration, test, and problem resolution with Common Services vendor, other vendors and with the State
 - For data stores that will be created and maintained by the individual "build" vendor, develop and execute data conversion load processes in accordance with the state-defined data conversion plan
 - Conform to established standards for interfaces
- Other organizations supplying or consuming information
 - Conform to established standards for interfaces

7.5 Role of Standardized Processes and Documentation

While the State prefers to give vendors wide latitude in defining the process and document standards associated with their solutions, such flexibility on a multi-vendor DDI would likely result in chaos. As such certain processes and documentation will need to be standardized.

Examples of processes and documentation likely to require standardization include:

- Requirements documentation
- Design documentation
- Scope documentation
- System test documentation
- Some test documentation below the system level
- System level test processes

Examples of processes and documentation likely to require less standardization include:

- Architecture and design methodologies
- Construction methodologies
- Unit testing processes and documentation
- Most internal integration test processes and documentation

7.6 Common Technologies

While the list of common technologies is likely to change multiple times prior to publication of the Common Services Management RFP, this list currently includes:

- Electronic Document Management System (EDMS)
- Business Process Management System/Suite (BPMS)
- Business Rules Management System (BRMS)
- Enterprise Service Bus (ESB)
- Call Center/Interactive Voice Response (IVR) System
- Electronic Data Interchange (EDI)
- Data management tools
- Program e-mail/calendaring tools
- Geographic Information System (GIS)
- Medicaid portal
- Customer Relationship Management (CRM)
- Integrated testing tools
- Graphical user interface (GUI) development tools
- Learning Management System (LMS)

7.7 Sources of Standard and Specifications

A key goal of MITA is migrating to the use of standards for data, interfaces, etc. Many standards that will be necessary on this program are not defined in the MITA Framework. Where practical, the State will use the following hierarchy to define program technical standards:

- Published formal standards
- Industry common usage standards
- Domain unique standards
- Program standards
- Vendor proprietary standards

7.8 Human Factors Engineering

Human factors engineering is the discipline of applying what is known about human capabilities and limitations to the design of products, processes, systems, and work environments⁵. Too often, the user interface on large software systems is designed by software developers with little experience in human factors engineering. This situation results in systems that require extra user training, have features that are rarely used, and that push users into low productivity scenarios.

A major factor influencing the acceptance and success on this program will be usability. The State and vendors must create a system that is intuitive and relatively easy to use. The State plans to define user experience and interface standards for the Replacement MMIS.

Applicable portions of the system and training materials must support Section 508 of the Rehabilitation Act. Additionally, certain portions of the system must be accessible to persons for whom English is not their primary language.

8 Testing and Quality Assurance (QA) Strategy

While testing and QA are important to all IT projects, their importance to this program is even greater due to its multi-vendor nature. The principal testing and QA challenge the program will face is how to consistently ensure high quality results and deliverables when there is no single vendor responsible for the entire system or operations. The total solution is a shared responsibility. Ultimately, the State will have to take responsibility for the final results, but this is truly a case where the sum of the parts is greater than the whole.

8.1 General Quality Assurance

Quality assurance is applicable to all activities conducted by and deliverables produced by every participating organization. While automation will help coordinate and ensure that these outputs are of high quality, ultimately, most quality measures will contain a substantial human element. The program will likely use all of the typical verification methods: inspection, analysis, demonstration, and test. While the use of recognized quality standards (such as those published by the International Standards Organization) might be helpful, in most cases, the State will address these on a vendor by vendor basis because the initial effort required to bring the State and the entire program up to those standards likely exceeds the State's available capacity. The State may use selected quality standards, where appropriate.

⁵ Sandia National Laboratories Web site, http://reliability.sandia.gov/Human_Factor_Engineering/human_factor_engineering.html, downloaded on 8/4/10.

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Well-executed reviews will be important to project success in QA. Depending on the purpose and the organization conducting the review, these activities may range from ad hoc, informal discussions up to formal, scheduled Fagan inspections. For each contract, the State will establish an acceptable range of acceptable contract vendor-State-associate vendor review cycles. Vendors should propose review periods based on the size, complexity, and criticality of the items being reviewed. In general, each deliverable should go through two rounds of review. In the first round, the reviewers should identify defects and questions needing resolution. The originating organization should then correct the defects and answer questions (including any meetings or discussions necessary to achieve resolution). In the second round, the reviewers should ensure that the identified defects have been corrected, that the questions have been properly answered and addressed; and that no new defects have been introduced and that no new questions have been generated as a result of the changes.

The ability of all parties to succeed in the review process strongly depends on the actions of the other participants in the process. Each party has an obligation to the other parties to perform in a high quality manner. In particular, the State (and associated vendor reviewers) must supply qualified personnel who provide timely, thorough, consistent, and accurate feedback to the originating organization on a deliverable. The originating organization must supply a timely, high quality initial draft deliverable, and be responsive to the reviewers' inputs. Poor initial quality guarantees that a two-round review process will not succeed. This situation often results in "peeling the onion" on a deliverable whereby the more problems that are corrected, the more additional problems are discovered.

The State understands that the review process is often a sore spot in MMIS projects, and that vendors attempt to employ methods to reduce the risks associated with obtaining customer sign-offs. While many of those methods are prudent and acceptable, the following methods are examples of those that are not acceptable:

- Attempting to limit the review discussion or comments very narrowly to only the content of the specific deliverable or addressing only comments from a previous round of review for a specific deliverable. While random, wide-ranging conversations are not usually productive, the inter-related nature of the various elements on this program means that reviews must necessarily touch upon related topics.
- Attempting to "pile on" deliverables over a short time period in such a fashion that the State (and associated vendor reviewers) cannot practically provide feedback in the designated time. The purpose of quality assurance is quality, not sign-offs. The State will require vendors to propose schedules that reasonably space deliverable reviews. If project schedules change after contract award, those new schedules must also adhere to this principle.
- Attempting to limit review cycles to just two rounds for deliverables that have significant quality issues upon initial delivery.
- Attempting to frame changes to signed-off deliverables that are driven by the natural discovery process of software development as scope changes requiring change orders. There is a difference between requirements changes and necessary deliverable refinements. While parties can reasonably disagree over which category into which a change falls, the change itself does not automatically constitute scope creep.

Quality metrics will most frequently fall into the categories of defect counts (both open and resolved), and the time to resolve defects. The State and vendors may identify other quality metrics, as necessary.

8.2 General Testing Approach

The State's general philosophy for testing is:

- Testing should be comprehensive but not unnecessarily duplicative.
- Automated testing, particularly for regression testing, is crucial to program success
- The test management process must be flexible, and all parties must participate at all times. Testing changes in one vendor's software generally mandates the participation of all vendors.

As discussed in Section 3.3.11, the State is considering competitively procuring test management services. This decision on this strategy should affect only the State's team and the Common Services Management vendor's team. The choice to outsource these services separately will not affect the planning and execution of system level testing, only the organization performing the majority of the effort.

8.3 Individual Vendor-Centric Testing

The types of testing that will typically fall into this category include:

- Unit testing
- Internal integration testing
- Targeted system level testing

The State plans to oversee such testing on an as needed basis, but will generally not intervene unless specific issues drive greater involvement. Clemson University will support this testing as the hosting agent, as necessary.

8.4 Multiple Vendor-Centric Testing

The types of testing that will typically fall into this category include:

- System testing
- Support of User Acceptance Tests (UATs)
- Multiple vendor integration testing
- Defect and issue resolution
- Regression testing and retesting
- Specialized testing such as security and load testing
- Interface testing with external entities

The State plans to have a greater role in this type of testing in its role as principal integrator. The Common Services Management vendor and, if procured, the Test Management Services vendor will also have a great role in this type of testing. Clemson University will support this testing as the hosting agent. When necessary, external entities with which the system interfaces may need

to participate in order to have a successful test. This situation will require additional pre-planning and coordination.

8.5 State-Centric Testing

The principal type of State-centric testing is the UAT. Consistent with the philosophy explained at the beginning of this Section, UAT will not be a repetition of system testing. While targeted verification of vendor test results is likely, particularly for high risk areas, UATs will be geared towards execution of operational scenarios. While these tests, like any other disciplined test, will require planning and structure, they will not step-by-step, scripted tests. It is not possible to understand how a system will react to “real” users without letting these users exercise it the way they plan to do on a daily basis. Additionally, since training for a complex new system is crucial, the failure of the user-testers to be able to perform required functions will be a clear indication of problems in the system, its documentation, or the training that has been provided.

As an important element of incremental/staged development and delivery, the State plans to test increments of functionality as they are completed, even if some of those increments will not be immediately deployed. In this way, all parties receive early feedback from real users on the success of the developed components.

8.6 Automated Testing

As mentioned previously in this Section, successful automated testing will be crucial to the success of the program. Given the investment required to implement automated tests, not every test is worthy of being automated. For those that have value, the use of a service oriented architecture should substantially improve the program’s ability to test the services, individually or in composition.

Automated testing is one of the keys to system agility. The program’s ability to change user interface, business rules, and workflows on short notice requires an equally rapid test capability to increase confidence that no unintended system impacts have occurred.

8.7 Independent Verification and Validation

The principal duties for the IV&V vendor are:

- Perform an independent review of major deliverables and processes.
- Evaluate vendor deliverables to ensure that they are suitable and comprehensive enough to transfer to a different vendor in the future.
- Identify areas of risk to the system and associated projects.
- Recommend risk mitigation options and corrective actions.
- Identify deviation from plans or execution of those plans that jeopardize SCDHHS programs and projects.
- Monitor the system certification efforts to identify pertinent risks and issues and required corrective actions
- Ensure findings are documented clearly so that the State can use these findings in its decision-making processes.

- Provide an independent evaluation of system payment accuracy and serve as an “honest broker” in evaluating provider payment complaints in the initial period after deployment of claims adjudication and payment capabilities.

The primary “customers” for IV&V are the Replacement MMIS program management, SCDHHS executive management, and CMS. While the State is interested in IV&V vendor recommendations in all pertinent areas, the State does not plan to utilize the IV&V vendor in a general management or technical consulting role because doing so would violate the independent nature of the vendor’s evaluation.

9 Life-Cycle Support Goals and Strategy

9.1 Life-Cycle Support Goals

The principal goals of life-cycle support are:

- Ensure the system and system support functions remain viable throughout the system’s life-cycle.
- Reduce life-cycle costs by extending the system’s lifespan in economical ways

9.2 Hosting, Monitoring, and Maintenance Planning

9.2.1 Hosting and Monitoring

As previously stated, Clemson University will host the Replacement MMIS with the exception of externally-owned services (e.g., State licensing board), commercial or commoditized services for which the State would not benefit by replication (e.g. credit card payment system), and other special situations on a case-by-case basis. The costs of hosting will normally be amortized by Clemson University over the lifespan of the procured items plus labor and overhead costs and invoiced monthly. On certain occasions, SCDHHS may make direct capital investments up front for higher cost products or systems.

At a minimum, Clemson will host the production, system test/QA, and training environments. There may also be some value in having Clemson host one or more development environments, but the State does not currently know in what situations this would apply (other than Clemson’s own development environment).

Vendors will be required to propose suitable hardware and software configurations to support their services and applications. If the required configurations differ significantly from the proposed configurations due to inadequate vendor specification, vendors may be required to indemnify the State for the additional costs. The purpose of this strategy is to avoid overly optimistic specification intended to make life-cycle costs appear lower during a competitive procurement.

Hosting management duties will generally extend from the operating system and/or virtual machine “down” through the hardware as well as setup and management of systems and services outside of the server hardware, such as networking. Clemson follows processes generally consistent with the Information Technology Infrastructure Library (ITIL) in performing hosting

duties. Vendors will normally manage the services and applications for which they are responsible. Clemson will collect and report on reliability metrics at least monthly for both hardware and software portions of the system.

Likewise, the hosting agent will monitor the health of the systems and services for which it has the duty to manage. Additionally, the hosting agent will monitor the health of the applications, principally via tools and techniques supplied by the developing vendor, and will notify the vendor if it notices anomalies. The ultimate duty for monitoring the health of the developed services and applications, however, resides with the responsible vendor.

The State will identify a suitable disaster recovery/backup location for the Replacement MMIS, and procure the necessary hardware, software, and services to ensure this is operational. At this time, the State does not know whether such location will be made via a cooperative agreement with another data center (e.g., another state or university) or whether these services will be procured commercially.

9.2.2 Maintenance Planning

Hardware. Clemson University will manage all hardware it uses for hosting including maintenance spares support, consumables, facilities, power, cooling air, physical security, and other related items. Vendors will assist in the planning and installation of hardware hosting assets. SCDHHS and Clemson University will coordinate on the replacement cycle of hardware, and vendors will provide recommendations concerning such upgrades.

Each party will maintain its own client computing systems and internal server systems.

Software. Normally, vendors will maintain the source code that they developed in response to governance procedures described in Section 6, including vendor-initiated changes. There is a strong likelihood that business area vendors will develop utility services, user interfaces, or other functionality that can be used by multiple business areas. These capabilities will be candidates for transfer to the Common Services Management vendor for long-term maintenance. Business rules should also be allocated to the business area most associated with the rule, but must be available to all business areas to avoid duplication of business rules throughout the system. Workflows functioning within a single business area (even if service compositions go outside that business area) should be maintained by the developing vendor. Workflows that cross multiple process areas normally may either be maintained by the vendor supporting the business area that triggers the workflow or by the Common Services Management vendor. The State need vendor feedback and further analysis on this area.

Clemson will maintain the general purpose COTS software used in the system, and vendors will assist this effort by providing feedback and analysis on potential changes.

Each party will maintain the software supporting its own client computing systems and internal server systems.

9.3 *Manpower*

The change in technology and IT/contract alignment with the SCDHHS business driven by the Replacement MMIS program will likely have some impact on the manpower supporting the enterprise.

State Personnel. Roles that will likely have a greater presence in the future include integration activities, training, and enterprise architecture. Roles that will likely have a decreased presence in the future include administrative roles associated with existing paper-driven processes, clinical specialties and coding specialties. For the latter two roles, the State has repeatedly had difficulties hiring and retaining staff in these areas. If this problem persists, the State may choose to outsource certain specialties, most likely to the Healthcare Services Management vendor.

State Support Contractors. The majority of the MITA Project team will be made up of support contractors obtained via the State's IT Staffing contract. While this team will diminish as parts of the new system go live, the greater integration role and the emphasis on enterprise architecture may result in retention of certain positions or creation of new support contractor positions to supplement the State staff.

Vendors. The State does not currently manage vendors on an individual basis. On a contract/company basis, the number of vendors will be reduced as increments of the new system are deployed and legacy solutions are decommissioned. Additionally, the State predicts that increased productivity driven by the new system and contract realignment will reduce the number of vendor personnel (on an equivalent work basis as for the legacy solutions).

9.4 *Technical Data and Publications*

9.4.1 **General Strategy**

The following principles outline the State's approach to technical data and publications:

- The most maintainable documentation is that stored in its original electronic form, such as that generated by an integrated development environment (IDE). The need to transform development artifacts, while sometimes necessary, results in a perpetual "tax" on the program.
- Vendor-to-vendor consistency is important for data and publications intended to be consumed by an audience whose interests cross business area boundaries. For example, service contracts cannot practically be maintained in five different formats. This principle will occasionally conflict with the previous principle on using documents in their original forms. If vendors use different tools that generate documentation, then the formats and content of those documents have the potential to differ.
- Even if technical data and publications are stored or generated in different locations (physical or virtual), access to these documents must be centralized for ease of access.

9.4.2 **Requirements**

Requirements must be maintained centrally to ensure uniform access by all parties and to maintain their configuration consistently. The State intends to administer the requirements management solution. The MITA Project team may choose to use a low-cost requirements

management tool initially to minimize the investment should a future change need to be made. If the selected tool cannot meet the program needs as vendors are added, the State may choose to migrate to a different tool.

The State also plans to keep a current set of requirements posted to the MITA Repository. Because of the nature of that tool and the need to minimize user access issues, this copy of the requirements is likely to be created as an export from the requirements management tool. Certain requirements documents, such as the exact business rules describing claims adjudication edits and audits, may be withheld from the MITA Repository due to the potential for abuse of this information by fraudulent providers.

9.4.3 System Technical Documentation

Some types of system documentation that will need to be maintained include:

- Information, application, and technical architecture information
- Source code, build files, and other related construction information
- Test planning, execution, reporting, and management information
- Release notes
- System configuration information

Centralized access to this information is also desirable, even though the audience is likely smaller. Portions of this information (particularly architecture information) will likely be duplicated to the MITA Repository; however, other portions may be available to outside parties only by request with approval, such as detailed design information, source code, etc. The purpose of doing this is to avoid potential security issues. Additionally, some portions of the system technical documentation may be proprietary vendor material that is unavailable for release outside the program.

9.4.4 User and Administrator Manuals and Help Files

It is important to maintain the manuals and help files to ensure high user productivity and to avoid negative training incidents. With the assistance of the Common Services Management vendor, the State will establish general standards for these artifacts. They will be accessible centrally, and State anticipates moving away from printed documents as the primary source of user documentation towards contextually-sensitive online documentation. While maintenance in source formats is useful for the user and administrator manuals, the State still desires the ability to print them out in a usable format for situations where electronic documentation is not suitable. Rather than mass producing them in fixed versions that go out of date quickly, printed versions should be available on demand with currency clearly marked on the document components.

9.5 Training and Training Support

The general approach to training for the program is that vendors will largely have the duty of content development and administrative support, and the State will largely have the duty of managing training needs and performing training delivery.

9.5.1 Targeted Audience

State. Users for the State include the staff from SCDHHS, Clemson University, and other State agencies.

Vendors. Users for vendors include the staff of the developing vendor, and staff from other vendors needing cross-training.

Providers. Users from the provider community include the staff of institutional providers, individual and group professional providers, and atypical providers. All groups include potential enrollees; however, in most cases pre-enrollment training should be minimal.

Members. Users from the member community include potential eligibles, enrolled members, disenrolled members, as well as agencies and organizations supporting the same. Because the ability to provide formal training to these types of users, it is crucial that the portions of the Replacement MMIS exposed to members be extremely intuitive, and that help files and training resources be easily to access and use.

9.5.2 Training Development Strategy

Training will be developed incrementally and in a modular fashion, similar to that of the system software. Vendor will need to develop training materials to support a train-the-trainer approach. This will require materials geared towards the trainers, as well as the end users. Vendors will need to create cohesive, standalone training content for external users not participating in face-to-face sessions.

The content for training may be in the form of printed materials, multimedia content, and computer-based content.

The two major challenges in training development will likely be:

- Keeping the material consistent and current given the interrelated changes occurring on the system and supporting operations via multiple vendors. Training content will require governance similar to that of program software.
- Integrating the training content to form a cohesive body of training material.

9.5.3 Training Execution Strategy

Training execution will consist primarily of train-the-trainer sessions, end user training sessions, and self-training sessions. The training team will need to conduct mass training for users prior to and just after deployment of releases. Additionally, new hire training will need to begin shortly after deployment increments, and refresher training will need to start within a year or so of incremental deployments. The program incremental deployment strategy could cause significant challenges for provider and member training as well as training for users from other State agencies. The State and vendors will need to carefully consider the software release strategy to avoid requiring repeated field training for these types of users.

9.5.4 Roles

The principal training roles for the State are:

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- Develop the training calendar and schedule
- Conduct skills inventories and level set end user skills
- Develop skill mastery criteria
- Develop and ensure compliance of training standards and requirements
- Conduct quality assurance testing and review of training materials supplied by all vendors
- Design, develop, and implement train-the-trainer (T3) sessions
 - Vendors need to provide training on their solutions and provide support to the State's T3 training. If a T3 has questions for end users
- Implement end user training
- Conduct end user supplemental training, as needed, to ensure mastery of skills

The principal training roles for the vendors are:

- Design and develop training materials for the Replacement MMIS including:
 - Instructional content design and development
 - Audio and video development
 - Graphic art development
 - Alternative language training materials, as needed or required by law
 - Training material compliant with Section 508 of the Rehabilitation Act, as needed
- Other activities related to training material development including:
 - Working with associate vendors to provide training material consistency
 - Developing and maintaining supplemental and reproducible training materials
- Common Services Management vendor will maintain the Learning Management System (LMS) including:
 - User registration
 - Online evaluations
 - Online training modules
- Support train-the-trainer and end user training
 - Create reproducible training materials
 - Develop and maintain portable training packages suitable for field trainers to conduct computer based training and face-to-face training
 - Develop and implement a post-training help system for end users
 - Populate and maintain the training library
 - Provide answers to end user questions when T3s cannot answer them, and update training based on these questions, as necessary

9.6 Computer Resources Support

9.6.1 Operational Help Desk

The State is still investigating the best approach to take concerning how to provide help desk support for the Replacement MMIS (note that this does not include general desktop support provided by the SCDHHS Bureau of Information Technology Services). The likely options are:

- Use the common call center telephone number and a unique help desk e-mail address and have requests routed to the proper support organization based on the type of support needed similar to any other call center request.
- Use the Common Services Management vendor to provide first and second tier help desk operations. More complex issues would be routed to the vendor responsible for the affected part of the system.
- Use a State-run help desk (SCDHHS, Clemson University, or a combination) for first tier help. More complex issues would be routed to the vendor responsible for the affected part of the system.

To assist in self-policing software and training materials quality, the State believes that the best help desk solution will require vendors to contribute to help desk operations affecting their parts of the MMIS in some fashion.

Note that the term “help desk” applies to systems and services already deployed. During DDI, vendors will have to provide “technical support.”

9.6.2 Account Management

User accounts can either be managed by the same entity providing help desk support or by the Common Services Management vendor.

9.7 Facilities

9.7.1 State

The bulk of the State team will be located in downtown Columbia and at Clemson University. The majority of the MITA Project team will be located in the Dennis Building and most of the remainder of the SCDHHS personnel will be in the Jefferson and Klondike Buildings. Clemson University team members are likely to split their time between Columbia and Clemson.

The State may station certain individuals within Columbia-based vendor facilities if this will improve teamwork. Should the State choose to do this, it will expect that a vendor will supply suitable office space and general office support to include Internet access (which may be routed outside the vendor’s network).

9.7.2 Vendor

Co-located Personnel. The State may request that certain vendor personnel work out of the State’s office in the Dennis Building or a building at Clemson University if it will improve teamwork. The State will supply suitable office space and general office support to include Internet access (probably routed around the State’s network).

Columbia-area personnel. The State strongly prefers that vendors maintain an office in the Columbia area to support personnel working directly with the State on a daily basis. Reasonably close proximity to the State's facilities will likely improve the working relationship and save money in time and travel for all parties.

Remote personnel. The State has no specific requirements for remote vendor personnel other than the State currently plans to require that all work be performed in the United States or its territories. Given the sensitive nature of Protected Health Information (PHI) and the intellectual property rights associated with this program, the State does not believe that it is in its best interest to have to deal with international legal issues.

10 Intellectual Property (IP) Strategy

The following principles will guide the State in managing intellectual property used in conjunction with this program.

- The State and CMS must retain rights to all software and other intellectual property created during the program. This is a requirement from the Code of Federal Regulations that applies to activities receiving FFP.
- The State must retain ownership of all data supplied to or created during the program.
- For IP not owned by the State, the State must secure perpetual usage rights to all IP needed to properly operate the system and conduct business operations. Data that are most typically available by time-limited licenses are an exception to this rule.
- For IP not owned by the State, the State must secure perpetual modification rights and the right to transfer the IP to another party serving the State for the purpose of serving SCDHHS. Products that are true COTS are an exception to this rule.
- The State and CMS may grant vendors the right to use State-owned IP as long as the vendors and their customers using the IP participate in the common governance process, and as long as the vendors can demonstrate that they will apply a reasonable system for tracking the use of State-owned IP in a fashion that ensures that no customer (public or private sector) remunerates the vendor for the use of the State-owned IP.

11 Business Operations Goals

The goals in this section are currently immature because the State has not yet begun formal requirements development. Project acquisition strategy documents will provide greater insight of business operations goals.

The goals identified in this section are a subset of internal working documents and include CMS certification objectives as well as internally-derived goals and objectives. CMS certification objectives are identified with "(CMS)" at the end of the objective.

11.1 Member Management Operations Goals

- Maintain information on each Beneficiary's Medicaid benefits to support claims payment and other financial processes. (CMS)
- Allow verification of Beneficiary Medicaid eligibility information by external entities.
- Comply with HIPAA requirements. (CMS)

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- Collect and manage information about the Beneficiary population from diverse sources. (CMS)
- Manage the Medicare Buy-in and Part D data exchange processes (optionally supported by MMIS) (CMS)
- Empower beneficiaries by providing greater access to searchable provider and health information.
- Support the submission of electronic applications and scannable applications.
- Create a policy- and procedure-driven, system-guided eligibility determination and redetermination process to help eligibility staff render more consistent decisions including automated eligibility determination for all categories and programs.
- Manage beneficiary cost-sharing requirements and be flexible enough to allow implementation of future cost-sharing arrangements
- Automate periodic eligibility reviews to reduce the burden on the beneficiaries and State staff including automatic disenrollment for appropriate situations.
- Provide multiple methods of eligibility verification (e.g., voice response system, EDI, Web, etc.)
- Streamline the enrollment process by providing the option for online enrollment and automating tedious activities such as income and resource calculations and program and category eligibility.
- Improve understanding of beneficiary status by maintaining historical information about benefit package enrollment and services used for each beneficiary.
- Align managed care enrollment with the eligibility process.
- Improve enrollment quality, reduce beneficiary/State effort, and increase visibility by performing real time eligibility determination and inquiry.
- Improve the likelihood of identifying and recovering payments made on behalf of ineligible beneficiaries by automating the tracking and recoupment management processes.
- Use State-wide work queue management to balance case worker workload rather than managing on an office-by-office basis.
- Manage premium collections from Beneficiaries, if applicable (optional).
- Analyze Beneficiary enrollment, participation, and program usage to predict utilization trends.
- Improve the State's ability to transfer claims to other insurers by tying third party liability (TPL) and health insurance premium payments (HIPP) more tightly to the eligibility determination process.

11.2 Provider Management Operations Goals

- Enroll and maintain adequate provider network for the Medicaid Beneficiary population. (CMS)
- Comply with HIPAA requirements. (CMS)
- Maintain provider information. (CMS)
- Ensure quality of provider network and accuracy of payment arrangement. (CMS)

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- Meet CMS objectives and more accurately pay claims by collecting business structure information from the providers.
- Use online access to credentialing sources to improve and accelerate the enrollment, verification, and periodic re-verification processes.
- Improve our ability to manage the Medicaid program effectively and improve our understanding of the provider community by collecting more demographic information about providers and by allowing providers to update certain information directly.
- Migrate to an online provider enrollment process for virtually all providers
- Improve beneficiaries' ability to locate suitable providers by collecting and publishing information on provider offices hours, specialties, openings for new Medicaid patients, languages spoken etc. and by allowing providers to update this information directly.
- Improve provider understanding of DHHS programs and benefit plans by placing provider manuals online and improving their format and searchability.
- Migrate away from reliance on maintaining State-specific, proprietary provider identification and towards NPI and taxonomy.
- Improve the speed and accuracy of communications with providers while maintaining privacy standards by providing secure mailboxes.
- Provide online access to Remittance Advices (RAs).
- Reduce payment of claims to providers who are ineligible due to sanctions and other restrictions by automatically matching enrolled providers with sanctioning lists.

11.3 Healthcare Services Management Operations Goals

- Validate that claims are for eligible Beneficiaries. (CMS)
- Provide for the timely disposition of prior authorization requests. (CMS)
- Validate that claims are from properly enrolled and eligible providers. (CMS)
- Route claims for processing and track claim progress, status, and, location. (CMS)
- Improve the timeliness and effectiveness of claims research by maintaining adjudication details in the system (e.g., failed edits, eligible benefit plans, etc.).
- Improve management of adjustments by applying most adjustments at the claim level, where practical, rather than relying on gross level adjustments and by allowing multiple adjustments to be applied to individual claims. Note that some adjustments (e.g., Disproportionate Share Hospital Program) will still need to be made at the gross level or via a separate payment process.
- Improve standardization of claims status and reduce provider calls concerning status by ensuring that the claims adjudication and reporting process is consistent with Claims Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC).
- Improve the timeliness and effectiveness of the claims adjudication and correction processes by providing for online resolution of pended and online claims update and re-filing for providers and eliminating the Edit Correction Form (ECF) process.
- Incorporate National Correct Coding Initiative and more sophisticated, standards- and rules-based editing and auditing into claims processing.
- Improve the efficiency, effectiveness, and timeliness of prior approvals via automation and allowing other approving agencies access to the MMIS.

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- Improve claim quality, reduce provider/State effort, and increase visibility by performing real time adjudication and inquiry of claims.
- Accept claims and other transactions electronically and via hard copy. (CMS)
- Accept attachments and other materials related to claims and other transactions as required for review and approval. (CMS)
- Comply with HIPAA requirements. (CMS)
- Substantially reduce the number of paper claims filed by providers.
- Improve closeout of accounts and recovering revenue due to the State for deceased beneficiaries in long-term care or nursing facilities by managing estate recovery processes.
- Automate the service authorization process.
 - Allow for electronic submission of authorization requests and electronic notification of decisions.
 - Automatically validate authorization numbers submitted on claims
 - Automatically notify beneficiaries when services are denied
 - Ability to authorize services with time and unit limitations
 - Provide system access to other State agencies to approve PAs for which they are responsible
- Ensure timely and accurate adjudication of provider claims. (CMS)
- Verify that services are medically appropriate, conform to Federal and State policies, and result in the maintenance or improvement of patient health. (CMS)
- Verify authorization for services that require prior approval in order to manage costs or ensure patient safety. (CMS)
- Support other business processes that require pharmacy claims data, e.g., rebate invoicing, retrospective DUR, and decision support. (CMS)
- Maintain interfaces between POS and reporting applications, e.g., Federal reporting, data warehouse/decision support, drug manufacturer rebate invoicing, program integrity, and others. (CMS)
- Maintain interfaces between the POS system and comprehensive, accurate, and up-to-date sources required to approve and adjudicate claims according to State and Federal rules. (CMS)
- Deny claims for members with third party coverage, including Part D Medicare, or flag for pay-and-chase activity. (CMS)
- Use ProDUR and RetroDUR in combination to improve outcomes, reduce costs, and identify abuse patterns.
- Improve capture of drug rebate revenue by acquiring and maintaining information needed to identify rebateable events; calculating rebate amounts; and managing the rebate invoicing process.
- Create and submit to CMS the Federally required EPSDT reports. (CMS)
- Create and submit to CMS the Federally required HCBS Waiver reports (optional, not needed if State has no waivers). (CMS)
- Create and submit to CMS the Federally required MSIS reports. (CMS)

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- Meet all other Federal Reporting Requirements. (CMS)
- Produce individual Explanation of Benefits (EOB). (CMS)
- Provide online access to Recipient Explanations of Medical Benefits (REOMBs).
- Analyze provider performance to show extent of participation and service delivery. (CMS)
- Maintain an efficient and effective management reporting process. (CMS)
- Support data exchange between stakeholders using standard data formats. (CMS)
- Process accurate and timely automatic or choice-based enrollment, re-enrollment, and disenrollment of Medicaid eligibles into a Managed Care Organization (MCO), Primary Care Case Manager (PCCM) or Primary Care Physician (PCP) program, including into a Health Maintenance Organization (HMO). (CMS)
- Manage premium collections from Beneficiaries, if applicable (optional). (CMS)
- Maintain the privacy and security of enrollment information in transit and at rest. (CMS)
- Improve use of EPSDT services via better tracking and automated notices to beneficiaries and providers.
- Control enrollment of participants into the HCBS (1915(c))waiver programs to meet the State's objectives. (CMS)
- Provide services as described in the individual's approved plan of care. (CMS)
- Process waiver provider claims and make timely and accurate payments. (CMS)
- Enroll traditional and nontraditional service providers meeting identified standards of care into the program to provide services to the target population. (CMS)
- Produce program data necessary to satisfy Federal Medicaid reporting requirements, monitor utilization, and assess quality of care provided to participants. (CMS)
- Generate reminders and recall vaccination notices to parents or guardians for each Medicaid child registered at intervals when vaccination is needed. (CMS)
- Meet Federal reporting requirements for reporting vaccination rates for Medicaid children enrolled in the Early Periodic Screening, Diagnosis and Treatment (EPSDT) Program. (CMS)
- Ensure the privacy and security of immunization information in transit and at rest. (CMS)
- Ensure standardized data is available for measuring immunizations provided to protect all children in the State from communicable diseases. (CMS)
- Make Beneficiary-specific vaccination history available to authorized providers at time of encounter to ensure appropriate vaccinations are provided. (CMS)
- Provide interfaces to and from the registry. (CMS)
- Generate reminders and recall vaccination notices to parents or guardians for each child registered at intervals when vaccination is needed. (CMS)
- Monitor and report vaccination rates for all children within a statewide area. (CMS)
- Ensure the privacy and security of vaccination records stored in the immunization registry. (CMS)
- Ensure standardized data is available for measuring immunizations provided to protect all children in the State from communicable diseases. (CMS)
- Control costs and improve care coordination by continuing the State's migration to the managed care model. (CMS)

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- Support specific functions, as applicable, related to the administration of Section 1115 Waivers. (CMS)
- Identify services covered under capitation premiums and block duplicate fee-for-service payments and supplemental payments to providers. (CMS)
- Receive, process, and store MCO encounter records for use by the Medicaid agency in managing MCO performance. (CMS)
- Collect and report on financial data related to Medicaid managed care programs. (CMS)
- Collect data and provide reporting to support MCO contractor monitoring (optional). (CMS)
- Make accurate payment to MCO for managed care services provided to enrolled members. (CMS)
- Provide information to support assessing quality and cost of care provided to enrollees. (CMS)
- Support assessment of members' access to services. (CMS)
- Increase Beneficiary access to care and qualified PCCM providers. (CMS)
- Support enrollment of Medicaid eligibles into Primary Care. (CMS)
- Process accurate and timely payment to PCCM for gatekeeper service. s(CMS)
- Make accurate and timely payments to providers. (CMS)
- Generate reports to monitor quality and cost of care provided to enrollees. (CMS)
- Identify services covered under capitation premiums and deny duplicate fee-for-service payments. (CMS)
- Receive and process encounter records from PIHP/PAHP and/or its providers. (CMS)
- Support accurate and timely automatic or choice-based enrollment of Medicaid eligibles into a PIHP and PAHP. (CMS)
- Make accurate and timely payment to providers for managed care services provided. (CMS)
- Monitor access to and availability of qualified providers to serve participants enrolled in PIHP and PAHP. (CMS)
- Monitor quality and cost of care provided to enrollees. (CMS)

11.4 Accounting & Financial Management Operations Goals

- Support management of program funds. (CMS)
- Ensure that accounts payable and receivable transactions are recognized and posted in accordance with State and Federal regulations. (CMS)
- Ensure that all financial transactions related to program delivery are processed as defined by State and Federal regulations. (CMS)
- Maintain fiscal accountability for monies received from external sources by managing a lockbox process.
- Improve funds management via interfaces with the South Carolina Enterprise Information System (SCIES).
- Automate reconciliation of retrospective cost settlements and other similar cost adjustments for providers, as applicable.

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- Calculate and manage Federal, State, and County shares of financial transactions in a way that supports, but does not duplicate, the State's accounting systems.
- Manage data gathering and reporting activities needed to meet IRS and SC DOR regulations.
- Analyze Medicaid program costs and trends to predict impact of policy changes on programs.
- Meet all other Federal Reporting Requirements. (CMS)
- Improve the efficiency and accuracy of Federal reporting by automatically generating the CMS 64 report.
- Automate the hospital cost reporting process.
- Provide efficient and timely identification and maintenance of Third Party Liability (TPL) resources. (CMS)
- Obtain the maximum cost avoidance and reimbursement for Medicaid Beneficiaries covered by other insurance. (CMS)
- Improve management of Health Insurance Premium Payment (HIPP) by expanding outreach and maintaining relevant data in the replacement MMIS.
- Ensure that TPL is able to pursue claims against long-term care insurance policies.

11.5 Contractor and Business Relationship Management Operations Goals

- Improve DHHS access to contract information by imaging and electronically storing contracts and contractor files.
- Improve and centralize reporting on contractor performance.
- Improve security, accuracy, and timeliness of data interfaces by applying rigorous management processes with respect to data sources for and consumers of MMIS data.

11.6 Common Services Management Goals

The State has not yet developed these goals.

11.7 Program Integrity Operations Goals

Note that these capabilities are not currently in scope of the program.

- Support analysis of and provide reports for fraud and abuse analysis and investigations. (CMS)
- Improve delivery of health care services and the integrity of the Medicaid program by reducing the waste, fraud, and abuse through analysis of Beneficiary utilization. (CMS)
- Improve delivery of health care services and the integrity of the Medicaid program by reducing waste, fraud, and abuse through analysis of provider performance. (CMS)
- Identify and analyze program trends and directions in provider, Beneficiary, and service utilization and expenditure patterns. (CMS)
- Reduce PI administrative effort and improve PI case management by better automating case management activities.
- Reduce fraud, waste, and abuse via "low tech" methods such as the broader use of lock-in programs and an improved PI referral intake process.

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- Support provider, group, and recipient profiling.
- Support closed-loop feedback from Program Integrity findings and analyses to benefit program management in order to improve the prevention of waste, fraud, and abuse rather than merely detecting such problems only after payment.
- Improve case management by recording reviews, queries, and history on a claim record.
- Support tracking recovered funds by reflecting such recoveries in the MMIS.
- Improve the State's ability to detect fraud through automated computer learning
- Support fraud analysis by being able to link any record/entity/object to any other record/entity/object.

11.8 Decision Support Objectives

While decision support is not a business area, there are enterprise-wide objectives that will be met by the decision support system. Note that these capabilities are not currently in scope of the program.

- Support improved analysis for decision making. (CMS)
- Provide timely and effective reports for management planning and control. (CMS)
- Support better understanding and management of the Medicaid program by collecting and organizing Medicaid-related data and making this data available in a timely and effective manner. (CMS)
- Support establishing macro/microscopic norms and benchmarks and evaluate performance against these (to include comparison to State and national norms and benchmarks as well as provider and network comparisons)
- Support benefit plan definition, refinement, and projections
- Broaden usage of the decision support/business intelligence tools by providing technical/operations solutions suitable for users with duties ranging from management to technical specialists
- Support cross-program analysis to evaluate comparative efficiencies and efficacies
- Provide predictive modeling and forecasting tools to support the planning process
- Assist strategic planning by allowing analysis of:
 - Budget plans/budgetary constraints to include rate setting
 - Citizen needs
 - Resource allocation
- Provide tools to:
 - Analyze the business
 - Inform State leadership
 - Inform CMS and/or other Federal organizations
 - Inform the General Assembly
 - Inform the public and media
 - Answer "What if?" questions using ad hoc and canned reports
- Display and highlight trends in key indicators

- Support rich visualization methods (including graphing, map-based displays, etc.) to improve users interpretation of query results

11.9 Hosting Operations Goals

The State has not yet developed these goals.

11.10 Other/Common Goals

These goals cross business areas:

- Reference data:
 - Comply with HIPAA requirements. (CMS)
 - Manage reference data to support claims processing, data to consist of proper procedure, diagnosis, formulary and drug pricing codes, charge information, and data that supports different payment methods (e.g. Outpatient Prospective Payment System (OPPS), Diagnosis Related Group (DRG), etc), and other items as needed by the State. (CMS)
 - Rearchitect and simplify the management of reference data by improving consistency, reducing redundancy, and taking an enterprise approach to reference data change management
- Control access to system and data. (CMS)
- Protect the confidentiality and integrity of electronic Protected Health Information (ePHI). Monitor system activity and act on security incidents. (CMS)
- Support individual rights specified in the HIPAA Privacy regulations. (CMS)
- Improve efficiency and reduce the likelihood of errors in changing rates and reference information by automating data loading processes.
- Improve consistency and completeness by documenting and maintaining program information and processes.

12 Key Risks, Issues, and Opportunities

Table 12-1 lists some of the key risks, issues, and opportunities on the Replacement MMIS programs along with additional notes. The MITA Project team has attempted to be very straightforward in identifying these risks, and it believes that the first step in managing risks is to be thorough and realistic in identifying potential risks.

Reference Number	Description	Notes
Opportunities		
1	The State may be able to achieve a greater number of MITA goals because it is pursuing those goals more aggressively than most other states.	
2	The State may enable other states to pursue	Intra-state or inter-state reuse must be

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Reference Number	Description	Notes
	vendor-agnostic SOA systems because it is emphasizing multi-state reuse in its strategy.	proactively pursued because reuse rarely happens efficiently by accident.
3	The program may be able to deliver needed capabilities sooner to the users because of pursuing an incremental development strategy.	
4	The State may be able to implement its health insurance exchange better and with less effort because a new Member Management capability built on a SOA foundation will more easily integrate with the needed capabilities of the exchange.	
Risks		
1	The State may fail to manage the program effectively because it may be more difficult than expected and because there is little precedent for this type of strategy.	This is the most significant risk on the program. The number of unknowns on this program is larger than normal.
2	The State may miss key requirements for common services and related integration duties because it solicits proposals and awards a Common Services Management contract in advance of completing the business requirements analysis.	
3	The State may be unable to manage the complexity of an incrementally-developed, multi-vendor, SOA solution due to the challenges in partitioning functionality appropriately and the vendor challenges of designing service compositions in the context of an incomplete system design.	Thomas Erl states that the irony of building a SOA-based system is that to achieve the goal of agility, you must pursue a counter-agile initial strategy to ensure that the architecture and design are solid. ⁶
4	The State may fail to attract the best vendors to submit proposals because they do not have faith in its acquisition strategy or because they do not have the belief that the State will view them as competitive, responsible bidders.	The MITA Project team intends that early publication of this acquisition strategy and modification of the strategy based on external feedback will mitigate much of this risk.
5	Planning for and conducting end-to-end	

⁶ SOA: Principles of Service Design, Thomas Erl, Prentice-Hall, 2008, p. 87

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Reference Number	Description	Notes
	testing with high coverage may be very challenging because of the multi-vendor environment where no single vendor is responsible for the entire system.	
6	The program may have difficulty maintaining suitable test environments because different vendors will be in different life-cycle phases throughout most of DDI.	
7	The development process may have unpredictable and unrepeatable bugs due to an inadequate multi-vendor configuration management process and the difficulty for one vendor to discover configuration changes to software or hardware made by another vendor.	
8	Vendors may not fully cooperate with each other because they do not trust that other vendors will protect their intellectual property and because they believe that they must still compete with each other for future work.	The State plans to use ACAs and limits on multiple contracts to help address this risk.
9	The program may not accurately and adequately capture the to-be business architecture/requirements because of a shortage of business unit staff.	The financial crisis and systemic hiring difficulties for certain skill sets have resulted in numerous agency vacancies.
10	The State may have to create a non-standard type of incentive contract because the State and/or vendors cannot adequately manage Federal-type cost reimbursement contracts.	
11	The program may not be able to adequately respond to recent and future changes in healthcare legislation during DDI because the rate of change is so high.	
12	The State may have substantially underestimated cost and schedule for this program because there are few, if any, analogous past programs to use for comparison.	
Issues		
1	The State will be unable to complete	

Reference Number	Description	Notes
	pertinent portions of the Replacement MMIS in time to avoid the need to modify the legacy systems for ASC X12 5010 and ICD-10 because there is not enough time to execute the planned strategy by the required dates.	
2	The program will likely require some redesigns throughout DDI because of the rapidly changing requirements and solutions for HIT and healthcare reform legislation.	

Table 12-1. Initial Opportunity, Risk, and Issue Assessment

13 Market Research

The MITA Project team plans to use the following techniques to aid in market research prior to publishing solicitations and during DDI:

- Web searches. The ubiquity of product and service information on the Internet can rapidly accelerate market research.
- Responses to Requests for Information.
- Vendor presentations and demonstrations.
- MITA Project team use of demonstration products (trial versions, sandbox versions, etc.).
- Other interactions with vendors via conferences, public demonstrations etc.
- Trusted sources of non-vendor information such as other states, Federal agencies, non-aligned consulting vendors, paid research services, etc.
- Current knowledge of MITA Project team members

Attachment 2

Proposed Common Services Duties and Deliverables

Common Services - Roles and Responsibilities

CSM vendor = Common Services Management vendor

Assumptions;

1. Unless otherwise indicated;
 - a. duties and responsibilities span DDI and Operation phases
 - b. where “Services” are referenced, it will include data, business, and technical services collectively
 - c. The Call Center/IVR technical functions are for the new MMIS system only, and are not a full telephony solution for the entire agency
 - d. The Data Center Hosting entity will perform and/or provide the following for hardware infrastructure
 - Infrastructure
 - • Installation and setup of hardware for integrated test and production environments
 - • High availability network configuration
 - • High availability hardware configuration
 - Security
 - • Physically secure data center
 - • Networking security (routers, firewalls, intrusion detection)
 - • Single sign-on infrastructure for MMIS
 - Disaster Recovery
 - • Backup and recovery services
 - • Disaster recovery site (2nd site)

Common Services Technologies Description of features and capabilities	Duties and deliverables for Common Services Management Vendor	Duties and deliverables for State Team	Duties and deliverables for business area vendors
<p>1. Electronic Document Management System (include fax and workflow)</p> <p>The EDMS will be used to track and store electronic documents and/or images of paper documents.</p> <p>Features should include;</p> <ul style="list-style-type: none"> • Document Capture, to include both character recognition and image • Storage • Versioning • Workflow – rules based • Metadata – keyword, date received, etc • Integration with other applications • Security (to include encryption) • Indexing • Retrieval and search – partial, full-text, unique ID • Collaboration – allow multiple users to markup at the same time • Publishing - in a format not easily altered without a specific knowledge or tools, but is read-only or portable 	<p>Design, Development, Implementation</p> <ul style="list-style-type: none"> • Develop schedule for installation and deployment of EDMS product(s) • Install and configure hardware and software <p>DDI and Operations</p> <ul style="list-style-type: none"> • Maintain compatibility with established project document and image file types • Provide training and technical support to state team and other vendors on usage of EDMS <p>Operations</p> <ul style="list-style-type: none"> • Provide proper handling and secure storage of source documents 	<ul style="list-style-type: none"> • Approve deployment schedule • Establish document and image type standards (structured and unstructured) • Define the MMIS requirements for business and technical process functions to be performed by the EDMS 	<ul style="list-style-type: none"> • Define the sub-project's EDMS needs of EDMS • Coordinate with CSM vendor to design, develop, test, and implement the interface mechanism/service to connect the sub-project system to the EDMS

Common Services Technologies Description of features and capabilities	Duties and deliverables for Common Services Management Vendor	Duties and deliverables for State Team	Duties and deliverables for business area vendors
<p>2. Business Process Management System/Suite</p> <p>Supports the design, modeling, execution, monitoring, and optimization phases of the BPM lifecycle. Product components to include;</p> <ul style="list-style-type: none"> • Process Engine – for modeling and executing process-based applications, including business rules • Business Analytics — to identify business issues, trends, and opportunities, including reports and dashboards • Content Management — for storing and securing documents, images, and other files (related to business process) • Collaboration Tools — discussion forums, dynamic workspaces, and message boards * • BPEL generation • Version control and management <p><i>*Need to research what collaboration tools are included in available BPMS's</i></p>	<ul style="list-style-type: none"> • Develop schedule for installation and deployment of BPMS product(s) • Install and configure hardware and software • Utilize the BPMS to develop and document design details, and generate BPEL code, associated with the business processes associated with the “common services” • Perform modifications to generated BPEL (after receiving approval from State) • Provide training and technical support to state and other vendor personnel on the use of the BPMS 	<ul style="list-style-type: none"> • Approve deployment schedule • Define analytics and reporting parameters • Identify process flows and sources of information for content management and workflow • Approve vendor requests to modify generated BPEL when necessary 	<ul style="list-style-type: none"> • Utilize the BPMS to develop and document design details, and generate BPEL code, associated with the sub-project’s defined business processes. • Perform modifications to generated BPEL (after receiving approval from State)
<p>3. Business Rules Management System</p> <p>Provides the ability to: register, define, classify, and manage all the rules, verify consistency of rules definitions, define the relationships between different rules, and relate rules to IT applications that are affected or need to enforce one or more of the rules</p>	<ul style="list-style-type: none"> • Develop schedule for installation and deployment of BRMS product(s) • Install and configure hardware and software • Provide training and technical support to state and other vendor personnel on the use of the BRMS 	<ul style="list-style-type: none"> • Approve deployment schedule • Define business roles conditions and events (including error thresholds) • Validate that business rules are working properly 	<ul style="list-style-type: none"> • Utilize the BRMS to develop and modify software and documentation artifacts associated with the business rules within a given business area.

Common Services Technologies Description of features and capabilities	Duties and deliverables for Common Services Management Vendor	Duties and deliverables for State Team	Duties and deliverables for business area vendors
<p>4. Enterprise Service Bus</p> <p>A software architecture construct which provides services for complex architectures via an event-driven and standards-based messaging-engine (the bus), supports the following functions;</p> <ul style="list-style-type: none"> • Invocation - for synchronous and asynchronous transport protocols, service mapping • Routing - addressability, static/deterministic routing, content-based, policy-based, and rules-based routing • Mediation- adapters, protocol transformation, service mapping • Messaging – message processing, transformation, and enhancement • Security – encryption and signing • Transaction management • Monitoring, logging, audit, etc. • general agnosticism to operating-systems and programming-languages • general use of XML as standard communication language • support for web-services standards • support for various Message Exchange Patterns • adapters to support integration with external systems • a standardized security-model to authorize, authenticate and audit use of the ESB • transformation of data formats and values, including transformation services 	<ul style="list-style-type: none"> • Develop schedule for installation and deployment of ESB product(s) • Develop the orchestration for multi-vendor development as a standards-based mechanism that defines how web services will work together, including business logic, sequencing, exception handling, process decomposition, and service and process reuse (applies to external systems) • Develop the choreography as an agreed-upon model for interactions that may consist of a series of orchestrations. • Evaluate new service requests for potential duplication or possible reuse • Install and configure hardware and software • Provide training and technical support to state and other vendor personnel on the use of the ESB 	<ul style="list-style-type: none"> • Approve deployment schedule • Approve vendor requests for service orchestration • Approve vendor requests for new services 	<ul style="list-style-type: none"> • Provide Configuration, guidance, consultation and documentation for Services installation and maintenance • Provide expertise to include guidance and direction for business rules, Workflow, Design, Build and technology nuances associated with the services • Provide expert guidance and support in a production support scenario as called upon • Provide Services knowledge transfer to Common Services Vendor and hosting agency

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Common Services Technologies Description of features and capabilities	Duties and deliverables for Common Services Management Vendor	Duties and deliverables for State Team	Duties and deliverables for business area vendors
5. Call Center Technology with Interactive Voice Response Call center technology to support; <ul style="list-style-type: none"> • Speech recognition • Automatic call distribution • Interactive voice response • Call recording and linking to database records • Text mining • Skills based routing • Knowledge base • Possible CRM functions 	<ul style="list-style-type: none"> • Develop schedule for installation and deployment of ESB product(s) • Provide multiple language support for recorded messages • Implement State defined routing and escalation rules • Install and configure hardware and software • Provide training and technical support to state and other vendor personnel on the use of the call center technology 	<ul style="list-style-type: none"> • Approve deployment schedule • Identify language requirements • Define high-level routing and escalation policies for the Call Center and the IVR 	<ul style="list-style-type: none"> • Provide scripts and work flow to support the functions of the IVR related to a business processes applicable to that vendor's process group
6. EDI Translator Functions to support include; <ul style="list-style-type: none"> • Transaction Management • Data Validation • Transaction Repository • Adherence to standards (HIPAA X12, 5010) 	<ul style="list-style-type: none"> • Develop schedule for installation and deployment of translator product • Maintain support for all applicable HIPAA transaction types • Configure transaction editing in accordance with established State policies • Install and configure hardware and software • Provide training and technical support to state and other vendor personnel on the use of the call center technology 	<ul style="list-style-type: none"> • Approve deployment schedule • Establish edit criteria for each transaction type • Define mapping sets 	<ul style="list-style-type: none"> • Process the data received on transactions process by the EDI Translator associated with the business processes applicable to that vendor's process group.

Common Services Technologies Description of features and capabilities	Duties and deliverables for Common Services Management Vendor	Duties and deliverables for State Team	Duties and deliverables for business area vendors
<p>7. Data Management Tools</p> <p>Functions to support include:</p> <p>Data Governance</p> <ul style="list-style-type: none"> • Preparation of as-is assessment and classification (guided) of DG maturity level • Creation of to-be performance metrics • Performance monitoring (outlier detection, pattern analysis) • Results reporting via electronic dash-board (data visualization) • Tracking of over-due actions <p>Data Discovery</p> <ul style="list-style-type: none"> • Create metadata asset inventory • Conduct metadata analysis (locate, extract, identify and classify relationships, define data anomalies, inventory and catalog metadata, create metadata repository) • Provide data anomaly resolution recommendations 	<ul style="list-style-type: none"> • Develop schedule for installation and deployment of data management product(s) • Install and configure hardware and software • Provide training and technical support to state and other vendor personnel on the use of the data management tools <p>Data Governance</p> <ul style="list-style-type: none"> • Comply with state data governance policies and procedures • Maintain common services data governance performance metric data • Publish common services data governance performance reports <p>Data Discovery</p> <ul style="list-style-type: none"> • Comply with data artifact design guidelines common services 	<ul style="list-style-type: none"> • Approve deployment schedule • Define training and technical support requirements <p>Data Governance</p> <ul style="list-style-type: none"> • Document as-is state and assessment (maturity model) • Publish Charter • Publish To-be Data Governance Policy <p>Data Discovery</p> <ul style="list-style-type: none"> • Create data artifact design guidelines • Establish data anomaly standards and resolution business rules • Define requirements for inventory locations, metadata requirements, and formats for data asset repository • Determine data assurance quality standards • Approve data anomaly remediation recommendations • Document data conversion/translation and migration needs 	<p>Data Governance</p> <ul style="list-style-type: none"> • Comply with state data governance policies and procedures • Maintain business area data governance performance metric data • Publish business area data governance performance reports <p>Data Discovery</p> <ul style="list-style-type: none"> • Comply with data artifact design guidelines in business area

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Common Services Technologies Description of features and capabilities	Duties and deliverables for Common Services Management Vendor	Duties and deliverables for State Team	Duties and deliverables for business area vendors
8. High Volume Print Technology Technology to provide print services to include: <ul style="list-style-type: none"> • Color printing • 2-sided printing • Sorting • Collating • Binding • Transportation to Mail Room 	<ul style="list-style-type: none"> • Develop schedule for installation and deployment of printing product(s) • Install and configure hardware and software • Provide training and technical support to state and other vendor personnel on the use of printing technologies • Define print standard and service configurations for development teams (part of development approach?) 	<ul style="list-style-type: none"> • Approve deployment plan • Define thresholds for high volume printing and where performed 	<ul style="list-style-type: none"> • Configure applications to utilize print standard configurations
9. Email & Calendaring For program efforts, not the entire agency	<ul style="list-style-type: none"> • Develop schedule for installation and deployment of email/calendar product(s) • Install and configure hardware and software • Provide application administration support • Provide training and technical support to state and other vendor personnel on email and calendar tools 	<ul style="list-style-type: none"> • Approve deployment schedule • Establish project standards and usage for email and calendar 	<ul style="list-style-type: none"> • Utilize email and calendar applications based on project standards and guidelines
10. GIS (Geographic Information System) Further definition needed here to match technologies with needs.	<ul style="list-style-type: none"> • Develop schedule for installation and deployment of GIS product(s) • Install and configure hardware and software • Provide application administration support • Provide training and technical support to state and other vendor personnel on GIS application • Perform upgrades to geospatial maps and locations when released • Install and configure hardware and software 	<ul style="list-style-type: none"> • Approve deployment schedule • Define where GIS information is applicable to the MMIS business processes 	<ul style="list-style-type: none"> • Utilize GIS, as necessary, to meet business area requirements

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Common Services Technologies Description of features and capabilities	Duties and deliverables for Common Services Management Vendor	Duties and deliverables for State Team	Duties and deliverables for business area vendors
11. Medicaid Portal All users (internal and external) and customers will use one Medicaid portal to access applications and information. Portal technology should include; <ul style="list-style-type: none"> • Search engine • Access control and procedures for multiple applications and databases • Support for established standards 	<ul style="list-style-type: none"> • Develop schedule for installation and deployment of portal product(s) • Install and configure hardware and software • Provide application administration support • Provide training and technical support to state and other vendor personnel on portal technologies • Develop and maintain portal content 	<ul style="list-style-type: none"> • Approve deployment schedule • Establish browser standards and support requirements • Approve portal content 	<ul style="list-style-type: none"> • Develop the applications related that a given process group to support the external portal
12. Customer Relationship Management system (MITA business relationship and contractor relationship)	<ul style="list-style-type: none"> • Develop schedule for installation and deployment of CRM products • Install and configure hardware and software • Provide application administration support • Provide training and technical support to state and other vendor personnel on CRM products • Perform customization of selected CRM software in accordance with approved design modifications 	<ul style="list-style-type: none"> • Approve deployment schedule • Identify modifications to vendor-supplied software necessary to meet business requirements • Define business requirements where CRM could be leveraged 	<ul style="list-style-type: none"> • Utilize the CRM tool to develop and maintain applications where applicable to a vendor's assigned business processes.

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Common Services Technologies Description of features and capabilities	Duties and deliverables for Common Services Management Vendor	Duties and deliverables for State Team	Duties and deliverables for business area vendors
13. Testing Tool(s) Will include; <ul style="list-style-type: none"> • System test • Integration test • Regressing test • Load test • Acceptance test 	<ul style="list-style-type: none"> • Develop schedule for installation and deployment of testing products • Install and configure hardware and software • Provide application administration support • Provide training and technical support to state and other vendor personnel on testing products • Use common testing tool during system, integration, and user acceptance testing 	<ul style="list-style-type: none"> • Approve deployment schedule • Define requirements for testing • Define test scenarios 	<ul style="list-style-type: none"> • Use common testing tool during system, integration, and user acceptance testing
14. Graphical User Interface Development Functions include; <ul style="list-style-type: none"> • Common screen navigation (radio buttons, drop-down list, checkboxes, etc) • Support for multimedia • Compatibility with established display device and ADA standards 	<ul style="list-style-type: none"> • Develop common GUI screens • Integrate business area specific user interfaces (developed by other vendors) with the common GUI functions • Coordinate with SCDHHS and sub-project vendors to resolve duplication and/or gaps between screen functions 		<ul style="list-style-type: none"> • Develop GUI for sub-project specific processes

Technical and Management Consulting Services	Duties and deliverables for Common Services Management Vendor	Duties and deliverables for State Team	Duties and deliverables for business area vendor
<p>1. Technical Standards</p> <p>Standards to include;</p> <ul style="list-style-type: none"> • Configuration and deployment for all technologies introduced • Technical service standard operations and procedures for integration during DDI • Databases and servers • File and program naming standards • Development and methodology standards • Enterprise Architecture and SOA standards • Service boundaries • Service contract design • General systems engineering • Data communication • Security • Access and roles • GIS • 501/508 ADA compliance • Graphical User Interface (GUI) 	<ul style="list-style-type: none"> • Review established standards with State • Develop standards documentation • Recommend changes where standards conflict with established industry standards, or when other risks are identified • Validate selected tool(s) against PMO-established standards for compliance 	<ul style="list-style-type: none"> • Define and approve standards • Define quality assurance procedures for evaluating compliance to standards • Ensure all vendors adhere to established technology standards • Provide governance over the standards establishment and maintenance process • Establish “look and feel” standards for screens • Establish various types of display device standards 	<ul style="list-style-type: none"> • Ensure all development is done in accordance with established standards • Recommend new standards and/or modifications to existing standards where appropriate

Technical and Management Consulting Services	Duties and deliverables for Common Services Management Vendor	Duties and deliverables for State Team	Duties and deliverables for business area vendor
<p>2. System Test Management</p> <p>Includes;</p> <ul style="list-style-type: none"> • System/integration • User acceptance • Performance • Regression <p>Alternatives;</p> <ul style="list-style-type: none"> A. CSM vendor and state team develop overall strategy and plan, while separate testing vendor conducts tests B. CSM vendor develops strategy and plan, and performs all testing (state team approves plan) C. CSM vendor and state team develop strategy and perform testing D. Separate testing vendor develops strategy and performs all testing E. Some other combination of responsibilities divided between CSM vendor, State, and separate testing vendor 	<p>Depending on alternative selected</p> <p>Example, Alternative “A”:</p> <ul style="list-style-type: none"> • Develop overall test strategy and plan for multi-vendor development scenario to include regression, system, integration, load and user acceptance testing • Develop system test scenarios, test cases, and test scripts • Coordinate integration testing between vendors • Generate reports of test results and submit to PMO for approval • Support User Acceptance Testing • Test conversion processes (Extract and Transform in conjunction with State & Clemson, Load in conjunction with other vendors) in all test environments 	<p>Depending on alternative selected</p> <p>Example, Alternative “A”:</p> <ul style="list-style-type: none"> • Approve test strategy • Approve test plans • Provide quality assurance for test scenarios and test scripts when executed • Manage and execute user acceptance testing • Review and approve test results • Establish entrance and exit criteria for testing processes <p>Hosting agent (Clemson)</p> <ul style="list-style-type: none"> • Perform database fail-over, backup, and recovery consistent with to-be Data Governance Policy (CS) in test environment 	<p>Depending on alternative selected</p> <p>Example, Alternative “A”:</p> <ul style="list-style-type: none"> • Support testing as needed

Technical and Management Consulting Services	Duties and deliverables for Common Services Management Vendor	Duties and deliverables for State Team	Duties and deliverables for business area vendor
3. Data Development <ul style="list-style-type: none"> Design and develop technical data architecture components (models, dictionaries, matrixes, scripts, procedures, and schemas) Create and configure development, test, and to-be database platforms Process (extract, clean, transform, migrate), load, development, test, and to-be production database platforms Update as-is production database platform data Identify, troubleshoot and repair data process and load defects in development, test and to-be production database platforms 	Data Development <ul style="list-style-type: none"> Create data development schedule for common services Design and develop technical data architecture components per design standards for common services Perform data cleaning, transformation/ conversion consistent with to-be Data Governance Policy for common services Create pre-defined reports (definition, data-binding, testing) for common services Provide ad-hoc report generation capability for common services Identify data anomalies during loading and conversion for common services and provide data anomaly remediation recommendations in test environment Execute state approved data anomaly remediation recommendations for common services in test environment <ul style="list-style-type: none"> Propose methods/technologies to satisfy data conversion/translation and migration needs for common services 	Data Development <ul style="list-style-type: none"> Approve data development schedule Define technical data architecture component design standards Develop data cleaning, transformation/conversion and migration approach & strategy Perform legacy data validation (determine whether legacy data meet standards) and identify data cleansing/conversion opportunities consistent with to-be Data Governance Policy Establish database tuning, optimization, data process, load, back-up and recovery procedures Monitor data process, load, back-up and recovery performance metrics Approve data anomaly remediation recommendations Document data conversion/translation and migration needs Confirm data process and load defect resolution reports Define data governance policy(s) for data quality, conversion, loading and migration – publish to-be Data Governance Policy 	Data Development <ul style="list-style-type: none"> Create data development schedule for business area Design and develop technical data architecture components per design standards for business area Perform data loading, cleaning, transformation/ conversion and data migration consistent with to-be Data Governance Policy for business area Create pre-defined reports (definition, data-binding, testing) for business area Provide ad-hoc report generation capability for business area Perform database fail-over, backup, and recovery consistent with to-be Data Governance Policy for business area in test environment Implement database performance tuning and optimization actions consistent with to-be Data Governance Policy for business area in test environment Identify data anomalies during loading and conversion for business area and provide data anomaly remediation recommendations in test environment Execute state approved data anomaly remediation recommendations business area Propose methods/technologies to satisfy data conversion/translation and migration needs for business area

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Technical and Management Consulting Services	Duties and deliverables for Common Services Management Vendor	Duties and deliverables for State Team	Duties and deliverables for business area vendor
4. Technology deployment and support	<p>The Common Services vendor will perform the following duties for the products they provide:</p> <ul style="list-style-type: none"> • Deliver deployment plan for development, Test, QA, and production environments for the technology • Develop plan for how the technologies will be utilized by the project team and user community • Provide knowledge transfer to the State team and other vendors on technologies used • Implement procedures for security and governance (developed by State) • Provide maintenance and upgrades to products based on SLA requirements (as established by State) • Perform backup, archival, and retrieval in conformance with established policies • Perform system and user administration duties to include initiation, assignment of roles, and access privileges. • Create, test, and maintain services (technical, business, and data) that are applicable across multiple vendors 	<ul style="list-style-type: none"> • Approve deployment and utilization plans • Ensure vendor deliverables are in conformance with PMO standards and guidelines • Oversee and approve the integration activities to ensure compliance with SOA and Medicaid EA architectures • Establish key performance indicators and evaluate progress toward overall deployment plan and integration activities • Prepare and deliver accurate and timely status and communication to management and user community • Establish policies for backup, archival, and retrieval • Identify user roles and access privileges for each user • Define minimum requirements for hardware and software configuration • Define training and technical support needs for application software tools 	<ul style="list-style-type: none"> • Establish development and/or unit test environments for products they provide

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Technical and Management Consulting Services	Duties and deliverables for Common Services Management Vendor	Duties and deliverables for State Team	Duties and deliverables for business area vendor
5. Disaster Recovery & Business Continuation Plan, & System Availability/Reliability Could split these apart (hosting agent responsible for DR and backup, while the State or CSM vendor would responsible for coordinating the BC)	Develop and coordinate testing of plans for the following with the Data Center Hosting entity and the sub-project vendors: <ul style="list-style-type: none"> • Backup, recovery, archival • Availability • Reliability • Business continuity • Disaster recovery 	<ul style="list-style-type: none"> • Approve the DR and BC plans for common services – incorporate into strategy for overall enterprise DR/BC plan • Establish and develop list of requirements • Incorporate requirements into SLA • Schedule annual disaster recovery exercise • Assess results of the disaster recovery exercise • Establish standards and policies for DR & business continuity and backup 	<ul style="list-style-type: none"> • Provide plans and procedures for files and information critical to maintain the system with minimal to none disruption due to outage • Provide plans and procedure for specific business process area backup and recovery • Provide best practice guidance for High Availability, load balancing and scalability
6. Integration with other vendor provided services	<ul style="list-style-type: none"> • Coordinate integrated testing with vendors and hosting agent (Data Center) • Implement architectural designs as business services • Coordinate and communicate with other vendors the integration between the service components during implementation phases • Consolidate bug reports into a project-wide report • Manage and resolve post-deployment issues, escalate when needed • Develop and maintain contingency plans 	<ul style="list-style-type: none"> • Approve and manage development, implementation, and integration plans • Oversee development and integration work among multiple vendors • Monitor progress • Resolve escalation issues • Schedule and manage maintenance windows and activities • Monitor and generate reports for tasks and issues/problems • Approve contingency plans • Monitor, report, and track progress on tasks and issues/problems 	<ul style="list-style-type: none"> • Coordinate with CSM vendor to integrate sub-project application(s) to the Common Service technologies (EDMS, ESB, Etc.) • Implement architectural designs as business services • Manage and resolve post-deployment issues, escalate when needed • Develop and maintain contingency plans

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Technical and Management Consulting Services	Duties and deliverables for Common Services Management Vendor	Duties and deliverables for State Team	Duties and deliverables for business area vendor
7. Release Management	<p>For software releases associated with the technologies provided by the CSM Vendor:</p> <ul style="list-style-type: none"> • Develop and distribute release notes • Manage source and configuration version control • Maintain release inventory documentation • Manage components in the release package • Release communication • Execute deployment preparation tasks (meetings, communications, signoffs) • Develop and manage backout strategies and contingencies • Administer deployment problems 	<ul style="list-style-type: none"> • Manage the release plan, schedule, and calendar • Approve release inventory report • Obtain signatures to approve releases 	<p>For software releases associated with the technologies provided by the business area vendor(s):</p> <ul style="list-style-type: none"> • Manage source and configuration version control • Manage components in the release package • Develop and manage backout strategies and contingencies • Administer deployment problems
8. Governance	<ul style="list-style-type: none"> • Identify risks and issues associated with the technologies supplied by the sub-project Vendors • Follow established governance procedures • Participate in Change Control process • Identify risks and issues associated with the technologies supplied by the CSM vendor 	<p>Define governance policies and procedures to include:</p> <ul style="list-style-type: none"> • Problem resolution • Escalation routing • Change Control (things that will impact scope, schedule, or cost) • Boards of review • Performs leadership function on governance boards • Release management • Data management • Service management 	<ul style="list-style-type: none"> • Identify risks and issues associated with the technologies supplied by the CSM vendor • Follow established governance procedures • Participate in Change Control process • Identify risks and issues associated with the technologies supplied by the business area vendors

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Technical and Management Consulting Services	Duties and deliverables for Common Services Management Vendor	Duties and deliverables for State Team	Duties and deliverables for business area vendor
9. Training Support	<ul style="list-style-type: none"> • Implement and Maintain a Learning Management System to include; <ul style="list-style-type: none"> ○ Management of other vendors training modules ○ Online training ○ User registration ○ Self-helps ○ Online evaluations • Create and maintain training library • Support post-deploy user help triage • Ensure 501 compliance (disabilities training setup) • Create bi-lingual training development materials • Conduct training and QA on LMS 	<ul style="list-style-type: none"> • Establish and maintain training standards • Develop and maintain training calendar and schedule • Maintain skills inventories • Develop and maintain skill mastery criteria • Conduct new hire orientation • Conduct annual compliance training • Develop, conduct, and maintain training evaluations • Provide and maintain training-in-a-box (equipment for training – laptops, projector, network box, environments, etc) 	<ul style="list-style-type: none"> • Create and maintain training library • Support post-deploy user help triage • Ensure 501 compliance (disabilities training setup) • Create bi-lingual training development materials
10. Training Development	<ul style="list-style-type: none"> • Maintain and develop training audio and video • Create instructional content (Captivate, HTML, development) • Print/burn training needs • Conduct train-the-trainer sessions • Create graphical art • Provide technical writing – system help file development 	<ul style="list-style-type: none"> • Conduct training QA • Select train-the-trainers training recipients • Conduct user training 	<ul style="list-style-type: none"> • Maintain and develop training audio and video • Create instructional content (Captivate, HTML, development) • Print/burn training needs • Conduct train-the-trainer sessions • Create graphical art • Provide technical writing – system help file development

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Technical and Management Consulting Services	Duties and deliverables for Common Services Management Vendor	Duties and deliverables for State Team	Duties and deliverables for business area vendor
11. Project Mgmt	<ul style="list-style-type: none"> Submit project plans and updates to SC State Team 	<ul style="list-style-type: none"> Coordinate creation of project plans Maintain and monitor project plans Create WBS (internal) Conduct Project Server administration Conduct Sharepoint administration Produce project reports and metrics Disseminate Communications Process change requests Maintain PMO structure and processes Provide project oversight and administration Ensure compliance with certification checklists Maintain RACI matrix Obtain and archive signoffs at various stages throughout lifecycle Administer estimate management Administer risk management Provide work pipeline management (new projects) 	<ul style="list-style-type: none"> Submit project plans and updates to SC State Team
12. Enterprise Architecture	<ul style="list-style-type: none"> Create and update required artifacts 	<ul style="list-style-type: none"> Perform ongoing Governance of the Enterprise Architecture Establish policies for creation and maintenance of artifacts Create Architectural Designs 	<ul style="list-style-type: none"> Create and update required artifacts related to the business area processes
13. Technical Support (during DDI) Tech support for common service software and hardware that was installed and configured by the CS vendor	<ul style="list-style-type: none"> Provide technical support during DDI Capture and report adherence to support requirements 	<ul style="list-style-type: none"> Establish performance requirements for support during DDI 	<ul style="list-style-type: none"> N/A

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Technical and Management Consulting Services	Duties and deliverables for Common Services Management Vendor	Duties and deliverables for State Team	Duties and deliverables for business area vendor
15. Security Data Center, Application, Infrastructure and Technical Security	<ul style="list-style-type: none"> • Develop schedule for installation and deployment of security products • Install and configure hardware and software • Provide application administration support • Provide training and technical support to state and other vendor personnel on security products • Design and develop triggering and notification mechanisms for potential data, infrastructure, or application security breaches • Provide additional layer of data security for Protected Health Information (PHI) passing through the ESB 	<ul style="list-style-type: none"> • Approve deployment schedule • Define data, infrastructure, and application security policies to include encryption & decryption 	<ul style="list-style-type: none"> • Provide product specific roles, rules and policy documentation and guidance • Provide product guidance for software adoption and best practices • Provide product documentation for install, configure and tune the software for optimum performance

MMIS Business Operations Services (Post-Implementation)	Duties and deliverables for Common Services Management Vendor	Duties and deliverables for State Team	Duties and deliverables for business area vendor
1. Mailroom Common mailroom function for the MMIS	Support incoming mail activities; <ul style="list-style-type: none"> Envelope opening Transportation of documents to the EDMS for scanning Support outbound mail activities; <ul style="list-style-type: none"> Envelope Stuffing/Sealing Addressing Packaging Postage Capture and report performance in accordance with established requirements	<ul style="list-style-type: none"> Establish policies and performance metrics Provide quality Assurance checks 	<ul style="list-style-type: none"> N/A
2. High-Volume Printing services This is the operational process of high-volume printing services for MMIS only (not agency) Examples include: <ul style="list-style-type: none"> Letters to Members Provider Manuals 	Produce large volume print runs, to include: <ul style="list-style-type: none"> Color printing 2-sided printing Sorting Collating Binding Transportation to Mail Room Capture and report performance in accordance with established requirements	<ul style="list-style-type: none"> Establish policies and performance metrics Conduct quality assurance checks 	<ul style="list-style-type: none"> Adhere to policies and performance matrixes
3. Call Center Operations <ul style="list-style-type: none"> Inbound call routing Interactive Voice Response Call logging w/audio capture 	<ul style="list-style-type: none"> Staff and manage call center operations Capture and report performance in accordance with established requirements 	<ul style="list-style-type: none"> Establish policies and performance metrics Conduct quality assurance checks 	<ul style="list-style-type: none"> Facilitate the technical support routing rules and escalation procedure and provide expert guidance within their product domain or services

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MMIS Business Operations Services (Post-Implementation)	Duties and deliverables for Common Services Management Vendor	Duties and deliverables for State Team	Duties and deliverables for business area vendor
4. Ongoing tech support Operational support for software & hardware installed by CSM vendor	<ul style="list-style-type: none"> Staff, manage, and oversee incident management and provide 1st and 2nd tier support. Capture and report performance in accordance with established requirements 	<ul style="list-style-type: none"> Establish policies and performance metrics Conduct quality assurance checks 	<ul style="list-style-type: none"> N/A
5. Data support <ul style="list-style-type: none"> Maintain data design artifacts (models) Monitor and administer database platforms Monitor process, load, and update production database platform data Update data support documentation (data dictionaries, mapping documentation) 	Data support <ul style="list-style-type: none"> Prepare technical and end-user support requirements - Data Support Manual(s) for common services in production environment 	Data support <ul style="list-style-type: none"> Document data administration and end-user support roles and responsibilities Define data support documentation review procedures 	Data support <ul style="list-style-type: none"> Prepare technical and end-user support requirements - Data Support Manual(s) for business area in production environment

Attachment 3

SCDHHS MITA State Self-Assessment

South Carolina Department of Health and Human Services



Self-Assessment Report for the Medicaid Information Technology Architecture State Self-Assessment



November 2009



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Appendix F: Use Case and Activity Diagrams

Appendix G: Process Profiles

Appendix H: Business Area Business Process Relationship Diagrams

Appendix I: South Carolina Healthy Connections Medicaid Transformation Plan

Appendix J: MMIS Interfaces

Appendix K: MEDS Interfaces

Appendix L: PC Applications

Appendix M: Common Answers

Appendix N: MMIS Interfaces, MEDS Interfaces & PC Applications Related to Business Processes

Appendix O: OAC Systems Request Form

(See Self-Assessment Report Appendices)



1 MITA and the South Carolina Medicaid Enterprise

The South Carolina Department of Health and Human Services (SCDHHS) recognizes the need for the Medicaid Information Technology Architecture (MITA) initiative in modernizing the current Medicaid Enterprise. Through the State Self-Assessment (SS-A) process we have come to better understand our state's goals, advantages and challenges, and to articulate how they line up with CMS' vision for the future Medicaid Enterprise.

We are completing this SS-A report at a critical time: as we move forward with the MITA project, we are also working to implement key health information technology (HIT) provisions of the American Recovery and Reinvestment Act of 2009 (ARRA). These provisions are intended to promote health care quality and health information exchange through the use of certified electronic health record (EHR) technology. They have major consequences for the development of the Medicaid Enterprise:

- SCDHHS is the agency tasked with promoting, measuring and rewarding meaningful use of HIT for the state of South Carolina. The future Medicaid Enterprise must facilitate the measuring, tracking and reporting of meaningful use and the distribution of entitlement payments to meaningful users – and it must do so soon.
- Use of a statewide Health Information Exchange (HIE) will promote sharing of health care information and improvement of health outcomes throughout our state. South Carolina plans to scale up an existing HIE for statewide use. The future Medicaid Enterprise must make optimal use of this data exchange.

MITA and ARRA are thus highly interdependent. MITA emphasizes the role of technology in improving health outcomes, and ARRA lays out a few key routes for that transformation.

Section 6 of this report articulates in detail the agency's executive goals for Medicaid. Other sections of the report detail our specific recommendations for improving and automating business processes. These results can be summarized briefly as follows:

- We have identified manual processes that can be improved through automation. Automated processes will in some cases be more effective and cost-efficient; in other cases, they will provide better service to providers, beneficiaries, or other stakeholders. Better service produces better health outcomes.
- We have identified some agency-internal business processes that can be standardized and streamlined. A more efficient agency can better serve the Medicaid community.
- We have identified system interfaces and software applications that should be pulled into the Medicaid Enterprise system in order to provide more security, better data access, and more interoperability between systems.

Some key priorities for the Medicaid Enterprise transformation are:

- Real-time adjudication of claims



- Enhanced screening and credentialing of enrolling and enrolled providers
- Better, faster, more accurate communication with beneficiaries, providers, and other stakeholders
- Empowering beneficiaries by providing them more access to provider and health information
- Laying the groundwork for a future all-health-services enterprise through participation with other state health agencies

The shared underlying goal of all these priorities is the improvement of health outcomes for South Carolinians.

In short, through the MITA transformation, we will use technology to improve the way we do business and serve our state. This report assesses where we are and begins to address how we will get there.

1.1. **SS-A Approach**

To carry out the MITA SS-A, SCDHHS formed a team within its Bureau of Federal Contracts to document business processes, systems, and interface details and to gather “wish list items” for help in developing agency goals.

The SCDHHS team also documented the Medicaid Management Information System (MMIS) and the Medicaid Eligibility Determination System (MEDS) interfaces, software, and other technical applications that will be brought into the Medicaid Enterprise system.

A team of analysts at Clemson University mapped business processes, documented interfaces, and provided technical knowledge.

The results of these teams’ efforts were then presented to SCDHHS executive staff. This document will guide the agency in developing the future Medicaid Enterprise.

1.2. **Report Structure**

Section 2 discusses the agency’s current mission and goals, followed by an overview of the organization, services, scope, and history of the Medicaid program in South Carolina.

Section 3 is the **Business Process Assessment**. It explains the methodology used to analyze business processes and provides thorough narrative documentation of each business process. Each business process also includes discussion of “wish list” items. This section also briefly outlines for each business area the high-level current state and future goals.

Section 4 is the **Infrastructure Assessment**. It contains detailed documentation of all the data interfaces of the MMIS and MEDS, as well as software applications and other technical tools that SCDHHS hopes to pull in to the future Medicaid Enterprise system.



Section 5 contains the **Technical Capabilities Assessment**. It presents the MITA Technical Capability Matrix (TCM) and explains its role in the MITA Framework and how SCDHHS and its vendors will use it to design and implement better Medicaid systems.

Section 6, **Preliminary Plans**, contains Template 3, which charts our “As Is” and “To Be” capabilities and analyzes the current levels of maturity of each process as compared to the MITA maturity levels. Template 3 also contains a Gap Analysis. The remainder of the chapter is a discussion of the goals and future state of the Medicaid Enterprise.

Supplementary materials attached to this report provide other data gathered during the “As Is” analysis. Even more information, such as record layouts and reports, is housed in our shared project repository.



2 Agency Overview

2.1. South Carolina Department of Health and Human Services: Mission, Goals, Values

2.1.1. Mission and Vision

The mission of SCDHHS is to manage the Medicaid program to provide the best healthcare value for South Carolinians.

The Department fulfills its mission by planning, setting policy, pursuing resources, developing programs, building partnerships, providing program oversight, and ensuring fiscal accountability to promote an accessible system of quality health and human services.

2.1.2. Agency Goals

- Provide a benefit plan that improves member health and is consumer driven.
- Provide a credible eligibility process.
- Provide value-added administrative support.

2.1.3. Values: Serve

- **Service** We are dedicated to service; we will place others first.
- **Excellence** We are committed to constant improvement and will persevere in achieving quality with efficiency.
- **Response** We will be alert and react quickly to the needs of those we serve; we embrace opportunities to improve our processes.
- **Value** We will ensure that all of our decisions and actions will be measured by the value they return; we guarantee honest and open measurement of outcomes.
- **Everyone** We are a team; every employee is involved in our success; we believe in servant leadership and empowering employees to solve customer problems; as a team we will encourage and hold each other accountable.

2.2. South Carolina Medicaid Program Overview

Healthy Connections (Medicaid) is South Carolina's grant-in-aid program by which the federal and state governments share the cost of providing medical care for needy persons who have low income. Title XIX of the Social Security Act, signed into law on July 30, 1965, authorized the Medicaid program; South Carolina began participation in Medicaid in July 1968.

SCDHHS is the single state agency designated to administer the South Carolina Medicaid program in compliance with state and federal laws and regulations and the South Carolina State Plan.



2.2.1. *South Carolina MMIS and MEDS*

South Carolina's MMIS is unique in CMS Region IV in that it is a state-run system. Clemson University, a state university, through a contract with SCDHHS provides the system hardware, software, and staff to support the MMIS.

The MMIS system was developed as a project between the South Carolina Department of Social Services (SCDSS) and Clemson University in the late nineteen seventies with some help with requirements through a request for proposal (RFP) with Touche Ross consultants and utilizing some concepts from Minnesota's MMIS. It was developed on Clemson's mainframe using COBOL and Assembler programming languages, Cullinane's IDMS database management system, and a proprietary online system. In 1981 it achieved federal certification – the first federally certified database oriented MMIS. In the late 1980s, the proprietary online system was replaced with CA-ADS/O.

Over time, SCDHHS has undertaken projects to enhance the functionality of the MMIS and to meet certain external and mandatory requirements.

Today the MMIS, in addition to the mainframe, also includes a real-time Eligibility Verification System (MEVS) developed by Clemson in 2001 using the X12 270/271 transactions. In 2003, as part of the HIPAA remediation done under a contract with EDS, an Electronic Data Interchange (EDI) component for handling HIPAA X12 transactions to/from trading partners and a web application providing claims data entry/submission and eligibility inquiry were added. Claim status inquiry was added to the web application in 2005.

The MMIS also includes new interfaces to contractor-supplied systems that replaced paper-based or other manual processes (see interfaces section).

MMIS has seven core subsystems: Recipient, Provider, Reference, Claims Processing, Payment, Management and Administrative Reporting (MARS), and Third Party Liability (TPL). The MMIS has evolved in response to state and federal programs and the overall health care environment.

Through the MMIS, SCDHHS can enroll providers, adjudicate claims, pay providers, report costs and utilization, and enroll recipients in special programs. Providers can verify Medicaid eligibility 24 x 7 and inquire on the status of their claims.

The MEDS system is also managed, operated, and maintained through a contract with Clemson University. The system houses Medicaid eligibility data. In 2002, Clemson replaced the twenty-eight-year-old batch eligibility system operated by the SCDSS with a real-time and batch MEDS system operating on the same mainframe as the MMIS. The database management system is relational IDMS.

Using MEDS, eligibility workers throughout the state take applications from potential beneficiaries and determine their eligibility based on financial and resource data, as well as citizenship, identity, and several other criteria. MEDS interfaces with federal agencies (Social Security Administration—SSA, CMS, Internal Revenue Service—IRS, etc.) and state agencies (SC State Retirement System—SCSRS, Employment Security Commission—ESC, DSS, etc.) to verify data and assist in determining eligibility. Eligible beneficiary information in MEDS is passed to MMIS for use in claims processing and special Medicaid programs.



2.2.2. Medicaid Population

As of June 2009, 924,806 South Carolinians are enrolled in the Medicaid program, 22.2% of the state's population. The number includes 891,542 federally matched Medicaid members and 33,264 GAPS and Refugee/Entrants.

Medicaid beneficiaries are:

- Children = 57%
- Non-Disabled Adults = 21%
- Disabled Adults = 13%
- Elderly = 9%

As of March 2009, 395,147 Medicaid beneficiaries were enrolled in regular fee-for-service Medicaid – about 50%. Another 303,271, or 39%, were enrolled in a Medicaid Managed Care Organization (MCO). The remaining 82,989, or 11%, were enrolled in the Medical Homes Network (MHN), another managed care option.

2.2.3. Medicaid Coverage Groups

There are many categories of eligibility under South Carolina Medicaid. Not all coverage groups are eligible for the same services; for example, Family Planning Waiver enrollees are eligible for Family Planning services only. The general categories are:

- A. Low Income Families (LIF)
- B. Supplemental Security Income (SSI)
- C. Qualified Medicare Beneficiaries (QMB)
- D. Specified Low Income Medicare Beneficiaries (SLMBs)
- E. Optional Coverage for (Pregnant) Women and Infants (OCWI)
- F. Family Planning (FP) Waiver Services
- G. Healthy Connections Plans for Children Under Age 19 (HCPC) - Ages 1-19
- H. Home and Community-Based (Waiver) Services (HCBW)
- I. Optional State Supplementation (OSS)
- J. Children For Whom a State Adoption Assistance Agreement is in Effect
- K. Children Under 21 With Special Living Arrangements (a foster home or a group home)
- L. Aged, Blind and Disabled (ABD) Individuals
- M. TEFRA (or Katie Beckett) Children
- N. Working Disabled Individuals
- O. Qualified Disabled and Working Individuals
- P. Breast and Cervical Cancer Program (BCCP)

2.2.4. Programs

South Carolina Healthy Connections provides traditional fee-for-service medical care coverage for eligible individuals. The Medicaid program also provides services under several other coverage options:



2.2.4.1. **Healthy Connections Choices—Medicaid Managed Care Organizations (MCOs)**

The MCO program consists of contracted MCOs that, through a developed network of providers, provide, at a minimum, all services outlined in the core benefit package described in the MCO contract, for certain eligibility categories. An MCO must receive a Certificate of Authority from the South Carolina Department of Insurance and must be licensed as a domestic insurer by the State to render Medicaid managed care services. SCDHHS pays a capitated rate per member per month, according to age, gender, and category of eligibility, to MCOs. Payments for core services provided to MCO members are the responsibility of MCOs, not the fee-for-service Medicaid program. MCOs may elect to provide expanded services that are outside of the core benefit package to their members.

South Carolina contracts with an Enrollment Counselor to help beneficiaries select and enroll in managed care plans.

2.2.4.2. **Primary Care Case Management/Medical Homes Networks (PCCM or PCCM/MHN)**

The MHN program is a Primary Care Case Management (PCCM) program. An MHN is composed of a Care Coordination Services Organization (CSO) and the primary care providers (PCPs) enrolled in that network. The CSO supports the member physicians by providing care coordination, disease management, and data management. The PCPs manage the healthcare of their patient members either by directly providing medically necessary health care services or authorizing another provider to treat the beneficiary. The Network receives a per member per month care coordination fee. Reimbursement for medical services provided is made on a fee-for-service basis.

2.2.4.3. **SC “Healthy Connections” Kids SCHIP**

The children’s health program Healthy Connections Kids (HCK) is administered by MCOs only. SCDHHS has formulated a capitated rate and contracts with MCOs to develop comprehensive networks of providers to deliver services. All service provision is reimbursed to MCOs with the exception of dental services, which are reimbursed using the fee-for-service system.

2.2.4.4. **SC “Healthy Connections” Health Opportunity Account (HOA)**

In May 2008, SCDHHS implemented the Health Opportunity Account (HOA), a Medicaid option that allows beneficiaries to manage their own health care spending and set aside money to be used when they no longer need Medicaid. The HOA participant is rewarded for staying healthy and seeking preventive care. HOA is a five-year pilot program. A set amount of funds (\$2,500 for adults and \$1,000 for children) is deposited in the HOA each year. As the participant receives Medicaid covered services, the cost of the care is deducted from the account. Payments are made directly to the Medicaid enrolled provider. Preventive care, such as an adult physical or child's well care or immunization visit, is not deducted from the account. Participants are required to pay an out-of-pocket deductible (\$250 for adult and \$100 for child), if they spend all the money in their account before the end of the year, or they may disenroll from the HOA program.



2.2.4.5. Waivers

South Carolina Medicaid administers or co-administers several waivers to provide additional products and services not covered under the State Plan to certain eligible individuals.

Head and Spinal Cord (HASCI) Waiver – In a joint effort, SCDHHS and the Department of Disabilities and Special Needs (SCDDSN) provide a broad range of home and community-based waiver services to Medicaid-eligible individuals with the most severe physical impairments involving head and spinal cord injuries. HASCI Waivers are designed to help clients who would otherwise require services in a nursing facility or ICF/MR to remain independent in the community.

Mental Retardation/Related Disabilities (MR/RD) Waiver – In a cooperative effort, SCDHHS and SCDDSN provide a broad range of special home and community-based waiver services to Medicaid-eligible individuals with mental retardation or related disabilities to help them live in the community rather than in an institution.

Mechanical Ventilator Dependent Waiver (VENT) – Under the VENT waiver, SCDHHS serves Medicaid-eligible persons age 21 or older who are dependent on mechanical ventilation and have long-term care needs.

HIV/AIDS Waiver – The Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) Waiver is designed to serve Medicaid-eligible HIV/AIDS clients, regardless of age, who choose to live at home but have long-term care needs and are at risk for hospitalization.

Pervasive Developmental Disorder (PDD) Waiver – The PDD waiver provides for early intensive behavioral intervention services (EIBI) to children who have been diagnosed with a pervasive developmental disorder, including autism and Asperger's Syndrome and who meet the ICF-MR level of care criteria. SCDDSN operates the waiver with administrative oversight from SCDHHS.

Children's Personal Care Aide (PCA) Services – Children's PCA services provide PC aide services in the community to Medicaid-eligible children under 21 years of age who meet established medical necessity criteria.

Community Choices (CC) Waiver – The CC waiver provides services for individuals who are elderly and disabled and who otherwise would meet the criteria to enter nursing home care under a special waiver.

Palmetto SeniorCare (PSC) Program – Palmetto SeniorCare (PSC) is a federal Medicaid and Medicare capitated program serving clients in the greater Columbia area (Richland and Lexington counties) who are age 55 or older, meet a nursing home level of care, and wish to remain in the community.

Medically Fragile Children's (MFC) Program – The MFC waiver provides services for children who require private duty nursing, a personal care aide, and/or medical equipment or supplies who meet the criteria based on medical complexity.

2.2.5. Providers



As of August 2009, over 39,000 providers are enrolled in the South Carolina Medicaid program.

South Carolina Medicaid classifies providers according to the following provider types:

- 00 – Nursing Home
- 00 – Community Residential Care Facility (CRCF) Program for Optional State Supplementation (OSS)
- 01/02 – Inpatient/Outpatient Hospital
- 01 – Residential Treatment Facility
- 10/20 – Private Mental Health Centers
- 10/90 – Alcohol & Other Drug Abuse Services
- 10/91 – DDSN
- 10/92 – Continuum of Care for Emotionally Disturbed Children
- 15 – Health Maintenance Organization
- 19/04 – Audiologist
- 19/06 – Nurse Midwife/Licensed Midwife
- 19/25 – Certified Registered Nurse Anesthetist/Anesthetist Assistant
- 19/82 – Psychologist (MR/RD Waiver Providers)
- 19/82 – Psychologist
- 19/84 – Speech Pathologists
- 19/85 – Occupational Therapist
- 19/86 – Nurse Practitioner, Clinical Nurse Specialist, Physician Assistant
- 19/87 – Physical Therapist
- 20 – Physician
- 21 – Group Physician
- 21/04, 84, 85, 87 – Group Therapist
- 21/82 – Group Psychologist
- 22/04 – Speech & Hearing Clinics
- 22/21 – End State Renal Disease
- 22/51 – Department of Health and Environmental Control (DHEC) Clinics
- 22/50, 58, 97 – Clinic Providers (Federally Qualified Health, Federally Funded Health, Rural Health)
- 22/89 – Comprehensive Outpatient Rehabilitation Facilities (CORF)
- 22/89 – Commission of Accreditation of Rehabilitation Facilities (CARF)
- 22/93 – Ambulatory Surgery Centers
- 22/94 – Ambulatory Diabetes Patient Education Clinics
- 22/95 – Developmental Rehabilitation Centers
- 22/95 – Infusion Centers
- 22/95 – Outpatient Pediatrics Aids Clinics
- 22/96 – Maternal and Child Health Clinics
- 22/98 – Private Duty Nursing
- 30 – Individual Dentist
- 31 – Group Dentist
- 32 – Individual Optician
- 33 – Individual Optometrist



- 34 – Group Optometrist
- 35 – Individual Podiatrist
- 36 – Group Podiatrist
- 37 – Individual Chiropractor
- 38 – Group Chiropractor
- 41 – Group Optician
- 60 – Home Health
- 60 – Hospice
- 61 – Individual Community Long Term Care (CLTC)
- 62 – Group CLTC
- 70 – Pharmacy, Mail Order Pharmacies, Dispensing Physician
- 76 – Durable Medical Equipment (DME)
- 80 – Independent Laboratory
- 81 – Independent X-Ray (Portable and Stationary), Mobile Ultrasound, CAT Scan, MRI and Physiology labs
- 82 – Ambulance and Helicopter
- 84 – Individual Transportation
- 85 – Contractual Transportation
- 89 – Social Workers

2.2.6. Services

In addition to federally mandated services, SCDHHS offers an array of optional services, such as medical care for women diagnosed with breast cancer who otherwise would not qualify for Medicaid. The following are some of the mandatory and optional services provided through the agency:

Mandatory Services

- Inpatient and Outpatient Hospital
- Laboratory and X-Ray
- Access to Rural Health Clinics
- Access to Federally Qualified Health Centers (FQHCs)
- Nursing Facility Services
- Physician Services
- Pregnancy Related Services
- Emergency Dental Service
- Transportation

Optional Services

- Pharmacy Services
- CLTC
- Hospice Care
- Preventive Screenings
- Rehabilitative Services



- DME
- Physical Therapy
- Chiropractic Services
- Case Management

Medicaid benefits can generally be categorized into three distinct programs: Acute Medical Care Services, Long Term Care Services, and Rehabilitative and Behavioral Health Services.

2.2.7. *Other Medicaid Enterprise Players*

Other state agencies use federal Medicaid matching funds to support a range of important programs, many of which make up a large portion of those agencies' budgets. Because SCDHHS has sole federal authority to distribute federal Medicaid matching money, the agency works closely with other agencies to facilitate a steady stream of funds and provide oversight to ensure compliance with federal Medicaid requirements. Most services rendered by other state agencies are categorized as behavioral health or early intervention services. SCDHHS works with the following state agencies:

- Department of Mental Health (DMH)
- Department of Disabilities & Special Needs (DDSN)
- Department of Health & Environmental Control (DHEC)
- Medical University of South Carolina (MUSC)
- University of South Carolina (USC)
- Department of Alcohol & Other Drug Abuse Services (DAODAS)
- Continuum of Care (COC)
- School for the Deaf & Blind (SD&B)
- Department of Social Services (DSS)
- Department of Juvenile Justice (DJJ)
- Department of Education (DOE)
- Commission for the Blind
- Department of Corrections (DOC)
- John De La Howe
- Wil Lou Gray School
- State Housing Authority

2.3. *Medicaid Contracts*

MEDS and MMIS

Held by Clemson University

Clemson University provides a variety of services to SCDHHS in support of South Carolina Medicaid. Clemson provides manpower, hardware, operating systems, and utilities necessary for the successful and timely operation of both batch and online MMIS/MEDS applications systems. Software support, enhancements, and database administration for the MMIS/MEDS and their associated subsystems are a major part of the contracts.



In addition, Clemson receives and sends data files according to SCDHHS business agreements with state and federal agencies and other entities.

Front-end/Manpower Services, also known as Medicaid Claims Control System (MCCS)

Held by BlueCross BlueShield of South Carolina

The contractor receives, images, and enters paper claims, adjustments, and edit correction forms (ECFs); transmits electronic claims; resolves suspended claims; mails remittance advices and payments; keys reference file updates; enrolls and disenrolls providers; trains providers; updates provider manuals and other outreach materials; enrolls trading partners; and operates an EDI help desk.

Pharmacy Benefits Administrator

Held by FirstHealth

The contractor processes pharmacy claims transmitted via point-of-sale devices, pre-authorizes drugs, performs Drug Utilization Review, administers the drug rebate program, maintains the Preferred Drug List, provides clinical advice, and trains providers.

Third Party Verification

Held by ACS

The contractor researches and verifies third party liability (TPL) leads, receives and posts refunds, processes retroactive recoveries, and administers the Health Insurance Premium Payment Program (HIPPP) program.

Transportation Brokers

Held by Logisticare and MTM

The brokers provide non-emergency transportation for beneficiaries in their assigned areas of the state.

Dental Broker

Held by Doral Dental

The contract has been awarded and will be operational in April 2010.

Interactive Voice Response System (IVRS)

Held by First Data Government Solutions

The contractor operates a toll-free number allowing providers to verify beneficiary eligibility, special programs, service limitations, and TPL data as well as the amount of the provider's most recent Medicaid payment.

Decision Support System (DSS) and Surveillance and Utilization Review System (SURS)



Held by Thomson Reuters

The contractor stores data from MMIS, MEDS, and encounters and provides a suite of reporting and research tools for examination of the data.

Plastic Medicaid Cards

Held by BlueCross BlueShield of South Carolina

The contractor produces and mails new and replacement Medicaid and HCK plastic, magnetically encoded ID cards as part of a package that includes a Medicaid Handbook, Notice of Privacy Practices, and Card Holder.

Enrollment Counselor

Held by Maximus

The contractor provides enrollment counseling, sends notices and other enrollment materials, and enrolls managed care beneficiaries into plans.

Quality Improvement Organization (QIO)

Held by Qualis Health

The contractor receives and reviews prior authorization requests and notifies providers of the results. It also performs postpayment review.

Care Call

Held by FDGS Waiver Service

The Care Call contractor operates a phone line and monitoring system for CLTC providers to call in to report service hours, and transmits this data as claims to the MMIS.

2.4. Agency Organization

2.4.1. General Counsel

Office of General Counsel: The office represents the agency in state and federal courts and administrative hearings and advises the Director and staff on legal matters pertaining to the agency.

Bureau of Federal Contracts Initiation & Administration: The bureau is responsible for federal contract initiations, amendments, re-procurements, strategic planning, and monitoring of



several agency contracts. This bureau coordinates and manages the MITA project at the agency as well as the HIT grants as related to ARRA.

Bureau of Compliance & Performance Review: This bureau ensures that Medicaid and other funds are used effectively and in compliance with federal and state regulations. The bureau is comprised of three divisions: Program Integrity (PI), Internal Audit, and Surveillance and Utilization Review.

2.4.2. *Office of Medicaid Eligibility & Beneficiary Services*

Bureau of Eligibility Policy & Oversight: This bureau is responsible for Medicaid policy development, providing technical assistance to central and local eligibility staff, monitoring eligibility processes, constituent services, and disability determinations.

Bureau of Eligibility Processing: This bureau has two divisions that are responsible for processing Medicaid applications through local eligibility offices and the central eligibility office and working with several Medicaid programs.

2.4.3. *Office of Finance & Administration*

Office of Human Resources: This office provides a comprehensive human resources program for SCDHHS employees.

Bureau of Fiscal Affairs: This bureau manages agency funds and budgets for the administration and operation of the South Carolina Medicaid program.

Bureau of Administrative Services: This bureau is responsible for contracts, procurement, and appeals and hearings through three divisions.

Bureau of Reimbursement Methodology & Policy: This bureau is responsible for several reimbursement methodologies and rates including rate setting and cost settlements. The bureau manages the South Carolina Medicaid Disproportionate Share Payment Program.

Bureau of Information Technology Services: This bureau assists the agency to provide support through information technology, office automation, and telephone communication.

2.4.4. *Office of Medical Services*

Office of Reporting, Research and Special Projects: This office produces scheduled and ad hoc reports, assists and trains agency staff for the use of reporting tools, and works on other projects as needed.

Bureau of Health Services: This bureau is responsible for the administration of several hospital and physician based programs.

Bureau of Care Management & Medical Support Services: This bureau is responsible for the oversight of Managed Care Organizations, managed care beneficiary enrollment, medical support services that enhance direct care, school-based and private rehabilitative services, dental, and transportation services.

Bureau of Long Term Care & Behavioral Health Services: This bureau is responsible for all long term care programs and other special needs populations.



Bureau of Medicaid Systems Management (BMSM): This bureau is responsible for monitoring the operational aspects of the MMIS and MEDS. This bureau routinely collaborates with other areas for system modification and staff at Clemson University.



3 Business Capability Assessment

3.1. *Approach*

With input from executive staff, the SCDHHS team identified individuals throughout the agency responsible for each of the CMS-defined business processes. The team then interviewed those people to understand the processes and assess the levels of maturity. The CMS business process descriptions and business capability matrices were used as informal guides for the interviews.

The team kept the groups as small as possible; few meetings contained more than five interviewees. By encouraging feedback and maintaining an open but professional atmosphere, the team was able to gather valuable information while keeping the sessions constructive. Agency staff and contractor staff both contributed to the discussions.

For each business process, the SCDHHS team wrote a problem statement explaining in plain language how the business process is performed in South Carolina. Tools, time frames, accuracy, satisfaction, and other metrics were discussed when available. The team also documented “wish list” suggestions gathered during each interview. Some relate to individual business processes, while others relate to the Medicaid Enterprise as a whole.

The Clemson team then used each problem statement to develop one or more use case diagrams for each business process. Follow-up questions and clarifications were often necessary, as were subsequent modifications to problem statements. This collaborative review and modeling process between SCDHHS and Clemson helped ensure that project documents are as clear and comprehensive as possible.

Finally, the SCDHHS team evaluated the maturity level of each business process according to the most recent detailed business capability criteria issued by CMS.

The business process assessment took about six months, a time span that included scheduling and conducting interviews, writing problem statements, use case diagramming, follow-up with interviewees to address team questions, and review and approval of project documents. Both teams worked on several business areas at a time.

3.2. *Structure*

The results of the MITA business process assessment are organized by business area. For each area, some discussion of how the area operates in South Carolina Medicaid and how SCDHHS envisions each area evolving are first presented. The detailed problem statements describing each business process are then presented. Sections highlighted in yellow and italicized indicate a desired feature for the future system. The desired features are also noted in a “wish-list” table at the end of each business area section. Underlined red text refers the reader to an MMIS interface, MEDS interface, or PC Application.

Detailed use case diagrams are provided for each business process in the appendices. The appendices also contain other supplementary materials from this part of the project: a list of all interviewees (Appendix E), process profiles for select business processes (Appendix G), and Business Process to Business Area Relationship Diagrams (Appendix H).



The use case diagrams were created from the process profiles to provide a visual representation of the main functions and activities performed in the business process as well as the actors performing them. Additionally the diagrams have actors to show other business processes, mechanisms such as physical files and software systems, and external actors. As needed, these diagrams were shown to the responsible program areas for validation and/or input. In some cases activity diagrams were created as part of the analysis in order to clarify the business process.

The process profiles are an analysis tool used to pull and organize information from the text-based problem statements. The profiles are used to ensure that complete information was obtained from the program areas interviews. The documents contain information such as inputs, outputs, triggers, dependencies and so forth. Some of the Business Processes were complex, and several profiles were created to analyze the information. (See **Authorize Service** as an example.) The information in the process profiles and the problem statements was used to create the Use Case and Activity diagrams that graphically depict the processes.

The Business Process to Business Area Relationship Diagrams depicts the major relationships within that business area. The Relationship Diagrams were created using the Problem Statements and use case diagrams for that particular business area and contain some references to related processes in other Business Areas.



3.3. Business Areas

3.3.1. Member Management (ME)

As Is

South Carolina's Medicaid member population is large in proportion to the state population and is distributed throughout rural and urban areas of the state. To reach this population, South Carolina maintains eligibility offices in each county in the state and a Bureau of Central Eligibility Processing in Columbia. Using MEDS and a variety of other tools, SCDHHS staff work with applicants to determine eligibility and enroll members into Medicaid. MEDS and MMIS both store certain member data, and other data is stored in paper files.

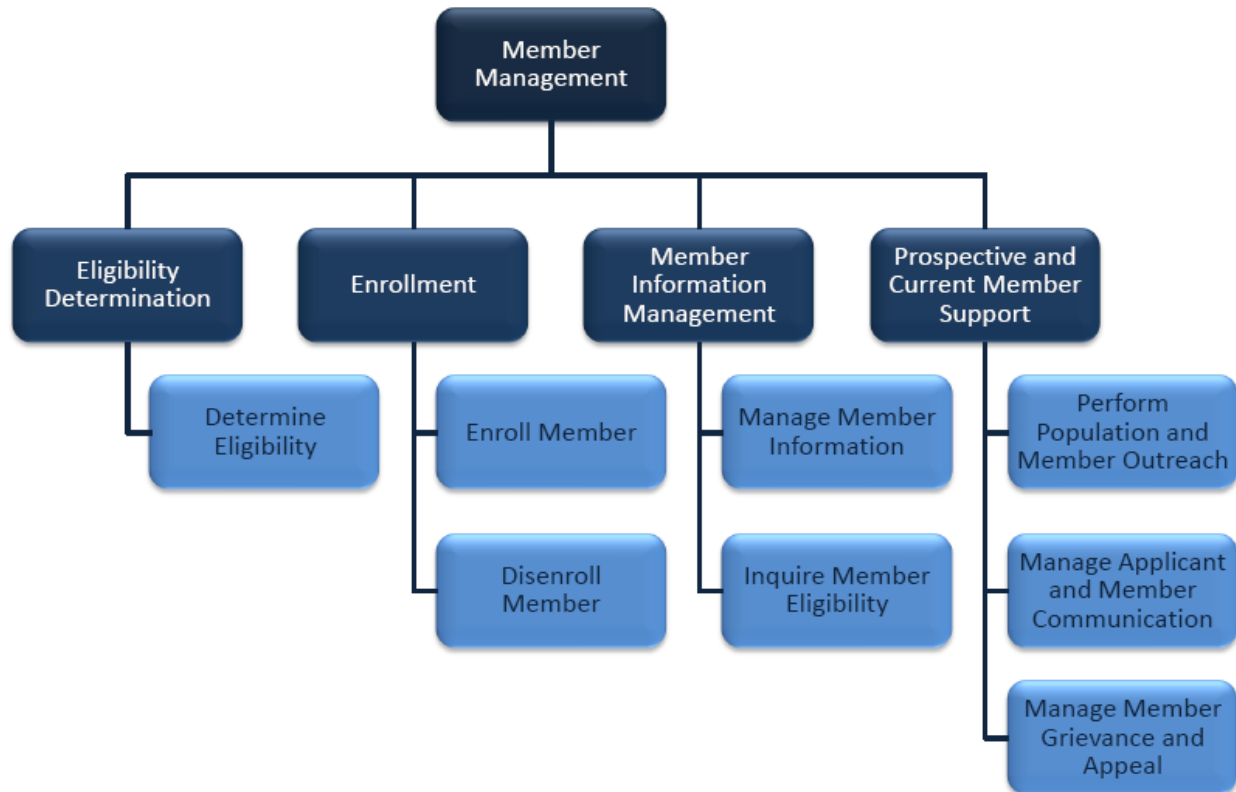
Over the last several years, the state has moved toward managed care as a delivery system. Managed care organizations now operate throughout the state, with counseling and auto-enrollment managed by a contracted Enrollment Broker.

To Be

SCDHHS intends to implement a MEDS that would facilitate eligibility decisions and be more user-friendly, allowing staff more face-to-face time with beneficiaries.

South Carolina's goals for Member Management include:

1. Create a system-guided eligibility determination and redetermination process to help eligibility staff render more consistent decisions.
2. Track all contact with potential eligibles and members.
3. Design automated notices to system users.
4. Online user help and user guides, with online tutorials and enhanced training.
5. System support for QA functions, appeals, monitoring fraud and abuse, and recoupment.
6. Design a beneficiary record to indicate the benefit package the individual holds. The record should also indicate what the individual is eligible for and the services already used.
7. Develop a workflow management system that displays a history of contact with the beneficiary.
8. Support the submission of electronic applications.



3.3.1.1. Determine Eligibility

Application Intake

Applications are available on the SCDHHS website for prospective beneficiaries to print and mail to the appropriate local eligibility office. Applicants may also apply in person at the local eligibility offices, federally qualified health centers (FQHCs), rural health clinics (RHCs), and at most hospitals. Individuals may also request an application online, and the Division of Central Eligibility will mail an application to the requestor. *SCDHHS would like to also offer an on-line application with web-based submission.*

All applicants are required to fill out an application. However, some counties require that an applicant fill out the application prior to coming to an office while others will assist the applicant with completing the application through an interview process. Some programs are complex and the assistance of an eligibility worker is very helpful in completing the application. *SCDHHS would like to have context-driven interviews to gather applicant information more effectively.*

Most hospitals, FQHCs, RHCs, and other state agencies have sponsored positions for eligibility workers to work onsite. The institutions pay match for salary for these workers. Some of these institutions have systems that track an application's status to show when the application was submitted, pended, accepted, or denied. The institutions will refer individuals directly to the worker to determine if they are eligible for Medicaid. The workers have access to all information as if they were in an eligibility office and make the same eligibility decisions as those in eligibility offices.



For brand new applications, the worker must verify citizenship and identity. The worker must see the original documentation, make a copy, and then write on the copy “original viewed”. In MEDS, the worker will indicate how the potential beneficiary proved identity and citizenship (e.g. birth certificate, driver’s license, etc.).

Some applicants drop off their application at an eligibility office with administrative office staff. Administrative staff will verify the applicant’s identity and citizenship and place the application in a folder for an eligibility worker. Some offices allow for the administrative staff to enter the application into MEDS and pend the case for the worker or even make an eligibility decision, depending on their level of training.

Depending on the county, applications are managed in different ways. Some larger offices divide the process into intake, processing, eligibility determination, etc. Other offices keep the application with the same worker for the duration of the process. Larger county offices allow workers to specialize and handle certain programs. Smaller county offices do not have this option, and workers are required to be familiar with all Medicaid programs. This requires workers to heavily rely on the procedure manual as each program has many intricacies unique to itself.

For mailed-in applications, the administrative office staff will initially go through the mail and then pass the documentation to an eligibility worker. The worker will then examine the application and send a checklist to the applicant of what information must be provided, if necessary. Varying by county, workers print the checklist and fill it in by hand, or workers fill out the checklist online and then print it. The checklist is available in the forms section of the MEDS website.

SCDHHS does not maintain case records for SSI cases. These individuals are automatically loaded directly into MEDS if they are eligible ([see SDX interface for technical details](#)). All other potential beneficiaries are required to submit an application.

Tax Equity and Fiscal Responsibility Act (TEFRA), FPW, BCCP, GAP, QI and several other types of applications are processed at the main SCDHHS site (i.e. Central Eligibility Processing, CEP). The remaining types of applications are processed at the county eligibility offices. If CEP receives an application that must be processed at the county office, they forward it via courier and vice-versa. Applicants may go to the county office to verify identity and citizenship. An eligibility worker sends these materials by courier to the main SCDHHS site.

Beginning in January 2010, the SSA will send an electronic referral to the agency for those individuals that currently receive Medicare Part B benefits and apply to the SSA for LIS, a subsidy to help pay Part D premiums. SCDHHS will treat these referrals as applications and process them to determine if the individual is eligible for Medicaid (which in turn determines their eligibility for the LIS). The referral will provide basic information like name, address, income, resources, and SSN, but SCDHHS will need to determine specific information concerning resources. SCDHHS plans to have MEDS automatically generate a checklist of information needed from the individual to fill out and return. If the individual qualifies for Medicaid, SCDHHS will communicate this to SSA.



The worker searches MEDS by name, social security number, or date of birth to check if the potential beneficiary is already eligible or if an old case exists.

CEP workers use the Partners for Health (PFH) Tracking System/Central Eligibility Tracking System to track the status of an applicant's application. The tracking system holds all information related to the application and is used to track the progress of cases ([See PFH Tracking System/Central Eligibility Tracking System for technical details](#)). Workers can also use the tracking system to document reasons for actions related to eligibility determination and the application. If an applicant is determined to be ineligible, MEDS will generate a notice for the beneficiary. However, if the worker uses a reason code that does not trigger letter generation, the worker can instead use the tracking system to generate a letter for the applicant (see **Manage Applicant and Member Communication**). The PFH system is also used for automated workflow management. Supervisors can route certain work to specific Central Eligibility workers. Work can be assigned and then re-assigned electronically by the supervisor. The county Eligibility offices do not have access to the PFH system. *SCDHHS would like to have a system with functionality similar to PFH (workflow management etc.) at the county offices.*

It is standard operating procedure for CEP worker to enter all relevant actions/changes that are made in MEDS into PFH. So if a CEP worker gets an alert (for a change of address etc.) in MEDS, that worker would know to then enter that information into PFH. This is a redundant step; however, the PFH system is essential to CEP operations.

The county Eligibility offices use various methods for tracking letters and applications. County Eligibility workers utilize the notes sections of MEDS to document letters that have been sent (and by whom etc.). Some county offices use MS Excel spreadsheets to track the status of applicant's applications. There is no standard method for tracking applications, letters and distributing workflow. Additionally, if MEDS does not generate a letter, eligibility workers create ad-hoc letters using MS Word or a similar tool to accomplish the task.

SCDHHS would like for MEDS to reflect how the application came in to the system (e.g. paper-based via an interview, mail, drop-off at office, etc.).

SCDHHS would like to incorporate tracking and reporting features into MEDS for eligibility determination including timeliness, verification, and redetermination reports available down to the location and user level.

Eligibility Data Sources and Determination

Different programs require different information to determine eligibility. Some programs take applicants at their word for resources while some programs require verification of resources or have differences in what counts as a resource. Certain information is verified for all programs, like income. Also, when a beneficiary has a change in income, he must notify the eligibility worker within ten business days as this may affect his eligibility. The following are some of the interfaces used to assist the eligibility worker to determine eligibility:

Eligibility workers use the Beneficiary Earnings and Data Exchange (BENDEX) interface as part of the Income Eligibility Verification System (IEVS) to aid in determining an applicant's eligibility via past and present income ([see BENDEX interface for technical details](#)). Another part of the IEVS is the ESC interface, which is used to verify



receipt/non-receipt of wages and other benefits for Medicaid applicants ([See ESC interface for technical details](#)).

SCDHHS receives data concerning who receives retirement benefits from the SCSRS via the DSS. Any changes to this information automatically alert eligibility workers that a redetermination of eligibility must be calculated ([see SCSRS interface for technical details](#)).

Eligibility may be established based on data from the State Data Exchange (SDX), which sends data to SCDHHS concerning who is receiving SSI from the SSA. If an individual is SSI eligible, Medicaid eligibility is automatically established if it wasn't already ([see SDX interface for technical details](#)). Also, if an individual loses his SSI eligibility, the beneficiary record is automatically updated to reflect ineligibility (see **Disenroll Member**).

Eligibility workers use the State Verification and Exchange System (SVES) and the Enumeration Verification System (EVS) to validate and verify information for new and prospective beneficiaries including SSNs, SSA benefits, SSI benefits, quarters of coverage, and prisoner status. Eligibility workers access this information online and submit an inquiry to receive information for an individual ([see SVES and EVS interfaces for technical details](#)).

Data returned from the Medicare Modernization Act (MMA) is used to automatically update an eligibility record to reflect dual eligibility for certain Medicare and Medicaid benefits ([see MMA interface for technical details](#)).

Eligibility workers use an Excel workbook developed by SCDHHS to determine if an individual meets the financial requirements for Medicaid eligibility. A link to the workbook is available in the forms sections of the MEDS website. Certain circumstances still require that a worker complete the calculations manually. *SCDHHS would like MEDS to have automated budget calculations (income and resources) for all programs to assist in the eligibility determination process.* The eligibility worker manually inputs financial information including income and resources into the workbook, which automatically determines if the financial requirements are met. This workbook is printed and filed hard copy at the local eligibility office. The worker then enters all income information and minimal resource data into MEDS. *SCDHHS would like to improve MEDS efficiency for eligibility workers' use (e.g. only entering data once, system prompt for mandatory fields, ability to make changes).*

Pregnancies must be verified by a medical professional (e.g. doctor, midwife, registered nurse, prenatal clinic) on official letterhead and include a date of expected delivery. This information is required for input in MEDS.

SCDHHS would like for individual eligibility workers to have the ability to tailor MEDS to their format and workload management. Currently, many workers have too much work to complete for an individual workload. Workload management would allow for the workers to have and create alerts, reviews, case transfers, and case notations in order to effectively manage their time in opening new cases and allow for even distribution of the workload.



In the near future, SCDHHS plans for all application paperwork to be scanned, set up in folders, and provide a full case record in MEDS. This would allow for all documentation to be passed electronically, and managers would then have the ability to distribute work to different areas.

SCDHHS would like to have an automated workflow, so that once an application is scanned, the work would be distributed throughout the state to allow for more timely and efficient work. SCDHHS would also like for all related application documentation to be linked to the case file (e.g. insurance policy, etc.).

The worker enters application information into MEDS and pends the case within three business days of receipt. If additional information is still needed, the case will go into pending status, and the eligibility worker provides the potential beneficiary with a checklist to show what information is still needed.

Workers can make an eligibility determination prior to information being entered into MEDS. The worker will still enter information into MEDS in order to generate a denial of eligibility notice.

MEDS does not currently have decision-making capabilities. However, MEDS does have edits to catch things like income limits for different programs, so if a worker enters an income that exceeds the limitation, an edit will catch this. *SCDHHS would like MEDS to have logic that would determine automatically all categories and programs for which an individual is eligible. Currently, an individual may be denied for Medicaid when in actuality he/she is eligible under a different eligibility category or program.*

If an applicant fails to supply the required information to complete the application, a worker will manually close the case after a certain period of time. Different offices have different standards for how long they will keep a case open. If they must close a case, they will use the reason code: "failure to provide information".

When a beneficiary loses his eligibility, eligibility workers research at what point his eligibility was lost. SCDHHS has a threshold for recouping money from beneficiaries when payments were made on their behalf during a period of ineligibility. SCDHHS will not pursue recoupment if the amount is below this threshold. The eligibility worker sends a letter and requests payment from the beneficiary (see **Manage Applicant and Member Communication**).

Ex Parte Process

If it appears that an individual is not eligible for the program he applied for, the eligibility worker will not take negative action until he has looked at all programs. This is known as the ex parte process. MEDS will assist in this process by determining the payment category, but otherwise, the worker must manually make this decision.

Ex parte would apply any time coverage cannot be established or is lost (when a new application is denied or a redetermination or review results in a closure).



Quality Control

Supervisors in each county review a small amount of eligibility workers' work each month. For new workers, a supervisor will review 100% of their work. The review consists partly of the work in the eligibility office and partly of what's entered into MEDS.

SCDHHS also contracts with a Quality Control contractor for other quality control reviews for eligibility determination:

Medicaid Eligibility Quality Control (MEQC) This review consists of two options: 1. A random sample is pulled, and the contractor assigns an error rate. 2. SCDHHS can identify a specific area that is known to have problems and then must make a corrective action plan.

Payment Error Rate Measurement Review (PERM) This review is conducted for Medicaid and SCHIP, and separate error rates and payment review processes are reported. If it is found that a case should have been ineligible, an error in claims payment is reported.

Assistance for Coaching Excellence (ACE Review) This review has a sample of cases from each supervisory unit. This review is different from the two above in that it is a desk review and information is not verified again.

The contractor also conducts other reviews on an ad hoc basis including a review of SCDHHS employees that receive Medicaid or a supervisor request to investigate an individual worker's cases. A supervisor will report their suspicions of the worker to the agency prior to the contractor conducting a review. Currently, every review requires a correction action plan. SCDHHS plans to require an annual corrective action plan instead.

The agency's plans for online record access would allow for more reviews to be conducted. Currently, SCDHHS sends the contractor the records to be scanned. The contractor has MEDS and MMIS terminal access.

Redetermination

Annually, MEDS uses information from BENDEX to automatically recalculate the countable income for beneficiaries also receiving SSA benefits. Findings may indicate that a beneficiary is no longer eligible for Medicaid, which begins the disenrollment process (see **Disenroll Member** and **Manage Applicant and Member Communication**).

SCDHHS would like for MEDS to close a case automatically once a death certificate is produced.

SCDHHS would like for cases for individuals who turn nineteen to automatically close. For this population, it will be necessary to include information about applying for other Medicaid programs if the beneficiary has a disability or is pregnant.

Any changes to a beneficiary's record can trigger a redetermination of eligibility. The interfaces described earlier in this document often supply data that affects a beneficiary's eligibility.



Reviews

Most eligibility reviews are done by the mail. Annually, eligibility workers mail a review form to beneficiaries. Some beneficiaries come in for an interview, but most choose to return the review form via mail.

When a form is returned and all information is provided, the eligibility worker will indicate in MEDS that the review was completed.

If a beneficiary does not return the form by the requested date, MEDS will auto-close the case, terminating eligibility.

If it is found that a beneficiary is no longer eligible, the worker must complete the ex parte process to ensure that the beneficiary is also not eligible for any other Medicaid program.

SCDHHS would like to generate a pre-populated review form that lists pertinent beneficiary information (incomes, household members, etc.) to send to recipients. This way, beneficiaries could confirm if nothing has changed or mark changes directly on the form. Currently, the review form mirrors the application and requires the beneficiary to complete a substantial amount of paperwork.

3.3.1.2. Enroll Member

Fee-for-Service

For new applications, all information is verified. Once an eligibility worker has entered all data into the MEDS application screen and is ready to make an eligibility decision, MEDS has edits to check things like the supplied income and resources against program requirements. The worker will also do manual checks to ensure the applicant meets the criteria and selects the “make decision” action. MEDS displays the information for the worker to review in case the worker needs to make any corrections (see **Determine Eligibility**). Once the information is correct, the worker selects the “act on decision” action, and MEDS inputs the date and changes the recipient status from pending to current to reflect enrollment.

The different program areas that oversee Recipient Special Programs (RSPs)/waiver programs are responsible for enrollment and entering beneficiary information into the MMIS via MMIS online, which interfaces with MEDS to update its files ([see MMIS to MEDS interface for technical details](#); see **Manage Member Information**). Waiver programs have certain criteria that qualify individuals for programs.

Managed Care

The agency contracts with an Enrollment Broker/Counselor for enrolling individuals into managed care programs.

If the payment category is eligible for Managed Care, MEDS sends a file to MMIS ([see MEDS to MMIS interface for technical details](#)). MMIS sends an 834 daily to the Enrollment Broker that includes individuals that are eligible for Managed Care based on payment category and



Recipient Special Program (RSP). No information is sent to the Enrollment Broker concerning individuals that are not eligible for managed care. Monthly, the Enrollment Broker sends enrollment decisions to MMIS, which confirms back to the Enrollment Broker that enrollment decisions have been accepted. MMIS approves everything unless a member is no longer eligible.

Within two day of receipt of the 834, the Enrollment Broker sends enrollment packets to managed care eligibles, which includes selection options and deadlines for returning their responses.

The Enrollment Broker will send three mailings prior to the initial deadline for plan selection.

Regular managed care members can choose a plan or be auto-assigned. Once a regular member chooses a plan, a confirmation letter is sent. If a regular member does not choose a plan, the Enrollment Broker will auto-assign the member to a plan and sends the member a notification letter.

Some managed care eligibles (e.g., foster care children) are not assignable, so they must choose a health plan. These members will remain in fee-for-service until they make a choice. The Enrollment Broker sends notification annually that these members must make a choice and includes all options available to the member.

Some managed care eligibles are assignable, but they choose fee-for-service Medicaid instead of a managed care plan. These individuals will receive an anniversary letter from the Enrollment Broker that says they must choose a managed care plan or the Enrollment Broker will select one for them.

Newborns are enrolled into an MCO if their mothers are in an MCO. Retroactively, the Enrollment Broker enrolls newborns into the health plan up to three months from birth. If a newborn is four months to one year, there is no retroactive enrollment. If the newborn is linked to a mother in an MHN or fee-for-service Medicaid, the newborn will not be enrolled into Managed Care.

Children eligible for HCK may choose their own health plan or have one auto-assigned. Typically, plans are auto-assigned. Eligible children remain in HCK up until the month in which they turn nineteen.

Depending on eligibility, a member can choose an MCO or an MHN. For members that are auto-assigned, the Enrollment Broker has an auto-assignment algorithm that attempts to evenly distribute members across all the health plan options. Family members are all assigned to the same plan regardless of when each enrolled with Managed Care. If a family is in multiple plans, the member will be placed in the plan with the higher number. If there is an even split between plans, the placement will be random.

Whether the member or the Enrollment Broker chooses the plan, the enrollment is for the next assignable period (occurs on a monthly basis), which depends on when the enrollment request is submitted.

Members can make one change within 90 days from entry into a health plan (known as the 90-day choice period). After 90 days, the member is locked into the health plan for the remainder



of the year (known as the lock-in period). Every anniversary date, the member has the option to remain in his current plan or choose another. The Enrollment Broker sends a letter to the member 60 days prior to the anniversary date. If a member chooses another plan this is known as a transfer. If the member does not choose another plan, he will remain in the same health plan.

If a member wants to move to another health plan and the 90 days has passed, he must provide “cause” (as defined by CMS regulations) and submit documentation to the Department of Managed Care. The department reviews and processes all paperwork, and a worker updates the MMIS to reflect new enrollment information. The Department of Managed Care tracks member enrollment requests using the Beneficiary Users System (BUS; [see BUS for technical details](#)).

3.3.1.3. Disenroll Member

The following may trigger disenrollment of a beneficiary from the Medicaid program:

- Loss of eligibility, which is triggered by:
 - Redetermination calculations (see **Determine Eligibility**)
 - Loss of SSI eligibility ([see SDX interface for technical details](#))
 - Change in medical condition (waiver programs have specific beneficiary health requirements)
 - Findings from a Program Integrity investigation:
 - Abuse and/or Fraud
 - Receipt of Medicaid benefits from more than one state ([see Public Assistance Reporting, Office of Children and Family Services \[PARIS\] interface for technical details](#))
- Hard copy disenrollment request sent from beneficiary

Fee-for-Service

Disenrollment letters include information concerning filing an appeal (see **Manage Member Grievance and Appeal**). Eligibility workers send these letters when a beneficiary loses his eligibility for one of the reasons listed above (see **Manage Applicant and Member Communication**).

The same worker or area that enrolled a beneficiary is responsible for disenrollment and updating the recipient file in MEDS or MMIS (for RSP only). Some disenrollments are automatically initiated based on information from an interface. See **Manage Member Information**.

Waiver program disenrollments are sent to MEDS nightly ([see MMIS to MEDS interface for technical details](#)).

Managed Care

Members that selected or were assigned to a plan may disenroll one time in the 90-day choice period by contacting the Enrollment Broker.



If a member wants to disenroll from a health plan and the 90-day period has passed, he must provide “cause” (as defined by CMS regulations) and submit documentation to the Department of Managed Care. The Department reviews and processes all paperwork, and a Managed Care worker performs a “zap” in the MMIS to reflect disenrollment. The Department of Managed Care tracks member disenrollment requests using the BUS ([see BUS for technical details](#)).

Some disenrollments are due to a loss of Medicaid eligibility and are automatically generated from the MMIS and sent to the Enrollment Broker (ex: a member is automatically disenrolled from HCK when he turns 19). These are known as auto-closures.

If a member is auto-closed and then regains eligibility within 60 days, he will be placed back into the plan from which he left and will keep the same anniversary date.

The Enrollment Broker sends a disenrollment notification to members for all managed care disenrollments. Eligibility workers send disenrollment notifications to these members if they are also no longer eligible for any Medicaid program.

Members enrolled with HCK may not disenroll and opt for fee-for-service Medicaid. SCHIP is the only insurer for these members.

3.3.1.4. Manage Member Information

Beneficiary Files in MEDS

MEDS holds all family and recipient data stores for enrolled Medicaid members. MEDS does not purge its recipient records and contains information for disenrolled recipients. *SCDHHS would like for MEDS to be web-based and easily scalable based on the number and location of users with no system impact.*

Eligibility office workers and workers in the Division of MED System Support update beneficiary files. If an individual wants to make changes to a record but does not have update access, he must go to his supervisor to make changes or the Division of MEDS System Support.

SSNs and some financial information are validated through various interfaces. In the future, SCDHHS plans to release an RFP for an income verification system. Addresses are not validated. *SCDHHS would like to validate addresses based on US postal standards and have data matches with credit bureaus.*

MEDS interfaces with the MMIS in a nightly transfer of data that includes the Recipient Update File (includes Budget group (family)) data and Member (Recipient/beneficiary) file, Medicaid Card File, and Managed Care Update File. This data is used to update MMIS with the latest MEDS data, to request production of Medicaid cards for new beneficiaries, and to supply information that the MMIS uses for a Managed Care file that is sent to the Enrollment Broker ([see MEDS to MMIS interface for technical details](#)).

SCDHHS would like for all MEDS interfaces to automatically populate beneficiary records. This would reduce time spent manually checking information received through an interface.



SCDHHS would like for MEDS to have more audit trails related to a beneficiary's record. SCDHHS would also like a more user-friendly notes section to show a user's reason for making changes.

SCDHHS would for the notices sent to beneficiaries to be directly accessible in MEDS.

Beneficiary Files in MMIS

MMIS interfaces with MEDS in a nightly transfer of data that includes beneficiaries to be included in the Managed Care file and information to update the RSP indicator for beneficiaries enrolled in waiver programs. After the MMIS applies Managed Care-specific edits, the Managed Care file is sent to the Enrollment Broker, and the RSP indicator update keeps data synchronized ([see MMIS to MEDS interface for technical details](#)).

All plan information is held in the MMIS. However, it does not show what specific services a person is eligible for. The service type indicator only reflects if a beneficiary is eligible for full, limited, or emergency services. *SCDHHS would like a central screen to show all the services that are available to a beneficiary.* The MMIS also indicates enrollment in Recipient Special Programs (RSPs) as updated by the program areas that administer RSPs.

Other Sources

- **Eligibility Offices**
 - Hard copy applications and supporting documentation
- **Interfaces and Systems**
 - The PARIS interface identifies individuals that may be receiving Medicaid benefits in more than one state. Findings do not necessarily indicate fraud as some beneficiaries may have forgotten to notify a state that they were moving ([see PARIS interface for technical details](#)). Findings may trigger communication with a beneficiary (see **Manage Applicant and Member Communication**) or a preliminary investigation (see **Identify Candidate Case**).
 - Central eligibility workers use the PFH Tracking System/Central Eligibility Tracking System to log and track information related to a Medicaid application ([See PFH Tracking System/Central Eligibility Tracking System for technical details](#)).
 - SCDHHS uses BUS to track enrollment, disenrollment, and changes requested by Managed Care members ([see BUS System for technical details](#)).
 - The Enrollment Counselor and MCOS/MHNs all have their own proprietary systems that house beneficiary information.
 - MEVS is another data store that houses eligibility data ([see MEVS interface for technical details](#)). This interface is populated nightly by extracts from the MMIS and used primarily in the **Inquire Member Eligibility** process.

There are many other sources for beneficiary information not listed. See the MMIS and MEDS interfaces section for a comprehensive listing of all interfaces that include the exchange of beneficiary-related information.

SCDHHS would like to have all beneficiary information centralized including all information relating to communication, grievances, appeals, and Program Integrity cases. Currently, eligibility workers have to consult several sources to gather information on one individual.



SCDHHS would like for the MEDS system to have more flexibility and adaptability to support small and large-scale changes. Currently, any desired changes may take several months, and some changes are never implemented due to other pressing agency issues. SCDHHS would like for the MEDS system to be adaptable to support functional organization changes (e.g. intake, processing, maintenance, privatized intake).

SCDHHS would like for beneficiaries to have access to an eligibility file in order to update information like addresses and access to other program information.

3.3.1.5. Inquire Member Eligibility

Prospective beneficiaries call the Central Eligibility office to find out the status of their application. Central Eligibility staff use the PFH Tracking System/Central Eligibility Tracking System to look up the status of an application and respond to the caller's inquiry ([see PFH Tracking System/Central Eligibility Tracking System for technical details](#)).

Other methods to determine a prospective beneficiary's eligibility are described below.

Data Match ([see Data Match interface for technical details](#))

Providers and authorized consultants submit requests for eligibility data (in order to verify eligibility for dates of service) on CDs, disks, or cassettes, and the BMSM returns the requested data on diskette and, if requested, in hard copy. Providers and authorized consultants use this process to request recipient data that is older than thirteen months (for queries within 13 months, the 270/271 HIPAA Transaction is used—see below). Currently, this is a manual task and few providers use this process. Most providers have moved to using the 270/271 HIPAA Transaction process described below.

IVRS

The IVRS can be used to check for an individual's eligibility ([see IVRS interface for technical details](#)).

Providers call the toll-free IVRS number and enter their Medicaid Provider ID or NPI number. They are then prompted to enter dates of service and one of the following:

- Medicaid Member Number
- Social Security Number and full name or date of birth
- Full name and date of birth

SCDHHS contracts with a company that runs the IVRS. It sends a 270 transaction to MEVS at Clemson, which is populated daily by eligibility information from the MMIS, and returns a 271. (The contractor also receives a weekly payment file; this information is available through the IVRS as well.) The 271 is used to generate an eligibility response to the provider.

270/271 HIPAA Transaction



As with other HIPAA transactions, SCDHHS exchanges 270/271 transactions with trading partners using an FTP server and the Translator at Clemson ([see HIPAA mailbox interface for technical details](#)). First, trading partner agreements and submitter IDs are established as described under **Establish Business Relationship**. Trading partners may also use the web submission tool or a direct connection to exchange 270/271 transactions.

Submitters, both either clearinghouses and individual providers, transmit 270 files to Medicaid's FTP server. A separate FTP mailbox is maintained for each submitter. A process called 'sniffers' polls the mailboxes, picking up incoming files almost immediately. When it finds a file, it sends it to the translator, which makes sure the file is HIPAA-compliant.

Noncompliant files generate an error message, which is placed in the outgoing folder for the submitter to pick up. Compliant files are passed to MEVS ([see MEVS interface for technical details](#)). In either case, a 997 (acknowledgment transaction – non-HIPAA but nonetheless widely used) and a trace file (non-HIPAA – generated by the software) are generated for the submitter. After translation, the file is uploaded to the mainframe; uploads happen every hour on the half hour.

270 files should identify the intended individual by the following criteria:

1. Recipient Medicaid ID
2. SSN and Date of birth
3. Date of Birth and Name (First name, middle initial, last name; must be an exact match)

If the 270 request doesn't match any of these, a value 75—subscriber/insurer not found—is returned to the requestor. If multiple individuals match, then a value 75 is also returned; information for the beneficiary is only sent when one match can be determined.

Failure reasons include the Translator, MEVS, or FTP server being down, in which case the transactions would just collect until systems were back up.

After identifying eligibility status for the appropriate individuals, MEVS generates an outbound file containing the beneficiary's information.

The 271 task on the translator is run hourly every day to pull the daily flat file (containing all 271 transactions that need to be returned to submitter's mailboxes) back down from the mainframe. The daily flat file is typically ready on the mainframe between 2:30pm and 7:30pm each day.

3.3.1.6. Perform Population and Member Outreach

Any materials intended for beneficiaries are reviewed by the Medicaid Eligibility and Beneficiary Services program area using the Common Sense Checklist. This tool was developed to ensure all communications are consistent, correctly targeted, well planned, and necessary.

Some materials are translated into Spanish by the Public Information Office staff or by a translation contractor, depending on the amount of work required.

To Potential Members



SCDHHS' outreach to potential Medicaid and SCHIP beneficiaries is limited by budget concerns. However, there is some outreach to potential beneficiaries.

Pressure from advocacy groups, the Medical Care Advisory Committee, and legislators often influences outreach decisions. The Medicaid Eligibility and Beneficiary Services program area consults with these outside entities and with internal stakeholders to identify outreach priorities.

The Medicaid Eligibility and Beneficiary Services program area works with the State Budget & Control Board to determine potential groups for outreach. For example, the board has run a list of food stamp-enrolled families with children against a list of Medicaid-enrolled children to find children potentially eligible for SCHIP or Medicaid; SCDHHS then prepared a targeted mailing to those families.

Other groups such as the United Way have also worked with the agency to target outreach through their programs in day cares, afterschool programs, unemployment offices, etc.

The program area responds to public requests for outreach. Speakers from the area make presentations at conferences and seminars, and staff may set up informational tables at health fairs and other events.

The managed care plans perform outreach of their own via billboards, flyers, etc., which have the effect of promoting the Medicaid program to potential beneficiaries.

To Existing Members

The program area has to balance the need to educate beneficiaries about Medicaid with the need to avoid information overload. The area reviews every policy or coverage change to decide whether beneficiaries need to be directly informed of it, or whether providers and/or eligibility workers can pass the information along. The Common Sense Checklist sometimes helps in this review in that it can lead to a planned beneficiary letter being rejected or revised.

Beneficiary newsletters are one common outreach method, as they allow SCDHHS to pass along information on several topics at once in a less formal manner than a letter. These newsletters are coordinated by the Public Information Office with the help of the Medicaid Eligibility and Beneficiary Services program area.

Letters and postcards are also used.

Mailings are often targeted by eligibility category type: there might be different versions of a newsletter for Family Planning and regular Medicaid beneficiaries, for example.

The handbook sent to all new Medicaid beneficiaries with their ID card is another important outreach method. The handbook is revised whenever supplies are low or a major change requires it.

The main SCDHHS website contains information for potential and existing beneficiaries, such as enrollment forms, contact information and eligibility criteria. There is also a page that lists providers that participate in Medicaid. This list can be searched by provider type, city, county etc. A worker from the BMSM utilizes a file from the MMIS_Provider database record created



from a job on the mainframe (the job is in library HHS.PROD.JCL(PROVWEB)) to populate the SCDHHS website with the Medicaid provider information.

The Enrollment Broker provides a website available to prospective and current members concerning information regarding the Healthy Connection Choices and Kids programs. It explains the plans and how to sign up for a managed care plan.

HIPP Outreach

SCDHHS staff conducts outreach to potential beneficiaries for the Health Insurance Premium Payment (HIPP) program in South Carolina. For example, a letter about the program is sent to every family of a TEFRA beneficiary, and some caseworker training has been held (see **Prepare Health Insurance Premium Payment** for an explanation of the HIPP program). *SCDHHS would like to expand and enhance HIPP outreach.*

3.3.1.7. Manage Applicant and Member Communication

It is possible for anyone in the agency to receive a call or communication from a beneficiary. If the agency worker is unable to assist the beneficiary, the communication is routed to the appropriate outlet (Managed Care area, local eligibility office, program area that manages a waiver program, agency resource center, another agency, etc.).

Managed Care Communication

The Managed Care area receives calls from members concerning eligibility, program information, etc. If the worker does not have access to the information needed, the caller is referred to the appropriate MCO for further information. There is no standard call log for tracking this communication. Each staff member maintains his own log either via hard copy or electronically. Staff may use the BUS to log information related to hostile phone calls ([see BUS for technical details](#); see **Manage Member Grievance and Appeal**).

DME Equipment

The DME area receives calls from beneficiaries concerning the status of prior authorizations for DME. The DME will give a status of the prior authorization (denied, approved, under review) but cannot send any information back to the beneficiary since the provider is the one who sent the prior authorization request. The beneficiary is encouraged to contact the provider who requested the prior authorization for additional information. This is the only program area that communicates with beneficiaries concerning prior authorization requests.

PFH Tracking System

The PFH Tracking System/Central Eligibility Tracking System generates letters based on application-related events (e.g. acceptance or denial into Medicaid program) and to request additional information from a prospective beneficiary. A prospective beneficiary that is denied eligibility has appeal rights, which are detailed in the letter (see **Manage Member Grievance and Appeal**).



The Division of CEP receives hundreds of pieces of mail each day that must be forwarded to the appropriate caseworker. The mail is opened, time stamped, and entered into the tracking system. The original mail is filed, and a copy is forwarded to the appropriate caseworker.

The tracking system is used when a prospective beneficiary calls to inquire about their application status. The worker receiving the call enters the tracking system to see what the status of the application is and responds to the inquiry ([See PFH Tracking System/Central Eligibility Tracking System for technical details](#)).

SCDHHS sends letters to those beneficiaries who will lose their eligibility based on a redetermination (see **Determine Eligibility**). These letters indicate that the beneficiary has certain appeal rights that may be exercised (see **Manage Member Grievance and Appeal**).

Medicaid Program Information

The card carrier, Medicaid ID card, and handbook sent out to newly enrolled beneficiaries are revised and updated according to the same standards as outreach materials. (See **Perform Population and Member Outreach**). SCDHHS has a contract for the printing of new Medicaid ID cards and re-printing for beneficiaries who have lost their cards ([see MCCA interface for technical details](#)).

The following item, though explained in the **Prepare EOB** business process for clarity, is also a function of this business process:

- Sending of Recipient Explanation of Medical Benefits (REOMB) letters to beneficiaries

The following item, though explained in the **Manage Member Grievance and Appeal** business process for clarity, is also a function of this business process:

- Any and all communication relating to a grievance or appeal

3.3.1.8. Manage Member Grievance and Appeal

The Manage Member Grievance and Appeal business process performs the necessary actions to resolve beneficiary grievances and appeal cases through case reviews and hearings. Grievances are managed and resolved by the Division of Constituent Services and Beneficiary Services or the MCO or MHN a beneficiary is enrolled with. Depending on the nature of the appeal, appeals are managed and resolved by different routes. Members enrolled in programs internally managed by SCDHHS appeal to the Division of Appeals and Hearings. Members enrolled in an MCO or MHN must first appeal to that organization prior to requesting an appeal through SCDHHS. Members enrolled in programs managed by another agency must first appeal to that agency prior to requesting an appeal through SCDHHS.

Grievances

The Division of Constituent Services and Beneficiary Services uses the Constituent Services Tracking System to track beneficiary issues and complaints ([see Constituent Services Tracking](#)



[System for technical details](#)). The database keeps a record of all issues and complaints that come whether by telephone, agency email box, hard copy correspondence, legislative referrals, etc. Users enter the name of the beneficiary into the system and information associated with the issue. There is no standard format for how the information is entered into the system as this occurs on an ad hoc basis. Division workers use the system to track the progress of the case and its resolution. Division workers resolve the case and may consult other areas for information. There is no standard process for resolving a grievance.

As stipulated in their contracts with SCDHHS, MCOs have an internal process for managing grievances, and those are not appealable to the Division of Appeals. Each MCO must log the following information for a grievance on a monthly basis (a table format is supplied in the Managed Care manual; created in Excel):

- Reporting month/year
- Date that the contractor received the grievance
- Member Name and Number
- Brief description/summary of grievance
- Status:
 - Number of contacts with member
 - Actions taken for resolution
- Resolution:
 - Type of resolution
 - Response given to member
 - Date of resolution
- Resulting Corrective Action (any action taken on by the MCO as a result of grievance)

In the Division of Care Management, information concerning specific grievances/complaints is communicated via a secure extranet site. Each MCO and MHN has its own secure site for this communication with SCDHHS. Program managers receive grievance reports quarterly.

The Department of Managed Care uses the BUS to log hostile phone calls and complaints and information related to these calls ([see BUS for technical details](#)).

Appeals

Beneficiary appeals may be triggered by the following:

- Loss of Medicaid eligibility
- Denial of Medicaid eligibility
- Recoupment for services for retroactive loss of eligibility
- Denial of Prior Approval for prescribed medication
- Denial of Prior Approval for medical procedure
- Discharge from a nursing home against the beneficiary's will

Federal regulations require that a prospective or current Medicaid beneficiary be informed of the cause for ineligibility or eligibility termination (see **Manage Applicant and Member**



Communication). SCDHHS sends a letter to the beneficiary informing him of his ineligibility/upcoming ineligibility, and he has 10 days to contact his case worker if he wants to dispute the decision before MEDS reflects the upcoming closing of the case. If the beneficiary contacts the Appeals and Hearings area instead of his case worker, the beneficiary will be referred to his case worker to begin the appeals process. The beneficiary has a 30 day window to appeal the ineligibility or eligibility termination. Within the thirty day window, there is a ten day window for the member to contact the eligibility/case worker (located in a county eligibility office) before the MEDS system reflects the upcoming loss of eligibility. This window allows the eligibility worker to correct an error if it is discovered that the beneficiary should remain eligible for Medicaid before the beneficiary's file reflects a change. If the beneficiary appeals within the 10 day time period, he may ask for continued benefits during the appeal, and the worker will leave the case open. If the beneficiary loses the appeal, the Program Integrity area will ultimately research previously paid claims to recoup any money that they may have paid on the beneficiary's behalf during the continued benefits period.

Once the beneficiary contacts his case worker, the beneficiary must complete and sign a hard copy "Request for Fair Hearing" form or submit a letter which acknowledges his desire to keep the case open and dispute the decision. The worker then writes up a narrative detailing the decision and provides supporting documents from the case file, such as copies of check stubs, bank statements, deeds of property transfer, trust documents, life insurance policies, etc. that were used in making the determination of ineligibility. This narrative and supporting information is then sent via hard copy to the Division of Appeals and Hearings with a copy to the applicant/beneficiary. If additional information is needed from the eligibility worker, the Division of Appeals and Hearings contacts the worker via telephone or email. Any additional information is returned via email, fax, or regular mail. The Division of Appeals and Hearings may also contact the beneficiary directly for additional information, which the beneficiary returns via fax or regular mail

Once an applicant/beneficiary files an appeal request (via regular mail), the Director of Appeals will determine if it is an appealable matter based on the supporting documentation that the worker provides. If the request for an appeal is honored, the Director of Appeals will assign a case number and hearing officer to the appeal request. The Director then passes the request on to an administrative assistant from the Division of Hearings and Appeals, who will key in relevant information that identifies a case (name, address, case number assigned) into the Appeals and Hearings Tracking System database ([see Appeals and Hearings System PC application for technical details](#)). If the request for an appeal is not honored, no information concerning the request is keyed into the tracking system. The administrative assistant prepares a Case Management Sheet (CMS), an MS Word document, which is then sent to the assigned hearing officer.

Certain boilerplate documents are identified on the CMS in drop-down menus, as well as drop-downs for date, time, possible hearing locations, and names of "common personnel" (a list of these individuals is maintained by the division) that are to be copied with the various correspondences associated with the case. When the hearing officer determines which document is needed, they select the appropriate responses from the drop-downs and email the CMS back to the administrative assistant to create the document, envelopes, certified cards, etc. Any and all mailed communication produced by the division is sent via certified mail. Some



communication may be sent electronically. The Appeals and Hearings Tracking System database tracks the case flow from the opening of the case to its closure. Currently, the administrative assistant is the only user of the tracking system. *The Division of Appeals and Hearings desires a more user-friendly tracking system, which would encourage division-wide use.*

A hearing officer will then examine the case. There is no standard operating procedure (SOP) for managing an appeal. Currently, the Division of Appeals and Hearings is working to draft the SOP. The Division of Appeals and Hearings has viewing capability of the MMIS, MEDS, BENDEX, and SDX to verify information for case research. The Division of Appeals and Hearings can contact the case worker at any time for additional information concerning the case. If the hearing officer determines that the case worker made no error in discontinuing Medicaid eligibility, an Interlocutory Order is sent to the beneficiary. The beneficiary has ten days to review and produce an error in writing or provide a cause. However, the beneficiary will not be asked to provide a cause for something like a denial of disability (up to hearing officer's discretion). If no error or cause is produced, the Division of Appeals and Hearings will dismiss the appeal. The hearing officer will then write an Order of Dismissal, including such information as when the records were sent to the beneficiary, the failure to produce an error or cause, etc. The Order of Dismissal will be signed by the Director of Appeals and sent out to relevant SCDHHS areas.

If anyone feels that the appeal should stand, the case may be appealed to the South Carolina administrative law court. The Appeals and Hearings Tracking System database will be updated to reflect the closing of the case.

When the appeal is not dismissed, the Division of Appeals and Hearings must give the beneficiary at least 30 advance notice for a scheduled hearing. The beneficiary can choose to waive the 30 days of preparation, which would expedite the case. The hearing office and an agency representative, and the beneficiary attend the hearing. The agency and the beneficiary each give testimonies in the quasi-judicial hearing and must provide copies for everyone present of any documents referenced. The hearing is recorded, and the hearing officer reviews the recording, documents, and evidence to reach a decision. Currently, the Appeals and Hearings area uses analog recorders, but they hope to move to digital recording in the near future. The Director of the Division of Appeals and Hearings reviews the decision, and a cover letter is signed. The decision is sent to the Petitioner (entity who filed the appeal) and other interested parties.

Final Decisions and Orders of Dismissal are imaged, and the case files are archived after two years. These documents are easily accessible through Application Xtender.

If anyone feels that the Hearing Officer's decision is in error, they have 30 days to appeal to the South Carolina administrative law court (ALC). The Appeals and Hearings Tracking System will be updated to reflect the closing of the case.

When a beneficiary chooses to appeal the decision, they must file with the ALC. The Office of General Counsel and the Division of Appeals and Hearings will receive a notice from the court informing them of the filing, and SCDHHS must prepare a full record. The Division of Appeals and Hearings has forty-five days from receipt of the notice to prepare a complete copy of the record and a written transcript of the recorded hearing. Kinko's prints and binds the full record copies. The hearing officer will review the entire record and sign off to verify its completeness. The



court receives three copies of the record, and the beneficiary and SCDHHS General Counsel each receive a copy. The court will affirm, reverse, or remand the SCDHHS decision. When the decision is remanded, SCDHHS must comply with the directives of the ALC, which may include holding a second hearing. If the beneficiary chooses to appeal from the second hearing, they must appeal to the South Carolina Court of Appeals.

Managed Care Appeals

Through the Managed Care area, the MCOs have an internal appeal process that beneficiaries must request prior to filing an appeal with the SCDHHS Division of Appeals. Each MCO must log the following information for an appeal on a monthly basis (a table format is supplied in the Managed Care manual; created in Excel):

- Reporting month/year
- Date that the contractor received the appeal
- Member Name and Number
- Brief description/summary of appeal
- Status:
 - Number of contacts with member
 - Actions taken for resolution
- Resolution:
 - Type of resolution
 - Response given to member
 - Date of resolution
- Resulting Corrective Action (any action taken on by the MCO as a result of the appeal)

Each MCO has its own appeals procedures. In the Division of Care Management, information concerning specific appeals is communicated via a secure extranet site. Each MCO and Medical Homes Network (MHN) has its own secure site for this communication with SCDHHS. Program managers receive appeal reports quarterly. In the case of a denial of Medicaid service to a beneficiary by an MCO, the beneficiary is told on the MCO denial notice that they can appeal to the SCDHHS Division of Appeals. A Managed Care area representative attends the hearing as a source of information and acts as a neutral party.

Other Agency Appeals

If a beneficiary is appealing to another agency (e.g. DDSN administers two waiver programs for SC Medicaid), the beneficiary is first instructed to request an appeal through that original agency. If the beneficiary is denied again, he/she is sent a summary of the decision, and informed of their appeal rights (through SCDHHS Division of Appeals). If the beneficiary decides to appeal, he/she contacts their assigned local eligibility worker, who then will begin preparing documents on their behalf.

3.3.2. *Member Management (ME) "Wish-list" Table*



Wish-list Item	Related Business Process
Online applications with web-based submission.	Determine Eligibility
Context-driven interviews to gather applicant information more effectively	Determine Eligibility
System should have functionality similar to PFH (workflow management etc.) at the county offices.	Determine Eligibility
MEDS should reflect how the application came in to the system (e.g. paper-based via an interview, mail, drop-off at office, etc.).	Determine Eligibility
Tracking and reporting features for eligibility determination including timeliness, verification, and redetermination reports available down to the location and user level	Determine Eligibility
Automated budget calculations (income and resources) for all programs to assist in the eligibility determination process	Determine Eligibility
Improve MEDS efficiency for eligibility workers' use (e.g. only entering data once, system prompt for mandatory fields, ability to make changes).	Determine Eligibility
Ability to tailor MEDS to user format and workload management. Create alerts, reviews, case transfers, and case notations.	Determine Eligibility
Automated workflow to distribute work throughout state once application is scan. All related application documentation should be linked to the case file.	Determine Eligibility
Logic to determine automatically all categories and programs for which an individual is eligible	Determine Eligibility
Close a case automatically once a death certificate is produced.	Determine Eligibility
Automatic case closure for individuals who turn nineteen. For this population, it will be necessary to include information about applying for other Medicaid programs if the beneficiary has a disability or is pregnant.	Determine Eligibility
Generate pre-populated review forms for beneficiaries.	Determine Eligibility
MEDS should be web-based and easily scalable based on the number and location of users with no system impact.	Manage Member Information
Validate addresses based on US postal standards and have data matches with credit bureaus.	Manage Member Information
All MEDS interfaces should automatically populate beneficiary records.	Manage Member Information
MEDS should have more audit trails related to a beneficiary's record. SCDHHS would also like a more user-friendly notes section to show a user's reason for making changes.	Manage Member Information
Notices sent to beneficiaries should be directly accessible in MEDS.	Manage Member Information
A central screen should show all the services that are available to a beneficiary.	Manage Member Information
All beneficiary information should be centralized including all information relating to communication, grievances, appeals, and Program Integrity cases.	Manage Member Information
MEDS should have more flexibility and adaptability to support small and large-scale changes. MEDS should be adaptable to support functional	Manage Member Information



Wish-list Item	Related Business Process
organization changes (e.g. intake, processing, maintenance, privatized intake).	
Beneficiaries should have access to an eligibility file in order to update information like addresses and access to other program information.	Manage Member Information
Expand and enhance HIPP outreach.	Perform Population and Member Outreach
The Division of Appeals and Hearings desires a more user-friendly tracking system, which would encourage division-wide use.	Manage Member Grievance and Appeal



3.3.3. Provider Management (PM)

As Is

South Carolina has a diverse network of providers, from rural dentists filing paper claims to large research hospitals and pharmacy chains. Providers enroll by paper application; their enrollments and updates are processed by the enrollment contractor.

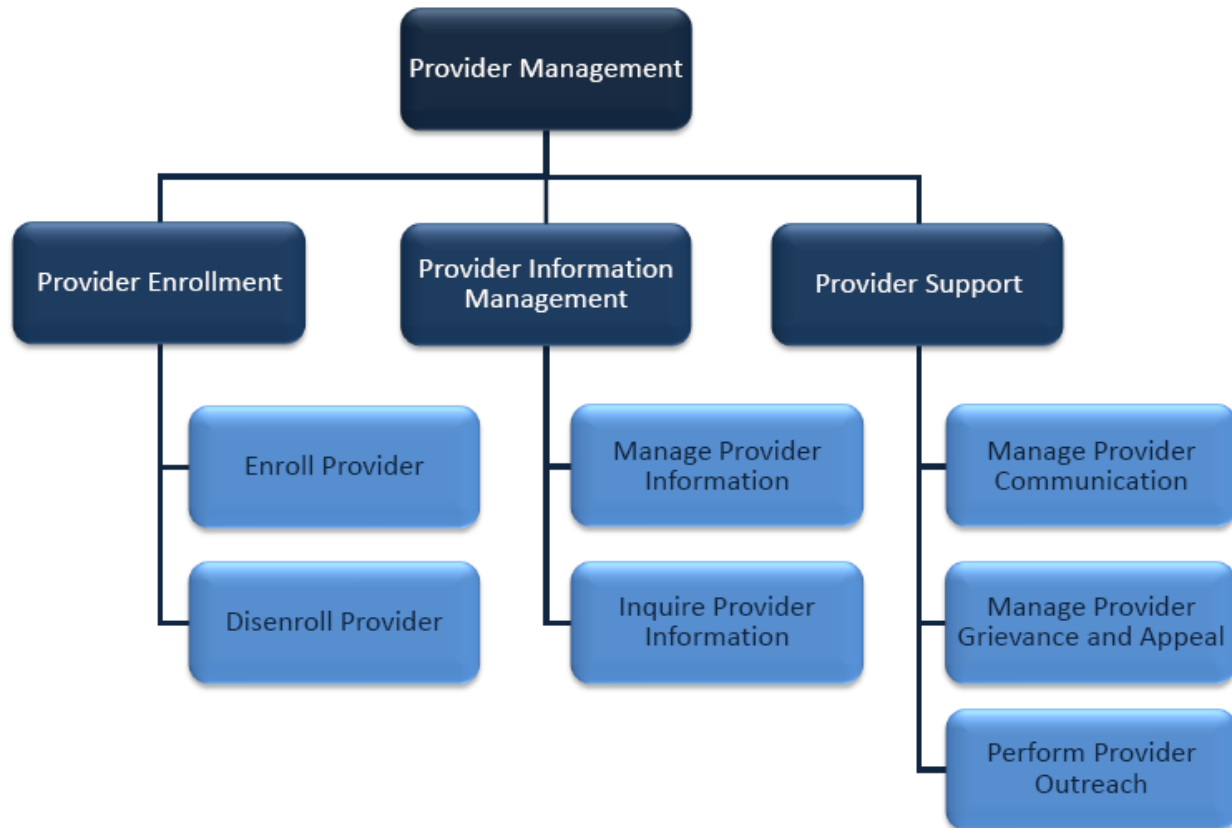
Contact with providers is fairly decentralized, with providers communicating with their individual program areas and very little tracking. Training and outreach are partly informal, via program areas, and partly delivered under the claims administrator contract.

SCDHHS seeks changes to the kinds of provider data gathered and the way the agency interfaces with providers.

To Be

The major goals for Provider Management are:

1. Collect more comprehensive information about providers:
 - Email addresses
 - Multiple billing and pay-to addresses
 - Office hours, languages spoken, and other member-friendly information
 - Provider ownership, controlling interest, and managing employees (Statement of Ownership and Disclosure) to comply with federal standards.
2. Improve the way providers interface with South Carolina Medicaid. Pivotal ideas are:
 - Implement a front-line, first-level call center for general provider inquiries from all provider types: claims status, address changes, eligibility verification, etc. More complex calls would be routed to the proper specialized program staff. Incorporate the call center into MMIS.
 - Increase communication via email and other electronic means.
 - Track all contact with providers in a central repository or tracking system that houses information concerning all provider communication.
3. Further develop and improve the re-verification process for enrolled providers.
4. Promote provider use of EHRs.
5. Develop a workflow management system that displays a history of contact with the provider.



3.3.3.1. Enroll Provider

South Carolina Medicaid enrolls providers into the Medicaid program, allowing them to render services and file claims for payment.

Providers who enroll with South Carolina Medicaid are divided into two major types: contracted and non-contracted. The steps for contract negotiation, rate setting, and other processes specific to contracted providers are covered under the **Award Contract** business process.

Providers initiate the enrollment process by contacting the program area or Provider Enrollment contractor (or, for contracted provider types, the Division of Contracts or the program area). The Provider Enrollment contractor or Division of Contracts sends the provider an application and associated forms depending on the type of services the provider renders. South Carolina Medicaid only accepts hard copy enrollment applications. The provider completes the forms and mails or faxes them to the Provider Enrollment contractor, MCCS.

Beginning in the first quarter of 2010, the Dental ASO will manage provider enrollment and credentialing for dental providers.

For contracted providers, the Division of Contracts mails enrollment materials to the Provider Enrollment contractor. They mark the applications by hand using internal procedures to signal the Provider Enrollment contractor that they've reviewed the documents and consider them complete/ready for the enrollment process.



MCCS tracks all enrollment applications using a proprietary tracking system; the MMIS has no enrollment tracking of its own. The system is used to record applications received and all actions taken and contacts made for each application. *SCDHHS is interested in incorporating tracking functions into the MMIS.*

MCCS staff check to see that all required information is included with the enrollment. If information is missing, the contractor sends the provider a letter requesting the missing information. These letters are generic and are designed by SCDHHS for use by the contractor.

MCCS staff then manually verify information on the enrollment application following detailed procedure manuals. The information varies according to provider type. State board licensure, CLIA certification, and other information are verified online through the websites of the various entities. Other information must be verified by letter or telephone. Providers are also manually checked against sanction lists: the Program Integrity exclusions list, the OIG, the LEIE, etc.

If a contracted provider fails screening/ verification, the provider enrollment contractor returns the enrollment documents to the Division of Contracts with a cover sheet stating why the provider cannot be enrolled. The Division of Contracts then makes contact with the provider and the program area informing them why the enrollment cannot be processed. For non-contracted providers, the contractor sends a notice directly to the provider.

SCDHHS would like to expand how information is gathered during the enrollment process. SCDHHS desires automated verification of provider information via interfaces. *For example, information from DHEC is needed for verifying facility licensure; an automated interface with DHEC would speed up the enrollment process.*

The provider is then assigned a legacy ID number. These assignments follow a compositional logic – for example, a dental provider ID may consist of a “DN” prefix followed by a sequential 4-digit number. The Provider Enrollment contractor and the Division of Contracts maintain separate paper logs of legacy ID numbers to help them assign the correct numbers. *SCDHHS is interested in automating the ID assignment process.*

SCDHHS would like to end the use of legacy numbers and use NPI numbers as the identifier in the system. However, the new system will need a way to assign a unique ID to a provider who does not have an NPI.

MCCS does not enter enrollment data into the MMIS until all enrollment requirements have been satisfied –that is, the MMIS holds no records of rejected or dropped applications.

The only thing that can result in a failed enrollment during data entry is NPI-related: if the provider has one NPI and multiple legacies, and the new enrollment NPI taxonomy and ZIP+4 matches information already listed in MMIS for that NPI, the keyer will get an online edit, thus stopping the enrollment process. SCDHHS program staff research the issue and update the taxonomy and zip, if possible. If SCDHHS can't update the info listed in MMIS, the provider is contacted to explain why the enrollment cannot be processed.

MCCS staff key the provider information into MMIS screens. The exact screens used vary by provider type. Online edits verify the data as it is entered.



A turnaround document showing the keyed data is generated by the MMIS and sent to the Provider Enrollment liaison (within the Department of MMIS User Services) at SCDHHS. For contracted providers, it is sent to the Division of Contracts.

The physical provider file is kept on file at the office of the Provider Enrollment contractor. It is not imaged.

If the enrollment is successful, MCCS sends the provider a packet of information including his or her provider number (if applicable), provider manual, and other program information.

3.3.3.2. Disenroll Provider

The Disenroll Provider business process performs the voluntary or involuntary disenrollment/termination of providers who no longer meet eligibility requirements to remain in the Medicaid program.

The following conditions would require the disenrollment of a provider:

- Listed on the HCFA/CMS exclusion List
- License Expiration
- Fraudulent activity
- Illegal activities or records
- Self-termination
- Inactivity (One year of no payments)
- Death

SCDHHS would like to improve and expand its processes for finding conditions that would cause disenrollment. Currently, this process is manual and takes significant staff time. Automated interfaces with DHEC, the SSA, and other relevant entities would assist in process improvement.

Once the qualifications for disenrollment are present, an MCCS worker updates the provider's record in reflect his or her termination from the program, along with the date of termination. No SCDHHS worker has the ability to update a provider record to reflect disenrollment. Only MCCS has update capabilities to provider records under the supervision of SCDHHS.

In order to change the provider's record, an update form must be completed with the necessary information and signed by an authorized SCDHHS worker. Program areas and the Division of Contracts both have workers who retain this authority. A listing of those authorized is created by the agency (hard copies are archived) and is maintained by MCCS.

Status indicators in the provider file indicate the reason for termination. MCCS then sends a turn-around-document (TAD) back to the agency containing screenshots verifying that the provider has been disenrolled from the system. In cases where the provider has decided to self-terminate from the Medicaid program, the provider will either call or send a letter to MCCS or the agency. If the agency is the recipient of the notice, they fill out the update form and send it



to MCCS. If MCCS is the recipient of the notice, they make the requested changes, and send the TAD back to the agency. No formal written notice is sent to the provider confirming the update.

The Division of PI monitors providers for potential disenrollment (e.g. suspected abuse of the Medicaid program). The PI Division does not notify MMIS User Services or MCCS that the provider is being monitored for potential disenrollment. However, when a provider is placed on suspension, the PI Division completes an update form with a termination status that only the division uses for suspension and forwards it to MCCS for processing. That termination status can only be removed by the division via an update form.

The Department of MMIS User Services performs file maintenance annually by running a routine maintenance report from the MMIS to find providers that have been inactive for over a year. Some program areas with inactive providers choose to review the inactivity report¹. The program area reviews the inactivity report and communicates to MCCS those providers to terminate and those to remain active. The program area uses predetermined annotations on the report, which indicate to MCCS whether the provider is to remain active or be terminated. The program areas also have the option to call their providers instead of mailing inactivity letters (which is noted in their annotations on the report). The program areas have 30 days from the date the report is sent to their area to notate actions and return the report back to MCCS for processing. Once the program area has returned the report, MCCS will then send out the letters, giving the providers 30 days notice to respond before they are terminated.

For program areas that do not choose to review the inactivity report, MCCS receives the inactivity report from the Department of MMIS User Services. MCCS automatically sends the inactive provider a letter (to the address listed in the MMIS) asking if the provider wishes to continue to participate in the program. If the provider does not respond within 30 days, he/she is automatically terminated, and his/her record will reflect the termination status and the effective date.

If a provider does not respond within 30 days but wishes to remain in the program, he or she will have to re-enroll. The provider will retain the same identification number, but the enrollment dates will indicate a break in service. The letters that MCCS sends to providers inquiring about their participation are manually tracked. MCCS assigns one worker to handle file maintenance, who notates all action on the report to include when the letter was mailed and the deadline to receive the letter back. When the letters are received back, they are then tracked in MCCS' tracking system.

¹ The decision to receive the inactivity report is left up to the individuals responsible for the management and maintenance of the program.



3.3.3.3. Manage Provider Information

The MMIS holds all enrolled provider information gathered during the enrollment process and during subsequent updates. MCCS is responsible for updating the MMIS.

Program areas, Provider Enrollment, the Division of Contracts, other areas of SCDHHS, and MCCS all receive information from providers about new addresses, license renewals, etc. via hard copy letters or calls in the **Manage Provider Communication** business process. If the provider calls, the SCDHHS or MCCS worker will request that the provider send in written correspondence, detailing the change in information. However, this is not a consistently exercised policy as there have been cases where the worker will take down information over the phone.

SCDHHS staff fills out universal paper update forms and forwards them to MCCS to update a provider's record in MMIS. If MCCS originally received the request to update information, they complete an update form indicating the requested changes from the provider and attach it to the letter sent by the provider.

Only certain MCCS staff members have MMIS update access to create and alter provider records; these workers key the information into the MMIS that is listed on the update form. The next day, the TAD is printed, which MCCS compares with the information on the update form to ensure changes were keyed accurately. If the changes were not keyed accurately, MCCS must wait until the next day to process the new TAD. Once the MCCS worker confirms the changes, a copy of the TAD is placed in the hard copy provider file along with the update form and the provider's written request. A second copy of the TAD is sent to the applicable SCDHHS program areas. No correspondence is sent to the provider confirming the update.

MCCS will only process the update form if it includes an authorized signature. MCCS maintains an Authorized Signature Card File that lists all of the authorized SCDHHS staff signatures that are acceptable for processing the update forms. SCDHHS management sends new authorized signatures to MCCS to add to the Authorized Signature Card File. *The program areas would like for the providers to have web-based access to verify updates for correctness and eventually allow providers to make changes themselves.*

Manual processes can lead to inaccurate provider information. For instance, provider addresses are not validated to ensure their accuracy in accordance with United States postal service standards. *The program area would like to interface with various entities that would allow for automated verification of provider information.*

SCDHHS would like to dramatically expand the amount and types of information the MMIS provider file can hold. Field length is a concern, as are the different types of fields. For example, they would like the "name" field to be longer than 28 characters and the "license number" field to be longer than six characters. They would like more fields for different types of addresses – currently, they have to lump "billing agent" and "pay-to" address together, and it would be useful to separate them. An end date on the license number field would also be useful, as would multiple CLIA certification categories.



Provider Exclusion Lists

The Office of Inspector General (OIG) sends a hard copy notification of newly excluded providers to the PI Division. The OIG website also lists the excluded providers. The exclusion notification triggers the PI Division to fill out an update form and send it to MCCS, if the excluded provider is enrolled in the SC Medicaid program. The PI Division uses a status 5 on the MMIS provider file to reject any claims submitted by the excluded enrolled provider. Only the PI Division can put this status on claims or remove it.

The OIG and the PI Division send notification letters (hard copy) to the provider, notifying him of the exclusion, via certified mail. The PI Division only sends a letter to the provider if he is currently enrolled in the SC Medicaid program.

The PI Division may also exclude a party convicted under State or Federal law of a criminal offense from participating in the Medicaid program. The PI Division website maintains an updated version of these two exclusion lists (OIG exclusions and SCDHHS exclusions). Currently, the SURS Division manages the two lists and sends them monthly to the SCDHHS webmaster for loading to the website. SURS also sends the updated list to designated individuals within the agency and to other agencies and/or professional entities. MMIS User Services and MCCS rely heavily on this information to stay informed of providers that have been convicted of a criminal offense or that have been excluded for some other reason. MCCS or MMIS User Services might learn about a criminal offense or some other circumstance that warrant exclusion from SC Medicaid via a less formal source (newspaper, prosecutors handling the case etc.).

MMIS User Services does ask as part of the Participation Agreement that providers disclose if they have been convicted of a criminal offense or any other circumstances that would exclude them from SC Medicaid. In addition, PI is working on an additional form to be included with the enrollment package that providers must complete and sign regarding convictions of criminal activity.

Other provider information stores include:

- Paper provider contracts are kept on file by the Division of Contracts.
- MCCS keeps paper enrollment applications on file.
- Program areas and areas such as the PI Division and the Division of Appeals and Hearings may keep performance data, contact records, complaints, case files, and other information on providers as needed. Such data are not centralized.
- The MCCS' proprietary tracking system holds information on enrollment applications, contact with providers, and other enrollment-related occurrences.

The following item, though explained in the **Enroll Provider** business process for clarity, is also a function of this business process:

- Input of enrollment application information into MMIS



The following items, though explained in the **Disenroll Provider** business process for clarity, are also functions of this business process:

- Reflecting disenrollment in a provider's record
- Routine maintenance report to flag inactive providers.

The following item, though explained in the **Manage Provider Communication** business process for clarity, is also a function of this business process:

- Tracking correspondence with a provider

The following item, though explain in the **Manage Provider Grievance and Appeal** business process for clarity, is also a function of this business process:

- Tracking information related to a provider grievance or appeal

3.3.3.4. Inquire Provider Information

The Inquire Provider Information business process manages inquiries related to enrollment verification of providers by providers, internal agency staff, or other outside entities. For example, North Carolina Medicaid requests additional information for their own verification process that includes the types of services provided and the date of enrollment.

Inquiries concerning enrollment verification come via telephone or letter to either SCDHHS or MCCS. If the correspondence is received by MCCS, they will respond to the enrollment inquiry based on information available in their proprietary tracking application (Remedy). If the correspondence is initially received by SCDHHS, they will respond to the enrollment inquiry based on information housed in the MMIS. Only enrolled provider information is housed in the MMIS. The MMIS does not house information related to pending or denied enrollment applications. Information concerning pending or denied enrollment applications is housed in MCCS' proprietary tracking application. SCDHHS will forward the call/letter to MCCS for inquiries when no provider record is found in the MMIS (letters are sent via interoffice courier).

If the correspondence is written, the Provider Enrollment specialist (located at MCCS) handling the inquiry will document contact with providers using the contractor's proprietary tracking application. However, if the correspondence is a phone call, the inquiry is not tracked. Information and records concerning enrolled providers are found in the MMIS.

3.3.3.5. Manage Provider Communication

The Manage Provider Communication business process manages communication to and from prospective and current providers regarding program and personal enrollment information.



Prospective or current providers contact program representatives, provider enrollment representatives (located in the Department of MMIS User Services or off-site at MCCS), or other areas within the agency looking for general Medicaid program information or a specific question concerning the eligibility of a certain or covered services. Contracted providers may be directed to the Division of Contracts or the program area that is the contract owner for specific information.

MCCS utilizes a proprietary tracking system, which provides information regarding the status of a provider's enrollment and is used to track provider communication. The MMIS houses other information including payment information, claims submission history, provider address information (to enable MCCS to mail communication) etc. The MMIS only houses information concerning enrolled providers. Agency workers may use the MMIS, the SCDHHS website, and/or provider manuals for research purposes to resolve a caller's inquiry.

Any number of areas, including program areas and MCCS, has the ability to mail requested materials to a provider.

Each program area has a different method for tracking communication with providers. For example, the Division of Physician Services logs the calls in a paper or online document, which includes information such as provider name, date and time of call, provider ID, and the comment and/or issue. The log also tracks when the program manager returned the call along with the resolution. The Division of Care Management and the Division of Hospitals requires each staff member to track their calls to and from a provider separately. There is no standardization for the logs. They may be managed via hard copy or electronically. *SCDHHS would also like to create a central communication tracking system to standardize the way the agency tracks any communication with providers.*

General Information including enrollment packages are mailed to inquiring prospective providers as well. The MMIS is used to look up a provider's address. Currently, SCDHHS is working to provide more information to prospective and current providers via the web to answer frequently asked questions and reduce the number of calls that the agency receives for these types of inquiries. Plans include posting enrollment procedures by provider type, which providers will click to view an entire enrollment package as well as an expansion of general program information. Currently, providers can access some Medicaid information pertaining to their specific provider type in the provider manuals on the SCDHHS website.

Currently, written correspondence sent to providers is not standardized throughout the agency. Some program areas utilize form letters while other areas manually draft correspondence as necessary.

In the future, a central call center could manage the call volume and direct inquirers to appropriate program areas. A central agency policy and information online resource is also desired to reduce call volume, answer FAQs, and standardize agency responses. This would also improve customer satisfaction by having information at hand instead of transferring calls.

The following items, though explained in the **Enroll Provider** business process for clarity, are also functions of this business process:

- Receipt of enrollment applications via hard copy or fax



- Request to provider for missing enrollment application information
- Failed enrollment notification

The following items, though explained in the **Disenroll Provider** business process for clarity, are also functions of this business process:

- Receipt of voluntary disenrollment request
- Tracking correspondence with inactive providers

The following item, though explained in the **Inquire Provider Information** business process for clarity, is also a function of this business process:

- Tracking correspondence related to enrollment status

The following item, though explained in the **Perform Provider Outreach** business process for clarity, is also a function of this business process:

- Sending e-bulletins

The following item, though explained in the **Manage Provider Information** business process for clarity, is also a function of this business process:

- Exclusion notifications

The following item, though explained in the **Manage Provider Grievance and Appeal** business process for clarity, is also a function of this business process:

- Any communication with a provider concerning a grievance or appeal

3.3.3.6. Manage Provider Grievance and Appeal

Grievances

Any grievances/complaints received by the Division of Appeals and Hearings are initially passed back to the program area that the provider is enrolled with. Program staff attempt to resolve grievances/complaints via telephone or hard copy letter response. Each program area tracks this communication by various methods. Most keep a hard copy or electronic file that details any communication associated with the complaint. Provider manuals that contain policy and procedure guides can be used as a tool in resolution of a grievance.

Appeals

Providers have the right to the appeal the following:



- Rejected claims²
- Denial of a prior authorization (PA) request
- Nursing home audits
- PI Audits
- Terminated Contracts
- Federal Exclusions

The notice a provider receives for any of the appealable matters listed above will inform the provider of his right to appeal. For instance, an exclusion notice (sent by the PI Division) will list the provider's right to appeal. However, the program area or other SCDHHS area will informally work with the provider to resolve the situation as much as possible prior to scheduling a hearing.

For nursing home audit appeals, the Division of Appeals and Hearings will issue an Order for Prehearing Conference, which is attended by the SCDHHS program area, the nursing home accountants and the State Auditor's Office. The purpose of this conference is to resolve or narrow the issues as much as possible prior to forwarding the case to a hearing officer (For non-nursing home provider audits, the PI Division offers a "pre-hearing" conference option prior to appealing to the Division of Appeals and Hearings as well. However, the Division of Appeals and Hearings is not involved in those conferences. Refer to **Manage Case** business process for further information). If no resolution is met or is unsatisfactory, the nursing home provider receives a notice explaining the findings and details their appeal rights. Other types of provider appeals usually only have a single or limited number of issues, so a pre-hearing conference to resolve or narrow the issues is not necessary. A provider who then decides to file an appeal sends a hard copy appeal request and any supporting documentation to the Division of Appeals and Hearings via regular mail.

Once a provider files an appeal request, the Director of Appeals will determine if it is an appealable matter based on the supporting documentation submitted by the provider. If the request for an appeal is honored, the Director of Appeals will assign a case number and hearing officer to the appeal request. The Director then passes the request on to an administrative assistant from the Division of Hearings and Appeals, who will key in relevant information that identifies a case (name, address, case number assigned) into the Appeals and Hearings Tracking System database ([see Appeals and Hearings System PC application for technical details](#)). If the request for an appeal is not honored, no information concerning the request is keyed into the tracking system. The administrative assistant also prepares a CMS, which is then sent to the assigned hearing officer.

Certain boilerplate documents are identified on the CMS in drop-down menus, as well as drop-downs for date, time, possible hearing locations, names of "common personnel" (a list of these individuals is maintained by the division) that are to be copied with the various correspondences

² SCDHHS does not have a reconsideration process for rejected claims. The appropriate program area will work with a provider to correct errors on a claim in the **Edit Claim** business process. If no resolution is met or is unsatisfactory, the avenue of last resort is for a provider to file an appeal.



associated with the case. When the hearing officer determines which document is needed, they select the appropriate responses from the drop-downs and email the CMS back to the administrative assistant to create the document, envelopes, certified cards, etc. Any and all mailed communication produced by the division is sent via certified mail. Some communication may be sent electronically. The Appeals and Hearings Tracking System database tracks the case flow from the opening of the case to its closure. Currently, the administrative assistant is the only user of the tracking system. *The Division of Appeals and Hearings desires a more user-friendly tracking system, which would encourage division-wide use.*

A hearing officer will then examine the case. There is no SOP for managing an appeal. Currently, the Division of Appeals and Hearings is working to draft an SOP. The Division of Appeals and Hearings has viewing capability of the MMIS, MEDS, BENDEX, and SDX to verify information for case research. The Division of Appeals and Hearings can contact the provider at any time for additional information concerning the case. If the hearing officer determines that the original decision stands, an Interlocutory Order is sent to the provider. The provider has 10 days to review and produce an error in writing or provide a cause. If no error or cause is produced, the Division of Appeals and Hearings will dismiss the appeal. The hearing officer will then write an Order of Dismissal, including such information as when the records were sent to the provider, the failure to produce an error or cause, etc. The Order of Dismissal will be signed by the Director of Appeals and sent out to relevant SCDHHS areas.

If anyone feels that the appeal should stand, the case may be appealed to the South Carolina administrative law court. The Appeals and Hearings Tracking System database will be updated to reflect the closing of the case.

When the appeal is not dismissed, the Division of Appeals and Hearings must give the provider at least 30 days advance notice for a scheduled hearing. The provider can choose to waive the 30 days of preparation, which would expedite the case. The hearing office and an agency representative attend the hearing. The agency and the provider each give testimonies in the quasi-judicial hearing and must provide copies for everyone present of any documents referenced. The hearing is recorded, and the hearing officer reviews the recording, documents, and evidence to reach a decision. Currently, the Appeals and Hearings area uses analog recorders, but they hope to move to digital recording in the near future. The Director of the Division of Appeals and Hearings reviews the decision. If the Director disagrees with the hearing officer's decision, the two will discuss the case and reach a consensus. The Director signs a cover letter. The decision is sent to the Petitioner (entity who filed the appeal) and other interested parties.

Final Decisions and Orders of Dismissal are imaged, and the case files are archived after two years. These documents are easily accessible through Application Xtender.

If anyone feels that the Hearing Officer's decision is in error, they have 30 days to appeal to the South Carolina ALC. The Appeals and Hearings Tracking System will be updated to reflect the closing of the case.

When a provider chooses to appeal the decision, they must file with the ALC. The Office of General Counsel and the Division of Appeals and Hearings will receive a notice from the court informing them of the filing, and SCDHHS must prepare a full record. The Division of Appeals and



Hearings has forty-five days from receipt of the notice to prepare a complete copy of the record and a written transcript of the recorded hearing. Kinko's prints and binds the full record copies. The hearing officer will review the entire record and sign off to verify its completeness. The court receives three copies of the record, and the provider and SCDHHS General Counsel each receive a copy. The court will affirm, reverse, or remand the SCDHHS decision. When the decision is remanded, SCDHHS must comply with the directives of the ALC, which may include holding a second hearing. If the provider chooses to appeal from the second hearing, they must appeal to the South Carolina Court of Appeals.

3.3.3.7. Perform Provider Outreach

The Perform Provider Outreach business process maintains provider manuals, conducts provider training, and sends information concerning program changes and updates to providers via electronic bulletins. There are also less formal ways that SCDHHS utilizes to conduct provider training, which includes the whole agency working to educate and reach out to the provider community.

Typically, SCDHHS does not conduct any provider recruitment. However, some program areas have reached out to providers in order to fulfill a particular provider need. For example, the autism waiver requires a highly specialized provider type, which is not common in South Carolina. SCDHHS may contact a specific provider to encourage enrollment into the Medicaid program. There is no defined procedure for contact.

Provider Manuals

SCDHHS holds a contract for provider outreach, and one aspect of the contract is to maintain all provider manuals (there are about 30). All manuals contain generic sections concerning the Medicaid program as a whole, and each manual has program-specific sections as well. The manuals have specific formatting standards as determined by SCDHHS or the specific program area. Manuals are updated for various reasons (policy change in a bulletin, overall program change, updated codes etc.) The program area that owns the manual will contact a contractor instructional writer to update the manual. Communication method varies based on the relationship established between the program area and the writer. The default contact is the provider outreach contractor manager. Currently, the provider outreach contractor utilizes a folder system on a shared drive to manage Word and PDF versions of the documents and all supplementary materials. *A document management system for all the documents associated with the manuals could enhance tracking, reporting, and issuing manual changes.*

Once the changes are written into the manual, the program area must sign off on them before the manual is published in an updated form. (Brand-new manuals require the signature of the Director, but changes/revisions only need program area sign-off.) The signoff process by the program areas is not formalized; program staff usually email the contractor to say they approve the changes.

If the change resulted from information in a bulletin, the new version may be published immediately. If it is a routine change, the updates occur once a month, and the new sections are posted on the SCDHHS website. The provider outreach contractor sends the final version of the



manual in a PDF file to the SCDHHS webmaster. There is a change control record that goes along with each manual to track the amendments. This record is posted online for providers to see changes.

New providers receive the manual on CD-ROM free of charge as part of the packet of materials mailed to new providers. Providers may also contact Provider Outreach to order additional CD-ROMs or hard copies for a fee. The contractor manages a small database to log manual orders and print invoices. Providers send checks for manuals to the contractor. A daily courier takes the checks to the Bureau of Fiscal Affairs at SCDHHS for processing.

Once a year, the State Library receives updated provider manuals free of charge. Program areas can order copies of provider manuals for their own use at any time.

Depending on the size and scale, manual printing may occur through the provider outreach contractor, SCDHHS, or another print shop. Currently, the manuals are quite long and not necessarily user friendly. *A more Interactive website with full look-up capability or a revised manual format would aid providers in finding the information they need.*

Provider Training Classes

Provider training classes are also part of the contractual agreement with the provider outreach contractor. The contract has certain specifications regarding the number and location of certain types of classes that the contractor must conduct. An example of permanent training would be a class called "Medicaid Basics," which offers a provider an overview of the Medicaid program from member eligibility to billing to payment. Specialized training is also conducted, and this depends on the needs of the agency or a specific program area. SCDHHS can utilize the contractor to conduct the training classes or set up their own training. Training classes may be updated to provide additional information if a program area or SCDHHS notices a pattern in the provider community.

SCDHHS must approve any presentations or handouts created for the training classes. The contractor advertises training through e-bulletins (SCDHHS recently discontinued the use of weekly remit stuffers), postings on the provider outreach contractor website, announcements in the Web Tool Times (the newsletter for users of the web-based claims tool), and other routes as necessary.

The contractor uses their EDI support call center and Provider Outreach website for enrolling providers into training classes and monitoring class size. Providers can view the class list and training calendar online, enroll online, or call the contractor to sign up for a class.

The training classes are hosted throughout the state at facilities that are free of charge (libraries, etc.). All training sessions are free to providers. As determined by SCDHHS, the contractor or someone within SCDHHS will conduct the training. The contractor utilizes an evaluation form (to be completed by attending providers) at the end of the session to monitor performance.

Some virtual training is also offered, which includes a live conference class plus an online tutorial. *SCDHHS would like to expand training to include more online training that is self-paced for providers.* SCDHHS program areas also conduct ad hoc individual training on an as-needed



basis. Program area representatives go onsite to providers' offices for this training. Any materials for this training are developed by the program area.

Provider Bulletins

Bulletins are typically developed when there is a policy change or policy clarification needs to be communicated to providers. Policy changes are approved by management and then the Bureau Chief assigns someone within the bureau to draft the bulletin. A program representative can also make the recommendation to the Bureau Chief that a bulletin is needed if he notices a pattern of misunderstanding a policy by the provider community.

Once the bulletin is ready for review by the agency, the bulletin creator emails a copy to a "Bulletin Review" email group (established by the bureau chiefs within SCDHHS) with a deadline for comments. The body of the email should read as follows:

Please review the attached draft Medicaid Bulletin. Reply to this email (no "reply all") with comments by close of business (provide due date). The bulletin will be finalized based on comments received by the deadline. If you have no comments, please reply to this email (again, no "reply all") with "No Comments".

All members of the group must respond either with comments or a message reading "no comments". Once the deadline for comments has passed, a manila folder is established with the following:

- All comments received
- A Transmittal for Director's Signature form on blue paper (Bureau Chief and Deputy signature is required, at minimum)
- A copy of the bulletin
- A completed copy of the Provider Distribution List

Once the transmittal form is signed, the folder goes to the public information coordinator, and the electronic version of the bulletin and distribution deadline is emailed to the public information coordinator. The bulletin is formatted, and the Agency Director's signature is obtained. The bulletin is converted to PDF, and a copy is emailed to the Bureau Chief, requesting approval for its release to the listserv and web. Upon approval, the bulletin is released to the listserv and sent to the webmaster for posting on the web. The hardcopy folder and all signatures are kept in the Office of Public Information.

Online registration is required to receive bulletins at <http://bulletin.scdhhs.gov/>. Bulletins are also available at www.scdhhs.gov. A provider must select the types of bulletins he wants to receive (the default is all Medicaid bulletins) and answer a few fields to provide contact information, etc. A confirmation email with a verification link will be sent to the email address. Once the provider clicks on the link, registration is complete, and the provider will receive future bulletins and newsletters. E-Bulletin subscription is also now part of the **Enroll Provider** business process for prospective providers.



3.3.4. Provider Management “Wish-list” table

Wish-list Item	Related Business Process
Add tracking functions into the MMIS.	Enroll Provider
Automate provider licensure verification steps.	Enroll Provider
Automate the ID assignment process.	Enroll Provider
Use NPI numbers as the identifier in the system. However, the new system will need a way to assign a unique ID to a provider who does not have an NPI.	Enroll Provider
Build an interface with DHEC, SSA, and any other relevant licensing boards/entities.	Disenroll Provider
Allow providers to have web-based access to verify updates for correctness and eventually allow providers to make changes themselves.	Manage Provider Information
Improve accuracy and automated of provider information verification.	Manage Provider Information
Dramatically expand the amount and types of information the MMIS provider file can hold.	Manage Provider Information
Create central communication tracking system to standardize the way the agency tracks any communication with providers.	Manage Provider Communication
Create a central call center and a central agency policy and information online resource and repository.	Manage Provider Communication
The Division of Appeals and Hearings desires a more user-friendly tracking system, which would encourage division-wide use.	Manage Provider Grievance and Appeal
Create a document management system for all the documents associated with provider manuals.	Perform Provider Outreach
A more Interactive website with full look-up capability or a revised manual format would aid providers in finding the information they need.	Perform Provider Outreach
Expand training to include more online, self-paced training.	Perform Provider Outreach



3.3.5. Contractor Management (CO)

As Is

Within the agency, the Contractor Management business processes are fairly decentralized, with multiple areas managing their own contractor relationships and data stores.

Many contractor management activities are handled at the state government level rather than the agency level. The state procurement office provides an automated web portal and other MITA-aligned contractor outreach/communication strategies.

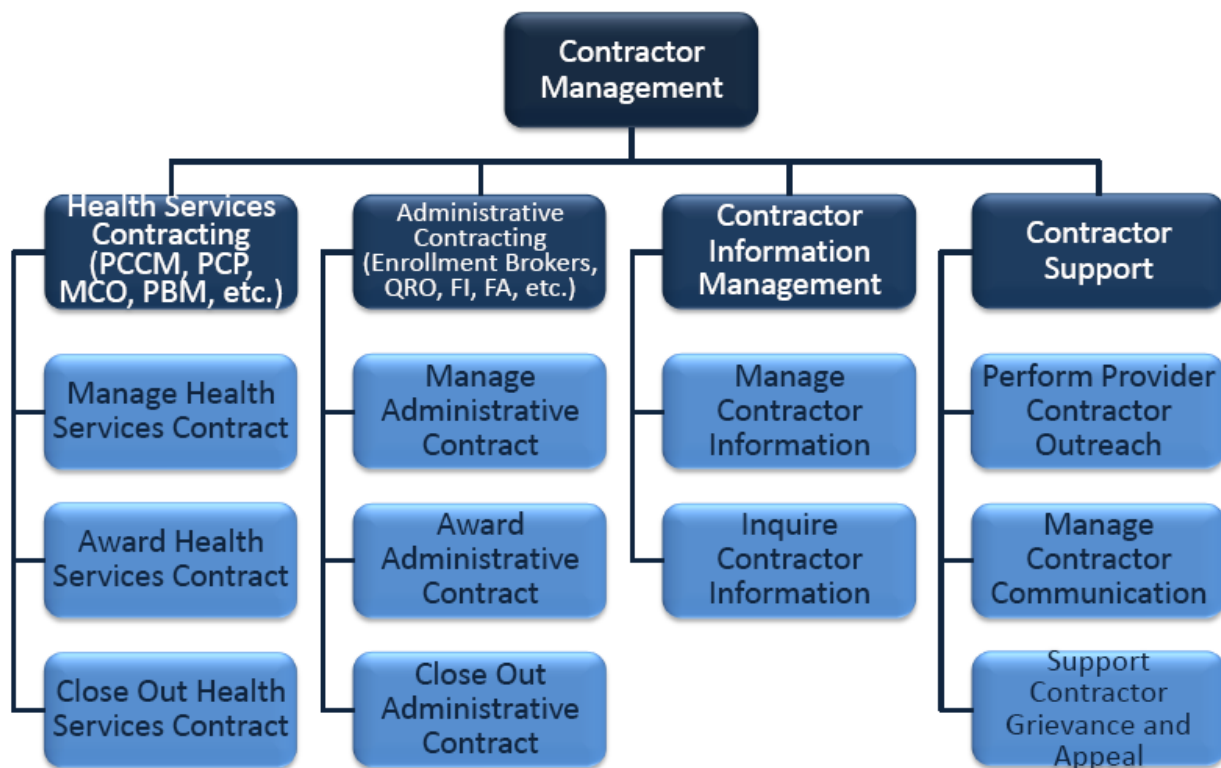
To Be

The state procurement office will continue to manage the procurement process for contracts above a certain dollar amount.

Within the agency there are two major goals for this business area:

1. Improve and centralize reporting on contractor performance.
2. Image and electronically store contracts and contractor files.

A centralized contract data repository would allow designated staff throughout the agency to access needed information about contract dates and contact information, for example.





3.3.5.1. Award Administrative or Health Services Contract

South Carolina awards contracts in many different ways depending on the type of commodity, service, or contracted entity. Some contracts also have a Memorandum of Understanding (MOU) when some sort of exchange is taking place. A Business Associate agreement and/or a Trading Partner Agreement (TPA) may also be used with a contract.

The state Materials Management Office or IT Management Office (MMO/ITMO) administers the contract process when the cost of the good or service exceeds SCDHHS' procurement authority, which is currently set at \$150,000 for goods and services and \$125,000 for IT procurements.

There is significant overlap between the administrative services and health services contracting processes. There is also significant coordination between the Division of Contracts, the Bureau of Federal Contracts, the Division of Procurement and Support Services, and state procurement agencies.

Contracts fall more or less into the following categories:

Provider Contracts

Certain providers are considered contracted providers because there are terms and conditions for their participation in Medicaid beyond the provider enrollment agreement. (For example, they may be required to submit cost reports.) Most provider contracts meet CMS' definition of Health Services contracts.

The program area, the Division of Contracts, and Provider Enrollment (Department of MMIS User Services and MCCS) are all involved in the provider contract process.

In most cases, the program area is contacted by a prospective provider, and the area works with the provider to gather required documentation. These requirements are set by the individual program areas. Required documents may include budgets, staffing plans, seclusion and restraint policies, etc.

The agency occasionally finds prospective providers using a bid or grant process; however, no such projects currently exist.

Next, the contract owner (program area) contacts the Division of Contracts to begin the contract process. The Division of Contracts works with the program area to complete the draft contract (ultimately, the program area is the one that drafts the contract – but the Division of Contracts assists when necessary). The Office of General Counsel reviews the contract to approve its content. The contract owner works with the provider to complete the enrollment application. The contract owner signs the Contract Approval Form (102), which accompanies the contract from the program area to the Division of Contracts. The Division of Contracts then passes the Contract Approval Form (102) and a copy of the contract to the SCDHHS Bureau of Fiscal Affairs. Fiscal encumbers the funds based off of the Contract Approval Form (102). The Contract Log System (CLS) is used to log all new contracts as they move through the Division of Contracts and the Fiscal Services.



The Division of Ancillary Reimbursements area works with the program area to set the provider's rates. The Office of General Counsel must approve all new contracts. Fiscal Services must encumber funds for all new contracts.

Once the contracting process is completed, the Division of Contracts forwards all enrollment information to the Provider Enrollment contractor, which completes the provider enrollment process as described under **Enroll Provider**. TADs generated by MCCS are sent to the Division of Contracts, which are put in the contract file.

Interagency Contracts

Certain administrative services and health services are performed by other state agencies under an agreement with SCDHHS. First, the Contract Approval Form (102) is completed by the contract owner and sent to the Division of Contracts. Next, the contract is drafted by the contract owner. If the contract is for certain administrative services, the Division of Contracts now completes an MMO Form 136 to justify the interagency contract (this is only required for some administrative services, and is not required for health services contracts). The Division of Ancillary Reimbursement must approve the contract if rates are involved. Also, as with all contracts, the Office of General Counsel reviews the contract to approve its content. Once the Division of Contracts has finalized the contract, the contract is returned to the contract owner for approval. Once approved, the Division of Contracts sends the contract, along with the Contract Approval Form (102) to the Bureau of Fiscal Affairs. Some of these other agencies are enrolled and reimbursed via the MMIS as though they were providers (i.e. submitting claims to receive payment). Others, like Clemson University or the State IT Office, operate under agreements with SCDHHS and submit invoices for payment. The SCDHHS contract owner signs the invoice and forwards it to the Fiscal area. The Fiscal area processes the payment outside of the MMIS (see **Perform Accounting Functions**).

Invitation for Bids (IFBs)

Most bid requests are for goods and services that do not meet CMS' definitions of administrative or health services contracts. There are exceptions, however: SCDHHS has procured items like eyeglasses via a sealed bid process, then enrolled the supplier as a Medicaid provider, setting the bid amount as the provider rate and paying the provider via the standard MMIS claims payment process.

Program staff or other SCDHHS staff complete a 192 form and send it to the Procurement division to begin the requisition process.

SCDHHS requests bids from vendors using an IFB. Bids for procurements over \$50,000 must be sealed and kept confidential. The state has established a standardized format for the IFB, with certain boilerplate, terms, and conditions. The agency includes the specifications for the material or service and releases the bid via the MMO website (www.mmo.sc.gov/); a link is also provided on the state Procurement website) to submit requests which are handled by the MMO; this system is part of the SAP/SCEIS (Systems, Applications and Products in Data Processing/South Carolina Enterprise Information System).

On the closing date, SCDHHS or the state procurement office opens the bids and compares the prices. The contract is awarded to the lowest bidder that meets the established requirements.



Awards are published on the state Procurement website (www.procurement.sc.gov/) and posted on a public bulletin board at SCDHHS' main office.

Request for Proposals (RFPs)

RFPs are issued as described under **Produce RFP**. Most RFPs are for administrative services.

For most RFPs, after the closing date, the state procurement office (ITMO or MMO) makes sure all bidders are compliant with the RFP requirements. A group of SCDHHS evaluators then reviews and scores the technical proposals according to evaluative criteria that were laid out in the RFP. The procurement officer calculates the scores, using a formula to balance cost against technical scores, and announces the Intent to Award. Vendors have 10 days to protest; these protest hearings are handled by the state procurement officer. Amounts under \$50,000 are non-protestable. After the protest period, the contract is officially awarded.

Grant Application Requests (GARs)

In rare cases, SCDHHS conducts internal RFPs (known as GARs); these GARs are conducted in nearly the same manner as those handled by ITMO or MMO except that no bids are accepted. Applicants are scored based on their ability to meet the criteria outlined in the GAR. The Division of Contracts functions as the procurement officer. Each GAR has a specific value and is evaluated on the following review factors: Scope of Work and Objectives, Coordination and Collaboration, Performance Measures Outcomes, Experience/Project Management Experience. The intent to award is sent via certified mail to all parties that were involved in the grant request process. Also, the intent to award is posted on the public bulletin board at SCDHHS' main office and the SCDHHS website. Participants in GARs have no appeals rights (all decisions are final).

Emergency and Sole Source Contracts

Under certain conditions, SCDHHS bypasses the standard IFB and RFP procurement processes. For sole source contracts, the agency must justify to the state procurement authority that only one vendor can provide a product and or service. In emergency situations, the agency makes a procurement decision to quickly obtain needed products or services without undergoing an extended bid or RFP process. The program area drafts the contract, which is sent to the Division of Contracts and the General Counsel for approval. The Contract Approval Form (102) is signed by the contract owner, and accompanies the contract from program area to the Division of Contracts and the Bureau of Fiscal Services.

The following items, though explained in the **Establish Business Relationship** business process for clarity, are also functions of this business process:

- Preparation and generation of other contract documents like the MOU, TPA, and/or Business Associate Agreement
- Establishment of data exchange requirements including privacy and security protocol



3.3.5.2. Close out Administrative or Health Services Contract

Contracts end for various reasons. Some expire. The program area, PI, or another area of SCDHHS may request that a contract be terminated. Contractors and providers may also request that a contract be closed or not renewed. Other conditions such as noncompliance, failure, the state's convenience, nonappropriation of funds, etc., are spelled out in the contract boilerplate.

In most cases, the Division of Contracts or Procurement sends a letter or change order to the provider or vendor announcing the end of the contract via certified mail. The agency aims to give 30 days' notice (or 90 days where a product is being manufactured for the agency). *General Counsel would like to add information concerning the appeals process to the termination letter,* so the contractor has the information ready and available for use if he chooses to appeal the termination.

Prior to sending the termination notice, the General Counsel may be consulted as part of the **Terminate Business Relationship** business process, but consultation is not a necessary precursor for termination of a contract. Termination negotiations may also occur as part of the **Manage Contract** business process.

The Division of Contracts or Procurement sends a copy of the termination letter to Fiscal Services to unencumber the funds by change order form or via email. For contracted providers, they notify MCCS to perform the **Disenroll Provider** process via hard copy update forms. Currently these processes are manual.

If the contract is a service contract, it is terminated out of the MMIS. The BMSM and/or EDI Support Center remove any data access for the contractor.

In each RFP, the vendor/contractor is required to submit a turnover plan, which outlines how all documentation, files, etc. will be transitioned at the end of a contract. At the close of the contract, if the vendor/contractor is not re-awarded the contract, SCDHHS requests the turnover plan and works with the two vendors/contractors to complete a smooth transition and turnover of deliverables.

The following item, though explained in the **Terminate Business Relationship** business process for clarity, is also a function of this business process:

- Division of Contracts' use of the CLS

3.3.5.3. Manage Administrative or Health Services Contract

The agency manages and monitors contracts at various levels. Individual program areas monitor the performance and compliance of contracted providers when the area is familiar enough with the contract to perform these duties. The Bureau of Federal Contracts and PI monitor administrative contracts and larger contracts. The Procurement division monitors supplier performance.

The agency contract contact (usually someone in the program area) routinely schedules meetings between the agency (could include staff from various areas) and the contractor. The



frequency of these meetings depends on the needs of a contract. New issues, upcoming changes, and other contract matters are discussed during these meetings.

A contract monitor (from the Bureau of Federal Contracts) tracks and measures contract deliverables (including reports) and performance standards for certain contracts (see **Develop and Manage Performance Measures and Reporting** and **Monitor Performance and Business Activity**). The contract monitor creates a deliverables spreadsheet, based on the contract, to monitor that all the deliverables are being met. The monitor also regularly schedules meetings with the contractor/vendor to go over any issues, missing deliverables, etc. The monitor also collaborates with the program area that holds the contract and the agency IT area throughout the duration of the contract.

Any issues discovered by SCDHHS require a detailed corrective action plan (to be submitted by the contractor). Some issues require immediate attention like safety. The monitor and program area will work to resolve issues with the contractor via meetings and on-site visits, as necessary. Any further deficiencies are addressed and escalated to the Office of General Counsel, as needed.

The Managed Care area (program area) is responsible for monitoring the Enrollment Broker/Counselor, MCO, and MHN contracts. The contract monitor (Bureau of Federal Contracts) schedules individual meetings with the contractors on an as-needed basis. The Managed Care area also schedules quarterly meetings with all MCOs and MHNs that are contracted with SCDHHS. These are advertised via the public notice website. In the past, quarterly meetings were scheduled for each individual contractor, but SCDHHS has found that it is more effective to combine the groups to talk through relevant issues.

Like the contracts monitored via program areas or the Bureau of Federal Contracts, Managed Care contract monitors have reporting requirements and performance standards that are monitored through various contractor-produced reports, depending on the contract. Some reports like grievances/appeals, subcontractors listing, etc. are sent via email or hard copy. Other reports that include encounter data, TPL are sent via Connect Direct (C:D). For reports that utilize Document Direct (D:D), *accessible records only date back by eighteen months, and the Managed Care area would like to increase the availability of data history. In general, the Managed Care area finds that there is limited access to reports utilized by other entities or interfaces (ex: the Enrollment Broker), so an overall increase in access for reports is desired.*

A current contractor may request an amendment to the contract based on a rate change, change in scope or size of contract, or any other number of reasons; or SCDHHS staff may request an amendment. If amendments to a contract are required, the program staff works out the details of the amendment with the contractor, then contacts the Division of Contracts and/or the Procurement division about the change. General Counsel also reviews contract amendments and updates (see also **Manage Business Relationship**).

Though not required by contract language, the agency may hold a termination negotiations period to resolve contract issues. Resolved negotiations may require an amendment to the contract. Failed negotiations will result in termination of the contract (see **Close Out Contract** and **Terminate Business Relationship**).



The following items, though explained in the **Manage Business Relationship** business process for clarity, are also functions of this business process:

- Monitoring contract expiration

3.3.5.4. Produce Administrative or Health Services RFP

For certain services, SCDHHS produces RFPs soliciting proposals from vendors.

RFPs are produced when the agency identifies a need that must be fulfilled by an outside entity. RFPs ask vendors to propose solutions; they are not issued when the agency will make its decision based on price alone (e.g., when procuring a copy machine of a particular desired brand and model). In those cases, the agency will use an existing state contract or use one of the other procurement methods described under **Award Contract**.

The state MMO or ITMO administers the RFP issuance and contracting process when the cost of the good or service exceeds a certain amount. That amount is known as SCDHHS' procurement authority; it is currently set at \$150,000 for goods and services and \$125,000 for IT procurements. Because RFPs are most commonly issued for larger, more complex projects, almost all Medicaid RFPs are handled by these two state procurement authorities.

The agency also produces an RFP when an existing contract is coming to the end of its term and must be re-procured.

To develop an RFP, the Bureau of Federal Contracts or the Procurement department works with the SCDHHS program area to design requirements and guidelines for the RFP. If the RFP is for an existing contract, they determine whether and how the Statement of Work should be amended.

If more than \$5 million of Medicaid funds will be spent over the entire contract term, and the procurement is related to automated data processing, the agency must produce an Advance Planning Document (APD) to submit to CMS (e.g. Clemson, MCO contracts). CMS has 60 days to review and respond to the APD. The agency also submits the draft RFP to CMS for review and approval.

Procurements with an IT component require the Division of Procurement to write and submit a State IT Plan to the State IT Planning group.

Approval of all final RFPs is done by the SCDHHS Bureau Chief of the program area and General Counsel. Once the agency has approved the RFP, it works with the state MMO or ITMO to develop, issue, and manage the RFP process.

In rare cases, SCDHHS creates and manages internal RFPs known as GARs. The Division of Contracts maintains a list of potential GARs to answer inquiring potential contractors of upcoming opportunities (this list contains those that have sent applications before, or that have specifically asked to be included in future opportunities etc.). These RFPs are conducted in the same manner as those handled by ITMO or MMO. The main difference is that the cost cannot exceed the agency certification of \$150,000 (MMO) or \$125,000 (ITMO), and the Division of Contracts will function as the procurement officer. RFPs for dollar amounts that exceed \$25,000



must be advertised in SCBO (South Carolina Business Opportunity Newsletter). Approval of all final RFPs is done by the SCDHHS Bureau Chief of the program area and General Counsel.

The Division of Procurement uploads the completed RFP and associated documentation to the state procurement website (<http://www.procurement.sc.gov/>).

The RFP is advertised in the SCBO newsletter (if it exceeds \$10,000) and is posted on the state Procurement website. The state procurement officer or SCDHHS Bureau of Federal Contracts may also contact individual vendors to let them know about the RFP (excluding GARs, which are handled strictly by the Division of Contracts). They may be vendors who expressed an interest in the contract or who SCDHHS has identified as important players in the industry.

The RFP process is governed by state and federal law; most requirements and procedures are set by outside entities over which SCDHHS has no control. Agency procurement staff does not use the MMIS and MEDS systems.

3.3.5.5. Manage Contractor Information

The Manage Contractor Information business process maintains any information associated with the contractor as well as updating the files to reflect the most recent information concerning the contractor.

The Division of Contracts utilizes a CLS to track any necessary information about the contract and its contractor. Information logged includes date stamps used for when paperwork was sent to/returned by program areas, contractors, and the Director.

The CLS also tracks when a 102 was finalized, which says all necessary paperwork has been distributed. The CLS does not track when enrollment sheets (processed by MCCS) are sent to the MMIS. Enrollment paperwork is tracked in the provider enrollment contractor's log (see **Provider Management**). If paperwork or an approval is still outstanding, the CLS also provides this information. Other information concerning contracted providers and renewal list reports is also housed in the CLS.

Currently, no contracts are kept electronically in the Division of Contracts (The Fiscal area scans the majority of contract-related paperwork that they receive using ApplicationXtender ([see ApplicationXtender PC application for technical details](#)), so the CLS also tracks where the original contract and supporting documentation is kept, down to the particular file cabinet it is housed in. Division workers are able to make necessary changes to a contractor's file. Common changes include a change of address, and the CLS is updated to reflect such changes. Changes within the CLS may also be triggered by action occurring in the **Manage Contract** or **Close out Contract** business processes.

The Division of Procurement utilizes the CLS to track contract numbers for contractor payments processed in the Fiscal area. Additional information is tracked in a hard copy spreadsheet. The spreadsheet manages contact information for the contractors and is updated manually by a Procurement staff member. Information from ITMO and MMO is also used to keep the spreadsheet up to date.



In cases where a vendor is suspended or debarred, a list is maintained on the MMO and the ITMO website. The Division of Contracts also utilizes provider exclusion lists to verify a provider is not excluded from participation (see **Manage Provider Information**). SCDHHS will not conduct business with a listed vendor for up to three years.

The following items, though explained in the **Manage Contractor Communication** business process for clarity, are also functions of this business process:

- Tracking correspondence with a contractor
- Maintenance of potential vendors list

The following item, though explained in the **Support Contractor Grievance and Appeal** business process for clarity, is also a function of this business process:

- Tracking information related to a provider grievance or appeal

3.3.5.6. Inquire Contractor Information

The Inquire Contractor Information business process responds to contractors' inquiries by verifying data housed in the CLS or referring a contractor to the appropriate program area.

Contracted providers will contact SCDHHS to inquire about their enrollment or contract status. The Division of Contracts receives these inquiries via telephone calls directly to their department. A staff member can confirm whether the provider is contracted by utilizing the CLS. Only contracted providers' information is kept in the CLS, whereas enrolled providers would contact a Provider Enrollment specialist to confirm their enrollment.

The Division of Contracts or Procurement occasionally receives FOIA (Freedom of Information Act) requests for agency contracts from outside entities and internal agency staff. These requests (via hard copy/fax/email) are logged and entered into the executive log system (an administrative system; [see Executive Log System for technical details](#)) by the Public Information Office and given a log number (assigned manually in sequential order) by the Public Information Office and then routed via the Deputy Director/Bureau Chief (of the Office of Finance and Administration/Bureau of Administrative Services) to the Procurement Division or Division of Contracts. The log letter also includes a blue sheet (prepared by the Public Information Office) that indicates the action and response required, along with the due date (FOIA requests must be completed within 14 days). The Division of Contracts or Procurement will complete the log letter and blue sheet and send the request back through to the Bureau Chief to the Public Information Office. The Division of Contracts does not track or log FOIA requests. The Public Information Office will prepare a letter, copy the contract, prepare an invoice for the copy fee, and mail the packet to the requestor. The log letter is then marked as complete in the executive log system. If it is an MMO contract, no packet is sent, and a response is returned to the FOIA requestor, which will provide contact information for the MM/ITMO. In cases of a request for a response to an RFP, the contractor or vendor reserves the right to mark certain pages as confidential, and those pages would not be sent in a request.

The following item, though explained in the **Inquire Provider Information** business process for clarity, is also a function of this business process:



- Inquiries related to a pending enrollment status (applies to contracted providers)

3.3.5.7. Manage Contractor Communication

The Manage Contractor Communication business process manages communication to and from current or potential contractors regarding program and/or contract information.

Potential contractors contact the Division of Contracts or Procurement via telephone for information regarding contracting with the Medicaid program, upcoming contracts, advertisement of vendor services, etc. A staff member will provide information based on the type of inquiry or route the inquirer to the appropriate agency area. Inquiries related to existing or upcoming contracts may be directed to the program area that holds the contract. Potential contractors that also need to enroll as Medicaid providers are encouraged to send a hard copy request to the Division of Contracts.

Current contractors contact the Division of Contracts, Division of Procurement, a program area, or the contract owner via telephone, email, or hard copy correspondence. In cases where the contacted area does not have sufficient information, the call or correspondence will be routed to the appropriate agency area for resolution. An agency worker researches the majority of requests by using the MMIS, the CLS (only Division of Contracts access), or hard copy files.

The Division of Contracts does not track any calls received from Health Services contractors. If a Division of Contracts worker feels that the call needs to be documented, a note can be attached to the paper file. There is no specific format for documenting the call.

The Procurement office does not maintain any communication records for existing contractors unless there is an issue that needs to be documented, which is attached to the paper file. Bid files for Administrative contracts must be maintained for seven years, so any communication tied to that file will be stored. The Procurement Office also keeps a manual list of who calls for a bid and then responds to that bid.

Program areas and contract owners each have their own method, electronic or paper-based, for tracking correspondence and call logs.

The Procurement office maintains an electronic list of vendors that would like to be added to a list to be considered for future contracts. A procurement specialist will ask for a copy of the vendor's W-9 and contact information. These records will then be sent to the buyer/owner for an upcoming or potential contract.

The Managed Care area maintains question and answer sheets for each MCO that is contracted with SCDHHS. Contractors submit questions through the spreadsheet, and the Managed Care area provides responses in the spreadsheet and returns to the contractor. The program manager responsible for the spreadsheet determines the schedule for sending questions/answers. The spreadsheet must be coordinated by one person in the MCO, which eliminates duplicate questions and encourages complete dissemination of the responses. These spreadsheets provide a complete history of communication and track where the questions have been forwarded. Copies are maintained electronically.



The Managed Care area does not formally track any calls received from contractors. Managed Care workers manually maintain call logs, which are kept via hard copy or electronically. There is no standard for the documentation of these calls.

The following item, though explained in the **Inquire Contractor Information** business process for clarity, is also a function of this business process:

- Tracking correspondence related to enrollment or contract status

The following item, though explained in the **Manage Contractor Information** business process for clarity, is also a function of this business process:

- Tracking receipt of information from a contractor

The following item, though explained in the **Support Contractor Grievance and Appeal** business process for clarity, is also a function of this business process:

- Any communication with a contractor concerning a grievance or appeal

3.3.5.8. Perform Contractor Outreach

The Perform Contractor Outreach business process allows for all necessary communication (bulletins, changes to a specific program, creation of a new program or contract) to be transmitted from a program area within the agency to relevant contractors.

For potential contracts, a Request for Information (RFI) will sometimes be posted in SCBO to gather information about available services from potential vendors. SCBO is a newsletter, available in hard copy or electronic form, which advertises all solicitations over \$10,000 by all state, local government, higher education and school districts. The newsletter provides contact information for vendors to request information on the solicitation from the agency. Potential vendors can then respond to the request providing their solution.

As often as quarterly, SCDHHS is invited to vendor and minority business fairs to learn about the newest advancements in technology and new services that vendors/businesses offer to Medicaid programs. The Division of Procurement attends these fairs to make contact with potential contractors and add interested vendors/businesses to a contact list for future contracts. In general, SCDHHS does not conduct any sort of recruitment to attract potential contractors. Like the **Perform Provider Outreach** business process, there have been rare cases in which a program area may contact a provider or hospital if they perform a specialized service.

For provider contracts, SCDHHS communicates program or policy changes on a regular basis to the contractors via e-bulletins and program manuals. Administrative and other contracts do not regularly receive bulletins, unless the contractor requests to receive any communication. The procedure concerning the creation of bulletins and registration to receive bulletins may be found in the **Perform Provider Outreach** business process.

The Department of Managed Care does not perform direct outreach to MCOs, but the area does utilize a website to provide information to prospective and current contractors. The website



provides information concerning contracts, Frequently Asked Questions (FAQs), policy and procedures, monthly listing of potential eligibles, etc. The website is also designed for use by potential or current members in the **Perform Population and Member Outreach**.

3.3.5.9. Support Contractor Grievance and Appeal

The Support Contractor Grievance and Appeal business process works to resolve grievances and appeals through data research and formal hearings (if pre-hearing conferences did not resolve the issue) to reach a decision suitable for the agency and the contractor.

Grievances

The Division of Contracts and/or the Procurement area will send a hard copy demand letter when a contractor is not performing to contract standards. This is attached to the contractor file. Otherwise, the Division of Contracts does not formally document any complaints or grievances that are not subject to appeal in an electronic record or log. If a worker feels that the situation should be documented, a hard copy note may be attached to the file.

Grievances or complaints that come through the Appeals and Hearings area are first routed to the appropriate program area for resolution. The program area may use contract documentation, MMIS data, or other agency resources as needed to resolve the grievance. Program areas do not use a standardized tracking system to track grievances.

Contract Award Protests

The MMO hears protests for Administrative service contracts/vendors against a state agency that are conducted by the MMO/ITMO. For contracts above \$50,000, the MMO/ITMO will hear the protest. Any contracts under \$50,000 are non-protestable. SCDHHS does not hear any award protests. SCDHHS reserves the right to reject any and all Grant Proposals that are deemed to not meet the requirements of the specific GAR. SCDHHS is the sole judge as to whether an applicant's Grant Proposal has or has not satisfactorily met the requirements of the GAR (See **SC CO Award Administrative or Health Services Contract** for details of GAR).

Contract Termination Protests

If a buyer at the MMO/ITMO conducted the solicitation/contract, then they are the buyer of the record and would hear the protest. When the buyer is at the agency, the agency is the buyer of the record and would entertain protests.

A contractor may protest a contract termination notice prepared by the Division of Contracts. The request for termination comes from the program area or contract owner. The Office of General Counsel assists the contract owner with the termination. Copies of this notice are sent to the Fiscal area, program area, and the Division of Contracts and/or Procurement Office. This notice (in some cases) offers the contractor 30 days' notice or the contract will be terminated. Communication regarding the dispute of a notice of termination is directed to the chief procurement officer. The appeals language included in the contract is provided below:

Requests for resolutions and disputes, claims whether for money or other relief arising hereunder shall be submitted to the appropriate chief procurement officer, in writing



not later than one (1) year after the date that ***** last performs work under this contract. Nothing herein shall preclude the State from requiring submission of an invoice for final payment within a certain time after completion and acceptance of the services and/or supplies herein specified. Pendency of a claim shall not delay payment of amounts agreed due.

When a contractor disputes a termination notice, the Procurement area will work with the contractor to resolve the dispute (the Division of Contracts refers the contractor to the program area for this situation). The contractor can dispute a termination notice by appealing the decision with the Division of Appeals and Hearings.

Pre-Hearing Conferences and Hearings

Pre-hearing conferences are often held between the contractor and the contract owner (i.e. the program area or other SCDHHS area will informally work with the contractor to resolve the situation as much as possible prior to scheduling a formal hearing). In rare instances, the Division of Contracts has participated in a contractor hearing. The hearing process is managed by the Division of Appeals and Hearings. Appealable matters include termination of a contract or audit findings. The Procurement area does not have an appeals process for contractor issues. Appeals are handled by the MMO for administrative service contracts that are approved by MMO.

The notice a contractor receives for either appealable matter will inform the contractor of his right to appeal. For instance, a termination notice (sent by the Division of Contracts) will list the contractor's right to appeal.

Once a contractor files an appeal request, the Director of Appeals will determine if it is an appealable matter based on the supporting documentation submitted by the contractor. If the request for an appeal is honored, the Director of Appeals will assign a case number and hearing officer to the appeal request. The Director then passes the request on to an administrative assistant from the Division of Hearings and Appeals, who will key in relevant information that identifies a case (name, address, case number assigned) into the Appeals and Hearings Tracking System database ([see Appeals and Hearings PC application for technical details](#)). If the request for an appeal is not honored, no information concerning the request is keyed into the tracking system. The administrative assistant also prepares a CMS, which is then sent to the assigned hearing officer.

Certain boiler plate documents are identified on the CMS in drop-down menus, as well as drop-downs for date, time, possible hearing locations, names of "common personnel" (a list of these individuals is maintained by the division) that are to be copied with the various correspondences associated with the case. When the hearing officer determines which document is needed, they select the appropriate responses from the drop-downs and email the CMS back to the administrative assistant to create the document, envelopes, certified cards, etc. Any and all mailed communication produced by the division is sent via certified mail. Some communication may be sent electronically. The Appeals and Hearings Tracking System database tracks the case flow from the opening of the case to its closure. Currently, the administrative assistant is the only user of the tracking system. *The Division of Appeals and Hearings desires a more user-friendly tracking system, which would encourage division-wide use.*



A hearing officer will then examine the case. There is no SOP for managing an appeal. Currently, the Division of Appeals and Hearings is working to draft the SOP. The Division of Appeals and Hearings has viewing capability of the MMIS, MEDS, BENDEX, and SDX to verify information for case research. Contract documents may also be used for case research. The Division of Appeals and Hearings can contact the contractor at any time for additional information concerning the case. If the hearing officer determines that the original decision stands, an Interlocutory Order is sent to the contractor. The contractor has 10 days to review and produce an error in writing or provide a cause. If no error or cause is produced, the Division of Appeals and Hearings will dismiss the appeal. The hearing officer will then write an Order of Dismissal, including such information as when the records were sent to the provider, the failure to produce an error or cause, etc. The Order of Dismissal will be signed by the Director of Appeals and sent out to relevant SCDHHS areas.

If anyone feels that the appeal should stand, the case may be appealed to the South Carolina ALC. The Appeals and Hearings Tracking System database will be updated to reflect the closing of the case.

When the appeal is not dismissed, the Division of Appeals and Hearings must give the contractor at least thirty days advance notice for a scheduled hearing. The contractor can choose to waive the thirty days of preparation, which would expedite the case. The hearing officer and an agency representative attend the hearing. The agency and the contractor each give testimonies in the quasi-judicial hearing and must provide copies for everyone present of any documents referenced. The hearing is recorded, and the hearing officer reviews the recording, documents, and evidence to reach a decision. Currently, the Appeals and Hearings area uses analog recorders, but they hope to move to digital recording in the near future. The Director of the Division of Appeals and Hearings reviews the decision. If the Director disagrees with the hearing officer's decision, the two will discuss the case and reach a consensus. The Director signs a cover letter. The decision is sent to the Petitioner (entity who filed the appeal) and other interested parties.

Final Decisions and Orders of Dismissal are imaged, and the case files are archived after two years. These documents are easily accessible through Application Xtender.

If anyone feels that the Hearing Officer's decision is in error, they have 30 days to appeal to the ALC. The Appeals and Hearings Tracking System will be updated to reflect the closing of the case.

When a contractor chooses to appeal the decision, they must file with the ALC. The Office of General Counsel and the Division of Appeals and Hearings will receive a notice from the court informing them of the filing, and SCDHHS must prepare a full record. The Division of Appeals and Hearings has forty-five days from receipt of the notice to prepare a complete copy of the record and a written transcript of the recorded hearing. Kinko's prints and binds the full record copies. The hearing officer will review the entire record and sign off to verify its completeness. The court receives three copies of the record, and the contractor and SCDHHS General Counsel each receive a copy. The court will affirm, reverse, or remand the SCDHHS decision. When the decision is remanded, SCDHHS must comply with the directives of the ALC, which may include holding a second hearing. If the contractor chooses to appeal from the second hearing, they must appeal to the South Carolina Court of Appeals.



The following item, though explained in the **Manage Provider Grievance and Appeal** business process for clarity, is also a function of this business process:

- Contracted provider's appeal of federal exclusions

3.3.6. Contractor Management "Wish-list" Table

Wish-list Item	Related Business Process
Add information concerning the appeals process to the termination letter.	Close-out Contract
Increase access to contract deliverables.	Manage Contract
The Division of Appeals and Hearings desires a more user-friendly tracking system, which would encourage division-wide use.	Support Contractor Grievance and Appeal



3.3.7. Operations Management (OM)

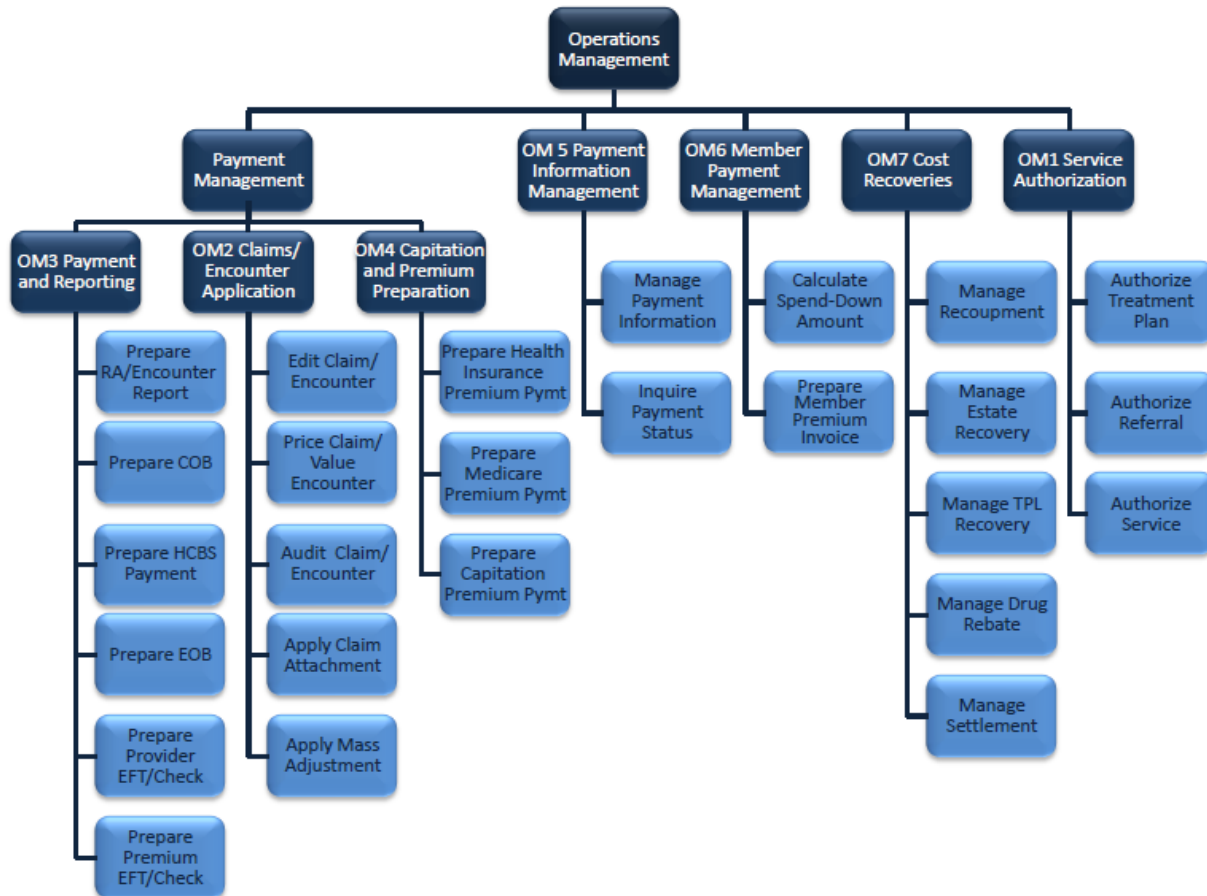
As Is

The capabilities and limitations of the MMIS shape many of the Operations Management business processes. In particular, South Carolina Medicaid moves a lot of paper, from hard copy claims and adjustments to paper TPL referrals to paper prior authorization requests.

To Be

A redesigned MMIS is the primary mechanism by which SCDHHS hopes to accomplish changes to this business area:

1. Automate the service authorization process.
 - a. Allow for electronic submission of authorization requests and electronic notification of decisions.
 - b. Automate the validation of prior authorization numbers.
2. Rethink how reference data is handled by the Medicaid Enterprise system, eliminating subfiles and program-area-specific files.
3. Incorporate National Correct Coding Initiative and more sophisticated rules-based editing and auditing into claims processing.
4. Improve audit trails and reporting.
5. Significantly extend the length of time claims history is maintained in the system:
 - a. Expand claims history information and improve its accessibility to MMIS users. Keep history of all claims, not just paid claims.
6. Centralize mailroom operations:
 - a. Image all documents and automate workflow for paper communication.
7. Incorporate a way for the MMIS to pay claims for QMBs based on the Federal Statute.



3.3.7.1. Authorize Referral

Department of Managed Care

The Department of Managed Care currently holds contracts with six MCOs and one MHN. Each plan authorizes referrals with internal forms, mechanisms, and procedures. The contract between SCDHHS and the plan lays out some guidelines, but it is up to each organization to decide what services require referrals and how the plan will accept and process referral authorizations.

SCDHHS does not monitor the specific referral authorizations. The encounter data passed to MMIS by each plan includes the referring provider IDs.

Each organization is also required to send a number of reports to SCDHHS (as determined in the contract). These reports are reviewed by the contract monitor and the Department of Managed Care. Further information about contract management is listed in the Contractor Management business area.

3.3.7.2. Authorize Service



Hospital Services and Physicians Services

SCDHHS contracts with a QIO contractor for reviews of prior/pre-authorizations and support documentation for services rendered by physicians.

Codes requiring PA or support documentation are listed in SCDHHS provider manuals.

It is the physician's responsibility to obtain prior authorization for a service or submit support documentation (i.e., for hospital-based services requiring authorization, the physician, not the hospital, obtains the authorization).

Urgent or emergent services go through back end or post authorization. MMIS generates an ECF, and MCCS sends the edit correction form (ECF) to the QIO contractor. The contractor then sends this documentation to the program area (as the service has already been provided and there is nothing to "prior authorize"). The program area makes the decision to pay or reject the claim and returns the ECF to MCCS for processing (see **Manage Edit Correction Forms**). All documentation is routed via fax or hardcopy. Elective services must receive PA.

There is a general prior authorization form for submitting PA requests to the contractor. Certain services also have specific prior authorization forms, such as:

- South Carolina Medicaid Program Surgical Justification Form for Hysterectomy
- Transplant Prior Authorization Request Form

The provider sends required forms for services and any accompanying notes must be sent to the contractor for review via hard copy or fax.

If the contractor grants prior authorization for the service, the contractor reviewer will assign an authorization number and send a hard copy letter. The provider puts the authorization number on the claim.

When a provider submits a claim to MCCS with procedure codes that are the contractor's responsibility to authorize and the provider attaches supporting documentation, these claims are scanned in the system at MCCS, and the document indicator on the claim record is set to "Y" indicating that the claim has attachments. As part of the **Edit Claim** process, the MMIS identifies that a procedure code on the claim requires authorization by the contractor. The MMIS checks the document indicator. Because of the "Y" document indicator, the claim suspends as an in-house ECF. MCCS sends the ECF and the claim attachment(s) to the contractor for review via fax or hard copy.

When a provider submits a claim to MCCS that includes a service requiring support documentation and does not also submit this documentation, the MMIS checks the document indicator field, finds an "N," rejects the claim, and generates a hard copy ECF, which MCCS mails to the provider.

The provider sends support documentation and the ECF to the contractor via fax or hard copy. Recently, the contractor implemented a new web-based program called i-exchange, which allows providers to also send documentation to the contractor via the web.



The contractor evaluates the support documentation and uses a proprietary tool to determine the medical necessity of the service.

If the support documentation is approved by the contractor, a reviewer will mark the ECF with his or her analyst ID to indicate the edit may be removed from the claim. The ECF is then returned to MCCS to process the claim for payment in the MMIS. If the support documentation is denied by the QIO contractor, the QIO contractor does not mark the ECF or return it to the provider or MCCS.

Some services have specific forms that must be completed and submitted with the claim, such as the Abortion Statement Form.

For both PAs and support documentation, if the provider did not send adequate information or the contractor does not determine the service to be medically necessary, the contractor's internal physician will contact the provider who submitted the request to gather additional information. If further documentation does not support medical necessity (or none is provided), the contractor mails or faxes a letter informing the provider of the decision to deny the request.

The contractor has its own internal tracking system for support documentation and prior authorization tracking. Requests from providers are not prioritized and are evaluated in the order that the contractor receives them.

The contractor does not validate a provider's participation or verify member eligibility in the Medicaid program. The contractor does not use 277 or 278 HIPAA transactions. Currently, there is no connection or interface between the MMIS and the contractor.

The contractor communicates with SCDHHS via hard copy, including a monthly report from the contractor that details what activities occurred.

Some hospital services go through agency-internal review. These are reviewed by the hospital services RN and medical directors. Currently, the internal review process is for unlisted drugs and services and for codes not covered under contract with the contractor. Unlisted codes require not only authorization but pricing, which is why they are handled internally. Unlisted codes suspend to the program area for this review (see **Manage Edit Correction Forms**).

Internally reviewed claims are tracked using the Hospital Tracking System ([see Hospital Services Tracking System PC application for technical details](#)).

Hospital and Physicians management recommend an interface between the agency and its contractor to automate the prior authorization and support documentation process and reduce hard copy communication. The contractor should not be responsible for marking up ECFs; their expertise is in medical review. This interface could also allow for prior authorization information to be included in member files. Having the contractor send prior authorization and support documentation approval directly to MCCS for payment processing would improve this process and greatly reduce fraud.



Behavioral Health Services

For behavioral health services, other state agencies such as DSS are responsible for the Authorize Service business function. SCDHHS provides guidelines for the referral authorization process but does not monitor it except through postpayment review (see **Identify Candidate Case**). The providers should receive the authorization/referral forms from the state agencies prior to rendering services. The agencies assign providers a PA number according to rules set by SCDHHS. Providers submit claims to SCDHHS, and the MMIS uses the PA number on the claim to identify the proper fund code for that agency so the reimbursement can come from the appropriate source.

The Behavioral Health area would like to allow these other agencies access to the Medicaid Enterprise system or provide some other program allowing them to enter prior authorization data. They would also like to automate the validation process of referrals.

DME

Certain codes relating to DME require PA. A provider submits a PA form (DHHS 214) to the DME area along with any supporting documentation via hard copy or fax. *The DME area recommends imaging or electronic submission of this information, which would greatly reduce the volume of hard copy materials received.* Documentation varies based on the code; required documentation for each code is listed in the DME provider manual and may include physicians' notes, lab reports, manufacturer's information, and/or a completed Medicaid Certificate of Medical Necessity for that equipment or service type. The DME area will review received documentation to determine if the code meets the criteria for medical necessity. *Increased functionality in the MMIS and MEDS system including the ability to view multiple screens and do criteria-specific searches would greatly improve this process.* The DME area also conducts an eligibility check for the beneficiary. In cases of new equipment or special cases, the medical director at the agency may review the request.

The DME area utilizes a tracking system that lists the name, date of birth, Medicaid beneficiary number, medical services provider, and the equipment requested and approved for prior authorization requests ([see DME PC application for technical details](#)). Only approved requests are tracked in this system. The tracking system is used frequently by DME staff to ensure that there are no duplications of requests.

If the request is denied, a hard copy letter will be mailed to the provider explaining the reason for not granting PA. The letter may request that the provider send additional information in order to grant prior authorization. The DME area will keep a copy of this letter until the provider sends additional information.

If the request is approved, the DME area will assign a unique PA number (always begins with 0, total of 7 digits) and enter the number and codes approved into the DME PA tracking system. Three copies of the letter listing the PA number are made — one for the provider; one for MCCC; and one for the DME area file.

The MMIS has edits that look for a prior authorization number, if needed, on DME claims. The claim will suspend in-house at MCCC with an ECF for resolution (see **Manage Edit Correction**



Forms). MCCC has a hard copy list of DME PA numbers to compare to the claim. If the number listed on the claim does not match the number MCCC has on file, the claim is denied.

Pharmacy Services

Certain drugs require PA including non-preferred drugs, which are those not listed on the Preferred Drug List (PDL). Some therapeutic classes or a drug within a therapeutic class may also require PA. The SCDHHS Pharmacy manual lists other reasons for requiring PAs and exceptions.

A prescriber sends PA requests via phone, fax, or web tool to the Point of Sale (POS) contractor. The web tool on the contractor's website is the encouraged route for prescribers, and the other mechanisms, phone and fax, also advertise and encourage use of the web tool. The contractor also recently increased their online capabilities to include look-up status for any drug (whether it is covered or requires PA, etc.).

The web tool provides real-time denial or approval of the PA. If the request is denied, the request will be forward to the clinical call center to verify that the request should be denied or if further documentation is required.

PA denials are sent via hard copy letter to the prescriber and the beneficiary. The beneficiary has appeal rights through the contractor. SCDHHS receives monthly spreadsheets of the prior authorization requests that have been denied.

The contractor tracks any and all prior authorization requests and their status.

If a request is approved, the contractor assigns a PA number and processes the request for use at a pharmacy.

Dental

PA is required for non-covered services deemed medically necessary via an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screening or for services that extend beyond service limits listed in the SCDHHS Dental provider manual. Any requests for prior authorization must be for cases of medical necessity. Certain services (ex: Dental implant) are automatically denied, and the PA request will be denied.

Providers submit a PA form (DHHS 214) and supporting documentation to the Dental area. The PA form can be found in the provider manual. A Dental consultant reviews the request to determine medical necessity. The request is either denied or approved and given a reimbursement rate if necessary (if a non-covered service). A standard rate sheet (based on Medicare rates) is used to establish a rate for the service. This rate is written on the hard copy PA form.

Requests for a covered service that exceed normal service limits (ex: an additional panorex/x-ray) can be authorized by the Dental area program area staff without referring the request to the Dental consultant. Any request that could come back as an appeal for medical necessity is initially reviewed by a Dental consultant. In the past, a Dental consultant has attended hearings for a Dental appeal. The Dental area utilizes the Dental Prior Authorization System (DPAS) tracking system for PA requests that have been approved. There is no place in the tracking



system to log denied PA requests. Information for the approved PA request is entered into this system (provider number, recipient number, reimbursement rate, services approved, etc.). DPAS then assigns a unique number for each approved PA request. This system also houses information concerning a beneficiary's prior authorized treatment history and the provider's use of the PA approval. Hard copy files of the requests are also maintained ([see DPAS for technical details](#)).

A request may require further documentation, which places the request in a pending status. The Dental area will usually call the provider and request that additional documentation be sent. Once the additional documentation is sent, the Dental area or Dental consultant can review the request again. If a provider does not send additional documentation within a set time period (as determined by the Dental area), the request will be denied.

The program area sends a hard copy letter approving or denying the request to the provider. If approved, the PA number and prior authorization form, with reimbursement rate, is sent back to the provider. When the provider submits the claim, the PA number is entered into the appropriate field. The claim is marked with a D9999 procedure code. The PA number is specific to a single service, with a one-time use, and will expire within a year. If the number is not used within a year, the provider must restart the PA request process.

The claim should suspend back to Dental area, so that the Dental area may write on the green suspended claim sheet the correct pricing value for the service.

SCDHHS recently awarded a contract to a Dental ASO to manage the PA request process for the Dental area in the future.

The entire PA process in the Dental area is manual and completed using hard copies. This process would benefit from automation in any way possible.

Department of Managed Care

The Department of Managed Care currently holds contracts with six MCOs and one MHN. Each plan authorizes services with internal forms, mechanisms, and procedures. The contract between SCDHHS and the plan lays out some guidelines, but it is up to each organization to decide what services require authorization and how the plan will accept and process prior authorizations.

SCDHHS does not monitor the specific service authorizations. The encounter data passed to MMIS by each plan does not include data about whether or not a service was authorized.

Each organization is also required to send a number of reports to SCDHHS (as determined in the contract). These reports are reviewed by the contract monitor and the Department of Managed Care. Further information about contract management is listed in the Contractor Management business area.

Division of CLTC Waiver Management

The Division of CLTC Waiver Management uses case managers (mostly providers who work for other agencies) to authorize services for individuals via a waiver program. All forms related to



authorizing services are located in the CLTC Case Management System (CLTC CMS). Each service requires a different form. After meeting with the beneficiary, the case manager determines the amount, scope, and direction of service to be provided. The case manager fills out the necessary forms in the CLTC CMS electronically, which are then uploaded to a central server, which makes them available for access by SCDHHS staff ([see CLTC CMS for technical details](#)). The case manager also faxes a copy of the authorization of service to the provider. The case manager is making all authorization decisions; SCDHHS (local area offices) reviews cases periodically to ensure that the case manager is consistently providing authorizations that are appropriate for need levels. The case manager can authorize a certain number of hours for a service up to a pre-determined limit (this limit is set by SCDHHS). SCDHHS does not have to approve the form prior to the service being provided unless the case manager exceeds the pre-determined threshold, in which case SCDHHS (local area office staff) must prior authorize the determination by the case manager. Care Call will receive the authorization that night ([see Care Call for technical details](#)). The authorization decisions are made outside of CLTC CMS –the case manager is simply entering the authorization information into CMS. Further information concerning the CLTC program is located in the **Care Management** business area.

Out-of-State Services

When needed services are not available in South Carolina or within 25 miles of its borders (the South Carolina Medical Service Area, SCMSA), South Carolina Medicaid providers can refer members to providers outside the SCMSA. No authorization is needed in emergencies. In non-emergencies, providers coordinate with an out of state provider and obtain written confirmation that the outside provider will accept Medicaid payment. The SC Medicaid provider then files a paper Referral Request for Out-of-State Services form to SCDHHS along with specified supporting documentation.

The agency's Out-of-State Coordinator at SCDHHS reviews the form and documentation and decides whether or not to approve the service. He or she sends a letter to the in-state physician saying whether the service is approved. There is no authorization number.

The Out-of-State Coordinator maintains a file on a shared network drive for each recipient of out of state services. The folder houses all documentation associated with the referral request. Access to the folders is limited.

Out-of-state providers must enroll with South Carolina Medicaid through MCCS Provider Enrollment before Medicaid will process claims for the authorized service (the providers often send the claim form and enrollment agreement to MCCS at the same time). The enrollment procedures are the same as for non-contracted providers under **Enroll Provider**. This is for both emergency services and pre-authorized services.

3.3.7.3. Authorize Treatment Plan

The Care Management business area describes how services are planned and coordinated for particular individuals. The "authorization" of those treatment plans is not a separate business process at SCDHHS.



3.3.7.4. Apply Attachment

Currently, the submission and validation of attachments is a strictly manual and hard copy process that varies in each program area. *SCDHHS desires to automate the submission of attachments.*

There is no way for a provider to submit an attachment electronically.

Providers can submit hard copy attachments with hard copy claims. Those attachments are scanned by MCCS and associated with the claim by CCN. All images are stored on microfilm. If a service or item on the claim requires further documentation or some sort of attachment, the claim will suspend with an in-house ECF or reject to the provider, depending on the rules for the claim. For in-house ECFs, the claims area at MCCS routes the attachment, hard copy claim, and ECF to the appropriate program staff. Once the documentation is received, the claim analyst or program representative will review the attachment and take appropriate action on the claim. (See **Manage Provider Communication** and **Manage Edit Correction Forms**).

Hard copy attachments can also be sent in with ECFs.

3.3.7.5. Apply Mass Adjustment

When the BMSM identifies a need (either internally or via communication with a program area) for a mass adjustment (e.g. retroactive rate change, system error), one of the following actions is completed based on the scope (volume of claims):

- Provider has to re-file the claim(s) or complete a 130 form for each claim³ (See **Perform Adjustment**)
- Affected program area(s) fills out a 130 form for each claim (See **Perform Adjustment**)
- Mass adjustment by Clemson via “void and replace” process

BMSM staff looks at the magnitude of affected claims by identifying the time period of affected claims and any other information that will narrow the affected claim pool. For example, a retroactive rate change has an effective date, so only claims that contain services on or after the effective date would be considered for the mass adjustment. Rate changes may affect only certain provider types or claim types. A BMSM staff member sends all identifying information to Clemson in an email.

Based on the identifying information sent from BMSM, Clemson runs a search of the MMIS and generates a report and a file that lists all the affected claims, which is sent to SCDHHS affected program areas. The process of having the MMIS run through all claims takes a significant amount of time. *BMSM management would like to automate and accelerate the process of identifying affected claims in any way possible.* Program staff view Clemson’s report via D:D to

³ Institutional providers cannot use the Form 130. They submit claim-level adjustments by coding the UB-04 claim form as an adjustment.



confirm and verify that the claims listed should be adjusted. The program area will email Clemson once the listed claims are verified; if multiple program areas are involved, the BMSM will coordinate this communication. Clemson then schedules the adjustment.

Once the identified claims are verified, Clemson schedules a “void and replace” mass adjustment job. This process essentially voids the original claim and replaces it with a claim containing the correct rate. When the claims are picked up in the MMIS for processing, they look like new claims. The void process creates a debit for the amount of the original claim, which will be debited from the provider (also known as a debit adjustment). When the “new” claim goes through the MMIS, a new payment (also known as a credit) processes through the MMIS for use in the payment process. The difference of the debit/credit amount will appear on the same remittance advice/check for a provider.

Once the payment of the mass adjustment is scheduled to run, the BMSM manually produces a provider community-adjustment letter. This letter identifies what will appear on a provider’s remittance advice and explains the reason for the adjustment. The letter also lists the date of the adjustment (this is the date that the credit or debit mass adjustments will appear in the provider’s payment), provider reference number, and submitter code. The reference number and submitter code are also two fields on the remittance advice to aid the provider in identifying the adjusted claims. BMSM photocopies the letter, produces mailing labels, and sends the information over to MCCS, which sends out the letter to the affected providers via the **Manage Provider Communication** business process.

BMSM would like to add to the functionality of the MMIS to include the ability to “void and replace” a claim (from individual claim level to mass adjustment level) that has already been replaced.

3.3.7.6. Audit Claim-Encounter

There is currently very minimal auditing of claims within the MMIS. These few audit processes are currently part of claims adjudication and are described under **Edit Claim/Encounter**. *SCDHHS would like to perform much more extensive auditing of claims and encounters, most likely through a third-party vendor that would audit claims in real time and determine whether they were edited correctly by the MMIS.*

The MMIS currently checks claims against skeletal history during the editing of the claims. It checks for duplicates and for exceeding frequency limitations.

SCDHHS would like to automate the validation of PA numbers. Currently, the claim suspends, and the program area or administrative contractor, MCCS manually checks the number against the PA form.

Correcting these deficiencies and contracting with a claim auditing service would improve claims payment accuracy.

3.3.7.7. Edit Claim-Encounter



Each claim that comes into the MMIS is assigned a Claim Control Number (CCN), which is unique to the claim. The MMIS has cycles (1st cycle, 2nd cycle, etc.), which identifies if the claim is new or a recycled claim. Regardless of the cycle a claim is on, the MMIS verifies all fields.

The MMIS verifies the claim against the following MMIS reference files:

- Skeletal history (checking for duplicate and conflicting claims and frequency)
- Duplicate CCN
- Provider Information: valid enrollment status, NPI/legacy ID, provider type
- Recipient Information: eligibility, age, demographics, special programs that a recipient falls under (RSP), benefit package
- TPL data
- Claim type
- Procedure Code file (lists age/sex limitations for certain services; codes listed compared to provider type)
- Diagnosis file
- Revenue code
- DRG Grouper information

The MMIS checks the claim against skeletal history. It checks for duplicates and for exceeded frequency limitations. Currently, MMIS skeletal claims history only extends back 18 months. Thus, procedures with lifetime limits are not verified against a true lifetime of claims history.

SCDHHS would like to automate the validation of PA numbers. Currently, the claim suspends, and the program area or administrative contractor, MCCS, manually checks the number against the PA form.

Any Information listed on a claim can generate an edit. The MMIS has 999 edit code slots and 386 active edit codes. Edit codes are driven by certain logic. If the right circumstances are present, an edit will occur, and the claim will either reject back to the provider or suspend in-house (MCCS resolution). For example, an edit relating to a prior authorization number may suspend to MCCS resolution for forwarding to the appropriate program area.

Edits can apply at the claim and line level. Some edits reject a whole claim while others can reject a single line. Some claim forms (like the CMS 1500 and dental claims) have lines, so a single line could reject while the rest of the lines pay. A single line could cause the entire claim to suspend as a result of a need for manual pricing (see **Price Claim-Value Encounter**).

“Clean”/approved claims (claims that have no edits or errors) and denied (those with reject errors) claims continue through the adjudication process. Denied claims move to a rejection status once they have completed the payment process. Rejected claims generate ECFs for providers to correct the errors (indicated by edit codes). Providers can also submit a new claim. Refer to **Manage Edit Correction Forms** for further information on this process.

Some claims receive an edit that suspends the claim and creates an ECF for in-house resolution. Refer to **Manage Edit Correction Forms** for further information on this process.



Adjustment claims, both gross-level and claim-level, are also edited by the MMIS. Like claims, they can be denied or approved or can suspend for in-house resolution.

Pharmacy Claims

Pharmacy POS claims are first edited by the Pharmacy POS contractor. When the claims are sent to the MMIS for payment, the claims go through additional high-level editing.

Encounters

Encounter data submitted by transportation brokers and MCOs goes through a separate process from regular (fee for service) claims. This process includes a variety of presence, validity, and consistency edits as well as checking for duplicate encounters. Some of the same MMIS reference files used in regular claims editing are used in encounter editing - for example procedure code file and diagnosis file. Encounters have their own skeletal history file and their own set of error codes which are assigned when an encounter fails an edit. Some errors are considered critical and cause an encounter to reject. Accepted encounters are added to encounter archives. As a result of the editing process, the MCO receives two files. One is a copy of their original file, and the other is a file of edited encounters, which contains any errors assigned to the encounters. The MCOs use this information to correct rejected encounters and resubmit them. In addition to the two files, the MCO receives a summary report which includes information such as the number of encounters accepted/rejected and a list of errors assigned and the number of occurrences.

Performance Standards

SCDHHS/MCCS meets the federal standard of processing a claim within 30 days from the date of receipt. Hard copy claims received must be keyed and transmitted to Clemson within five working days of receipt. Claims Resolution must resolve 98% of the suspended claims within 30 calendar days of receipt.



3.3.7.8. Price Claim-Value Encounter

Pricing is mainly an automated function of the MMIS. There are a variety of sources of pricing information in the MMIS database that form the basis of claims pricing. The major sources include:

1. Procedure Code Pricing Information – For purposes of editing as well as pricing, SCDHHS varies data related to a procedure code according to different categories called subfiles. Examples of these categories are: ADA, Nurse, Physicians Assistant, Diabetes etc. Within these subfile/procedure code combinations, pricing varies by a combination of procedure code modifier and pricing specialty.
2. The provider rate – for contracted providers. For certain provider types, the MMIS checks the database to see whether a contracted rate is listed for that provider number.
3. Diagnosis Related Group (DRG) – for Inpatient Hospital services. The DRG is assigned by MMIS via a vendor supplied “Grouper” program which uses information such as diagnosis codes, surgical codes, age, sex, and discharge status.
4. Revenue Codes – Outpatient hospital

The MMIS determines the rate for each listed service and if applicable, multiplies the service rate by the units associated with the service. There are numerous other factors in the algorithms. Examples include copayments, outliers, coinsurance and deductibles, bundling of codes, etc.

In some situations MMIS assigns an error causing the claim to suspend for manual pricing. For example, if the services do not have a specific rate or a miscellaneous code is listed, the claim suspends to the program area for manual review as an ECF. The procedure code book indicates which claims are manually priced.

Each program area has internal calculations to determine the rate for a service. Some miscellaneous services do not have a price, so the program area representative will use a pricing form to determine the amount. The procedure modifier and units of service listed on the claim are used to determine pricing. If the provider bills higher than the Medicaid reimbursement rate, the provider is only paid the maximum reimbursement rate. If the provider bills lower than the Medicaid reimbursement rate, the billed amount will be paid.

A program area representative corrects the ECF manually in red and lists his/her analyst number. The ECF is returned to MCCS for processing and payment. There are no automated or electronic features to manual pricing of claims.

Encounters

Encounters are not priced by SCDHHS. The MMIS accepts the amount listed by the transportation broker or MCO.

A project is underway to determine the accuracy of this encounter data and to begin setting managed care capitated rates based on encounter data rather than fee-for-service data.

BMSM would like to retain a complete history of all pricing for all services. Currently, the MMIS holds the current price and one prior price. A system request has been made for this new functionality.



3.3.7.9. Prepare COB

Most of South Carolina's TPL processes are described under **Manage TPL Recovery**. This problem statement only describes how the MMIS generates invoices to insurers for non-institutional claims identified in Pay & Chase and Retro Health processes. South Carolina Medicaid does not invoice third party insurers for cost avoided claims; in those cases, providers must bill the third party insurers themselves.

When there is a policy online that may potentially cover a service that falls under pay and chase, the MMIS processes and pays the claim but also creates a pay and chase record. These pay and chase records are pulled into weekly and quarterly jobs which ultimately result in the creation of retro claim and associated records in the potential action/retro area of the MMIS database. Another quarterly process extracts data from the potential action/retro area and generates an invoice for the third party payer/insurer. Clemson prints and sends these invoices to the Medicaid Insurance Verification Services contractor (MIVS), which mails them to the third party.

Also, at the end of each quarter Clemson runs a process referred to as Retro Health that identifies claims from non-institutional providers for which a third party may be liable. These also end up in the potential action/retro area of the MMIS database and are therefore included in the same quarterly extract and invoice process as the pay and chase claims. MIVS mails out the invoices. In some cases, MIVS generates claim forms to send in place of the MMIS-generated billings for certain carriers; those are proprietary agreements not negotiated by SCDHHS.

Insurers who do not respond are billed a second time four months later. Generally, the state takes no further action.

South Carolina Medicaid does not generate EDI claims or invoices to third parties, only paper.

Note that South Carolina Medicaid also retroactively invoices providers for certain claims. That process is described under **Manage TPL Recovery**.

3.3.7.10. Prepare EOB

Under the Bureau of Compliance and Performance Review, the PI Division manages the REOMB Program. No other EOBs are generated by SCDHHS.

Every month, Clemson University Data Center, as a function of MMIS, generates letters to a random selection of 400 Medicaid recipients. Clemson uses standard parameters (year, month, number of letters) to run the job. The PI Division can also request that Clemson modify the sample pool to select recipients based on specific criteria. *The PI Division would like to directly generate the sample selection and modify the criteria as necessary.* Currently, there is not enough staff to manage this process in the division.



The letter lists all non-confidential services paid on behalf of the recipient during the preceding 45 days. The letter requests that the recipient verify that he/she received the service(s) listed. Clemson sends these letters to the PI Division. Mailing the letters and receipt of responses is described in the Program Integrity **Identify Candidate Case** business process.

3.3.7.11. Prepare Home and Community Based Services Payment

Claims data for services under CLTC waiver programs is collected somewhat differently in South Carolina than for other claims. That process is described under **Enter Claim**. However, once the claims for these home and community-based services are in the MMIS, the claims are edited, priced, and paid the same as other claims. There is no unique **Prepare HCBS Payment** business process in South Carolina.

3.3.7.12. Prepare Premium EFT/Check

HIPP

HIPP premiums are paid by the TPL contractor and billed to SCDHHS as pass-through costs. The calculation of the HIPP premium is documented under **OM Prepare HIPP Payment**. The contractor collects the beneficiary's pay stubs, premium invoices, or other needed data, logs them to the HIPP Access database, and then prepares and mails a check to the beneficiary or other payee. The MMIS and the accounting system are not involved in the transaction.

TPL staff believe that if the HIPP program is directly administered by SCDHHS again in the future, it would make sense to pay these premiums through the MMIS so payments could be associated with the recipient file and claims history.

MCOs, MHN, and Transportation Brokers

All capitated payments are via electronic file transfer (EFT).

After the payment amount is calculated as described under **Prepare Capitation Premium Payment**, the EFTs are generated by MMIS.

EFT payments are pulled into a file and sent to Wachovia each Wednesday. The file contains the provider's bank routing number, account number, the check date, payment amount, and other relevant data for each payment.

Wachovia balances the report and creates an error report that must be worked each week by Fiscal staff, who access it online via the Wachovia website. Staff remove any providers for whom there are errors from EFT so they can resolve the problem and issue a manual check.

Wachovia sends the EFT file to the Federal Reserve, which routes the payments to the various payee accounts.

Medicare



The Buy-In payment amount that goes to CMS is based on the billing statement (paper document) received from CMS (see **Prepare Medicare Premium Payment** for a description on calculating the payment amount). MCCC prints a check for the amount in the MMIS payment file (the MMIS payment file and the billing statement from CMS may be two different figures). Using the standard check pull process, MCCC forwards the check to Fiscal (see **Perform Accounting Functions**). Fiscal then voids the check (that is based on the MMIS payment file) and processes a wire transfer (that is based on the billing statement) to CMS. If there is a discrepancy between the MMIS payment file and the CMS billing statement, BMSM staff determines the cause (the majority of discrepancies stem from rejected claims). The problem is corrected (if it is rejected claims that are the issue, they are corrected and rerun so the money in the MMIS payment file balances with the CMS billing statement).

3.3.7.13. Prepare Provider EFT/Check

The MMIS generates payments weekly based on adjudicated claims data from the previous week.

Claims processing jobs are normally run every evening after normal work hours. There is a limit of 50,000 claims to the number of claims that can be processed in a batch processing run. Depending on nightly production scheduling, multiple claims runs will be processed. Claims that are unable to be pulled into these runs are held until the next cycle. The weekly payment cycle will include all claims processed since the previous payment run. Priority adjustments, Care Call claims, Pharmacy POS, and other claim types as deemed necessary during processing are given priority; otherwise, claims payment is based on claim receipt date.

The MMIS calculates payment based on claims and adjustments in the system. It then generates a payment amount. Information generated by the payment file serves as the input to the remittance advices generated in **Prepare Remittance Advice Encounter Report**.

The provider database file in MMIS holds data about whether a provider is paid by EFT, paper check, or interdepartmental transfer (IDT). Provider payments are sent to the pay-to address on the provider file. That address cannot be overridden by information on the claim.

EFT: EFT payments are pulled into an ACH file and sent to Wachovia each Wednesday. ([See the EFT Interface Template for technical details](#)) The file contains the provider's bank routing number, account number, the check date, payment amount, and other relevant data for each payment.

Wachovia balances the report to ensure that all records were received. Wachovia also creates an error report that must be worked each week by Fiscal staff, who access it online via the Wachovia website. Whenever there is an error with an EFT payment, the Fiscal staff use MMIS to change the provider's payment method to paper check, then work to resolve the problem and issue a manual check to the provider. Once the problem is corrected, the provider can be put back on EFT.

Wachovia sends the EFT file to the Federal Reserve, which routes the payments to the various provider accounts.



Paper Checks: Paper checks are printed by MCCS. Check stock is stored in a safe at MCCS. The signature plate is kept by SCDHHS staff at the contractor site. When it is time to print checks, the check stock and signature plates are pulled. Check numbers are pre-printed on check stock. Before payment runs, the SCDHHS staff provides Clemson with the starting check number before beginning the payment cycle. The file concerning check information is sent from Clemson to the contractor's check printer. The SCDHHS staff supervises the check printing for the duration of the printing with an MCCS staff worker. The SCDHHS staff will verify throughout the printing process that the checks are printing properly. When printing is complete, the check stock and signature plate are returned to their safes. The SCDHHS staff will send the starting check number for next week's payment cycle to Clemson. MCCS staff manually burst the checks and stuff them with the remittance packages.

If checks were mutilated during the printing process, the affected checks are sent to Fiscal for regeneration and noted in Fiscal's record. The manual checks are then returned to MCCS for stuffing with the remittance packages.

IDT: State agencies who contract with SCDHHS are paid via IDT. The transactions are generated in the MMIS and sent through the interface to GAFRS. Fiscal staff post expenditure items to the correct agency IDT based on the agency ownership code which maps to a vendor in GAFRS. The IDTs are then sent to the Comptroller General to post the expenditure data to SCDHHS and the revenue data to the appropriate agency. Individuals IDTs are generated for each agency paid (e.g. DMH, DDSN, USC, COC, etc.). The State Treasurer's Office creates a credit and debit memo and emails this to SCDHHS and the other agencies.

MMIS generates remittances in payment type order. MCCS stuffs and mails remittance advices for EFT payments first. Then they stuff and mail the remits and paper checks, followed by IDT-associated remits. Paper checks are generally mailed out on Mondays.

Some debits and credits occur within the MMIS as a result of mass adjustments, recoveries, payment offsets, or other forms of recoupment (see **Apply Mass Adjustment, Perform Claim Level Adjustment, Perform Gross Level Adjustment, Manage Cost Settlement, Manage TPL Recovery, Perform Accounting Functions**). These debits and credits are entered into MMIS and calculated against the provider's MMIS payment.

Other debits/credits occur as a result of the check pull process. Garnishments by other agencies, liens against a provider, tax debts, etc., are not entered in the MMIS. Instead, those checks are removed manually from the check run by MCCS and delivered to the Fiscal Services area. The process is described under **Perform Accounting Functions**.

SCDHHS would like to be able to enter all debits and credits into the MMIS before the payment is calculated, doing away with the manual check pull process.

Early each Tuesday morning, the MMIS also generates a file to be loaded to GAFRS. That process is described under **Perform Accounting Functions** and **Manage State Funds**.

The payments are recorded to MMIS payment history, which is linked to the provider file. Systems such as the IVRS use this information (see **Inquire Payment Status**). The 1099 process also amasses payment history data (see **Manage 1099s**).



CMS mentions payroll processing as a potential function of this business process. The MMIS does not generate payroll payments. However, it does generate an 835 transaction that is sent to First Data Government Solutions, which provides the Care Call contractor with an 837 for provider payroll purposes.

3.3.7.14. Prepare Remittance Advice-Encounter Report

This process takes adjudicated claims data from the previous week (Tuesday through Monday night) and formats it into a remittance advice for each provider. The MMIS performs this function early Tuesday morning. The generation of remittance advices is included as part of the payment process.

The remittance advice shows the status (**Paid**, **Rejected**, or **Suspended**) of each claim adjudicated during the previous week, along with payment data, provider data, and other relevant data about each claim, adjustment, or encounter. A provider ECF is also generated for each claim with status “R,” and an in-house ECF is produced during claims adjudication for each claim with status “S.” (See **Manage Edit Correction Forms**.)

The weekly payment cycle includes all claims processed since the last payment run. Priority adjustments, Care Call claims, Pharmacy POS, and other claim types as deemed necessary during processing are given priority; otherwise, claims payment is based on claim receipt date.

Currently, many providers receive paper remittance advices. The formatted remits and provider ECFs are printed by Clemson and delivered to MCCS by courier for bursting, hand-stuffing, and mailing.

An indicator on the provider file allows providers to opt out of receiving paper remittance advices. In such cases, the MMIS does not generate a remittance advice. Provider Enrollment is responsible for updating the indicator field as requested by providers.

Providers can sign up for 835 electronic remittance advices (See **Establish Business Relationship**). The general process for exchanging HIPAA transactions is described under the **HIPAA mailbox** interface.

If a provider chooses to receive 835s, unless they also separately opt out of paper remittance advices, they will receive both 835s and paper remits.

The agency plans to discontinue paper remittance advices in fall 2009. Instead, providers will access PDF files of their remittance advices and ECFs online via a new secure web option. If the provider wishes to send in an ECF, he or she will have to print it from the web and fill it out.

3.3.7.15. Prepare Capitation Premium Payment

South Carolina Medicaid currently pays capitated rates to transportation brokers, MCOs, and the MHN. These rates are negotiated as part of the contracts with those entities.



SCDHHS exchanges data with these entities via the 834 (member listing) and the 820 (premium payment) transactions. All capitated payments are via EFT. See **Prepare Premium EFT/Check** for information on the actual payment.

All capitated payments are calculated by the MMIS. Rates are stored in the MMIS reference file and updated by MCCS as needed.

Transportation

Transportation brokers are paid a contracted per-member-per-month rate based on the number of eligibles in a particular region. Brokers are currently paid at the beginning of the month based on the previous month's enrollment numbers, but the agency intends to soon begin paying at the end of the month instead.

Each month, Clemson runs a job to calculate the payment, which creates a capitated premium claim (called a J claim) for each eligible. The claims are processed and paid but due to the volume are not stored in the database. They are written to an archive file for inclusion in reporting as needed. Currently no remits, 835s, or 820s are created for these. *The agency would like to store this data in the MMIS and in the DSS/SURS to show in which months premiums were paid for a member.*

Managed Care Organizations

MCOs are paid a per-member-per-month rate for all beneficiaries enrolled with that MCO. These rates are adjusted/impacted by age, sex, and pay cap.

MCO payments are prospective; they are calculated and paid for the upcoming month. That calculation is performed at the beginning of the month based on data from the previous month.

The RSP file of the MMIS holds information about beneficiaries' enrollment in managed care and other programs. Each day, as the MMIS determines potential managed care eligibles, a file of beneficiary data is sent to the Enrollment Broker, which maintains a count of eligibles for payment purposes and syncs the list to its own roster. The Enrollment Broker sends data on enrolled eligibles to the MMIS via the 834.

Based on 834 data received from the Enrollment Broker, the MMIS updates the RSP file and uses this information to calculate the payment to the MCOs.

A second payment is made later each month to reconcile any members who lost and then regained their eligibility within the month. Such members are declared eligible back to the beginning of the month, and a payment must be made to the MCO.

SCDHHS transmits a collective 834 to the Enrollment Broker, which splits it out for the various plans. The agency transmits a separate 820 to each plan.

Medical Homes Network

The MHN is paid a per-member-per-month fee based on a contracted rate. In the MMIS, the MHN is listed as a "board." Its associated providers are listed as primary care providers. Payments are calculated and paid twice monthly as for MCOs above.



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Any errors in the calculation of capitated payments must be handled manually. Agency staff must sometimes make adjustments, override gaps in member eligibility, and perform other MMIS functions to correctly prepare capitated payments.

3.3.7.16. Prepare Health Insurance Premium Payment

The HIPP program in South Carolina is managed by MIVS with policy and oversight provided by an SCDHHS liaison. Currently about 200 Medicaid beneficiaries participate in the HIPP program.

The program receives referrals from many sources, including providers, caseworkers, DSS, CLTC, and beneficiaries themselves. The sources send or fax in a referral form that includes information on the beneficiary and his or her insurance policies, employer information, etc. Program staff may also collect this information themselves from the beneficiary.

The contractor then sends out an initial contact package, which contains detailed information on the program.

If a beneficiary calls or sends a letter indicating he or she wishes to participate, the contractor must then gather data for a cost effectiveness decision. Four to six months' worth of claims data are needed, so the contractor asks for copies of EOBs sent to the beneficiary by the insurer, both health and pharmacy. In some cases, the MMIS may house claims data for the beneficiary as well. The contractor logs all this data to an Access database called SC HIPP.

Cost effectiveness is calculated based on 40% of billed charges, which is roughly what SCDHHS has estimated Medicaid would pay. A database called the SC HIPP Cost Saving Worksheet is used to calculate cost effectiveness. For the other side of the equation, the contractor staff input the cost of the premium, the deductible, the per-member-per-month administrative cost for a six-month period, and any other relevant costs. Program staff also looks at comparative data for the beneficiary's diagnosis, including expected procedures, drugs, and hospitalizations and forward the information to the contractor.

If SC Medicaid can potentially save \$600 every six months, the beneficiary's participation in HIPP is deemed cost effective.

The contractor performs a redetermination every six months, examining the same data as explained above for the recent utilization. Redeterminations are also performed anytime the contractor learns of a change such as an increased or decreased premium or new carrier.

If the case is approved, the contractor sends an approval letter to the beneficiary. It lists the terms of the agreement – i.e., who South Carolina Medicaid will pay (the employer, the beneficiary, the COBRA administrator, etc) and what the beneficiary will need to send to the contractor. Throughout their participation in HIPP, beneficiaries must send the contractor their EOBs, premium invoices, pay stubs, and other information required for continued cost effectiveness determinations and program recordkeeping. Staff must develop a working relationship with the beneficiary to encourage cooperation. The contractor logs into the SC HIPP



database all data elements required to calculate cost effectiveness and to generate checks. These documents are also scanned into the image workflow and storage system.

The generation of HIPP premium checks is explained under **OM Prepare Premium EFT/Check**.

When a beneficiary is to be dropped from the program, the contractor sends a letter explaining the decision. The beneficiary can appeal the decision through standard appeals channels (see **Manage Member Grievance and Appeals**), though the contractor will perform an informal reconsideration of the decision first.

All HIPP materials are imaged by the contractor along with other TPL mail and handled via automated workflow. A hard copy file of case materials is also maintained while the case is active. Contacts and other case-related data are logged to the SC HIPP database. These images are accessible by the on-site SCDHHS liaison that uses them to review and audit cases.

The MMIS recipient file contains no indication that a beneficiary participates in HIPP. However, the TPL Policy File contains an indicator in the Source field (a "P"), updated by MIVS, to show that the beneficiary is a HIPP participant. This excludes the beneficiary from the list of potential managed care eligibles sent to the Enrollment Broker. No HIPP information is sent to MEDS.

The outreach to potential beneficiaries for the HIPP program in South Carolina is handled by SCDHHS staff. For example, a letter about the program is sent to every family of a TEFRA beneficiary, and some caseworker training has been held (see **Perform Population and Member Outreach**). *SCDHHS would like to expand and enhance outreach.*

SCDHHS has attempted in the past to design predictive models to find potential HIPP participants based on claims history and actuarial projections. Such efforts have not been successful so far. *However, claims data could be used to provide leads in the future. Although SCDHHS is not allowed to target beneficiaries for HIPP inclusion based on diagnosis, they may be able to look for high-claim beneficiaries with other insurance, for example.*

3.3.7.17. Prepare Medicare Premium Payment

The purpose of the Buy-In program is to permit states to provide Medicare to certain groups of needy individuals. This arrangement benefits the states in that it has the effect of transferring some medical costs for those who are eligible for Medicaid away from the Medicaid program (which is partially state financed) to the Medicare Program (which is funded by the Federal government and by the payment of premiums).

Payment of Medicare premiums is a service provided by SCDHHS to SC Medicaid recipients. SCDHHS transmits the premium payments to CMS as documented under **OM Prepare Premium EFT/Check**. For certain payment categories, i.e. SLMB, QMB, and Qualified Individuals (QI1), payment of the Buy-In Part B premium is the only Medicaid benefit provided. The Buy-In system must be operational to provide this service.



Clemson University performs the matching process (using interface eligibility data described below) against MEDS that ultimately determines those that are eligible for the Buy-In program. Medicare data received through interfaces with the Social Security Administration (SDX and BENDEX), CMS (MMA), Coordination of Benefits Contractor (COBC), and from the Medicaid applicants and recipients is updated to the MEDS member records ([see MEDS interfaces for technical details](#)). The Buy-In subsystem extracts Medicare and other data from the MEDS member records to create a Buy-In transaction (See the data layout for the Buy-In Input record for a list of the data required for submission of a Buy-In request). The system identifies those who are potentially eligible for Buy-In and those who are ineligible and creates the Buy-In transactions to be sent to CMS.

From this, Clemson University generates two Buy-In files (one for Medicare Part A and one for Medicare Part B).

Weekly, the MEDS Buy-In interface transmits the Buy-In (Part A and B) accretions, deletions and changes to CMS. CMS processes the file and responds the next day sending multiple types of records

The Buy-In subsystem processes the files received back from CMS automatically, assessing the files for accuracy and completeness. Additionally, the Buy-In subsystem then posts the changes to MEDS. The Buy-In subsystem produces reports that list unmatched entries and other errors that require SCDHHS manual research. Workers are notified of discrepant information through reports and alerts. The SCDHHS workers use these various reports and alerts to research and correct as many as possible. SCDHHS may also send a problem discrepancy form(s) to the CMS Exceptions Processing if it requires action on their part. Additionally, the Department of Interfaces workers may make phone calls to CMS, the SSA etc. to resolve issues with the information. The Buy-In subsystem has a screen available that allows workers at SCDHHS to manually enter a record that will merge in with the MEDS automatic transactions. SCDHHS does not produce notifications to members concerning the Buy-In program.

The Buy-In subsystem processes the daily Buy-In transactions and monthly billing file received from CMS and generates a monthly file of claims to MMIS for processing of Medicare premium payments (see **Prepare Premium Payment EFT-Check** for a description of the payment process). The Medicare Buy-In payment amount is based on the billing statement (paper document) received from CMS.

Wish List:

- SCDHHS would like the Buy-In table to be re-written. The table has many flaws, which causes many processing errors.
- SCDHHS would like Buy-In to handle retroactive Buy-In eligibility automatically (e.g. a case worker approves someone for May – then later determines the beneficiary was eligible for April as well – currently a manual accretion is required by SCDHHS).
- SCDHHS would like for the eligibility office to always take the name of the potential beneficiary from the Social Security card (sometimes SCDHHS has the wrong name – this is an eligibility office issue).
- SCDHHS would like to have access to the EDB interface (listed on the CMS template).
- SCDHHS would like Buy-In to correctly update the QMB indicator.



3.3.7.18. Inquire Payment Status

Providers check claims status in three ways: calling their program representative, using the Web Tool, and sending/receiving 276/277 transactions. The IVRS can be used to check the amount of a provider's last check, but not to check claims status ([see IVRS interface for technical details](#)).

When a provider calls, program representatives can look up claims status in the MMIS and tell the provider the status over the phone.

The Web Tool maintains six months' worth of claims status data. Providers who are registered Web Tool users (they register through the EDI Support Center) can log in and check claims status using particular search parameters.

As with other HIPAA transactions, SCDHHS exchanges 276/277 transactions with trading partners using an FTP server and the Translator at Clemson ([see HIPAA mailbox interface for technical details](#)).

First, trading partner agreements and submitter IDs are established as described under **Establish Business Relationship**.

Submitters (either clearinghouses or individual providers) transmit 276 files to Medicaid's FTP server. A separate FTP mailbox is maintained for each submitter. A process called 'sniffers' polls the mailboxes, picking up incoming files almost immediately. When it finds a file, it sends it to the translator, which makes sure the file is HIPAA-compliant.

Noncompliant files generate an error message, which is placed in the outgoing folder for the submitter to pick up. Compliant files are passed to the MMIS. In either case, a 997 (acknowledgment transaction – non-HIPAA but nonetheless widely used) and a trace file (non-HIPAA – generated by the software) are generated for the submitter.

After translation, the file is uploaded to the mainframe; uploads happen every hour on the half hour.

276 files should identify the intended claim by the following criteria:

- Claim Control Number(CCN)
or
- If no CCN sent, must match Recipient ID, NPI (or legacy number for atypical providers), dates of service (first and last must match), and amount charged

If the 276 request doesn't match either 1 or 2, a 'claim not found' response is sent. If multiple claims match, then all claim matches are sent; a 276 can identify one or more unique claims.

Failure reasons include the Translator, MMIS, or FTP server being down, in which case the transactions would just collect until systems were back up.

After identifying claims status for the appropriate claims, the MMIS generates an outbound file containing the information.



The 277 task on the translator is run hourly every day to pull the daily flat file (containing all 277 transactions that need to be returned to submitter's mailboxes) back down from the mainframe. The daily flat file is typically ready on the mainframe between 2:30PM and 7:30PM each day.

Statuses returned are:

1. Paid
2. Rejected
3. Suspended
4. Approved
5. Denied

“Approved” and “Denied” are for claims that have completed processing but are awaiting the weekly payment cycle.

3.3.7.19. Manage Payment Information

MMIS Access is based on job role. The majority of staff has inquiry only access. Update access is given to staff that have a specific role requiring update. For example, a claims resolution clerk needs update access to the claims; a provider enrollment clerk needs update access to the provider file. All access is controlled by a user ID and password.

SCDHHS requires the use of a TPA for anyone outside of the agency to have inquiry-only access to the MMIS. The specific conditions within the TPA are established in the **Business Relationship Management** business area.

Each week, adjudicated claims from the previous week (Tuesday through Monday) are fed into a payment cycle in order to determine the providers' payments (See **Prepare Remittance Advice-Encounter Report, Prepare Provider EFT-Check** for more information). The date of the payment, the check number and the payment amount are stored in MMIS and connected to the provider.

Staff can perform inquiries on payment information by provider through MMIS. The payment information is also provided to the IVRS which allows a provider to obtain information on their most recent payment. Payment information is also used in many management reports (See **Manage Program Information**).

Payments cannot be manually altered through the MMIS.

Monthly, the payment data is written to electronic archives and is retained forever. The archives database exceeds state and federal record retention requirements. Archives are not available online.

3.3.7.20. Calculate Spend-Down Amount

This business process is not done by SCDHHS. SCDHHS previously had a spend-down program known as Medically Needy. This program is no longer in effect.



3.3.7.21. Prepare Member Premium Invoice

SCDHHS does not perform this business process.

3.3.7.22. Manage Drug Rebate

SCDHHS contracts with a POS contractor to manage drug rebates, both OBRA and Supplemental.

Each quarter, CMS mails SCDHHS a tape listing all rebate-eligible NDCs. The tape is passed on to the contractor. CMS is supposed to send the tape within 45 days of the end of the quarter; the contractor then has 15 days to prepare and send out invoices to meet the federal 60-day timeliness standard.

The contractor applies CMS' data to pharmacy claims history – both the POS claims, which are fed weekly to the contractor from the MMIS, and the claims with J codes (physician administered drugs), which are fed quarterly. The contractor determines which claims should be invoiced to the manufacturers for rebate.

The contractor then generates and sends out invoices to the manufacturers. Claims are rolled up by NDC, and each invoice contains all the NDCs produced by that manufacturer. Invoices are sent both on paper and on diskette in the same envelope.

Manufacturers send rebate checks to the contractor, which receives the checks through a lockbox (checks are made payable to SCDHHS). The checks are deposited directly by Wachovia, which then sends copies of the checks, any attached communication, and a Reconciliation State Invoice to the contractor, so they can post them to their rebate accounting system and track payments. Rebates are tracked at the NDC, manufacturer, and year/quarter level.

SCDHHS' Fiscal Services area accesses Wachovia daily online to monitor drug rebate payments. Fiscal Services enters these payments into a receipt tracking log accessible to both the pharmacy program area and Fiscal Services (hosted by Wachovia Bank).

The contractor forwards summarized invoice totals to SCDHHS. Fiscal Services tracks these in the Accounts Receivable database and GAFRS (see **Perform Accounting Functions**). Fiscal Services splits the drug rebate receivables into three categories using GAFRS journal entries: PDL/Supplemental, CMS/OBRA, or Diabetes Supplies.

At the end of the month, Fiscal performs a reconciliation between GAFRS, the contractor and Wachovia.

If manufacturers do not pay within 38 days, interest begins to accrue. The manufacturers are responsible for calculating and paying their own interest; however, the contractor tracks interest to make sure manufacturers pay correctly. These interest rates are calculated based on federal standards pinned to Treasury bills.

Should a manufacturer dispute the amount of a claim or group of claims, they will notify the contractor, which tracks and researches these disputes. The contractor first contacts the



manufacturer to say they've received the dispute. They then research the matter and write off any incorrect units before the next invoice cycle (the next quarter).

The process works well and meets federal standards. *However, the agency would like it if drug rebate data were stored along with claims history in the data warehouse, or was somehow made directly accessible to the agency. Attorneys preparing class action lawsuits often seek large volumes of drug rebate data which the agency has to retrieve through the contractor.* Currently, no drug rebate data is fed into the MMIS or the Thomson Reuters DW.

3.3.7.23. Manage Estate Recovery

The Estate Recovery (ER) process begins when the SCDHHS ER department learns of the death of a Medicaid member who was receiving CLTC or nursing facility services. Staff find out about deaths in various ways:

- MCCS sends all Form 181s indicating death to ER. (Nursing homes attach the 181 to their TAD billing and send it to MCCS.) This is a less useful avenue than it once was, as many members are enrolled in hospice care when they die and the billing process is different.
- Caseworkers send the 238 form to ER when they learn of a death.
- The agency receives daily file transfers from DHEC's Department of Vital Statistics. The file is run against the MMIS, and matches are pulled into a sub-database, then run against the ER database to determine whether cases exist yet for those potential matches.
- An MMIS report shows all dates of death recorded on claims.

Currently, only members who received CLTC or NH services within the past 18 months can be identified, since the above death data sources are all compared against MMIS claims history to determine whether there is a potential case. *The ER area would like to expand their ability to match deaths against claims for nursing home or CLTC services anytime in the past several years prior to the death.*

They would also like more automated death notifications and data matches.

Next, the ER staff searches MEDS for family contact information. They used to use MMIS, but find MEDS has more information of this sort. ER staff prints the Family and Recipient screens from MEDS. These screens are used to generate the initial contact letter and questionnaire. The screens are scanned for archival purposes if there is no case to pursue. If there are sufficient assets to pursue, then a paper file is maintained. Upon closure, the paper file is scanned and then destroyed. Application Xtender is used for archiving files.

The ER database maintains a file on each ER case ([see Estate Recovery PC application for technical details](#)). It allows staff to create notifications/alerts for follow-up contact – for example, they can set a notice to re-send a letter 30 days after initial contact. The system also helps staff generate letters based on Microsoft Word templates.



The staff sends an Estate Questionnaire to the deceased's family. The document asks whether there are assets, whether the estate is in probate, who the surviving family members are, who is handling the estate, etc.

In case the questionnaire does not provide enough information or contact information is unavailable, ER also contacts the probate courts. ER staff run a query of the ER database to capture the names of estates potentially in probate, and mails a monthly report to the probate court asking whether any are in probate and seeking documentation. The report has blank blocks next to the decedent names for filling in information ER needs. If the decedent has an estate, the probate court will fill out all the information requested by ER (case number, personal representative name etc.). If they do not have an estate, they put N/A beside the decedent name. The probate courts mail the same reports that were sent to them, with the requested information on them. (NOTE: There are about five counties that ER can get all of the necessary information online, so these counties don't get the report).

Using the completed questionnaire, and other research/follow-up if necessary, the ER staff decides whether the case should be pursued or closed. Estates worth less than \$10,000 are closed, because after court fees, funeral fees, etc., there is seldom money left for Medicaid to collect in those cases. ER must close cases where there is a surviving spouse, disabled, or minor child.

For cases ER wishes to pursue, the ER claim analyst researches the beneficiary's claims history using SURS (goes back 7 years), MEDS, MMIS, and data from caseworkers to determine how much is due Medicaid. This involves not only finding all appropriate claims, but also any adjustments, changes in eligibility, or other complicating factors. For nursing home residents, all claims can be recovered; for CLTC patients, only hospital and drug charges can be recovered, so the analyst must review each claim one by one. The analyst then compiles the data in a spreadsheet and sends it to the probate court.

The research process would be much easier if caseworkers' documentation was electronically accessible – perhaps uploaded and attached to the member file. As it is, the ER staff must ask the caseworker to dig up a paper file and send it in; sometimes files can be misplaced or incomplete. The ER staff also find discrepancies between MEDS and MMIS – for example, the TPL indicator is not always the same in both systems.

Next, from the probate court, ER should receive documentation of the estate's true assets, though sometimes ER must look to tax assessors or other sources for complete and accurate information. The agency is also sometimes asked to approve real estate sales or actions taken on the estate.

Once the amount due Medicaid is determined and any real estate or other transactions have occurred, the court or closing attorney will write a check to SC Medicaid and send it to the SCDHHS Fiscal department or directly to the ER department. When the check goes to Fiscal, the Accounts Receivable (AR) staff handles it like any other account receivable (see **Perform Accounting Functions**). AR staff enters the check into GAFRS (SCDHHS accounting system) as an ER check. If the check is received by the ER Department, the check is posted to the ER database, and then sent to Cash Receipts (in the Fiscal area) along with a Form 205 prepared by the ER



staff. The Fiscal area handles the check like other accounts receivable, entering it into the AR log and Cash Receipt log in addition to GAFRS (see **Perform Accounting Functions**).

ER staff receive a weekly cash report from AR that they use to reconcile the ER database with AR. If ER staff finds any checks that have been posted to ER in GAFRS, but are not logged in the ER database, they use ApplicationXtender ([see ApplicationXtender PC application](#)) to access and print the image of the ER checks and then post the checks into the ER database. ER staff collect the weekly cash reports and perform the reconciliation between the ER database and GAFRS on a monthly basis.

From beginning to end, the estate recovery process can take many, many months, susceptible as it is to everything from the housing market to family dynamics to legal issues.

ER staff often have a lot of contact with the families of deceased beneficiaries, as well as with realtors, probate courts, attorneys, and others. Each contact related to a case is documented in the ER database—staff write a description of the contact in the ER database) that occurred so anyone in the department can handle a case.

Through their research, ER claims analysts sometimes find billing errors that must be corrected by providers—for example, sometimes a nursing facility will bill for an entire month when the resident died partway through the month. ER staff sometimes work with providers to resolve these issues.

An overhaul of the ER database is planned in the future, including a way to attached scanned documents to files.

3.3.7.24. Manage Recoupment

Processes described in Program Management, Program Integrity Management, and Operations Management describe the recoupment process. **Manage Recoupment** is not considered to be a separate business process performed by SCDHHS.

3.3.7.25. Manage Cost Settlement

The Bureau of Reimbursement Methodology and Policy (BRMP) annually requests cost reports from certain providers via hard copy correspondence to conduct cost settlements. The following provider types submit cost reports (Medicaid and/or Medicare related) to the BRMP:

- Nursing Homes
- Nursing Homes-ICF/MR
- Hospital (inpatient and outpatient)
- Federally Qualified Health Centers (FQHCs)
- Rural Health Clinics (RHCs)
- Home health agencies



- Various state agency services (e.g. DDSN administers waiver programs for SCDHHS)

Some nursing home and hospital providers undergo a process similar to the retrospective cost settlement. However, a final settlement/rate is determined based on audit findings of the cost reports. All other provider types undergo a retrospective cost settlement.

Currently, only non-ICF/MR nursing homes submit electronic cost reports. *The BRMP would like to receive electronic cost reports from all providers and design agency-specific spreadsheets to reduce re-entry of data. This would reduce the amount of hard copy reports that the BRMP receives and would help to automate this process.*

Home health providers directly file their Medicare cost reports to the BRMP.

RHCs also file their Medicare cost reports to the BRMP. If the report is not sent, the BRMP will contact the Medicare intermediary (either Palmetto GBA or Riverbend Government Benefits Administrator) for the RHC report.

A BRMP worker uses the units of service that are listed on the report to calculate the reimbursement rate for the units using liable cost definitions. Liable cost definitions are based on federal and state regulations and manuals. There are also certain cost limitations based on provider type built into the state plan.

Some provider types have multiple payers, so the BRMP worker will look at the total units reported and the total units paid by Medicaid. If there is a difference, the BRMP worker will perform manual reconciliations with the provider prior to setting the rate.

The BRMP worker uses MARS reports (generated by the Division of MMIS System Management) and/or DS contractor reports (generated by a BRMP worker or the Office of Reporting, Research, and Special Projects) to pull statistics and payment information (Including TPL data reflected for any individuals).

The liable units (can range from minutes to days, depending on the service) are multiplied by the rate to determine the maximum amount a provider can receive. The maximum value is compared to the interim rate payment. If the provider was underpaid, a BRMP worker requests a gross adjustment by completing a 115 form, which is sent to MCCS for keying (see **Perform Adjustment**). If the provider was overpaid, the BRMP worker will complete a 1158 Accounts Receivable form, which is sent to the Fiscal area to recoup funds (see **Perform Accounting Functions**, payment offset process). Some providers like DDSN (administers services for the waiver program) could be underpaid in some areas and overpaid in others. The debits and credits for each provider are rolled up to generate one reconciliation amount.

The BRMP aims to have the cost settlement data and any calculations reviewed twice: first, by the original worker who prepared the computations and then a second worker reviews the data.

The BRMP prepares and sends hard copy letters to providers, which identify the cost settlement amount. Letters identifying overpayments that require the 1158 form or reconciliation are also sent to the Fiscal area.



For underpayments and overpayments that require debit adjustments (also known as a gross adjustment; see **Perform Adjustment**), the BRMP verifies that the adjustments went through the MMIS and processed. For overpayments that established the 1158, the Fiscal area monitors those to ensure payment is received.

The BRMP maintains hard copy files for each provider. The BRMP documents underpayments when paid to the provider.

Ideally, a BRMP worker will spend approximately three to four months to determine the cost settlement amount if all reports are received on a timely basis. However, cost settlement delays like not receiving a report in a timely manner or findings from an independent audit may cause the BRMP to take a few years to resolve the settlement.

The cost settlement process can impact the rate setting process as it may identify a need for an increased rate (see **Manage Rate Setting**). This is done on a case by case basis as the rate setting process is affected by many factors.

3.3.7.26. Manage TPL Recovery

SCDHHS contracts with a TPL contractor to provide TPL research and recovery services. An internal SCDHHS department called Health, Development, and Recovery in the Division of TPL, part of the Bureau of Fiscal Affairs, oversees the work of the contractor and handles other TPL matters.

TPL Leads, Research, and Updates

MIVS, the TPL contractor, researches TPL information from a variety of referral sources and data matches. These “leads” indicate potential policies that must be added to the TPL Subsystem of the MMIS.

MIVS uses an automated scanning, indexing, workflow, and tracking system to forward leads to analysts who research them using a variety of tools (phone, carrier websites, mail, etc.) The analysts add policies to the TPL Subsystem and make revisions to those policies in their own proprietary system, which is populated by information from the MMIS. MIVS’ TPL data is added to the actual MMIS throughout the day as leads are verified and QC-ed. These updates are made via the contractor’s proprietary automated data entry/user emulation process.

MIVS only adds lapsed policies if they find at least \$500 of recoverable claims in MMIS skeletal history.

Information on sources of TPL data appears below.

TRICARE-DEERS Interface – Through an annual data match with Department of Defense, SCDHHS receives new TRICARE policies and updates. SCDHHS sends the entire Medicaid enrollment file. DEERS identifies subscribers and offspring for those beneficiaries and passes the information back. Clemson creates policy records or updates existing policies as necessary. Clemson passes a file to MIVS to verify the leads for TRICARE for Life and to load all coverage ([see TRICARE-DEERS interface for technical details](#)).



ESC – Using ESC data match, Clemson automatically generates questionnaires, which are sent to employers (see following BCBSSC section). MIVS uses the returned questionnaires to identify Medicaid beneficiaries that hold insurance policies through their employer ([see ESC interface for technical details](#)).

BCBSSC – MIVS also receives the ESC files electronically from SCDHHS. MIVS has an automated monthly job that goes into the BlueCross BlueShield of South Carolina (BCBSSC) eligibility system to identify Medicaid beneficiaries that potentially have insurance with BlueCross. The job sends a screenshot of the BlueCross eligibility file to a MIVS proprietary application for viewing by the MIVS worker. The automated interface help to minimize the amount of letters sent.

Other Insurers – MIVS also sends the ESC file to CIGNA, Aetna, and United Healthcare to do a data match. Then a MIVS worker calls the employers to determine effective dates of potential insurance policies found by the data matches.

CSE – To be implemented February 2010, SCDHHS will exchange data with Child Support Enforcement (CSE, within the Department of Social Services). CSE will send SCDHHS a full data file of court-ordered insurance information (including the carrier name and policy number/subscriber) for SCDHHS to do a comparison to MMIS TPL data. Subsequently, CSE/DSS will send regular updates to SCDHHS. When SCDHHS discovers lapsed insurance, SCDHHS will have an interface back to DSS to say that it lapsed, so DSS may contact the non-custodial parent.

3230 – The eligibility form 3230 is faxed or couriered to SCDHHS or MIVS from eligibility offices. The faxed and hard copy documents are forwarded to MIVS, which images them and researches the lead. *TPL would like to streamline and automate this process, eliminating the need for MIVS to key information from paper forms when that information has already been captured by the eligibility worker.*

TPL Weekly Claims Processing Reports – Roughly half of all TPL leads are generated by providers entering TPL information on claim forms. If the provider indicates an insurance payment that does not match a known policy in the TPL file, the MMIS will flag the claim to indicate there is unmatched insurance paid (referred to as report 3) or unmatched insurance denied (report 7).

Reports 4 and H are also used for TPL research. Report 4 is a maintenance report of when a provider has reported a denial but there is no indication in the policy file that the claim should have been denied by the carrier. MIVS calls these carriers to determine why the claim was not paid. MIVS updates lapsed or altered policies in the MMIS. MIVS compiles reports of potentially fraudulent activity for the Division of Program Integrity from time to time.

Report H details claims that have an insurance payment on them when the beneficiary insurance indicates the insurance is lapsed prior to the date of service.

Clemson transmits these weekly claims processing reports to MIVS weekly. MIVS scrubs those reports electronically, then researches the remaining leads.

Lapse Exception Reports – When an insured policy record is lapsed, the MMIS is programmed to automatically check the TPL Recovery database for claims with dates of service that are after the lapse date. MMIS updates those to a status of "carrier denied payment" to prevent further



pursuit. Report TPL0175 reports on any of those claims for which a reimbursement has already been posted and therefore cannot be changed. MIVS researches or contacts the provider and/or insurance to determine whether or not the lapse date online is correct, or if the provider used an old insurance carrier code for new insurance that is in force.

SSA 8019 – Clemson receives insurance data from SSA and transmits to MIVS a file of beneficiaries with health insurance ([see SSA 8019 interface for technical details](#)).

MCO Leads – These are transmitted electronically from the individual Medicaid MCOs to Clemson, which transmits them to MIVS.

Insurer Inquiries – Insurance companies send letters to MIVS or TPL inquiring about beneficiaries' Medicaid coverage, asking if Medicaid will pay for a claim, etc. A worker researches the matter and answers the company's inquiry. At the same time, if the insurance is not listed in the MMIS, the letter is treated as a referral requiring follow-up and a possible policy load or maintenance.

Provider Refunds – Providers submit voluntary refunds to MIVS. MIVS researches these refunds to determine if new insurance has been identified. If so, this becomes a lead.

Health Insurance Information Referral Forms (HIIRF) – Providers may also mail or fax paper Health Insurance Information Referral Forms to MIVS. The HIIRF is an optional paper form that providers can fill out if they discover insurance changes that they don't think SC Medicaid knows about.

Casualty – When accident questionnaires are returned to MIVS, the questionnaires may indicate health insurance information. Any new information will trigger policy research/follow-up.

TPL Subsystem and MMIS

The MMIS TPL Subsystem includes the policy file, potential action file (recovery and cost avoidance files), and the tracking system.

The policy file houses detailed insurance policy information for each relevant beneficiary. Policies are start- and end-dated. Policies are identified by type, though *those policy types and their associated codes could be more specific and transparent to the provider (for example, HN = "Health No Restrictions," the most common and general policy type, could be defined/labeled more clearly in the system -- for example, "dental", "drug", "behavioral health", "LTC," etc.)*

The Potential Action File is made up of two parts: cost avoidance and recovery. The MMIS daily claims processing pulls into the cost avoidance file every claim that has either TPL information listed on the claim and/or TPL-related edits generated during processing. The file includes paid and denied claims. The retro-recovery file includes all claims in recovery (retro health, retro Medicare, Pay and Chase) and "chasing cost avoidance" claims (claims that should have been cost avoided and weren't – see Recovery section).

The tracking system is used to track and create health insurance employer letters and accident questionnaires, which are triggered when claims with certain trauma-related codes are



adjudicated by the MMIS. The Casualty section at the end of this document explains the questionnaires and the casualty process.

The “Exclusion File” (not part of the TPL Subsystem) contains claims that should be excluded from the retroactive billing process. Claim control numbers are added to a dataset in the MMIS by MIVS using a proprietary application. *MIVS and TPL staff would like a new way to handle exclusions. Currently there is no indication on a claim record that the claim is in the exclusions file; the exclusions file simply lists excluded claims. Exclusion information should be linked to the claim, not in a separate file. The current exclusion arrangement causes problems when, for example, a group of claims are re-priced and recycled, and some of those claims have already been voluntarily refunded. In this case, providers get paid a second time and have to refund Medicaid a second time. If refunds were posted back to the original claim rather than placed in the exclusions file, this would not be a problem.*

In addition, the exclusions file contains no input logic and does not validate the CCN, so it can contain errors.

For the most part, TPL staff are happy with the functionality of the TPL Subsystem, which was redesigned more recently than the rest of the MMIS. While they would like cosmetic and navigational improvements, the essential functions and abilities of the system support this business process well. They hope any future system will maintain all the functionality of the current system.

Cost Avoidance and Pay & Chase

Pay and Chase services in South Carolina are:

- Preventive pediatric services
- Dental services
- Maternal health services
- Title IV – Child Support Enforcement insurance records
- Certain DHEC services under Title V

The MMIS processes claims for pay and chase services. An invoice (outbound claim) is generated to third party payers/insurers. That process is documented under **Prepare COB**.

All other services are cost-avoided: SC Medicaid rejects them because they should have been billed to another party. Cost avoidance is one of many edit processes performed in **Edit Claim**. For cost-avoided services, an ECF indicates insurer’s information when a claim is rejected back to the provider. The provider is asked to file to the third party and report the results (denial or payment amount) to SC Medicaid on the ECF; see **Manage ECFs**.

Cost avoidance or pay-and-chase begins as soon as a policy is added to the TPL Subsystem.

Recovery



Retro Health For claims that have already been paid before a health insurance record is put online, the MMIS initiates a retro health recovery process. Clemson runs this process; MIVS mails invoices and posts responses in the Potential Action File.

Each quarter, Clemson runs a job to look for claims for which a relevant health policy has been added. The look-back period is this calendar year and the prior calendar year for institutional claims and 35.5 months for all other claims being billed to insurance companies. Clemson generates billings based on this job and gives them to MIVS. MIVS mails out the invoices, though it generates claim forms to send in place of the MMIS-generated billings for certain carriers.

Retro Health is handled differently depending on the provider type:

- **Institutional providers** are sent MMIS-generated letters notifying them that they must bill the other insurer and that Medicaid will recoup the money if the provider fails to respond. These letters are mailed at the beginning of the quarter, 4 months later, and 6 months after the initial invoice. 9 months after the initial invoice, the provider is sent a notification of automatic debit.
- **Non-institutional providers** are not notified of retro health recoveries. The MMIS generates an invoice to the insurer. That process is described under **Prepare COB**.
- **Retro Medicare** Providers (all types except pharmacists) are notified by letter at the beginning of the quarter that they should bill Medicare for the affected claim lines. MIVS also mails out these letters. Six weeks later, the provider's account is automatically debited.

These schedules allow providers time to bill Medicare or the insurer, if necessary, and to contact MIVS if a retroactive billing was in error. All invoices, worksheets, provider reports and debits are run on a set schedule created at the beginning of the year.

When MMIS does cost avoidance on claims, it uses a line by line reject. Therefore, if a provider files Medicare-covered and non-covered procedures on one claim, the MMIS can pay the Medicare non-covered service and reject the covered line with edit 953. When South Carolina Medicaid does retro Medicare recovery, the MMIS recovers only the covered services. Therefore the provider is invoiced the covered lines and the MMIS automatically generates claim and gross level adjustments.

The automated debits created by Clemson for health and Medicare recovery are claim level debits if the entire claim is to be recovered. Claims not being debited in full are submitted as a gross level adjustment.

Claims invoiced to providers are pulled into recovery when the provider has failed to respond. Before the automated debit, the following occurs:

- MMIS generates a "worksheet" that lists claims and policy types and a field that indicates some information on coverage. MIVS may post to the potential action/recovery area an amount that the MMIS should recover. If MIVS posts nothing, the claim is recovered in full, automatically, claim level.
- MMIS generates a terminated provider report for both health and Medicare and MIVS attempts to find a new number under which a manual debit can be performed. If it is found MIVS posts to the potential action file to stop the automated debit.



SCDHHS also sometimes performs recoveries of claims that should have been cost-avoided and weren't. These are called "chasing cost avoidance" claims. Sometimes these are handled by a special job: Clemson and TPL work together to designate a set of claims, then Clemson runs a job to pull them into the recovery file. Others are identified automatically by the MMIS – for example, pharmacy claims processed by the contractor and not correctly cost avoided are identified during the pharmacy claims extract and pulled into recovery.

Chasing cost avoidance claims are invoiced to providers for institutional claims and carriers for other claim types (just like other retro claims).

Refunds

Providers and insurers send money to MIVS in response to retroactive recovery billings. They may also request that MIVS create an adjustment to return claim payment.

MIVS receives these refunds and deposits them using Wachovia's web deposit tool. Then, regardless of the reason for the refund, MIVS initiates a Reason Code 12 adjustment to adjust the provider's 1099. An electronic list of these RC 12 adjustments is sent to Clemson weekly by MIVS for this purpose. The RC 12/1099 adjustment is independent of further research, categorization, and posting of the refund, which is explained below.

MIVS reconciles refunds between MIVS' various systems, the MMIS, and Wachovia daily.

When MIVS receives refunds in response to retro or pay-and-chase billings, MIVS workers must also post the amounts paid against the appropriate claims in the Potential Action file in the TPL subsystem of the MMIS. One payment can be connected to thousands of individual claims. This requires analysts to research the MMIS, review correspondence, and contact the provider or insurer, if necessary.

Once paid, refunded and posted, claims are excluded from future billings.

Note that providers can also use the Form 130 to adjust a claim that is in recovery, rather than sending a refund. In that case, the provider's account will be debited. (This does not apply to institutional providers, who can never use the Form 130.)

Occasionally a provider refund and an automated provider debit will overlap, in which case MIVS will initiate a credit adjustment on a paper 115 form and send it to MCCS. *MIVS would like to automate the adjustment process.*

Casualty

The MMIS automatically generates accident questionnaires when certain trauma-related codes appear on claim forms. Clemson prints and sends the questionnaires to SCDHHS for mailing to beneficiaries. The beneficiaries mail the completed questionnaires to the TPL Division at SCDHHS, which handles casualty-related recovery efforts. When questionnaires are returned, the response is posted in the tracking file of the TPL subsystem to stop subsequent letters from being mailed. The MMIS has recovery level indicators on the procedure code file that determines whether 1, 2, or 3 questionnaires will be sent.



The TPL Division enters the data from the questionnaire into a SQL database called the TPL Casualty Tracking System. The system tracks events, generates letters, and reports related to accident claims received by the agency's TPL department. The system also tracks case information related to the beneficiary, such as Medicaid number, address, other insurance coverage, etc.

The attorney's info (if applicable) may have been provided by the beneficiary on the questionnaire. The TPL Division sends the attorney the itemization form if it is determined that there are enough accident-related claims to warrant establishing a case.

A questionnaire is not always generated for all of the potential casualty recovery cases. Many attorneys already have the Medicaid itemization form on file. Because many questionnaires are not returned, most cases result from attorney itemization requests. They will fill it out and sent it to TPL; they sometimes do this without ever having received a questionnaire.

The attorney sends the TPL Department the itemization form with case information for the accident.

The TPL department then does research to find out if any claims were paid by Medicaid related to the accident. If Medicaid did pay claims related to the accident, and the beneficiary or liable party had insurance coverage that should have paid the claim, the TPL department will make an effort to recoup these funds from the insurance company (see **Perform Accounting Functions**).

Additional Wish List Items

- *The TPL indicator in MEDS doesn't tell a person much – they have to go into the TPL Subsystem for details. And the MEDS indicator isn't always consistent or correctly updated.*
- *The MMIS TPL indicator on the recipient screen doesn't indicate whether the policy is still active.*
- *MIVS uses employer prototypes; none are currently used in the MMIS but they could be useful. A prototype lists all the potential insurance choices an employee of a particular entity can choose from. For example, an employer may only offer two plans, and if MIVS can collect all the relevant data on those two options and complete a prototype, analysts won't have to spend so much time researching the particular policy details for each beneficiary.*
- *It would be helpful to have the claim total on the Retro Claim Detail screen. EOBs give you a claim total and this requires a look in skeletal to determine which DOS they are addressing.*
- *Staff would like to be able to access policy information from the MMIS recipient screen.*

Many other wish list items that relate in part to TPL are listed in Chapter 6 and at the beginning of each business area section.



3.3.8. Operations Management “Wish-list” Table

Wish-list Item	Related Business Process
Support an interface between the agency and its contractor to automate the prior authorization and support documentation processes.	Authorize Service
Allow other agencies access to the Medicaid Enterprise system to enter prior authorization data. Behavioral Health would like to automate the validation of the referral/PA process.	Authorize Service
Imaging or electronic submission of information for prior authorization and support documentation request.	Authorize Service
Increased functionality in the MMIS and MEDS system including the ability to view multiple screens and do criteria-specific searches would greatly improve this process.	Authorize Service
Automate the prior authorization process in the Dental area.	Authorize Service
Automate the submission of attachments.	Apply Attachment
Automate the process of identifying affected claims for mass adjustments.	Apply Mass Adjustment
Ability to “void and replace” a claim (from individual claim level to mass adjustment level) that has already been replaced.	Apply Mass Adjustment
SCDHHS would like to perform much more extensive auditing of claims and encounters, most likely through a third-party vendor.	Audit Claim-Encounter
Retain a complete history of all pricing for all services.	Price Claim-Value Encounter
The PI Division would like to directly generate the sample selection and modify the criteria as necessary for the preparation of EOBs.	Prepare EOB
Enter all debits and credits into the MMIS before the payment is calculated.	Prepare Provider EFT-Check
Store data that shows which months premiums were paid for a member in the MMIS and DSS/SURS.	Prepare Capitation Premium Payment
SCDHHS would like to expand and enhance outreach.	Prepare HIPP
SCDHHS would like the Buy-In table to be re-written.	Prepare Medicare Premium Payment
SCDHHS would like Buy-In to handle retroactive Buy-In eligibility automatically (e.g. a case worker approves someone for May – then later determines the beneficiary was eligible for April as well – currently a manual accretion is required SCDHHS).	Prepare Medicare Premium Payment
SCDHHS would like for the eligibility office to always take the name of the potential beneficiary from the Social Security card .	Prepare Medicare Premium Payment
SCDHHS would like to have access to the EDB interface. SCDHHS would like Buy-In to correctly update the QMB indicator.	Prepare Medicare Premium Payment
Store drug rebate data along with claims history in the data warehouse.	Manage Drug Rebate
Match deaths against claims for nursing home or CLTC services anytime in the past several years prior to the death.	Manage Estate Recovery
They would also like more automated death notifications and data matches.	Manage Estate Recovery
Have caseworkers’ documentation be electronically accessible.	Manage Estate Recovery
Receive electronic cost reports from all providers and design agency-specific	Manage Cost Settlement



spreadsheets to reduce re-entry of data.	
Eliminate the need for MIVS to key information from paper forms when that information has already been captured by the eligibility worker.	Manage TPL Recovery
Policy types and their associated codes could be more specific and transparent to the provider (for example, HN = "Health No Restrictions," the most common and general policy type, could be defined/labeled more clearly in the system -- for example, "dental", "drug", "behavioral health", "LTC," etc.)	Manage TPL Recovery
MIVS and TPL staff would like a new way to handle exclusions. Exclusion information should be linked to the claim, not in a separate file.	Manage TPL Recovery
The exclusions file should have input logic and validate the CCN.	Manage TPL Recovery
MIVS would like to automate the adjustment process.	Manage TPL Recovery
The MEDS TPL indicator is not always consistent or updated.	Manage TPL Recovery
The MMIS TPL indicator on the recipient screen doesn't indicate whether the policy is still active.	Manage TPL Recovery
MIVS uses employer prototypes; none are currently used in the MMIS but they could be useful.	Manage TPL Recovery
It would be helpful to have the claim total on the Retro Claim Detail screen.	Manage TPL Recovery
Access policy information from the MMIS recipient screen.	Manage TPL Recovery



3.3.9. Program Management (PG)

As Is

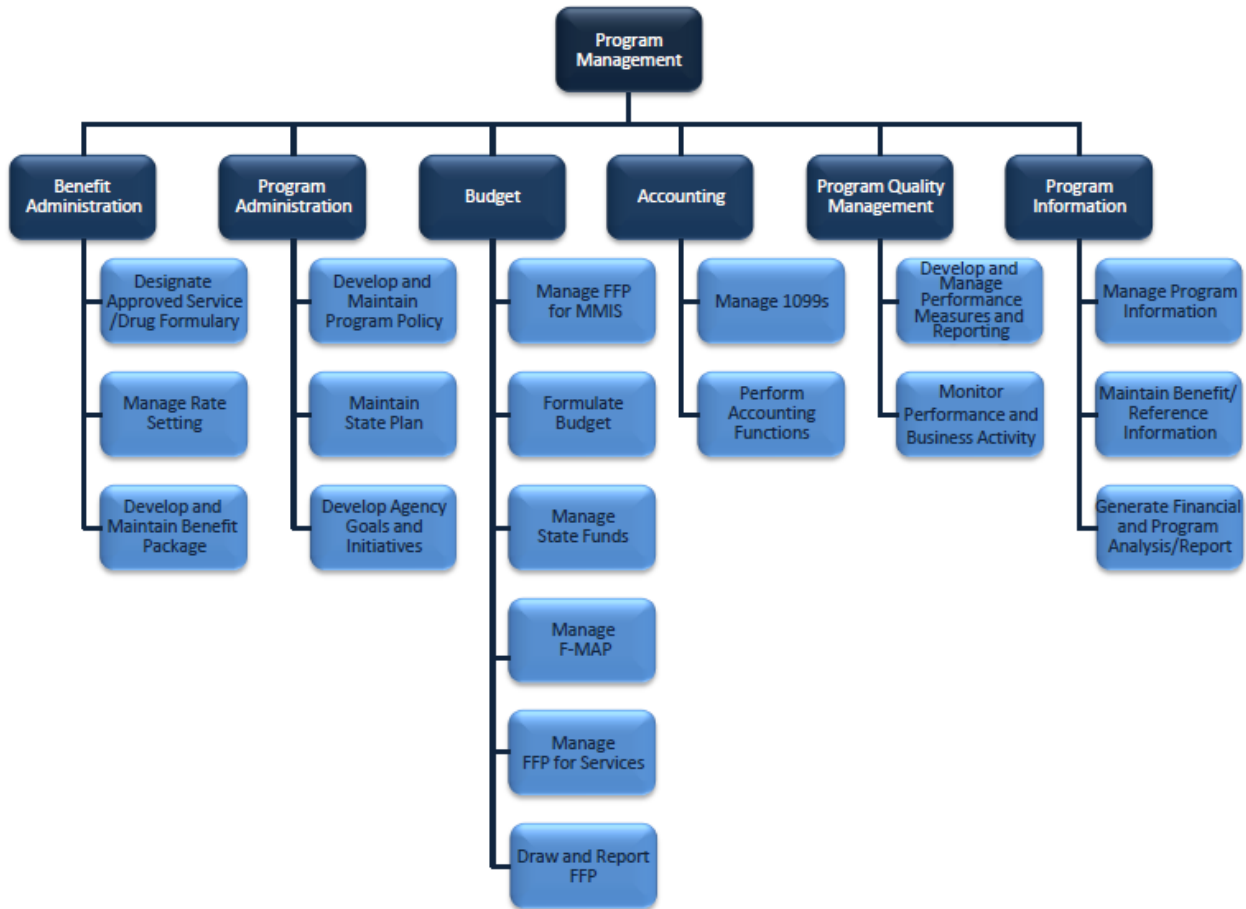
Like many government agencies, SCDHHS handles processes like decision-making, budget planning, and goal-setting through mostly informal, consensus-based discussion and planning. Federal reporting and Fiscal Services-related business processes are more rigorously defined; however, the ongoing transition to a new accounting system made some of these processes difficult to pin down. Most Fiscal procedures are documented in their pre-SAP state.

To Be

The transition to SAP/ SCEIS, a new statewide accounting system, has major implications for Program Management business areas. As a result the agency has less defined goals for how MITA can improve accounting and Fiscal functions. SCDHHS plans to assess the As Is and To Be states of all processes related to SAP once the system is fully in place.

In the areas of decision-making and program planning, South Carolina Medicaid is currently engaged in developing a new strategic plan that will help guide policy decisions. Improved ad hoc reporting and forecasting tools would also contribute significantly to this business area.

SCDHHS would also like to improve the agency's own documentation about Medicaid. For example, a more accessible, searchable electronic version of the State Plan and other program documents would also help facilitate research and understanding.



3.3.9.1. Manage 1099s

The BSM uses the MMIS to accumulate weekly data for management of the 1099s and to generate the annual 1099 data for providers and the IRS.

To collect data for management of the 1099 process, MMIS creates a weekly and year to date file, which reflect payment transactions applied during the weekly payment run. Two reports are created from these files and stored in D:D:

- PMT4525R01-Weekly 1099 Payment by Legacy-Reports weekly payment by legacy and NPI, sorted by pay to provider. This report shows the:
 - legacy number
 - the pay-to provider (for typical providers, would be an NPI; for atypical providers, would be a SCDHHS-assigned legacy number),
 - provider name
 - provider type
 - payment amount
 - refund/check cancellation amount
 - credit amount



- debit amount
- If the provider is paid federal share only by check, the report also includes:
 - check amount (federal share)
 - provider certified amount (state share)
- PMT4525R02-Same as PMT4525R01 except data reported is Year to Date.

The weekly file is also processed by a balancing program which matches each Pay to amount against the Payment history for the pay to provider. CLP4527R01 is generated by this process and reflects any out of balance situation found. This report is stored in D:D and also emailed automatically to designated staff at SCDHHS and Clemson.

If a discrepancy is found, a program CLP4526 has been written to correct any of the four amount fields (Payment, Refund/Check Cancellation, Credit and Debit). This program will produce a report of the before and after update amounts and will be stored on D:D. The weekly file that is in error will be corrected as well as the year to date file. New PMT4525R01 and R02 will be produced with the corrected amounts. These will be replacements for the original reports in D:D.

BMSM staff are responsible for researching and resolving any discrepancies found and providing two transaction files to Clemson for input of the correction job.

SCDHHS has made a Request for Changes for modifications to the 1099 process (to be worked on in summer of 2009).

When 1099s are generated for a given calendar year, the following reports are produced and stored in D:D:

- MAR1991 –Nonexempt Providers Monthly Payment Totals (these providers get a 1099)⁴
- MAR1992-Exempt Provider Monthly Payment Totals (these providers are exempt from 1099 reporting)⁵
- MAR1993-1099 Form-Individual provider data formatted for printing the 1099 form
(Currently stores the text formatted for 1099 printing. Storing the print image on the actual 1099 document is on the wish list.)
- MAR1994-Grand Total-Total number of providers and total 1099 amount
- MAR1995-List of Providers-Information for each provider formatted as a report as opposed to a 1099 form.

⁴ RFC09-0013-E includes a change to capture YTD totals (instead of monthly totals) for nonexempt providers

⁵ RFC09-0013-E includes a change to capture YTD totals (instead of monthly totals) for exempt providers



The telephone number of an auditor is listed on every 1099 prepared by SCDHHS. The auditor maintains documentation of calls received via hard copy. *The auditing area desires an automated online system to track these inquiries, manage the call volume, and keep a log of any other pertinent information.*

When a correction is requested to the actual 1099, the auditor will work with General Counsel to review the information before making a change. Corrections to the form are rare. The auditor maintains records of hard copy 1099s with the changes made.

SCDHHS is not responsible for switching the ID number that a provider is paid by (ex: SSN to Business Tax ID number). When requested, the auditor will fax the Internal Revenue Service (IRS) instructions to the provider on how to make that change.

The auditor or MSM Bureau will do manual research as necessary to answer provider inquiries via telephone. Communications from providers on official letterhead that request changes to provider records are forwarded to the relevant program area for research and resolution (see **Manage Provider Information**). If the provider is a contracted provider, the request for change will be coordinated with the Division of Contracts at SCDHHS.

Otherwise, provider inquiries or requests for record changes are routed through the **Manage Provider Communication** or **Inquire Provider Information** business processes to program areas.

1099s are reviewed and prepared at the close of the calendar year. SCDHHS sends 1099s to non-exempt providers before January 31st of each year. Clemson downloads a file from the mainframe to a PC, zips it, and then uploads it to the IRS website before March 31st of each year ([see 1099 interface for technical details](#)). Due dates are specified in the IRS Publication 1220 each year.

3.3.9.2. Perform Accounting Functions

Note: The SAP system implementation scheduled for 2009-10 will alter all the processes in this section. SAP will not only replace GAFRS but other systems as well, and will change how the agency interacts internally and with other state agencies and entities. SCDHHS does not yet know the extent or nature of these changes.

1. Periodic reconciliations between MMIS and the system(s) that performs accounting functions

The Reconciliations area of the Financial Systems division performs a monthly reconciliation between GAFRS and MMIS. The monthly reconciliation encompasses both the month's transactions and a year-to-date reconciliation.

Using reports from MMIS (the 8500 report) and GAFRS, Fiscal staff copy or key data into Excel spreadsheets and look for variances between the two.

These reconciliations are at the budget unit code level.



Sometimes variances occur because staff have made a journal entry/manual adjustment in GAFRS to adjust a funding source. Sometimes they occur because of incorrect MMIS coding – for example, a fund code may be incorrectly defined. Whatever variances occur, they must be researched and explained. Fiscal staff and MMIS technical staff must coordinate to resolve variances.

2. Assign account coding to transactions processed in MMIS

Account-related codes are associated with transactions in both MMIS and GAFRS.

In the MMIS, fund codes associated with particular procedure codes, provider types, and other identifiers splits the payment between federal and state entities and directs the allocation into the correct PCA for GAFRS. Fund codes are assigned to claim lines based on complex MMIS coding. A fund code manual documenting the fund coding logic is updated regularly by MMIS Systems Support and posted on the agency intranet. Budget unit codes (also called mini codes) indicate what kind of payment the service or administrative cost is. Every financial transaction entered into GAFRS is associated with exactly one PCA.

3. Process accounts payable invoices created in the MMIS.

Fiscal staff post a weekly file from the MMIS to GAFRS. For each payment, it contains:

- Amount
- Fund Code
- PCA
- Warrant number (this is the number associated with the CG's check that gets deposited into the agency's bank account).

The file is sent by Clemson to the CIO office (which maintains GAFRS), who send it to the Fiscal area for posting. The Fiscal staff runs a GAFRS job to format the data and upload it to the system (a JCL).

Using the MMIS fund codes and other markers, GAFRS directs the allocation into the correct PCA and splits payments into the appropriate categories by program cost account (earmarks, grants, other state agencies, restricted funds, etc.). Fiscal staff monitor the process using GAFRS reports and error messages. Each Tuesday morning, after GAFRS processes the weekly MMIS data, the staff review the reports and alerts to make sure there is sufficient money appropriated to each fund to fund the week's MMIS payments. Staff makes appropriation transfers in GAFRS to adjust the source of funds, if necessary. They move allocations between accounts and indicate the reason for the move. In certain circumstances, if money has to be moved from a service line to an administrative line or vice versa, the Fiscal staff must obtain the consent of the governor and Comptroller General using the BD100, a form used for additional appropriations.

On Wednesdays, the Fiscal area prepares a voucher and sends it to the state Comptroller General's office. In return, that office sends a check to deposit funds for the week's payment cycle into the Medicaid zero balance account that MMIS checks are drawn on. All adjustments to fund sourcing must be finished on Tuesdays so this exchange can occur on time and MMIS checks will not bounce.



4. Process accounts payable invoices created in Accounting System (gross adjustments or other service payments not processed through MMIS, and administrative payables) [invoices sent in by outside vendors and other state agencies for administrative payables]

SCDHHS staff enters accounts payable information into GAFRS through both file uploads and manual data entry.

For goods and services, every administrative accounts payable starts with a requisition form 192. Program areas fill out the form and submit it to Procurement (see the **Award Contract** business process), who then submit it to Fiscal. Fiscal staff review the request to determine where the funding will come from. They then manually encumber the funds in GAFRS and send the form back to Procurement to place the order. Fiscal maintains paper files of all pending requisitions.

When the program area accepts the good or service, they send a receipt of goods received to Fiscal. Accounts Payable staff matches the receipt of goods received with the invoice and key it into GAFRS to generate a voucher that prints out the next morning from GAFRS. The voucher is reviewed internally, then sent to the CG's office and reviewed there as well. It is then sent to the Treasurer, who creates a check and sends it back to the agency. Accounts Payable matches the check up with a copy of the invoice and sends it to the vendor.

For contracts, Fiscal uses the form 102 as described under **Award Contract** to encumber contract funds in GAFRS. Contractors invoice the agency at a predetermined frequency (usually monthly). When Fiscal receives an invoice, they send an approval memo to the program area asking whether the invoice is correct and the contractor can be paid. If so, Fiscal creates a voucher and sends it to the CG; the process proceeds as above.

Some other agencies that contract with SCDHHS are paid via IDT. IDT payments are keyed the same way as a voucher. The IDT prints out the next morning; the other agency also sends an IDT (lets the CG's office know whose codes to use, etc.) and the invoice to Fiscal, and it is matched up with the IDT that Fiscal keyed and it is sent to the CG's office. In those cases, the Treasury creates an IDT transaction rather than cutting a check, and sends reports called debit and credit memos to SCDHHS to report the IDT. Fiscal staff log those transactions into GAFRS.

5. Load accounts payable data (warrant number, date, etc.) to MMIS

This data is not fed into MMIS at all. It resides in GAFRS.

6. Manage canceled/voided/stale dated warrants

The Reconciliations area receives a monthly bank statement which it uses to figure out which MMIS checks remain outstanding after six months.

The area also receives letters, returned or rejected checks, and other correspondence requiring a check to be cancelled. Program areas forward these items to the area for voiding.

The area manually cancels each check using the Check Cancellation subsystem, a stand-alone system. Area staff key the check data into the subsystem ([see Check Cancellation for technical](#)



[details](#)). Each month, that information is exported to the Time Sharing Option at Clemson. Staff email Clemson to let them know the file has been exported.

Clemson then runs a Medical Reconciliation with the MMIS. This process creates a Reason Code 18 adjustment, which adjusts the provider's 1099 and generates information to be sent on tape to the bank to remove the checks from the master file. In the case of damaged or lost checks, the program area contacts the Reconciliations area to cancel the original check and order new checks. The program area must fill out a form requesting a replacement. The Reconciliations area will first research the check using the bank's online account service, making sure the check remains outstanding, then issue a stop payment on the original check. The Reconciliations staff forwards a request for a manual check to be keyed to the Division of Medicaid Finance. The division types the check and sends it to the provider, and adds the check number to the form and returns the form to Reconciliations. Reconciliations staff sends the new check number to Wachovia.

7. Perform payroll activities

Payroll activities originate with program areas. The program area fills out the 114 to initiate salary adjustments, new hires, location or job description changes, or any other such personnel changes. Human Resources (HR) reviews the 114 and sends it to Fiscal. The payroll budget analyst in Fiscal verifies the funding; funding for a position may be split between several PCA's (federal, state and other money sources). The form is then sent back to HR. HR keys their changes into SABAR (the payroll system) and then routes it back to Fiscal so that the payroll analyst can key the hours and any payroll changes into SABAR.

Payroll is run bimonthly (pay checks are issued on the 1st and the 16th). The SABAR system is used to generate a voucher and a change report, which are sent to the CG's office, then to the Treasury. The Treasury creates checks and sends them back to the agency for distribution. They also send a file, which is uploaded to GAFRS to post all the payroll expenditures against the proper accounts and budget unit codes.

All documents related to payroll and other HR functions are hand-delivered and kept in secure, locked areas.

8. Process accounts receivable (estate recovery, co-pay, drug rebate, recoupment, TPL recovery, and Member premiums)

The agency receives money from a variety of sources. Providers refund the agency because of third-party payments or incorrect billing. Recipients and providers may have to pay back funds related to fraud and abuse investigations. Other agencies pay SCDHHS their share of services and programs administered under Medicaid (called "donated funds").

Various areas of the agency can generate requests to establish a receivable – PI, TPL, etc. The areas fill out a 1158 form and send it to AR. Providers may also contact AR directly. The process is further described under #10 below.

Each month, using Excel, the area prepares invoices for recipients, other agencies, providers, and other entities that owe the agency money. The AR area handles all invoicing, collections, and related contact internally.



All receivables and refunds of expenditures are sent directly to the SCDHHS AR department. Only SCDHHS receivable related overpayments are sent to the AR department (e.g. the PI department finds that SCDHHS overpaid a provider, and PI then opens a receivable with the AR department to collect that money).

The agency's AR department processes cash receipts using the procedures described below under #9.

Other state agencies pay SCDHHS via IDT. The Comptroller General's office sends a daily transaction report (the 401 report) listing all IDTs. These payments are interfaced into GAFRS; AR staff key those payments that did not feed over into GAFRS.

AR can also collect from state residents using the State Income Tax debt setoff process. The agency is a member of the Municipal Association of South Carolina; each year, the agency submits to the association a list of names and amounts to be collected. The association handles the offset and takes their fee as a portion of the amount collected. They send the payments to SCDHHS via ACH.

Refunds

For all voluntary provider refunds, providers are asked to send in a Form 205, the form for Medicaid refunds, explaining the reason for the refund. Sometimes providers may send in their checks with other documentation – e.g., a remittance advice, a letter, or a copy of an invoice they received. Claim adjustment forms (Form 130) are forwarded to MCCS for processing.

All provider refunds for Medicaid overpayments and billing errors are sent to MIVS, the TPL contractor. The majority of provider receipts are sent to the refunds PO Box and processed by MIVS. These payments are not Accounts Receivable related (example: if a provider performs a self-audit and they realized they double-billed Medicaid, they would send the refund to MIVS).

MIVS researches the source of the funds, deposits the funds via a secure link with Wachovia, and uploads relevant claims and refund data to MMIS. MIVS categorizes the receipts by type, which sometimes requires splitting a refund into multiple sources. MIVS also summarizes the deposits in Excel format and sends the file to Fiscal/TPL so the deposits can be recorded in GAFRS.

9. Manage cash receipting process

When the agency receives money from recipients, contractors, providers, agencies, or other entities, the AR area processes those payments. Receipts are first logged into the Cash Receipts Log (CRL), which generates an AR number that will identify the receipt in all the agency's systems. Next, the payment is entered into the CRL ([see Cash Receipt Log System PC application for technical details](#)), which then automatically interfaces with the Accounts Receivable Log (ARL; [see Accounts Receivable Log PC application for technical details](#)). Information entered includes check number, payer name, date, and provider number, if applicable. The AR department may have to research the source of the check or provider information by using the MMIS, referring to attached documentation, or calling the check originator.



The receipts are also separately keyed into GAFRS. Using the Data Entry tab in GAFRS, Fiscal employees key batches of transactions. A batch can contain as many or as few transactions as desired. Also, all checks and documentation received are scanned and entered into Application Xtender.

The AR area sends MCCC a floppy disk of transaction data listing all the cash receipts to be keyed to the MMIS. MCCC keys the transactions as Reason Code 12. The disk is sent once a month.

Records of cash receipts processed by MIVS are uploaded directly to MMIS and are keyed as Reason Code 12's.

The AR area performs monthly reconciliations between the ARL and GAFRS.

10. Manage payment offset process to collect receivables

PI, TPL, and the BRMP area all generate requests for to establish a receivable (a provider's MMIS checks to be debited to satisfy the debt). The areas fill out a 1158 form and send it to AR. Providers may also contact AR directly.

If the 1158 form indicates the provider would like to be debited instead of forwarding a check, the AR area researches the provider's payment history in MMIS to determine whether the provider is usually paid enough for the offset to collect the desired amount. If so, the area forwards a 115 form to MCCC to be keyed into the MMIS. Providers may also contact AR directly to request their Medicaid payment be debited. The offset request must be sent to MCCC again each time a payment must be debited; for example, if a provider has asked for monthly debits, the AR area sends MCCC a monthly form requesting an offset. The AR area maintains a paper file of accounts requiring payment offset.

After MCCC enters the offsets (using Reason Code 19) and the debt has been offset, they send back a report to the AR area. AR enters the transactions into GAFRS.

The AR area would like to be able to enter these 115 offsets themselves (with a built-in management approval process) rather than sending them in hard copy to be keyed.

AR performs periodic reconciliations with PI and the TPL area to make sure money is being recouped properly.

The Check Pull process also involves a debit against a provider's MMIS payment, but in this case the check is pulled by MCCC after it has been produced.

The Weekly Check Pull List is a current listing of all providers whose checks need to be pulled for various reasons. Names highlighted on this list are those who are set to receive a payment for a particular week that must be held.

There are a number of reasons why a provider can be placed on the Check Pull List. The most common are for fraud investigation, failure to submit a cost report, receipt of a tax levy, and backup withholding. There are occasions where a special request is made by the program area or executive staff to have a provider's check pulled. A provider is not placed and/or removed from this list without notification in writing.



Providers who need to be added to the Check Pull List who are paid via EFT must be switched over to paper checks. Fiscal emails MCCS Provider Enrollment the provider's name and number. Once the provider is removed from the EFT file, he or she can be placed on the Check Pull List until a release notification is received. MCCS sends the pulled check to Fiscal. Fiscal holds the checks until the reason for the check pull is resolved –the provider submits cost reports, or the IRS receives updated information, for example. The Fiscal area will then release the checks. Held checks are cancelled through the regular check cancellation process after six months.

11. Develop and maintain cost allocation plans

The annual budget development process involves allocating funds to a variety of service lines and administrative sources. The weekly monitoring process involves reviewing the detailed MMIS payments compared against the Chart of Accounts in GAFRS to make sure there is sufficient money allocated to each fund to pay the week's warrants. Fiscal staff also monitor administrative expenditures using GAFRS reports. These processes are described in detail under **Manage State Funds**.

12. Manages draws on letters of credit

At the beginning of the state and federal Fiscal years, SCDHHS loads a borrowing limit into GAFRS that allows expenditures against federal grants.

Each week, after the MMIS-GAFRS interface, SCDHHS manages the weekly draws on letters of credit.

Data from GAFRS feeds Approach, a Lotus database used to summarize GAFRS data in a more accessible format ([see Approach system PC application for technical details](#)). The agency generates a report showing the week's expenditures against various federal grants.

Using the Approach report, a Fiscal worker keys data into the federal Payment Management System (PMS), an online system for reporting the use of federal funds. Expenditures are keyed by subaccount (grants may be split into several subaccounts) and amount. Reports from PMS are reconciled with the Approach reports each week.

After keying a draw into PMS, the Fiscal worker also enters the draw into GAFRS. The transaction is keyed as an ACH deposit; a Fiscal worker emails a report of the keyed transaction in PDF format to the State Treasury.

The federal government uses data from the PMS to transfer money via EFT to the State Treasury. The Treasurer uses the GAFRS report to match up the federal payment with the proper Medicaid account/transaction numbers.

13. Manages disbursement of federal administrative cost reimbursements to other entities

The process for drawing on federal funds is described under **Draw and Report FFP**. This process includes disbursement of funds to other entities/agencies as well as those used inside SCDHHS. All transfers of funds between state agencies are via IDT.



14. Respond to inquiries concerning accounting activities

The agency undergoes state and federal audits regularly. The Reconciliations area manages contact with auditors. The area acts as the single liaison, making requests to other Fiscal areas as needed to supply auditors with needed information. They also assist other parties – e.g., entities that are auditing providers or other agencies – with information requests.

Internal inquiries are dealt with by the appropriate department. External inquiries go through the public information officer, who contacts Fiscal as appropriate.

3.3.9.3. Designate Approved Services and Drug Formulary

Program staff make coverage decisions in different ways depending on the code type and program.

Decisions about coverage are tied closely with the **Manage Rate Setting** business process; the two processes often occur simultaneously.

Service and Supply Coverage

When new HCPCS, CPT, Surgical Codes and other codes are issued annually by CMS and other authorities, SCDHHS manually compiles the revisions and disseminates them internally to appropriate program staff. It is the responsibility of individual program areas within the agency to decide whether and how they will cover various products and services.

Program staff look to see whether codes are expansions or modifications of existing codes, and make coverage decisions accordingly. Because most program areas have limited medical staff, they usually base such decisions on existing coverage. Other decisions require consultation with the agency medical director or other medical staff.

Some programs also use data from the Thomson Reuters tools to understand the effects of approving certain services -- for example, they may run a report on the number of beneficiaries who received related services in the state last year. Program areas may also consult with the agency actuary to perform impact analysis on potential changes to coverage and rates.

Drug Coverage

- Pharmacy coverage:

SC Medicaid does not have a formulary. It has a Preferred Drug List. Drugs are grouped into classes; those coverage classes are laid out in the State Plan. Within those classes, SC Medicaid covers all drugs that are FDA-approved and meet OBRA'90 Drug Rebate Program guidelines. Certain drugs may require prior authorization; others may have guidelines for their use.

The agency's pharmacy contractor advises SCDHHS on the cost of new drugs as they come on the market. As part of a multi-state pool, the pharmacy contractor is able to negotiate special rates.



The Pharmacy & Therapeutics Committee, an independent body composed of physicians and pharmacists, advises the agency on drugs' clinical efficacy and safety.

Agency coverage decisions take into account both financial and medical advisories.

- Physicians/hospitals/infusion centers:

Drug coverage decisions for physicians, hospitals, and infusion centers, on the other hand, are more reactive. When new drugs enter the market but have not yet been given HCPCS codes or been approved or priced by South Carolina Medicaid, providers must contact their program area to request approval. (See **Authorize Service** under Physicians and Hospital Services for the section on unlisted codes.)

The agency's medical director reviews all such requests to determine medical effectiveness.

These new drugs are filed under "unlisted" codes on claims. When those drugs are eventually given HCPCS codes and a coverage decision must be made, program staff check to see whether the Medicaid program has been covering those drugs and how.

Staff may use MMIS reports to monitor usage of particular services. The physicians services area also maintains a spreadsheet to track drug authorizations – this log contains information on the diagnosis, treatment, beneficiary and prior authorization and can be used for later decisions on whether to cover particular codes. *The program area would like to automate the tracking of such authorizations, perhaps as part of a larger prior authorization system.*

When program staff approve newly listed drugs, they often place them on a two-year required prior authorization period so their usage can be periodically evaluated.

MCCS manually keys all code changes into the MMIS. Program staff write the changes on forms which are sent to the contractor for keying. Any corrections require more forms and manual updates. This process is described under **Maintain Benefits/Reference Information**.

This business process is inherently hectic, because all program areas must review code changes and make decisions at the same time when the new codes are released each September. *However, SCDHHS believes streamlined business processes or automation of code updates might make the process more efficient.*

3.3.9.4. Develop and Maintain Benefit Package

The federal government indicates the basics of what to include in the benefit package.



Legislators, lobbyists, and sometimes SCDHHS staff will recommend new benefits for inclusion in the benefit package. SCDHHS also meets with advocacy groups as requested, and those groups may also recommend additions or changes to the benefit package.

Once a request is received, the affected program area reviews the proposed benefit for budgetary impact. The program area may receive assistance from actuaries, the Fiscal area, or the Budget and Control Board to conduct the Fiscal analysis. The program area may also look to claims history and market-based rates.

New legislation or a CMS mandate requires SCDHHS to update their benefit package accordingly.

For smaller changes, authority rests with the Deputy Director for Medicaid Eligibility and Beneficiary Services. Large-scale changes require approval from the agency director or governor's office. When the program area approves the proposed benefit, they must determine the allowable units for the service, the scope of coverage, and eligibility criteria for the benefit. Program areas will consult other states that have similar programs (known as "sister states") for their level of coverage, as well as the State Employee Health Plan and Medicare.

A change to the benefit package often requires a change to the state plan (see **Maintain State Plan** for public input requirements and actual procedures for updating the State Plan.)

A change to the benefit package also usually requires a system change. The agency uses the Request for Change (RFC) process to complete these (see **Manage Program Information**).

Benefit package changes are communicated to providers via **Perform Provider Outreach** and to beneficiaries via **Perform Population and Member Outreach**.

3.3.9.5. Manage Rate Setting

A change in rate setting may be triggered by:

- Change in Federal rules/ or new legislation
- The Annual State Appropriations process with the General Assembly (allocates funds for specific rate increases and/or funds for maintenance of effort)
- Annual agency processes:
 - Annual updates for certain programs)
 - Appropriations process (occurs in the **Formulate Budget** business process and may occur in higher frequency)

SCDHHS uses different methods to determine rate setting. Actuaries that work with the agency use agency and/or provider generated data to develop capitated rates for various programs that are actuarially sound. They utilize the majority of SCDHHS reference files to run budget and rate analyses.



The BRMP determines the budgetary impact of a change in rate setting for institutional providers (hospitals, nursing homes, etc.) as well as non-institutional providers (e.g. RHCs, FQHCs, Home Health, etc.). This process is more difficult during a year with many changes in funding since budget changes may require multiple rate changes for one service in a given year. The bureau looks at cost reports submitted by providers as part of their evaluation in determining a change in rate setting. The bureau also uses Excel spreadsheets as a tool for many calculations in determining new rates. MARS reports such as the 14/140 are used as well during the rate setting process.

Currently, nursing home providers send their cost reports electronically. Other providers submit cost reports via hard copy. *Management in the BRMP would like to further automate this process to include electronic submission of all cost reports.*

A BMSM staff member works with program areas for rate changes relating to other provider types (physicians, lab, x-ray, ESRD). For services covered by Medicare, the Medicaid rate can be determined by taking a percentage of the Medicare rate. This is a common process to annual rate changes. SCDHHS calculates the rate change, and the changes are auto-loaded by Clemson (see **Maintain Benefits-Reference Information**).

Clemson initially loads the new rates into the test environment, and reports are generated for the affected program area to verify. Once they are verified, Clemson can move the rates into production.

Rates for services not covered by Medicare are set by the affected program area with the assistance of a worker in MSM and/or the BRMP. Spreadsheets are used for large-scale rate changes. The program area fills out either the spreadsheet or, for smaller updates, a rate change form/reference update sheet with the new rate.

Rate changes for contracted providers require the program area to send a rate change form/reference update sheet to the Division of Contracts and the administrative contractor, MCCS. For other provider types (physicians, lab, x-ray, ESRD), the program area sends the rate change form/reference update sheet or spreadsheet to the administrative contractor, MCCS.

MCCS keys the rate change (see **Maintain Benefits-Reference Information**). *This process is very manual. Adding any automation possible would improve this process.* A TAD is produced and returned to SCDHHS; it includes before and after screenshots to verify the change. The BRMP and/or the affected program area review the TAD to ensure accuracy of changes.

Currently, the MMIS only houses the current rate and its most recent predecessor. This can become a problem when there are multiple rate changes within the one-year timely filing limit. SCDHHS is in the process of maintaining a longer history of rate changes for services, which is planned for implementation in August 2009.

For institutional providers (hospital, nursing home, etc.), the public is notified of a rate change via public notice, which identifies changes to a rate and allows for a thirty day comment period from the public (including professional associations). After the comment period, a final public notice is issued. The final notice must be published at least thirty days prior to the effective date of the rate change (see **Maintain State Plan**).



Non-institutional providers also require the release of a public notice which details the rate change. However, there is no comment period required. The public notice must be published at least thirty days prior to the effective date of the rate change.

For MCOs and some other providers, no public notice is required prior to a rate change.

When a retroactive rate change is approved, the agency does a Mass Adjustment as described under **Apply Mass Adjustment**.

3.3.9.6. Formulate Budget

Each year, the South Carolina state legislature appropriates state funds for Medicaid and informs the agency of the allowed amount. The agency then produces a budget that matches the appropriated amount.

The state Fiscal year runs July 1 through June 30. The agency begins preparing a budget around April; it is usually approved around mid-June.

Within the agency, the budget generation process is primarily bottom-up rather than top-down. Individual program areas are asked to submit their budgets to their bureau chiefs, who submit them to the Fiscal area. Program staff request a particular amount based on estimates of their program expenditures for the next two years.

Projections at the Fiscal level are mostly made based on current expenditures and known program changes. There is little examination of eligibility trends, industry forecasts, or other such data.

The DSS/Data Warehouse (DW) does support some forecasting, and may be used by program areas to examine claim-related trends.

The Fiscal area, Fiscal Bureau Chief, and Deputy of Finance compile the budget data and present it to executive staff. The decision-making process requires assessment of agency goals, executive priorities at both the agency and governor level, etc.

Administrative funds are appropriated separately from funds for Medicaid services, but the processes are similar.

The final approved budget is sent to the agency by the Comptroller General's office and loaded to GAFRS by the Fiscal area. This official budget version is called the Chart of Accounts. It lists appropriated amounts by fund source.

The BD-100 is a form for modifying the chart of accounts should a change be needed during the Fiscal year (e.g., an increase in funding for a service). The chart can only be permanently modified by the legislature.

Besides GAFRS, Fiscal staff use Excel spreadsheets for most of their calculations and recordkeeping.



Outside of the annual budgeting process, legislative budget cuts may come at any time, requiring the agency to examine the existing budget and make adjustments. The agency follows the same executive decision-making process as for the annual budget development.

The agency is in the process of implementing a new financial system called SAP. It will replace GAFRS.

3.3.9.7. Manage FFP for MMIS

SCDHHS receives federal assistance for the maintenance and performance of the MMIS and any administrative costs associated (staffing, contractual assistance/procurements, etc.).

When CMS approves an APD, the associated FFP rates are also approved. Different rates apply to different phases of an APD. Implementation costs from an APD process are funded 90/10. Skilled professional services are funded at 75/25. Regular administration services are funded at the normal matching rate, 50/50. Like the Medicaid services side, some administrative services may be 100% federally reimbursed. The Bureau of Federal Contracts works with the Fiscal area to manage FFP rates for an APD or contract.

MMIS only tracks service/claim related payments; GAFRS receives these related payments via interface and track all other related costs for FFP reporting and other purposes. In GAFRS, a PCA is associated with each FFP rate or federal funding type

The Fiscal area allocates each administrative cost – contractor invoices, procurements, etc. -- into PCAs. For example, one invoice may need to be allocated into several different PCAs because it may contain both implementation costs and operating costs, or administrative services for several different federal programs with different match rates.

The Fiscal area and program areas communicate about changes that may impact the administration of the MMIS. A variety of factors (upcoming APDs, procurements, legislation, etc.) impact federal assistance for the MMIS. Communication is initiated by the program side of the agency since the changes directly affect the administration of a particular program.

Both the Program and Fiscal areas are responsible for monitoring costs associated with maintenance of the MMIS. The APD includes a proposed budget and cost allocation, which aids both parties in monitoring expenditures. The Fiscal area will contact a program area if overspending is discovered and work with the program area to re-allocate funds to cover the incurred expenses.

The program area may make changes that have Fiscal impact. These changes or modifications are communicated to the Fiscal area.

The Fiscal area determines the FMAP information needing to be included in GAFRS. The loading of the data occurs in the **Manage FFP for Services** business process.

3.3.9.8. Draw and Report FFP



The Fiscal area must submit a CMS-37 report in order to secure a grant from CMS for the next quarter. The CMS-37 report is the initial process by which the Fiscal area can estimate need for the upcoming quarter. Information for the CMS-37 report is compiled in the middle month of a quarter for the following quarter. The Fiscal area reviews the grant request before sending the CMS-37 report electronically via MBES to CMS. The SCDHHS budget also includes any monies received from a collections process, etc. All SCDHHS funds are netted together prior to drawing funds needed from the federal government.

Once the request is reviewed and approved by CMS, SCDHHS will receive a grant award from CMS. Federal authorization is applied to the Department of Payment Management System (DPMS).

Funds from the U.S. Treasury system go to the State Treasury system and are then passed to SCDHHS weekly via the DPMS based on expenditure requests for the federal share. The draw of funds occurs on Wednesday mornings, and the funds are paid via check or Electronic Funds Transfer (EFT) Friday of the same week in accordance with the Cash Management Improvement Act. The CMS-64 and CMS-21 reports are submitted to CMS via MBES quarterly through the **Manage FFP for MMIS** business process.

CMS performs quarterly reconciliation to the original budget and the final expenditure report (CMS-64). If the final report indicates that more funds were spent than the original grant request, CMS will award additional money to SCDHHS. If the original awarded funds were not all spent, CMS will initiate an action to reduce a subsequent award.

SCDHHS undergoes a standard review via a CMS audit. The CMS-64 preparation and supporting documentation to validate the CMS-64 are part of the auditing process. A CMS auditor comes on-site twice a year to SCDHHS. During the other two quarters, a desk review is performed. SCDHHS provides supporting dates and expenditures claims when requested to the auditor.

A state audit is also done annually. Certain state programs, including the Medicaid program, are reviewed then.

A state auditor issues an audit report, which may identify an inconsistency. The Fiscal area responds to the auditor's request and gives further explanation, makes an adjustment, etc. When the auditor returns the following year, the audit report is followed up on. Once the auditor confirms that the issue was taken care of, the audit report is closed for review. The Fiscal area maintains documentation that supports the auditing process. Specific program areas also keep documentation to manage the auditing process.

3.3.9.9. Manage FFP for Services

Different services have different FMAP rates. Most hospital, nursing home, and general provider services are set at the standard FMAP rate (Currently 70.07/29.93). Services under SCHIP and the Breast and Cervical Cancer program are funded by the enhanced FMAP rate (Currently 79.05/20.95). Services under capitated programs are funded 75/25. Family planning reimbursements are funded 90/10. Some services like those under the Qualified Individual (QI)



program are 100% federally funded. Depending on the poverty level, other services may also be 100% federally funded.

The Fiscal area coordinates with Clemson to determine the FMAP information needing to be loaded into the MMIS. An RCF is used to communicate changes. Clemson is responsible for loading the changes.

FMAP rates are assigned to services or claims in the MMIS by fund codes. Fund codes identify the FMAP rates that should be processed for a claim. Within the MMIS, fund codes are triggered by an identity or definition associated with a particular service – it could be a particular provider type, procedure code, or other trigger. The fund code determines the state and federal splits for that particular service or claim.

Weekly payment data generated in the MMIS is sent to GAFRS via a weekly interface. The splits determined in the MMIS are sent to GAFRS in a summary format. GAFRS generates various expenditure reports (identifies the amount of funds to draw, etc.) based on the data received. One report shows the Fiscal area how to categorize expenditures to ensure that services are reported on the correct service line on CMS-64.

Reporting of waivers and certain programs (SCHIP, BCCP) is currently a very manual process. The interface to the MMIS doesn't determine the split. A "journal entry" is made in GAFRS for the manual split and posted back in. The only journal entry that is necessary is for Breast and Cervical Cancer. The journal entry reverses the expenditures that split at the regular FMAP rate and post the expenditures to a PCA that is setup in GAFRS at the enhanced FMAP rate. A unique fund code is created at that particular rate. PCAs that are setup in GAFRS for Breast and Cervical Cancer split at the enhanced FMAP rate do not use unique fund codes. Once Fiscal makes its transition to SAP, it is desired to improve the reporting and interface from the MMIS. Currently, an RFC has been released for such improvements.

In GAFRS, the percentages for the service splits are assigned to program cost accounts (PCA) created by the Fiscal area. Service expenditure percentages are 90/10 for Family Planning, currently 70.07/29.93 for regular services and currently 79.05/20.95 for SCHIP and Breast and Cervical Cancer. Qualifying Individuals and Indian Health Service facilities are the only service expenditures at 100% federal participation. Administrative expenditures are also applied to PCAs (they are not tied to fund codes, which are used only in MMIS). The rates for administrative expenditures are 90/10, 75/25, and 50/50. Administrative expenditures for SCHIP are at the enhanced FMAP rate, which is 79.05/20.95. A PCA indicates the source of the funds. Multiple PCAs are often associated with a single service, APD, or contract.

The Fiscal area monitors expenditure data with the aid of weekly, monthly, and ad hoc reports produced by GAFRS. Potential program area changes and upcoming APDs, procurements and/or contracts impact Fiscal planning for the following year. Communication concerning changes to programs is driven by the program area, and the Fiscal area has the financial responsibility to reflect changes in their projections and planning. If there are changes to existing programs or new programs added, Fiscal staff is notified by the program staff. The application for the new program and the CMS approval letter are forwarded to Fiscal staff for the proper setup and reporting of those expenditures.



The Fiscal area submits reports to CMS electronically via the Medicaid Budget and Expenditure System (MBES). An electronic template is provided to input data by service lines for the CMS-64 form. The Fiscal area uses the fund splits and other data necessary to the form pulled from various reports generated by GAFRS. Once all the information is confirmed to be correct and accurate, the document is signed and sent to CMS. The electronic version only lists the name and title of the person who certified the report. A hard copy of this report contains a signature and is kept by the Fiscal area for auditing purposes.

3.3.9.10. Manage F-MAP

If there are changes to existing programs or new programs added, program staff notifies the Bureau of Fiscal Affairs. The application for the new program and the CMS approval letter are forwarded to Fiscal staff for the proper setup and reporting of those expenditures. The changes may be a result of a grant award, new legislative actions, or other conditions.

The standard FMAP rate is calculated annually by the Office of the Secretary, DHHS. The Office of the Secretary publishes the FMAP rate in the Federal Register. The current FMAP rate is 70.07/29.93.

The enhanced FMAP rate is also calculated annually and reported in the Federal Register by the Office of the Secretary, DHHS. The current enhanced FMAP rate is 79.05/20.95.

Fiscal staff establish program cost accounts and budget unit codes for new programs and will assign the appropriate funding levels. In GAFRS, the percentages for the service splits are assigned to PCAs created by the Fiscal area. A PCA indicates the source of the funds. Multiple PCAs are often associated with a single service, APD, or contract.

Fiscal staff enter the FMAP rates into GAFRS into the PCA table. Any changes to the rates can be entered directly into the PCA, but since the Fiscal area has so many PCAs, that process leaves room for human error. Rates are updated each October by loading the current PCA table loaded into the GAFRS test system. Fiscal staff have a JCL that is run to make the changes. When the changes have been completed, the PCA table with the new rates is loaded back into the GAFRS production system.

To update the MMIS with new FMAP and SCHIP rates, Fiscal staff notifies Clemson to make the changes in the MMIS.

3.3.9.11. Manage State Funds

Manage state funds for Medicaid service budget

Throughout the year, with each payment cycle, agency Fiscal staff must make sure funds are flowing out of the appropriate accounts and categories.

The Chart of Accounts maintained in GAFRS is the official appropriated budget for the year. GAFRS interfaces with MMIS weekly to obtain payment data.



The MMIS does not maintain details on the source of funds; it only identifies the state and federal percentages (70.07/29.93, 90/10, etc.). Particular fund codes are associated with each MMIS payment – these fund codes could be tied to provider number, procedure code, or other factors. When MMIS passes weekly payment information to GAFRS, the fund codes act as a signal to GAFRS as to which specific fund to draw down. The MMIS also passes a task code, the amounts, a state/federal indicator, and a reason code (e.g., void, debit, etc.). GAFRS splits payments into the appropriate categories (earmarks, grants, other state agencies, restricted funds, etc.) and summarizes the data so funds are drawn from the proper sources.

Fiscal staff monitor the process using GAFRS reports or error messages. Each Tuesday morning, after GAFRS processes the weekly MMIS data, the staff review the reports and alerts to make sure there is sufficient money appropriated to each fund to fund the week's MMIS payments. Staff make appropriation transfers (manual "journal entries") in GAFRS to adjust the source of funds, if necessary.

On Wednesdays, the Fiscal area prepares a voucher and sends it to the state Comptroller General's office. In return, that office sends a check to deposit funds for the week's payment cycle into the Medicaid zero balance account. All adjustment to fund sourcing must be finished on Tuesdays so this exchange can occur on time and MMIS checks will not bounce. The weekly payment cycle will be explained in detail under other business processes.

The voucher sent to the Comptroller General is split by budget unit codes unique to each service type (e.g., hospice, lab and X-ray, inpatient hospital, etc.). The CG makes this data publicly accessible, providing an up-to-date picture of how Medicaid funds are being used.

Fiscal staff send monthly reports to program areas to help them monitor the use of state funds. They hold quarterly meetings to discuss their expenditures and budget.

The Fiscal area also prepares a monthly budget briefing for the legislature that shows expenditure data and comparisons to other years, etc.

In general, MMIS/GAFRS would be more useful if they had more robust indicators as to the source of funds, and more automated splitting of payments from those funds. For example, payments under waiver programs and some other types of interagency agreements require manual adjustment in GAFRS.

The agency is in the process of implementing a new financial system called SAP. It will replace GAFRS.

Manage state funds for administrative budget

SCDHHS receives the Chart of Accounts from the Comptroller General's Office with our annual Appropriations by Mini Code (Budget Unit Code). The Medicaid Finance and Accounting Operations departments prepare an AFI file and send it to the Financial Systems department for loading Appropriations into GAFRS. Appropriations are loaded into GAFRS by Mini Code, Fund and Expenditure Object codes 1100 and 1201.

Based on the approved funding levels, allotments are developed for each Bureau/Division. The information is entered into EXCEL spreadsheets and must be approved by executive staff. When



allotments are approved by executive staff, Accounting Operations prepares an AFI file to send to Financial Systems for loading into GAFRS. This is both a manual and electronic process handled through EXCEL, ACCESS, FTP and GAFRS. Allotments are loaded for Other Operating and Salary by Index, PCA and Expenditure Object.

After Appropriations and Allotments are loaded into GAFRS, beginning cash balances for state 1001 funds are loaded into our Grants. This is done by taking the total amounts allocated by Mini Code and allocating it to each Grant based on the previous year's expenditures. Borrowing limits for Federal funds are loaded into GAFRS. This is both a manual and electronic process handled through EXCEL, ACCESS, FTP and GAFRS.

State Restricted and Earmarked funds are monitored within the Department of Financial Systems.

SCDHHS has a TPL contractor that receives refund payments from insurance companies and providers. Another SCDHHS contractor receives refund checks from pharmaceutical companies. These contractors deposit these monies into a Lock Box account at Wachovia Bank. The State Treasurer's Office sweeps that account daily and posts these funds to J02 (DHHS). Each night, the Comptroller General's office sweeps the State Treasurer's Office for transactions completed by DHHS. A Revenue Interface is conducted (based on specific criteria we established for the interface) to post funds into GAFRS. The following morning, the batch is available in GAFRS for Financial Systems staff to release, activate and post.

All financial reports are generated in GAFRS. They are created daily, weekly, monthly, quarterly, annually, and ad-hoc, and are available for viewing electronically in D:D. The primary reports used for monitoring cash, appropriations, allotments, etc., are as follows:

DAFR9424 - Appropriation Summary Status Report; DAFR9427 - Program Structure Appropriation Summary Status Report; DAFR 9428 - GAFRS Financial Data Summary Analysis Report; DAFR 9053 - Allotment Detail by Selected Expend Object & BUC Report; DAFR 9213 - Summary Pre-Encumbrance/Encumbrance Status Report; DAFR 9110 - Statement of Cash By Fund Report; DAFR 9001 - Compare Appn Authorized to Allot Issued by Fund

3.3.9.12. Develop Agency Goals and Objectives

SCDHHS has a strategic plan called the "South Carolina Health Connections Medicaid Transformation Plan," which guides the agency in goal and objective setting to achieve the plan's vision. Currently, SCDHHS is writing an RFP to hire someone to assist the agency in developing a revised strategic plan in considering new initiatives like MITA and HIT use.

The agency does not have a specific area or department dedicated to planning, so setting of goals and objectives often occurs on an ad hoc basis. However, the following may trigger a need to develop a goal or objective:

- Transition to a new agency director
- Notification of a state or federal mandate
- Federal requirement (HIPAA 5010, ICD-10, DRG updates, SCEIS)



The agency holds monthly bureau chief meetings, which are attended by the agency director, deputy directors, bureau chiefs, Public Information Office staff, and other staff as needed. Depending on current agency projects, the focus of these meetings varies. Participants in current projects will report on progress and new information. Any new ideas presented lead to follow-up with affected staff. “GO sheets” (also known as goals and objectives sheets) are sometimes used to propose new ideas. However, in recent years, the agency has taken a reactive role and responds to national changes and current events that impact the Medicaid program.

3.3.9.13. Develop and Maintain Program Policy

The process of developing and maintaining program policy differs depending on the magnitude of the affected group. Some policy changes may be minor and affect SCDHHS at the staff level in a particular program area. Other policy changes may have agency-wide impact and be expensive to implement.

Regardless of the scope of the change, bureau chiefs drive the analysis of policy changes and must approve all such changes. For major changes, the bureau chief will seek approval from the agency director.

A policy change is submitted using a variety of methods (e.g., may come from a provider, program representative, legislator, etc.). The affected people meet to analyze the policy change. Inclusion for the meetings is based on past history and shared knowledge on who the change affects. Often, the medical director also provides input. Advisory boards like DME and transportation offer feedback about the policy change.

Informal public education sessions may also be held for input from stakeholders.

The program area will research other states’ approaches to similar program policy and review best practices or recommended best practices by professional agencies.

Depending on the change, SCDHHS may issue a Medicaid bulletin or revise a provider manual (see **Perform Provider Outreach**). Some policy changes require renegotiating or amending a contract or creating a new contract (see **Award Contract, Manage Contract, Establish Business Relationship, Manage Business Relationship**). Internal changes may require revision of policy manuals, staff training, or other internal communications.

Policy changes that affect fee-for-service Medicaid also require consultation with actuaries to determine the effect on Managed Care and capitated reimbursement rates (see **Manage Rate Setting**).

3.3.9.14. Maintain State Plan

Like all states, South Carolina maintains a CMS-approved State Plan outlining its Medicaid programs and coverage.



The master version of the State Plan is a hard copy kept in a secure, locked area with limited access. Electronic (.doc) versions of the plan are organized into folders and kept on a shared network drive; one designated staff member (referred to in this document as the State Plan administrator) makes all required changes to the electronic documents. Obsolete versions of the State Plan are maintained in hard copy format for audit and public information purposes.

The document is not currently publicly available in electronic form, but it is available to SCDHHS employees via the agency intranet. CMS plans to post State Plans to its website, but has not yet done so. State libraries and other public institutions in South Carolina maintain updated hard copies of the plan.

The agency modifies the South Carolina State Plan in response to a variety of triggers:

- State budget reductions or increases
- New state and federal laws
- Agency goals
- Provider or beneficiary requests
- Regular updates (e.g., annual revised blood deductible rates for hospitals)

State Plan revisions may originate with program staff, reimbursement staff, executive management, legal staff, or other areas. The affected program area drafts the changes to the State Plan. Depending on the change, the agency may determine the impact by generating and reviewing reports, and talking with provider associations and other stakeholders.

Program staff and reimbursement staff calculate the Fiscal impact of the proposed modification, including the change in federal dollars for the current and future federal Fiscal years.

Once the modification is drafted, it is circulated internally for discussion and revision.

The Medical Care Advisory Committee (MCAC) is presented, as information, updates to the State Plan that may impact policy. Agency staff may also meet with provider associations to discuss the change.

Executive staff, legal staff, and the bureau chief and division director of the affected program area must sign off on the proposed change.

The State Plan administrator places a public notice in the three leading newspapers in the state, and sends a notice to Eligibility to send to the SCDHHS county offices prior to the effective date of the changes to the State Plan. This notice must be available in the county offices for public review for thirty days. At the end of the thirty day review period, this document must be retained as a permanent record in their office. For reimbursement changes affecting institutional providers, the program area releases a proposed public notice with a 30 day comment period; the final notice must be published at least one day before the effective date.

The proposed change is accompanied by the HCFA-179, a required document recording details about the change and its impact on federal funds. The State Plan administrator is responsible for completing the form and compiling all information to send to CMS.



The State Plan administrator then sends the draft modification as an email attachment to CMS' eSPA web portal, which generates an automated response. CMS sends a State Plan Amendment Review Sheet specifying who at CMS will work on the amendment. CMS has 90 days to approve, disapprove or send a letter to request additional information (RAI) from the state. Once the RAI is sent, the 90 day clock stops, and the state has additional time to make changes in the plan or to answer CMS's questions. Various SCDHHS staff respond to questions from CMS depending on the type of questions. Once the RAI has been returned to CMS a new 90 day clock will start on the eSPA.

If CMS approves the amendment, it sends an approval letter and the final approved wording of the amendment. The SCDHHS State Plan administrator updates the master hard copy document and any electronic versions. The administrator also sends the hard copy amendment to a distribution list of affected staff, other state agencies and libraries, legal staff, and others.

SCDHHS notifies providers and beneficiaries of relevant State Plan changes through the **Perform Provider Outreach** and **Perform Population and Member Outreach** business processes.

3.3.9.15. Generate Financial and Program Analysis Report

Much of the agency's program analysis information comes from the Thomson Reuters suite of tools. These capabilities are explained in great detail under the **Manage Program Information** business process.

Financial and program analysis reports are generated using GAFRS. Both preset reports and ad hoc reports are available. Using the Reports tab, a worker will select criteria for a report – period, sorting, fields, etc. Reports are archived by date, type, and frequency in Document Direct. Reports can be viewed on screen, printed, or downloaded to Excel.

A representative GAFRS financial report might be broken out by budget unit code – that is, by the individual service line – with the appropriated amount, the year-to-date expenditures, and the percentage of the Fiscal year that has elapsed for each line. This way, trends can be compared against the budget.

Fiscal staff generate monthly GAFRS reports for program areas to track their administrative and service line expenditures against the year's allocations. The Fiscal area generates reports for legislators, the governor's office, and other state government entities to track Medicaid spending. They generate internal reports to track cash and allocated amounts to ensure sufficient funds are available for provider payments and other accounts payable; this process is described under **Manage State Funds**.

3.3.9.16. Maintain Benefits-Reference Information

Once program areas and/or the Bureau of Medicaid Systems Management perform the **Manage Rate Setting, Develop and Maintain Benefit Package, or Designate Approved Services or Drug Formulary** business process, the changes are entered into the MMIS in one of two ways.



Some updates can be loaded en masse by Clemson – for example, annual rate changes where there are corresponding Medicare rates of which a Medicaid percentage can be calculated. Clemson initially loads the new rates into the MMIS test environment, and reports are generated for the affected program area to verify. Once they are verified, Clemson moves the rates into production.

Other updates to codes, rates, or other reference file data are keyed by MCCA, the agency's administrative contractor. The program area fills out either a spreadsheet or, for smaller updates, a reference update sheet with the new rate and sends the sheet to MCCA.

MCCA keys the update directly into the MMIS production environment. A TAD is produced, and MCCA returns it to SCDHHS; it includes before and after screenshots verifying the change. The BRMP and/or the affected program area reviews the TAD to ensure the accuracy of the changes. If the TAD contains errors, the reviewer marks corrections directly on the TAD and returns it to MCCA for re-keying.

The manual keying of updates is laborious and prone to error. More automation of updates would help speed the process.

Some rates or reference type information may be hard coded in a program and require a system modification through the RFC process (see **Manage Program Information**).

3.3.9.17. Manage Program Information

Data Stores

The MMIS and MEDS systems serve as SCDHHS' core databases: MEDS houses member eligibility data and MMIS houses provider and program data and processes claims. SCDHHS contracts with a Decision Support Contractor for data-mining and investigative tools that provide analysis reporting and decision support capabilities to various SCDHHS areas ([see Thomson Reuters interface for technical details](#)).

SCDHHS would like to greatly expand the capabilities of the MMIS. It would like to expand from the current space limitations as some reports are at their maximum size. Fields are being reused instead of adding to the end of a record. They would also like to have an expanded fund code field to eliminate the use of special characters (the use of special characters does not transfer well to interfaces with contractors).

In addition to basic provider information and complete claims history for the past seven years, all reported encounter data is housed in the DS contractor tools including care management, MCO, and transportation data. In the near future, SCDHHS will request to include voided and denied encounter data.

Program policies are not loaded into any data store. A comprehensive history of program policy changes that may or may not have resulted in system changes could be found by reviewing the Medicaid Provider Bulletins (see **Perform Provider Outreach** for further information on bulletins).



Creating and Modifying Data Elements

To add, change, or delete data elements, the agency utilizes the RFC process. Normally, the addition of a new program (like the transition to NPI) will trigger the need for an RFC. Once the RFC process is submitted, analyzed, changed, and validated, Clemson will make the modifications to the MMIS. The following details the RFC process:

1. Request for Production or Project Support:

Requests are submitted via the online RFC form found in the Wiki section and via email to the Project Management Office in the BMSM. The requestor (usually a program area representative) enters information into the form regarding the scope, requirements, and benefits of the request, as well as the consequence if not completed. Production Support requests (like a change/addition/deletion of a data element) are coordinated with Clemson by BMSM. Projects require Change Control Board (CCB) review and approval.

The requestor will respond to a set of standard questions that functions as a check list to ensure all aspects of the request have been addressed.

2. Internal Review of the Request

After requirements have been gathered from the program area, an internal SCDDHS design team will meet to perform a high-level review. Possible solutions are examined, and alternatives are evaluated.

3. Presentation of Request to the Technical Review Committee (TRC)

The program area makes the presentation to TRC, which includes a project description, a brief business case review, the number of stakeholders impacted and any known resource requirements. Prior to the meeting, Clemson receives information concerning the request. Meeting minutes are also sent to Clemson.

4. Request Preliminary Level of Effort (LOE) by Clemson

Clemson then reviews the requirements in order to provide a preliminary level of effort (LOE). Clemson may request a meeting and/or more information from the program area to ensure accuracy of the LOE.

5. Presentation to CCB

The program area presents the request to the CCB, which includes a project description, a detailed business case, an analysis of stakeholders impacted, compliance with MITA, and consequences if not completed. If insufficient information is presented, the meeting with the CCB will be rescheduled.

6. Review Process of CCB

The CCB is comprised of SCDHHS executive management. Requests are reviewed based upon predefined criteria. The CCB also defines the content/format for all requests-whether



originating from the program area, TRC, and/or Clemson. Members of the CCB (or alternates) vote to approve, defer, or reject the request.

7. Adding a Request to the Monthly Calendar

The CCB determines if the request has high, medium, or low priority:

- Medium and low priority projects will be scheduled for a future “lock down” period. BMSM staff determine the implementation date after completion of business requirements and detail design documents.
- A high priority project should be reviewed to determine if it will replace another project in current “lock down” period or can be scheduled for a future period (complexity and completeness of business requirements must be considered). Involved parties must sign-off on the established schedule to affirm commitment to the date.

8. Review of Monthly Calendar

The CCB monitors the calendar for requests completed on schedule or completed late (and reasons). Any change to an implementation date and supporting reason is reported to the CCB.

9. Business Requirements Document

Upon approval of a request by the CCB, BMSM and the program area will complete the business requirements document. This document may be completed through a series of meetings, a JAD session to possibility include participation by Clemson depending on the complexity of the request.

10. Detail Design Document

Upon completion of the business requirements, Clemson, the program area, and BMSM will develop a detail design document for each request. The detail design document must be approved by the program area and BMSM prior to Clemson beginning system development. Once sign-off has occurred, any change to the business requirements must go through a Change Control process.

11. Final LOE and Sign-Off by All Parties

Clemson finalizes the LOE, and an implementation date determined. Once an implementation date has been established, the program area will have a maximum of five business days to respond to questions concerning business requirements. After that time, the implementation date may be extended on a day-for-day basis.

12. Monitoring System Development

Once Clemson begins system development, the Project Management Office in BMSM will monitor the project in an effort to keep on schedule. Updates will be provided to the program area on a weekly basis via the Monthly Calendar.

13. Quality Assurance



Once system development has been completed, Clemson and an analyst assigned by BMSM will conduct testing to ensure programming changes meet the requirements specified in the business requirements and detail design documents. Test cases with pre-defined results will be used to test the quality and accuracy of the programming changes.

14. User Acceptance Testing

Once QA is complete, the program area will assign qualified staff to participate in user acceptance testing. This will involve developing test scenarios, entering data into the test system and comparing test to pre-defined results. Once successful, the program area must provide sign-off in order to move the programming changes to production.

15. Documentation and Lessons Learned

Once the request is moved to production, all documentation will be completed and, if designated as a “large” project, a lessons-learned session will be scheduled with the program area, Clemson and BMSM.

There is also a change control process with the DS contractor for scheduling when things will be loaded and available for use in the tools. The majority of the new DS contractor releases are derived from MMIS data. Changes to an existing value are included in the monthly update. An addition of a new value would be held for a build/release on an as needed basis. Thomson Reuters sends out user alerts that notify users of changes, new fields, etc.

Reporting

The Office of Reporting, Research, and Special Projects works with many SCDHHS areas to assist with reporting needs to assess program needs, potential changes, and future plans.

The request for a new report is directed to the DS contractor tools via the Office of Reporting, Research, and Special Projects rather than running the job through the MMIS or MEDS. The DS contractor tools feature significantly more advanced analytical reporting capabilities than the MMIS or MEDS. In some cases, it may take days of programming to extract the same information from the MMIS while the DS contractor tools complete the job in under an hour. However, if a request came in for something like adding or modifying standard agency reports, such as the RSS (Eligibility) and CCA (Financial and Utilization) report, the requests are coordinated with Clemson through the RFC process. The standard reports such as the RSS and CCA reports are automatically generated from MMIS on a monthly basis and located in Document Direct. Overall, the abilities of the DS contractor tools minimize the number of requests sent to MMIS or MEDS.

The DS contractor tools have capabilities for automated reports, which reduce the creation of manual reports. The Office of Reporting, Research and Special Projects has worked with the DS contractor in developing their 4.0 version (to be released) to include additional “built-in” reports for program staff use.



If a new report is requested, a worker within the Office of Reporting, Research and Special Projects will work with the requestor via meetings and/or email to understand the type of report they're looking for. A form was created to request an ad hoc report, but this form is not utilized for requests. Typically, the request comes to the office via telephone or email. If the report is going to be recurring, it will be added to the office's report schedule, which consists of an excel spreadsheet currently.

Various SCDHHS staff have been trained to use the decision support tool (part of Advantage Suite). Access is through the Thomson web-portal with a secure log-in. A user must enter his pin number, user id, and password. A user can create a report and save it in his folder to be accessed by another user. Information generated into a report can be exported to Excel, if it doesn't exceed space limitations.

Voluntary monthly training sessions on the reporting tools are open to program staff, which are conducted by the Office of Reporting, Research, and Special Projects. The training sessions cover information like common mistakes and features of the decision support tool. Currently, SCDHHS divisions' usage of the tools varies greatly. It is hoped that when the new version is released by the DS contractor that it will encourage more use as more standards reports have been built into the version. Program staff only needs to insert data parameters in order to run the pre-built reports.

DataProbe (also part of Advantage Suite) works with raw data, requiring a higher skill level including technical and programming knowledge. For example, the Division of Program Integrity uses this tool as an investigative measure for testing and developing fraud algorithms. The developed algorithms are used in the **Identify Candidate Case** business process to flag potential cases of fraud and/or abuse.

Net Effect (part of the DS contractor package) is a high-level executive reporting tool. The tool is used for high-level overviews and is not used for in-depth reporting. This tool is not utilized very much in its current form as there are established monthly reports through the Advantage Suite that monitor monthly trends and executive staff depend on ORRSP to provide this information.

Common reports requested include:

- Monthly monitoring reports
- Fund code activity
- Percent of Medicaid population that has X service/condition/etc.
- Eligibility reports
- Annual reports:
 - Trend utilization
 - Percent increases
 - State agency versus Medicaid usage
 - Birth history

The Office of Reporting, Research and Special Projects (and sometimes in conjunction with the Fiscal staff) will pull reports based on audit requests, legislative inquiries or other formal information requests. BMSM also has the ability to pull data straight out of the MMIS to



compare to information generated via Thomson tools. Further information concerning auditing inquiries is located in the **Perform Accounting Functions** business process.

The Office of Research and Statistics (ORS) of the South Carolina Budget and Control Board Reports also fulfills report requests from the agency ([see South Carolina Budget and Control Board-ORS interface for technical details](#)). The office supports ad hoc report requests for Medicaid statistics for state agencies.

Versioning

The DS contractor puts out releases and sends email updates to users concerning recent changes. The DS contractor moves to a mirror/replica site when doing their monthly load of changes. Usually, the system is available at all times during the workweek; the exception is scheduled weekend maintenance.

Access to Records

SCDHHS requires the use of a TPA for anyone outside of agency to have access (typically, that is viewing capability of information) of the MMIS. The specific conditions within the TPA are established in the **Business Relationship Management** business area.

The MMIS and MEDS keep all records and archive electronically. The DS contractor has seven years of basic provider data and complete claims history available. All three databases exceed state and federal record retention requirements.

All data is secured and accessible by anyone that is using the system or receiving data through a TPA with a user ID and password.

Program Quality Management Measures

The DS contractor tools have the ability to do HEDIS-like measures, though they are not HEDIS-certified. SCDHHS did not elect to purchase the HEDIS capabilities from the DS contractor.

3.3.9.18. Develop and Manage Performance Measures and Reporting

Developing and Managing Contract Performance Measures and Reporting

The written contract dictates what is monitored such as the deliverables that are in or implied within the contract. However, vague language in a contract may lead to additional monitoring measures. These are handled on a case-by-case basis and require collaboration between the contract monitor (within the Bureau of Federal Contracts) and the affected program area(s).

If the RFP did not include performance measures, the contract monitor will work from the proposal submitted and develop a format for reporting that is agreed upon between the agency and contractor.

Some requirements are not spelled out in RFP as a performance measure, but the contractor is still required to perform those requirements (e.g. Is the contractor taking calls?).



Contract monitors would like to improve the process of preparing a contract to include enough details in the contract and up-front involvement with everyone that needs to be included, so that upon award, the contract has definitive measures to monitor and track performance. The contract needs to stipulate specific deliverables, appropriately numbered, for every contract expectation. Some deliverables have been standardized, which is indicated on the contract tracking template (an excel spreadsheet), but the bureau would like to continue to work toward further consistency.

Ad hoc reporting also occurs as an informal process that is driven by need, lack of clarity of requirements, or lack of data. The contract monitor and program area will determine what reporting will assist in the monitoring process. The contract monitor and program will meet formally and informally, depending on the situation. The meeting can function as a JAD session or an informal requirements gathering session. If there is MMIS or MEDS impact, the contract monitor and program area will have to use the formal RFC process (see **Manage Program Information**).

When performance reporting needs changed for a contract, the contract is amended. This may occur during a renewal phase of a contract, internal preparation for the release of RFP, or even during a contract phase. The program area determines the necessary contract change and will work with the Contracts area and Office of General Counsel to adjust the written contract (see **Manage Contract**).

Developing and Managing Employee Performance Measures and Reporting

SCDHHS uses a third-party system known as EPMS, which aids in applying the criteria defined by an employee's position. Four or five main job duties of an employee serve as the performance measures that an employee's work is compared against.

Developing and Managing Stakeholder Satisfaction and Performance

SCDHHS would like to identify ways to conduct formal satisfaction surveys and performance monitoring. Currently, the provider outreach contractor measures stakeholder satisfaction for provider training classes and use of the EDI Support Center. The contractor utilizes a hard copy evaluation form for providers who have attended a training class. The EDI support center mails hard copy survey forms to providers that are selected from the Access database that holds provider contact information.

3.3.9.19. Monitor Performance and Business Activity

Monitoring Contract Performance and Activity

The Bureau Chief of the Bureau of Federal Contracts decides which contracts are monitored within the bureau. Typically, larger contracts that are more expensive and involved like the transportation or dental contract are monitored within the bureau by contract monitors. The program area associated with a contract monitors other smaller contracts. With additional resources, the bureau would be able to monitor more, if not all, contracts.



In addition to monitoring the deliverables of a contract, performance incentives, etc., the monitor's duties extend to more of a program manager for the contracts.

The monitor uses a contract tracking template (Excel spreadsheet), which contains information on deliverables, responsible parties, performance measures, damages, an issues template, and anything else from the RFP. This is filled out as the contractor sends deliverables and other actions occur that affect the contract. One monitor uses the issues template as a way to build requirements for a future contract. Another monitor documents these issues separately. The bureau is currently working to streamline this process to have consistent reporting.

Formal meetings are scheduled between vendors/contracts and SCDHHS as a form of monitoring. These meetings are part of the periodic, regular communications for contract monitoring.

The monitor conducts on-site monitoring for a contract. On-site visits range from multiple visits in one month to quarterly, depending on the needs of the contract. The monitor uses a review plan document (developed in MS Word by the monitor) for this monitoring to track contract requirements noted during the visit via checklists.

Contract documents and any monitoring documents are on a shared drive only accessible to staff of the Bureau of Federal Contracts. Other shared drives store documents utilized by staff of the Bureau of Federal Contracts and program areas. There is no formal notification process when a document is updated with day-to-day information. If there is a total update—such as a rate update or changing basic algorithms—the Bureau Chief, Division Directors, and Senior program manager will be notified that the document has changed.

Several areas within the agency (from Executive management to program staff) read information from monitoring a contract's performance. However, the monitor and program area review the actual reports. Sometimes, the Office of General Counsel will also review information.

Contracts may also be monitored by outside auditors. Contract boilerplate says that any state or federal agency can monitor or investigate a contract.

Monitoring Employee Performance and Activity

The HR area tracks all the review dates and results generated by the Employee Performance Management System. The EMPS is used to evaluate job performance by state workers on an annual basis. If job performance on some of the duties is not satisfactory, the supervisor and employee will create a correction plan to improve those areas for the following year. If the employee is not performing job duties satisfactorily overall, then termination procedures would begin.

Job performance is also monitored on an individual basis by supervisors to address issues throughout the year between reviews.

Monitoring Stakeholder Satisfaction and Performance



As stipulated in contract language, the provider outreach contractor periodically tabulates results from the provider training survey and sends the results to SCDHHS. The EDI support center also compiles survey results and sends the results to SCDHHS. The provider outreach contractor or the EDI support center may meet with SCDHHS based on survey findings to modify procedures. These meetings occur on an ad hoc basis and do not follow a standardized procedure (see **Manage Contract**).

Conducting Audits

The Division of Audits performs in-house audits, other state agency audits (e.g. those agencies that receive Medicaid money), MCO audits, or audits for any other entity that is contracted with SCDHHS. (Annual audits are conducted by the State Auditor's office and an independent third party group and are not relevant to this business process). Unlike annual audits, these audits are conducted on an as-needed basis and do not follow an annual schedule.

The need for an audit may be triggered by one of the following: an audit request from an agency Deputy Director or Bureau Chief, discussions between staff in the Bureau of Compliance and Performance Review, or audit findings that identify the need for an additional audit. Two audit managers and the Division Director (within the Division of Audits) will meet with the Bureau Chief to discuss potential audits and determine a schedule for identified audits.

Reports run from Thomson Reuters tools are used in the planning process for an audit ([see Thomson Reuters interface for technical details](#)). The Division of Audits will meet with the SURS Division during this planning stage. The Division of Audits is dependent on SURS staff to pull requested reports and look for "flags" (things that would identify a need for an audit). Staff from both divisions and the Bureau Chief work together to select a data sample, which justifies the need for the audit.

The Division of Audits would like an increased ability to access information directly from the MMIS, run reports themselves and have more direct access to reports on D:D. The Thomson Reuters tools are difficult to learn since each report is unique to a particular audit. The Division of Audits' dependence on other areas to gather data and reports can slow the audit process.

Each audit has an administration file which includes the planning memo, concerns that led to the audit, information about the outside entity or SCDHHS area, past audit information, and internal controls of the entity. All audit documents are stored on a shared drive accessible by the Division of Audits and the Bureau Chief.

A planning memo (developed in MS Word) summarizes what preliminary work was completed during the planning process for the audit. From the planning memo, the Division of Audits designs an audit program, which determines the audit objective and will drive the steps to be taken during the audit. The Division of Audits follows guidelines of GAGAS (generally accepted government auditing standards), which are issued by the Comptroller General of the United States. Each audit standard is addressed by GAGAS and includes steps to complete the audit standard.



The audit program is often made from scratch, as each audit is designed with specific and unique objectives. The program also notes which staff will be assigned to the audit and estimates the number of hours to be dedicated to the project.

In-house audits are also developed in conjunction with the Deputy Director and Finance Director. All planning meetings concerning the audit are documented in a Word file, which details what occurred during the meeting and who attended.

The Division of Audits prepares a hard copy engagement letter for the auditee. The letter states that the entity will be audited, identifies the time period of the audit, and lists the objectives of the audit. If the objectives of the audit are unknown at the time the letter is sent, a revised letter is sent to the auditee when the objectives are determined. The letter prompts the auditee to contact the Division of Audits to schedule an entrance meeting to discuss the audit further. The time period for sending the engagement letter, scheduling the entrance meeting, and going onsite to the auditee varies with each audit.

The Division of Audits aims to have open and constant communication with the auditee during the audit via meetings, hard copy correspondence, emails, and phone calls. The auditor will document communication with the auditee on an as needed basis. This is documented in a narrative form (using MS Word) and is included with the audit work papers. Emails may also be incorporated into the work papers, if they provide evidence for the audit.

Auditors will go to the auditee's site (whether in-house or to an outside entity) and complete field work. This includes requesting records, viewing databases, reviewing policy and procedure guides, conducting interviews, and reviewing any other documentation from the auditee that may be useful to complete audit steps. For internal audits, data in GAFRS may also be used.

The Division of Audits would like to have a common tool to pull data needed from other state agency systems. Currently, each state agency's system is functionally and operationally different, which can make it difficult for the auditors to gather necessary data.

If the scope of the audit changes once it is in progress, the auditor will make a notation in the planning memo and/or the audit program. Also, the changes will be communicated with the auditee

Audit work papers document what steps and actions the auditor took during the audit and includes the initial data sample. The audit findings sheet (a standard sheet) is also part of the audit work papers and lists what conditions were examined and the criteria. Information in the work papers will determine if there are any audit findings. The auditor will review the information and make a recommendation based on any audit findings. The auditor will meet with the Bureau Chief to discuss the findings (or lack thereof in rare instances). Common audit findings include identifying overpayment to the auditee, violation of a contract or MOU, failure to meet provider manual provisions, or violation of a federal regulation. Findings may trigger another business process like **Perform Accounting Functions** or **Terminate Business Relationship/Contract**.

Any audit findings are added to the draft audit report. If there are no findings, the report includes what the objectives were, how the auditors conducted their field work, and that there were no findings.



The Division of Audits would like to image all documents and correspondence by acquiring an electronic work paper system or another comparable method. An electronic work paper system would allow for more automated workflow and reduce the reliance on paper. Currently, “cut and paste” is prone to human error and requires checking documents multiple times. Similarly, the indexing process of the draft report is very manual. All work papers are numbered to match the audit program. An auditor notes in the margin of the draft report the number of the supporting work paper. Each piece of information is manually traced to supporting documentation, which can take days to complete for a single report. The indexing process is essential to the audit process as it aids in answering inquiries related to the audit. An electronic work paper system would eliminate the manual indexing process as it has the ability to automatically create a link to the supporting documentation.

An audit exit conference is usually in two stages. The Division of Audits will “pre-exit” audit findings with the auditee. This is intended to ensure that the auditors have made no major errors or incorrect assumptions. The Division of Audits has an audit tracking report that audit recommendations are entered into to ensure recommendations are addressed by management. During this meeting, the draft audit report is shared with the auditee and allows the auditee ten working days to respond and comment on the draft report. The auditee may request additional time, depending on workload and other factors, which must be approved by the Bureau Chief.

The Division of Audits and the Bureau Chief will review the auditee’s comments. If the comments are a disagreement with fact, the auditors will request the supporting documentation. If the comments are a difference of opinion, the Division of Audits may review the report to ensure there is no biased language.

If the auditee does not respond with comments, the Division of Audits will follow up, and if there is still no response, the Division will communicate this to the Bureau Chief and will document it and issue the report as the final report.

If the draft audit report does not include any findings and recommendations, the Division will note that in the report and issue the report as final. The same number of days and time for a follow-up is provided to the auditee.

The draft audit will be revised as necessary, and the final audit report is sent to the Deputy Director and auditee. For an MCO audit, the appropriate program area also receives a copy of the report.

The Division of Audits would like to post audit reports on the SCDHHS wiki. All audit reports are public information and do not require a FOIA request.

Overall, the Division of Audits would like greater access to documents electronically like contracts. Recently, the Division of Audits acquired a portable scanner to help with this request, but a further reduction of paper, increased availability of electronic documents, and additional scanning abilities is desired.

3.3.10. Program Management “Wish-list” Table



Wish-list Item	Related Business Process
Automated online system to track inquiries related to 1099s.	Manage 1099s
The AR area would like to be able to enter these 115 offsets themselves (with a built-in management approval process).	Perform Accounting Functions
Develop tracking system for prior authorizations.	Designate Approved Services and Drug Formulary
Automate of code updates.	Designate Approved Services and Drug Formulary
Allow for electronic submission of all cost reports.	Manage Rate Setting
This process is very manual. Adding any automation possible would improve this process.	Manage Rate Setting
Reporting of waivers and certain programs (SCHIP, Breast and Cervical Cancer Program) is currently a very manual process. Once Fiscal makes its transition to SAP, it is desired to improve the reporting and interface from the MMIS.	Manage FFP for Services
In general, MMIS/GAFRS would be more useful if they had more robust indicators as to the source of funds, and more automated splitting of payments from those funds.	Manage State Funds
Automate keying of updates.	Maintain Benefits-Reference Information
Expand space limitations for reports and fields.	Manage Program Information
Contract monitors would like to improve the process of preparing a contract to include enough details in the contract and up-front involvement with everyone that needs to be involved. The contract needs to stipulate specific deliverables, appropriately numbered, for every contract expectation.	Develop and Manage Performance Measures and Reporting
SCDHHS would like to identify ways to conduct formal satisfaction surveys and performance monitoring.	Develop and Manage Performance Measures and Reporting
The Division of Audits would like an increased ability to access information directly from the MMIS, run reports themselves and have more direct access to reports on Document Direct.	Monitor Performance and Business Activity
The Division of Audits would like to have a common tool to pull data needed from other state agency systems.	Monitor Performance and Business Activity
The Division of Audits would like to image all documents and correspondence by acquiring an electronic work paper system or another comparable method. An electronic work paper system would allow for more automated workflow and reduce the reliance on paper.	Monitor Performance and Business Activity
The Division of Audits would like to post audit reports on the SCDHHS wiki.	Monitor Performance and Business Activity
Overall, the Division of Audits would like greater access to documents electronically like contracts and increase scanning abilities.	Monitor Performance and Business Activity



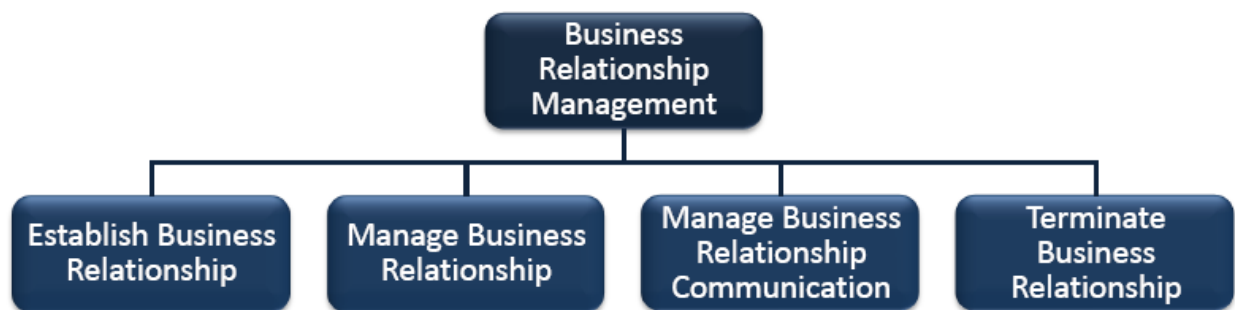
3.3.11. Business Relationship Management (BR)

As Is

Business Relationship Management is not a discrete, well-defined business area at SCDHHS. The CMS model combines some South Carolina EDI functions – managing the way outside entities transmit to and receive data from Medicaid – and legal functions – managing contractor and other entities’ legal agreements with the agency.

To Be

Automating the management of correspondence and data stores at the agency will affect how we manage business relationship data. In particular, staff throughout the agency would like to have better access to business relationship information. The goals of this area overlap significantly with those under Contract Management.



3.3.11.1. Establish Business Relationship

The establishment of a business relationship includes some or all of the following documentation:

- Memorandum of Agreement (MOA)/MOU⁶
- Business Associate agreements
- TPAs (for data exchanges)
- Other agreements/contracts⁷ between SCDHHS and other agencies or entities

⁶ The terms MOA and MOU are interchangeable

⁷ Further information concerning contract establishment may be found in the Contractor Management business area.



An MOU is used without a contract when an agreement needs to be established between SCDHHS and their business associate that has no associated cost. However, a contract may also have an MOU, if some sort of exchange is taking place, but all contracts do not require an MOU. A Business Associate agreement is used with a MOU and/or a contract and is never used as a standalone document. A TPA is used in conjunction with an MOU and/or a contract.

MOUs are written when an operational area has a need for an agreement with another agency or outside entity. Both sides (SCDHHS and their business associate) will communicate with the General Counsel to determine what is wanted in the MOU and each party's role. Boilerplate from the Division of Contracts is also utilized in this process.

When privacy requirements must be set, there are two different business associate agreements: one for state agencies, one for non state agencies. If the exchange of PHI is a SCDHHS function—that is, if SCDHHS is sending data that contains PHI, a business associate agreement is attached as part of the MOU or the contract.

Entities (providers, clearinghouses, etc.) that wish to submit or receive HIPAA-regulated electronic transactions with SCDHHS must complete an EDI agreement called a TPA. The EDI Support Center department of MCCC receives and reviews completed agreements from potential submitters. Agreements then go through legal review at SCDHHS. Once the TPA is approved and on file, the EDI Support Center works with the trading partner to assign a submitter ID and test electronic transactions.

MSM will only release electronic data once all conditions have been met. These conditions vary based on the agreement/contract. SCDHHS is currently defining these conditions to standardize procedures for data release.

The operational area or the General Counsel will draft the MOU. The MOU will then be presented, discussed, and modified based on the feedback received from each party. The operations area is consulted when the other party identifies needs to be included in the MOU. Through discussions between the involved parties, specific business rules are established in the MOU including:

- How the data will be used
- Data security
- Security/authentication protocol for the data exchange
- Effective date of the agreement

Information is validated, and the BMSM area works to develop the security/authentication protocol for the data exchange. In addition to the standard protocol, agreements that involve Protected Health Information (PHI) must establish a secure site for the data exchange.

General Counsel does not retain any of the documents associated with the agreements/contracts. The CLS tracks all information related to business relationship documentation. The Division of Contracts retains hard copies of any documentation.

3.3.11.2. Manage Business Relationship Communication



The Manage Business Relationship Communication business process maintains communication between the business associates through routine correspondence and unscheduled communications. The operations or program area may consult the General Counsel area prior to initiating communication to their business associate.

The MOU lists a contact person for the agreement usually from the operations or program area that holds the business relationship. Similarly, a contract lists a contract “owner” that functions as the contact person. The Division of Contracts utilizes the CLS to track any paperwork associated with the agreement/contract. For example, a 206 contract form must be completed for the MOU, and this form would be tracked by the CLS. The CLS is also utilized for the **Manage Contractor Information** business process.

Routine correspondence includes scheduled meetings to review the MOU/contract, schedule progress updates, etc. These are established by the contact person at SCDHHS and vary depending on the size and scale of the agreement/contract.

Unscheduled communications relate to the resolution of unexpected issues, new developments, change in the scope of work, negotiations to prevent contract/MOU termination etc. These are resolved via telephone, email, meetings, or other methods by the contact person and the business partner on an as needed basis.

The General Counsel area does not maintain any files on communication between business associates. The operations or program area and the CLS will track this information on as needed basis.

3.3.11.3. Manage Business Relationship

The Manage Business Relationship business process maintains any information concerning the agreement between SCDHHS and its business associate.

Every time a contract is renewed (in the **Manage Contract** business process), the MOU is renewed between the parties as well. MOUs are processed in the same manner as a contract. If an MOU does not include funds, it may not have an ending date.

The Division of Contracts is responsible for monitoring contract and MOU expiration within the Contract Log System. The Division of Contracts prepares and distributes a Contract Renewal List report that is generated out of the Contract Log System for all bureaus; the report contains all contracts and MOUs that will expire in a given state Fiscal year. If a contract or MOU is not renewed, the agreement is terminated (see **Terminate Business Relationship**).

An MOU and/or a contract may require updates for the following reasons:

- Change in size or scope of work
- Change in agreement or contract owner
- Change in contact information
- New or modified policies
- Any other situation that would require an update to documentation



- Results of a termination negotiation period (Failed termination negotiations go to the **Terminate Business Relationship** business process)

These changes go through legal review and work in conjunction with the **Manage Contract** business process as necessary.

3.3.11.4. Terminate Business Relationship

The MOUs/contract language stipulates that an MOU/contract can be terminated for any reason at any time by either party. Some expire. Other situations include noncompliance, failure, the state's convenience, nonappropriation of funds, etc., which are spelled on in the contract boilerplate. If the termination is initiated by the outside business associate, the outside business associate contacts the operations/program area contract contact to request termination and submits a written request for the termination to the Division of Contracts. If the termination is initiated by SCDHHS, the termination requestor (e.g. General Counsel, program area contract contact, PI Division, etc.) submits a written request for the termination to the Division of Contracts.

If the business associate is not meeting the provisions of the agreement, the MOU or contract contact can terminate the agreement without any negotiation period. Though a negotiation period is not required, the program or operations area that holds the agreement may mitigate the situation prior to requesting MOU/contract termination (see **Manage Business Relationship**).

Prior to termination, the operations or program area may consult the General Counsel concerning provisions for termination, etc. However, General Counsel does not need to be informed of the termination prior to the business associate's receipt of termination.

A termination letter is sent to the business associate via certified mail from the Division of Contracts and works in conjunction with the **Close Out Administrative or Health Services Contract** business process. If the contract is a service contract, it is terminated out of the MMIS. The BSM and/or EDI Support Center removes any data access for the outside business partner. A copy of all termination letters are sent to Fiscal Affairs, and the corresponding SCDHHS program manager. The letter lists the reason for termination and refers the business associate to the appeals section of the contract. Once the termination letter has been sent, the contract/MOU is made inactive in the CLS. A note is made in the remarks section on the CLS to indicate that the contract/MOU has been terminated. Each Procurement Specialist has a hard-copy pending file which contains copies of the termination letter and any other documented correspondence associated with the termination.

General Counsel would like to add information concerning the appeals process to the letter, so the business partner has the information available if he chooses to appeal the termination.



3.3.12. Business Relationship Management “Wish-list” Table

Wish-list Item	Related Business Process
Add information concerning the appeals process to the termination letter.	Terminate Business Relationship



3.3.13. Program Integrity Management (PI)

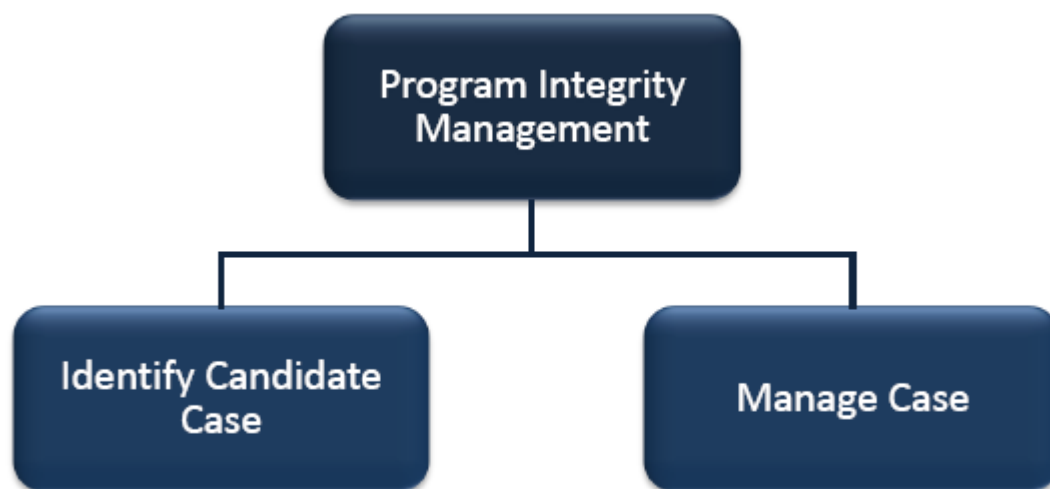
As Is

South Carolina Medicaid's PI efforts are handled by a single agency division that investigates fraud and abuse of all sorts and manages cases. The division collaborates with the state attorney general's office to prosecute cases that fall outside the agency's jurisdiction.

To Be

Improvements to PI will come from both technological and business process redesign. Better audit trails, a more robust SURS system, and more advanced claim editing will significantly improve the agency's efforts to detect and combat fraud and abuse. A tracking system for PI referrals and case management would also allow staff to spend less time on paperwork and more time on program integrity functions.

The agency also seeks new business resources for detecting fraud and abuse, such as additional lock-in programs for beneficiaries beyond the Pharmacy program, and a redesigned front-line intake department for PI referrals.



3.3.13.1. Identify Candidate Case

The Identify Candidate Case business process safeguards against medically unnecessary services, inappropriate use of services, and excessive or improper payments by conducting preliminary reviews (cases) to identify waste, fraud, and abuse by providers and beneficiaries alike. Identified cases of potential waste, fraud, and/or abuse are referred to the **Manage Case** business process for further investigation and corrective action.

The PI Division (under the Bureau of Compliance & Performance Review) receives complaints from numerous sources (SCDHHS personnel, referrals from other agencies, providers, and anonymous tips) via e-mail or the Fraud Abuse hotline. The Department of Recipient Utilization



(DRU) manages the Fraud Abuse hotline and all complaints. The DRU screens complaints to determine the action needed for complaint resolution.

The DRU must first confirm that the person associated with the complaint has a connection to Medicaid. If a complaint refers to another agency or professional entity, it is forwarded to the appropriate contact. Some callers are not issuing a complaint, and the DRU resolves the call or forwards it to a program area. If a complaint refers to a MCO beneficiary's eligibility, the complaint will be investigated to determine if it requires further review in the **Manage Case** business process. Any other MCO beneficiary complaints are passed to the Division of Care Management.

If another area within the Bureau receives a complaint, any information is passed to the DRU.

The DRU does not investigate provider cases but handles and screens complaints from all sources. If the complaint concerns a Medicaid provider, DRU may conduct a preliminary analysis (i.e. pull up a list of all the claims submitted by that provider, and then pass that complaint to the appropriate Program Integrity department for review). PI will tell the DRU what action they took on the complaint. If the complaint concerns a beneficiary, DRU again does preliminary review to make sure they are an active Medicaid recipient and to analyze the dollar value of the benefits received. If fraud is suspected, the case is referred to the Attorney General's Office. The DRU monitor the status of PI cases in the Case Management System (CMS). The DRU handles complaints, and when the complaint is referred or resolved by the DRU, they close the complaint.

Cases can also be initiated without a complaint (e.g. PI suspects provider fraud based on analysis of claims data, and they decide to monitor this provider by directly initiating a case). In this scenario, designated staff members (within the PI Division) would enter the information into the CMS and proceed with the case. Multiple people have the authority to identify a case for referral to the **Manage Case** business process including the supervisor of the fraud hotline, PI supervisor, Division Director for PI, and Division Director for SURS.

Depending on the nature of the complaint, more research may be required by the DRU before it is closed or passed on for review in the **Manage Case** business process. The supervisor of the Fraud Abuse hotline ultimately decides which complaints require a review by the PI Division. The DRU tracks complaints and produces an annual report on the number of complaints referred, closed, and sent for further review to the **Manage Case** business process in their PI CMS. An electronic complaint intake form from within this system is used to document a complaint. Once the necessary research is done, and a complaint is deemed worthy of taking further action, the complaint is submitted as a case in the PI CMS. In situations where a case is initiated by something other than a complaint, the information is entered into a case management form. The DRU may also prepare claims data for the review. Otherwise, the reviewer is responsible for gathering data in the **Manage Case** business process. *PI management would like to create a complaint/referral intake department separate from the DRU unit.*

As part of the effort against fraud and abuse, the PI Division uses a REOMB program letter. Each month, Clemson University Data Center, as a function of MMIS, generates letters based on a random sample of recipients (see **Prepare EOB**). Clemson sends these letters to the PI Division, where the administrative assistant for PI is responsible for mailing the letters and distributing



the responses to either DRU or another department within PI. The administrative assistant's phone number is listed on the letter for any recipient inquiries. A stamped self-addressed envelope is included with the letter for the recipient response. These letters list all non-confidential services that were paid on the beneficiaries' behalf during the previous 45 days. These beneficiaries are requested to verify that they received the services described in the letter and return their response to the Division of Program Integrity. The PI Division administrative assistant maintains a hard copy of who receives a letter. The PI Division administrative assistant tracks the number of letters returned (not who returns the letters) and compiles a monthly report. The rate of return varies each month, but is often around 50%. *The PI Division would like to improve the appearance of the letter.* Currently, it looks very computer-generated, which may impact the response rate. If a recipient returns a negative response ("No, I did not receive this service"), the letter is forward to the DRU for a preliminary review. The administrative assistant also attempts to contact recipients to update addresses when a letter is returned as undelivered. Findings from this review may trigger a referral to the **Manage Case** business process. Negative responses related to pharmacy services are also forwarded to the Division of Pharmacy and DME Services. Returned letters are filed in the PI Division.

SURS data analysts, in conjunction with PI staff, create rules, algorithms, and parameters to feed into SURS. MMIS feeds all paid claims data, reference files, and provider and member files into SURS. Then SURS provides norms, statistical deviations, and patterns that are used to flag potential fraud and abuse in the target group files. SURS staff (Division Director and 2 staff members) produces reports using Thomson Reuters tools (see Thomson Reuters interface for technical details) for the PI area which target specific claims and/or providers that may merit further investigation in the **Manage Case** business process. The PI Division also has access to run SURS types of queries to generate reports. These reports are often generated based on:

- Complaints and referrals
- Deviation from the norm compared to peers
- Suspected fraud, abuse or misuse of the Medicaid system
- Repeated failure to comply with program policy
- Discovery that a provider has not followed required standards, Medicaid policy, or guidelines
- Previous data reports and analysis leading to providers with outlier net payments, excessive use of certain codes and high utilization

Post-Payment reviews are completed on a regular basis by PI. PI performs data mining, data analysis and documents review of all providers enrolled in the Medicaid Program in order to determine non-compliance with program policy, abuse, overpayment and/or fraud. Any findings from an initial post-payment review may require further investigation in the **Manage Case** business process.

For a previous overpayment case, the provider file is monitored to ensure SCDHHS is recouping funds. The Fiscal area monitors this through their AR area. Annually, the SURS area pulls a report to look at providers who have had a case closed for one year. This report is used to examine a provider's claim volume and examine trends in his claims submission. Suspicious activity may trigger a second investigation of the provider. In some situations, the PI area has put a provider



on a prepayment review process for monitoring and investigative purposes. A program area can suspend all claims from a provider, if needed, by using an edit.

3.3.13.2. Manage Case

The Manage Case business process is performed by four departments: DRU, Department of Medical Service Review, Department of Medical Service Review/Ancillary Programs, and Department of Pharmacy and DME Review. Each of these departments conducts reviews and investigations of cases that have been identified via the **Identify Candidate Case** business process.

The supervisor of the fraud hotline, PI supervisor, Division Director for PI, and Division Director for SURS are authorized to decide that a case merits investigation under the Manage Case business process. Those individuals present the DRU with identified cases that require investigation. Cases derived from a complaint use a complaint intake form to notify the DRU of a new case. Cases derived from another source are directly entered into the PI Division's proprietary CMS ([See PI CMS PC application for technical details](#)).

The DRU assigns the case to the appropriate department for further investigation by a reviewer. If the case involves a beneficiary, the DRU will investigate the case. For a provider investigation, the provider type will determine which department (Department of Medical Service Review, Department of Medical Service Review/Ancillary Programs, Department of Pharmacy and DME Review) investigates the case. Further details on each department's function are explained below.

The DRU enters the case and assigned department/reviewer into the CMS. The assigned reviewer accesses information concerning the case through the CMS.

The CMS manages case files by tracking basic information about the case, including the source of the case; open and closure dates; the reviewer and department conducting the review; provider type under review; type of allegation; outcome of the case, including any sanctions; and the amount of the overpayment identified and recouped.

Currently, the CMS is not used by the PI Division to the frequency and extent that is desired. Those who do use the CMS have common definitions/triggers for using the CMS. Supervisors and Division Directors use the CMS to varying degrees. *PI management desires to improve the tracking system by acquiring a comprehensive PI review and case management system that would automate the management of the case and replace hard copy files, and improve accessibility of necessary records (policies, medical records, claims screens, etc.).*

The four departments responsible for PI cases are:

The DRU is responsible for investigating fraud, abuse, and/or misuse of the Medicaid program by beneficiaries (which may include overuse of pharmacy services, sharing Medicaid cards, eligibility, abuse of benefits etc.) including administering the pharmacy lock-in program. If certain criteria are met, abuse relating to overuse of pharmacy services may trigger the DRU to "lock in" or restrict the beneficiary to a single pharmacy. Cases of fraud could include false



applications, sharing and/or selling a Medicaid card, hidden assets, unreported income, and drug diversion.

The Department of Medical Service Review is responsible for post-payment reviews of physicians and other medical specialists as well as out-patient hospital services.

The Department of Medical Service Review/Ancillary Programs is responsible for post-payment reviews of dentists, home health agencies, therapists, clinics, labs, mental health facilities, state agencies, non-emergency transportation providers, and other provider types.

The Department of Pharmacy and DME is responsible for the monitoring and conducting post-payment reviews of drug utilization patterns of pharmacy and DME providers.

The most common actions during a PI review include:

- On-site visits to providers (both announced or unannounced)
 - A PI worker provides a letter to the provider or office staff upon arrival, explaining the purpose of the on-site visit. Once the audit is complete, a letter is sent to the provider along with a detailed list of claims supporting the overpayment determination. The findings letter also encourages the provider to contact the PI Division to schedule a conference to discuss the findings. After the conference (or if a provider elects to not schedule a conference), the PI Division issues a revised notice of their findings and recoupment amount and informs the provider of his appeal rights.
- Notification that overpayment has been found and that refund to Medicaid is due;
 - This letter asks that the provider send a check for the identified overpayments as indicated by the review.
- Desk review of medical and support documentation
 - A record request letter is sent when the reviewer writes to request that copies of support documentation be mailed to SCDHHS for further analysis.
- Provider self-audit
 - A provider self-audit letter is mailed when the reviewer needs to notify the provider of suspected problems in billing claims and to ask that a self-audit be performed, with the resulting findings and overpayments be returned to SCDHHS.

After careful comparison of documentation supporting paid claims to Medicaid provider manuals, the reviewer makes a decision to proceed based on the following findings:

Fraud

If provider fraud is suspected, the case will be referred by Program Integrity to the Medicaid Fraud Control Unit (MFCU) in the Attorney General's (AG) Office and appropriate licensing boards. If beneficiary fraud is suspected, the case will be referred to the Medicaid Recipient Fraud Unit (MRFU) in the AG's Office for investigation. The PI case is suspended pending MFCU actions. PI is often asked to provide additional information and assistance. The provider is not contacted at this point, and if the MFCU returns a case as unsubstantiated (no fraud was detected), the PI Division will receive the case back from the AG's office, whether it be recipient or provider, PI will continue processing the case if abuse resulting in an overpayment is involved (see "abuse")



section below). If no overpayment is identified, the case would be closed with no actions. Convictions follow processes guided by the judicial system.

Abuse

If abuse is detected the provider is sent a detailed letter explaining the findings and advising the provider of recoupment of overpaid monies (notification sent gives thirty days for provider response). Sanctions that may be imposed for abuse can include recoupment of any overpayment, educational intervention, suspension, prepayment review, fines or penalties, and termination. While the provider is paying back the overpayment, the PI Division monitors the provider for 30 - 90 days through a collections report to make sure they are getting their money back. Further monitoring of an overpayment case is also conducted in the **Identify Candidate Case** business process, to ensure there are no further abuse findings against a provider that would trigger a second case opening.

Non-compliance with Policy

A letter is sent to the provider notifying him/her and detailing the review findings, referencing the program policy in violation and giving a recommendation for correction. Often, an educational intervention assists the provider in correcting billing and/or coding errors. Sanctions that may be imposed for aberrant billing can include recoupment of any overpayment, educational intervention, suspension, prepayment review, fines or penalties, and termination.

No findings

A letter is sent to the provider stating that there were no significant findings.

Educational Intervention

A detailed letter explaining the findings and a corrective recommendation is given. In some instances, a Program Representative contact with the provider may also be recommended.

The provider may refuse to submit the recoupment for an identified overpayment, which requires PI to take the following actions: If the provider is still active in the Medicaid Program and sending in claims, PI may advise the Fiscal staff members to debit an amount from future checks cut for the provider. If the provider is still active in the program but no longer sending in claims, PI has the ability to exclude the provider from Medicaid (3-5 years). The exclusion will be reported to the federal government, which could lead to further exclusions from Medicare and other federally funded health care programs. If the provider is no longer active, the legal department will be contacted to begin pursuing collections and if necessary, take other legal action.

The PI Division coordinates with the Division of Accounting Operations to ensure that providers are paying back any overpayments and penalties identified as a result of a PI case or fraud conviction, and that all requirements of a settlement agreement are being followed.

Currently, there is not a common definition within the PI area for determining when to close a case, but some factors will prompt case closure. If there are no findings that require action after the investigation is complete, the case is closed. Once a final overpayment amount is



communicated to a provider and the Division of Accounting is notified, the PI area closes the case in the PI CMS. If a provider appeals the outcome of a PI investigation, the case is usually kept open until the appeal is adjudicated. However, some appeals take many months or years, which can disrupt PI statistical reporting. A case is kept open if referred to the AG's Office. The case stays open until legal proceedings are finalized, and then the case is closed. The supervisor of a case reviewer closes the case in the CMS.

3.3.14. Program Integrity Management "Wish-list" Table

Wish-list Item	Related Business Process
PI management would like to create a complaint/referral intake department separate from the DRU unit.	Identify Candidate Case
Improve the appearance of the REOMB letter.	Identify Candidate Case
Improve the tracking system by acquiring a comprehensive PI review and case management system that would automate the management of the case and replace hard copy files, and improve accessibility of necessary records (policies, medical records, claims screens, etc.).	Manage Case



3.3.15. Care Management (CM)

As Is

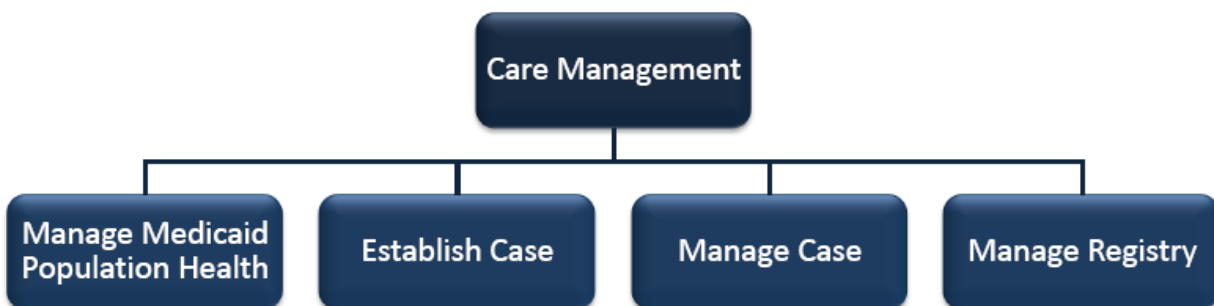
SCDHHS performs very little care management of its own, choosing instead to let the managed care organization design and deliver care management for Medicaid members. Moreover, in South Carolina, DHEC is responsible for tracking and managing public health information. This business area describes the care management performed within the agency: primarily EPSDT and small programs that encourage providers to educate and manage care for certain categories of member.

To Be

SCDHHS envisions a continued shift toward managed care and care coordination in the state Medicaid program. This will continue to place the responsibility for care management in the hands of managed care organizations, which possess the clinical staff and experience to manage care for the state Medicaid population.

The agency is also interested in how a redesigned Medicaid Enterprise system can help reinvigorate the EPSDT program in the state, allowing for notices to providers and members and better tracking of EPSDT cases.

In the long-term, a more streamlined, centralized, modular Medicaid Enterprise system will facilitate better collaboration with other state health agencies, improving population health across the state.



3.3.15.1. Establish Case

SCDHHS does very little care management of its own. Contractors and providers are primarily responsible for care management functions. For example, Medicaid managed care organizations are responsible for managing care for their own members; they set their own policies and track their own management and outcomes.



SCDHHS also partners with other state agencies – DDSN, DSS, etc. – that manage care for Medicaid beneficiaries. Those other agencies maintain their own methods for establishing cases, authorizing services, and managing care.

This document explains the Establish Case component of the care management programs that are actually overseen, administered, or tracked in some way by SCDHHS.

EPSDT

Providers are responsible for identifying beneficiaries eligible for EPSDT screenings and services. Schedules and policies listed in the Physicians Provider Manual guide providers in when and how to render these services.

SCDHHS no longer sends out EPSDT notices to beneficiaries and their families, nor does it schedule appointments on behalf of beneficiaries. *Agency staff would like to resume this practice, perhaps via a more cost effective route than mail.*

Diabetes Education

Certified diabetes educators can enroll with Medicaid as providers of diabetes education services. The providers bear the responsibility for identifying patients and rendering services. (See **Manage Case** for the SCDHHS component.)

Preventive/Rehabilitative Services for Primary Care Enhancement (P/RSPCE)

P/RSPCE providers work with primary care physicians and beneficiaries, developing a plan of care to ensure the beneficiary's optimum use of Medicaid services. These services are intended to support and complement primary medical care. DHEC is responsible for the administration of this program.

SCDDSN waivers.

DDSN operates certain waivers (MR/RD, HASCI, PDD, Community Supports). DDSN is responsible for the administration of these waivers with SCDHHS oversight.

Currently, the authorization process is paper-based. Beginning with the HASCI waiver, DDSN plans to implement electronic service authorizations and automate service plans.

CLTC / HCBS waivers.

These waivers are managed by the CLTC area of SCDHHS. Some case managers are SCDHHS employees; others are contracted providers.

Beneficiaries apply for the waiver programs by filling out an application available in local eligibility offices and most hospitals and health clinics.

Each CLTC regional office maintains a waiting list for each waiver.

CLTC providers create service plans for beneficiaries based on the “problems”—reasons a person may need long-term care services, the “goals”—preferred results for person, and the “intervention”—means to reach the goals. This information is entered into the CLTC Case



Management System (CMS; [see CLTC CMS for technical details](#)).

Behavioral Health Services

Certain other state agencies (DSS, etc.) identify individuals who are eligible for these programs. Providers develop treatment plans for these beneficiaries.

3.3.15.2. Manage Case

This business process is closely tied to **Establish Case**; see that template for more explanation of these programs.

EPSDT Providers are responsible for rendering EPSDT services and coordinating care as needed. The SCDHHS Physicians Services program area tracks EPSDT services via MMIS reports of EPSDT procedure codes billed. They use those reports to complete the annual CMS 416 report of EPSDT visits in the state. They do not monitor follow-up services or other care coordination.

The Physicians Services area would like the MMIS/MEDS to track billed EPSDT visits per beneficiary based on age and periodicity – this would facilitate outreach to parents by eligibility caseworkers, the Enrollment Broker, etc. Staff would also like to be able to search the MMIS based on CPT codes billed.

Diabetes Education. Providers bear the responsibility for identifying patients and rendering services. SCDHHS Diabetes Education staff are responsible for making sure providers are billing for diabetes education services regularly; if not, they may not be meeting the needs of the beneficiaries in their area. Using MMIS reports by provider type and services billed, the staff checks regularly on an ad hoc basis to see if providers are billing for diabetes education. They may then reach out to individual providers to remind them about the program and its billing to ensure services are being rendered.

P/RSPCE

DHEC manages this program with the assistance of public health nurses, social workers, dietitians, health educators, home economists, and public health assistants. Group and/or individual counseling sessions may be held to administer this program, depending on the beneficiary's needs.

SCDDSN Waivers.

These waivers are administered by SCDDSN, though they are billed to SCDHHS.

CLTC/HCBS Waivers.

CLTC providers use the CLTC CMS for the management of CLTC waivers ([see CLTC CMS for technical details](#)). The databases are maintained daily by the CLTC regional offices, with nightly updates to the central database. Providers use the CMS to enter information from assessments based on the service plan created in **Establish Case**. The CMS is also used for generating reports to track timeliness of assessments, reassessments, care plan development, tracking missed provider visits, and identify participants at risk in the event of an emergency.



Providers use Care Call to log the time spent at a patient's residence by calling in and entering information at the beginning of the visit and again at the end of the visit ([see Care Call interface for technical details](#)). This information is used later for claims processing (see **Enter Claim**).

CLTC staff at the agency monitor reports related to these waivers.

Behavioral Health Services

Certain other state agencies (DSS, etc.) authorize services and manage care for beneficiaries in these programs. The agencies pay for the services, though providers submit their claims through the MMIS; the prior authorization number marks the claims with a fund code tied to each agency so SCDHHS uses funds from the appropriate sources.

Treatment plans developed when a beneficiary is identified undergo postpayment review by SCDHHS' medical review contractor. The medical review contractor may refer cases of overuse to the Division of Program Integrity for further postpayment review (see **PI Identify Candidate Case**).

SCDHHS would like improved interfaces with these other agencies and the ability to monitor care and authorizations performed by these other agencies and providers.

3.3.15.3. Manage Medicaid Population Health

SCDHHS does not target populations by cultural, diagnostic, or other demographic indicators. Outreach initiatives and communications to beneficiaries are explained in **Perform Population and Member Outreach** and **Manage Applicant and Member Communication**.

3.3.15.4. Manage Registry

SCDHHS does not maintain any registries. DHEC maintains immunization and disease registries. Through continued collaboration DHEC and other agencies for the development of a statewide HIE, SCDHHS will have access to this information.

3.3.16. Care Management "Wish-list" Table

Wish-list Item	Related Business Process
Agency staff would like to resume the practice of sending out EPSDT notices, perhaps via a more cost effective route than mail.	Establish Case
The Physicians Services area would like the MMIS/MEDS to track billed EPSDT visits per beneficiary based on age and periodicity.	Manage Case
SCDHHS would like improved interfaces with other agencies and the ability to monitor care and authorizations performed by these other agencies and providers.	Manage Case



3.3.17. State-Specific Processes

As Is

Three South Carolina-specific business processes were documented as part of the SS-A:

Enter Claim explains the many ways claims can enter the MMIS. Because this is an area we feel may change significantly with a system redesign, we wanted to describe exactly how paper, web, and electronic claims are submitted by providers and entered into the claims processing system, including the capabilities and limitations of EDI and the claims processing contractor.

Manage ECFs documents South Carolina's unique paper-based processes for correcting suspended claims and allowing providers to correct denied claims.

Perform Adjustment explains two adjustment types: Gross-Level and Claim-Level. (The CMS business process **Perform Mass Adjustment** describes how we adjust large groups of claims at once. We suggest the following improvement to the MITA model: Rename Perform Mass Adjustment to "Perform Adjustment". Perform Adjustment would then include all three types—mass, claim-level, and gross-level)

Business capability matrices were also developed and maturity levels assigned to these three business processes (see Chapter 6).

To Be

South Carolina would like to eliminate the ECF process outright, instead allowing for online resolution of suspended claims and requiring providers to re-file denied claims.

The state also hopes to eventually eliminate gross-level adjustments, linking all adjustments to individual claims for better auditing and reporting.

3.3.17.1. Enter Claim

Professional, Dental, and Institutional Claims

Providers submit professional, dental, and institutional claims using one of the following methods:

- Paper (CMS-1500, ADA, and UB-04)
- Web-based claims submission tool
- Electronic media (tapes, diskettes, CDs, zip files; modem; file transfer protocol (FTP))

Use of the web-based claims submission tool or electronic media requires completing a TPA (see **Establish Business Relationship**).

MCCS receives paper claims. Before scanning them, MCCS performs an initial prescreening/verification to determine whether to accept the claims. Certain claims – those lacking a provider number, for example – are mailed back to the provider. **SCDHHS would like to track claims that fail prescreening and are returned to providers.**



Then, using a combination of OCR technology and manual data entry, MCCS enters claims data. Several proprietary applications are used to image claims, key the data, and track and assign batches of claims.

MCCS transmits batch files of claims data to Clemson via a direct line (T1).

See Claim Control Number section below for details on the make-up of the CCN and how it is used in getting claims into the adjudication process.

Some batches are assigned priority status, which MCCS indicates by assigning a batch range in the 300s. Priority batches are keyed and transmitted before other claims. Priority batches are processed in the beginning of a run. If the claims volume exceeds 50,000 claims (limit for a batch processing run), those remaining claims will be the first to process after the priority batches in the next claims run.

Clemson operates the Web-Based Claims Submission Tool, which allows providers to enter claims, store frequently used information, check claims status, and perform other functions. In the near future, SCDHHS will begin gathering requirements to re-write the tool.

Physical electronic media are sent or delivered to MCCS, which uploads the data and transmits it to Clemson via the direct line. Clearinghouses and providers also transmit claims data via various channels (modem, FTP); the EDI 837 claims are received by Clemson through the EDI translator ([see Companion HealthPort and HIPAA mailbox interfaces for technical details](#)).

Nursing Facility and OSS Claims

Claims for nursing facilities and OSS payments are submitted using the TAD, a paper-only process. Each month, Clemson generates a listing for each facility of all Medicaid residents from the previous month and mails it to the provider. The provider makes corrections, additions, and deletions on the paper document, attaching authorizing documentation as needed, and mails it back to MCCS. MCCS keys the TAD claims data directly into the MMIS. SCDHHS currently has a project underway to switch to electronic submission of nursing home claims.

CLTC Claims

South Carolina relies upon the CMS for the day-to-day management of three Medicaid waivers (Elderly/Disabled, HIV/AIDS, and Ventilator Dependent).

CMS contains information from assessments, and service plans for the Medicaid home and community-based services waivers listed above. The service plan includes information on the reasons a person may need long-term care services (the “problems”), the preferred result for the person related to the problems (the “goals”), and the means to reach the goals (the “intervention”). Case managers enter the service plans, and information obtained during assessments into the CMS. In addition to supporting intake, assessment, care planning, and service initiation functions, CMS is also used to support quality management through its report-generation function (e.g. reports on timeliness of assessment, reassessments, care plan development, tracking missed provider visits, identifying participants at risk in the event of an emergency or natural disaster etc.). ([See Case Management System \(CMS\) PC app. for more detail.](#))



On a nightly basis a subset of information is automatically transmitted from CMS to Care Call through an FTP website.

The state of South Carolina implemented Care Call, an automated monitoring system (with real-time data) to provide monitoring and verification of providers delivering services under the state's HCBS waivers. Care Call is an electronic database system, which requires that providers call a toll-free number as soon as they enter and exit a recipient's home. The providers identify themselves by entering a unique provider identification number. When the provider calls in, the Care Call system automatically verifies that the telephone number he/she is calling from matches the home telephone number listed for that participant and then records the visit's start and end times.

Information is passed from CMS to Care Call so the Care Call system will know what waiver service(s) a beneficiary is to receive, how often the service is to be received, the amount of service, and who is to provide the service.

Care Call is essentially a three part system. The first part is the IVR (phone line) that providers use to document service delivery. Secondly, there is a website that providers, CLTC staff, and case managers access to run reports on service delivery (this website is administered by the Care Call contractor. Lastly, Care Call electronically submits claims to the MMIS. The contractor submits the claims on behalf of the providers to the MMIS, and then the MMIS sends an electronic report to the contractor. [\(See Care Call System PC app. for more detail.\)](#)

Once a week, the data from the Care Call system is automatically transferred to MMIS (via an 837 transaction). This data serves as the providers' claim information and makes billing easier for providers since they don't have to administer the billing process themselves. Care Call is used to electronically submit claims for the majority of CLTC providers. The MMIS pays CLTC providers in the same manner as other Medicaid providers. However, not all CLTC claims go through Care Call. Some services, such as incontinence supplies and pest control bill outside of Care Call (They bill via the Web Tool or CMS 1500). CLTC would like to eventually have all CLTC services bill through Care Call.

In addition to MMIS, Care Call also interfaces with another system for the purpose of claims payment. CLTC provides financial management services called "Attendant Care" to a specific group of CLTC providers. This portion of the Care Call contract was created for self-employed providers. Historically, Medicaid used to reimburse these providers directly; however, a few years ago, the federal government mandated that these providers be employed in order to ensure that all taxes were being properly withheld. The Care Call contractor sub-contracts with another contractor to supply these self-employed providers with the Attendant Care financial management services which fulfill the mandated employer requirements for all CLTC providers. Care Call interfaces directly with the other contractor's software. These unique CLTC providers are entered into the MMIS with individual provider numbers, but are all listed as members of a specific provider group (EXG300). The amount that is paid to this special provider group is sent to the Attendant Care contractor who pays each individual provider once overall payment is received.

Pharmacy



SCDHHS holds a contract with a pharmacy benefits administrator. The contractor adjudicates pharmacy claims through POS. Providers do have the option to submit claims via hard copy or electronically (using the universal claim form), but nearly all claims are submitted as POS. The contractor sends a claims file to SCDHHS weekly for payment.

Dental

SCDHHS recently awarded the Dental ASO contract to Doral. The ASO is scheduled to be operational April 2010. The Dental ASO will adjudicate claims and handle prior authorization processes for all dental claims (services currently billed on the ADA form as well as oral and maxillofacial services currently billed on the CMS-1500). The Dental ASO will also manage provider enrollment and credentialing. The Dental ASO will send a claims file to SCDHHS weekly for payment.

Managed Care Encounters

All encounter data is submitted electronically via file transfers from the MCOs ([see MCO interface for technical details](#)).

Transportation Encounters

Transportation encounters come in as 837s through the HIPAA Mailbox Interface but are stripped off and reformatted into the proprietary transportation encounter format.

Claim Control Numbers

Each claim receives a unique CCN, whether assigned by MCCC or the MMIS. The CCN is composed of a five-digit Julian Date indicating when the claim was received at MCCC, a five-digit Document Sequence Number (sometimes referred to as the Claim Sequence Number), a four-digit Batch Number, and a one-character Claim Type (sometimes referred to as the Document Type). Claims are batched for submission and tracking purposes. The combination of Batch Number and Document Sequence Number make up the unique key for the batch. This key is used to store a Batch-Heading record in MMIS to track the entry of each claim in the batch as it comes into the adjudication process. If the Batch-Heading record indicates that the claim (the particular CCN) has already entered the process, the claim is removed from further processing and appears on a rejected claims report as a duplicate CCN. If a CCN is missing from a batch, those are also listed on a report.

MCCC reserves a range of batch numbers for paper-based claims (first digit is zero) and likewise for electronically-submitted claims (first digit is one or greater).

For paper claims, MCCC builds the CCN and assigns it during the scanning process. For claims not submitted through MCCC, the MMIS assigns the CCN.

MMIS Cycles

The MMIS has cycles (1st cycle, 2nd cycle, etc.), which identifies if the claim is new or a resubmitted claim. Duplicate claims are automatically rejected (see CCN and Batch-Heading information above). If a claim is not approved, it is available for recycling via the MMIS online



system. Recycled claims are pulled into the claims adjudication process and are re-edited as if they are new claims.

3.3.17.2. Perform Adjustment

Perform Claim-Level Adjustment

A claim level adjustment is a void (debit) or void/replacement adjustment at the detail/claim level and is tied to a particular claim. This type of adjustment is limited to one claim per adjustment request.

Currently, a claim can only go through void/replacement adjustment process one time – that is, the MMIS does not allow us to adjust a replacement claim. *SCDHHS would like to have the functionality to perform an unlimited number of void/replacement adjustments on a claim.*

Claim level adjustments are only for claims in MMIS active claims history—those paid less than 18 months ago. Claim-level adjustments are used when the total claim amount is being recouped.

Remittance advices for claim-level adjustments will reflect detail-level explanation.

A void only claim-level adjustment is used when the original claim is removed from the system and not replaced. If a claim is voided and later needs to be replaced, the replacement claim must be submitted as a new claim.

A void/replacement claim-level adjustment is used when the original claim was paid in error and needs to be corrected.

Submission Methods

Claim level adjustments are submitted electronically or hard copy.

Hard copy adjustments can be initiated by SCDHHS, MIVS, MCCS, or certain providers using the Form 130. The Form 130 can be used by professional and dental providers. Institutional providers cannot use the Form 130; they submit hard copy claim-level adjustments by coding the UB-04 claim form as an adjustment.

Providers (professional, institutional, and dental) can use the Web Tool to submit electronic adjustments. Clearinghouses and other electronic submitters can submit HIPAA-compliant electronic Void or Replace transactions to SC Medicaid as part of the 837 code set.

See the end of this section for pharmacy adjustments. Other provider types (nursing facilities, etc.) cannot initiate adjustments and must contact their program representative.

Provider Initiated: For a void only adjustment, a provider completes Form 130 and indicates the provider as the originator. For a Void/replacement adjustment, a provider completes Form 130, indicates the provider as the originator, and attaches a hard copy claim to the Form 130 as the replacement claim. A provider submits all forms/documentation to MCCS for keying.

Institutional providers submit adjustment UB-04s through the regular claims submission



process, coded as adjustments in the “Bill Type” field and including the original CCN on the claim.

Internally Initiated: For a void only adjustment, SCDHHS/MIVS completes Form 130 and indicates SCDHHS/MIVS as the originator. For a Void/replacement adjustment, SCDHHS/MIVS completes Form 130, indicates SCDHHS/MIVS as the originator, and indicates changes to be made on the replacement claim in the “Comments” field or indicates changes on hard copy print-out of the basic screen for the original claim and attaches to the Form 130. SCDHHS/MIVS submits all forms/documentation to MCCS for keying.

MCCS uses the 130 form as well.

A variation of the Form 130, the 130G, is used specifically for nursing facility adjustments. Providers cannot use it; only SCDHHS or MCCS uses this form.

Just like regular claims, adjustments can suspend for resolution by MCCS and/or SCDHHS.

The information from the Form 130 is transmitted as an adjustment claim from MCCS to Clemson. It is then pulled into the next claims adjudication cycle at Clemson for processing.

Adjustments are edited by the MMIS (see **Edit Claim/Encounter**) and can be rejected. If a provider-initiated adjustment is rejected, an Edit Correction Form (ECF) is not generated, but the denial appears on the provider’s remittance advice along with edit codes for the denial.

Pharmacy Adjustments

Pharmacy providers submit adjustments (“reversals”) to the POS contractor using their POS device. The POS contractor “reverses” the claim in its proprietary system and then sends a gross level adjustment to Clemson in the MMIS proprietary adjustment claim format as part of the weekly transmission of POS claims. The adjustment claim goes through a separate MMIS adjudication process for POS adjustments and is stored in the database for MMIS payment processing. While the adjudication process also includes marking the original claim in the skeletal history database as voided, the MMIS does not treat this as a true claim level adjustment when it comes to reporting.

Perform Gross-Level Adjustment

A gross-level adjustment is a debit or credit adjustment made at the provider level that is not tied to a particular claim or recipient. Multiple claims can be adjusted on a single gross-level adjustment request.

Situations that require gross-level adjustments:

- Adjustments that are not “claim-specific” (e.g. cost settlements, disproportionate share)
- Claims no longer available on skeletal history (18 months from paid date)
- Claims from institutional providers that are pulled into recovery for Medicare or other health insurance when only a portion of the amount is being recouped
- Claims from non-institutional providers that are pulled into recovery for Medicare when only a portion of the amount is being recouped



- Any other partial recoupment of a claim

Gross-level adjustments are initiated using the paper Form 115 by: program area representatives, MCCC, and MIVS. The TPL area and the BRMP can also request gross-level adjustments using the same method.

The program area representative, MIVS, MCCC, the TPL area, or the BRMP identifies the exact data to be changed on the claim and calculates the amount of payment difference based on changed data. The individual completes the adjustment form 115 and submits it to MCCC for keying.

The information from the form 115 is transmitted as an adjustment claim from MCCC to Clemson. It is then pulled into the next claims adjudication cycle at Clemson for processing, resulting in a payment being applied to the provider's account as a debit or credit.

SCDHHS would like to eliminate the use of gross-level adjustments wherever possible and instead link all adjustments to claims.

3.3.17.3. Manage Edit Correction Forms

An ECF is generated by the MMIS for the purpose of making corrections to a claim. Information on the ECF reflects what was listed on the claim form. An exception to this is the potential for a data entry error.

Providers can alter rejected claims in one of two ways: by submitting a new claim form or by making manual corrections (in red) on the ECF, which recycles the original claim.

The MMIS generates in-house ECFs as part of the claims runs and provider ECFs as part of the weekly remittance advice run. In-house ECFs are printed by MCCC. Provider ECFs are printed with the weekly remit cycle by Clemson and delivered by courier to MCCC.

In-house edits

The MMIS produces ECFs for in-house resolution. The ECF indicates what on the claim resulted in an edit and requires resolution. All ECFs are marked with a tracking stamp by MCCC (indicates to/from/date), so the location of the ECF is known at any point. Each program area has a location code number. When a claim suspends that requires an in-house edit, an MCCC worker uses a hard copy list that indicates what program area in the agency can resolve the claim based on the provider and claim type. Each program area is assigned a unique location number. MCCC sends the ECF, hard copy claim, and any attachments to the program area for review.

The program area will resolve the suspended ECF based on edit code steps developed by the program area. Each program area has its own methodology for resolving edits as certain procedures and steps are not applicable across the whole agency. The program area has thirty days to resolve the suspension. Otherwise, the suspension goes into aged suspense, and those are tracked by MCCC as they are out of timeliness standards. An aged suspense could be a result of the program area waiting on additional information from the provider. MMIS aged suspense reports are used for this tracking.



A program area representative will mark the ECF manually in red to indicate the resolution or rejection (if no resolution can be made). Once completed, the program area representative completes the tracking stamp with their location code number and the date and returns the ECF to MCCS. MCCS brings up the CCN and keys in the resolution information directly into the MMIS or marks the claim as rejected and sends it through for processing. MCCS has two days from the receipt of the suspended claim to key it into MMIS and must meet a 98% accuracy standard.

Provider ECFs

MCCS mails ECFs to providers to correct rejected claims. MCCS manually stuffs any ECFs generated along with the weekly provider payment and remittance advice. When only some lines on a claim are rejected, an ECF is not provided since some payment was made on the claim. Any unpaid lines can be resubmitted on a new claim form.

The provider corrects any errors (as indicated by edit codes) in red and returns the ECF to MCCS for keying. The provider can contact his/her program area representative for assistance in correcting the ECF. A provider can also resubmit the information on a new claim form instead of correcting the ECF. 100% of provider ECFs must be resolved within thirty calendar days of receipt and must meet a 98% accuracy standard.

The agency plans to discontinue paper remittance advices in fall of 2009. Instead, providers will access PDF files of their remittance advices and ECFs online via a new secure web option. If the provider wishes to send in an ECF, he or she will have to print it from the web and fill it out.

BMSM staff would like to eliminate the use of ECFs. Instead, providers will be required to resubmit a new claim for each rejected claim. This would greatly reduce manual tasks and the use of hard copy documents.

3.3.18. South Carolina New Business Processes “Wish-list” Table

Wish-list Item	Related Business Process
Track claims that fail prescreening and are returned to providers.	Enter Claim
Functionality to perform an unlimited number of void/replacement adjustments on a claim.	Perform Adjustment
Eliminate the use of gross-level adjustments.	Perform Adjustment
Eliminate the use of ECFs.	Manage ECFs



4 Infrastructure Assessment

With input from executive staff, the SCDHHS team identified technical staff throughout the agency responsible for each of the interfaces and the PC applications that have been developed in-house for operational purposes. The process was a combination of interviews, phone conversations, and email exchanges.

A template was developed by the SCDHHS team that gathers as much operational and technical information as possible concerning the interfaces and PC applications utilized by SCDHHS in the Medicaid Enterprise. Initially, SCDHHS staff conducted interviews with SCDHHS technical staff and explained the template and instructed the staff to fill it out and return it by a specified deadline. This approach wasn't very effective as staff would easily misplace the template or forget the assignment as other more pressing tasks presented themselves. Because of this, SCDHHS staff began meeting with the technical staff, explaining the information needed and getting a basic overview of the interface or PC application. After this initial interview, SCDHHS staff would email or call the technical staff with additional questions until the templates were completed.

The documentation of the interfaces was a combined effort between the SCDHHS team and Clemson. Clemson is charged with the "production" of all the interfaces. BMSM supports many of the interfaces and the ones they do not support are handled by Clemson (**see MMIS/MEDS Overview Document**). Since Clemson maintains the MMIS and MEDS and supports many of the interfaces, they answered many of the technical questions for the interface templates.

The PC applications are systems / applications at SCDHHS that were developed by technical staff for support of operations throughout the agency. The SCDHHS team completed the documentation for these templates via the process described above.

Once the template had been completed, Clemson would review the interfaces and PC applications, producing questions of their own. These questions were meant to clarify responses contained in the templates, or prompt for additional information. In some instances, Clemson had enough knowledge to complete the templates, and the SCDHHS team was responsible for the review of these completed templates. After all questions and reviews had been completed for an individual template, SCDHHS would make the final approval.

The SCDHHS team also documented "wish list" statements gathered during the interviews, calls, and email exchanges with the SCDHHS technical staff. The "wish list" statements gathered from the staff consisted of things they would like to see implemented in a new system, changes to the way things are currently done or redesign of workflow in the current operations.

4.1. *MMIS /MEDS Interfaces Overview*

C:D is a point-to-point file transfer product used as the preferred method for sending and receiving Medicaid-related production files to all of the various agencies, partners, and contractors etc. that SCDHHS interfaces with (MMIS / MEDS). DSS acts as the central "hub" for these Medicaid-related production files to pass through via C:D for South Carolina. Files physically go through DSS, and sometimes, DSS will grab and manipulate the file (if required for formatting reasons etc.). The majority of the time, the files will pass through as a "touch and go" with little, if any, DSS intervention.



RACF (Resource Access Control Facility) is the security system that protects all mainframe resources at Clemson. Anything from who can view or edit a dataset to who can logon to specific systems at Clemson is secured this way.

C:D requires a username and password to sign-on to the online system. Additionally, to utilize C:D for transmission of files, you must have RACF access.

BMSM maintains an extranet that is used for transmitting ad-hoc non-production files to various agencies, partners, contractors etc. The extranet is a secure website accessible by authorized users via the internet. These files are sent using the extranet because they contain PHI (may be reports / results etc.).

All MMIS / MEDS jobs run on a mainframe at Clemson, so Clemson technically “executes” the jobs through a mainframe job scheduler known as Zeke (COTS application). Clemson is responsible for putting together run schedules, maintaining the job scheduler, releasing jobs to execute, and monitoring the jobs when they are running etc.

The MMIS interfaces are supported by both BMSM at SCDHHS, and Clemson Medicaid Services Interfaces (MMIS and MEDS contractor). The MEDS interfaces are completely supported by Clemson. For the interfaces BMSM supports, they are responsible for requesting the jobs to be put into the job scheduler and for making any changes to these jobs. BMSM uses a database program they developed, commonly referred to as the, “Job Master”. This database simply tracks information about which jobs BMSM supports and when they need to be submitted to Clemson for execution. BMSM is notified via email or a phone call by Clemson should the job terminate abnormally. If Clemson supports the interface, they are responsible for these tasks. The MMIS jobs located in the HHS.PROD.JCL library are supported by BMSM. The jobs located in MMIS.HHS.PROD.JCL library are supported by Clemson.

BMSM would like the flexibility to do ad-hoc functions. If these functions turn out to be long lasting items then BMSM would like for Clemson to pick up the jobs as part of the core system.

Later in this document is a listing of all MMIS / MEDS interfaces and their support owners.

4.2. PC Applications Overview

PC applications systems (both COTS and developed in-house) that are maintained at SCDHHS for use by various program areas around the agency to support SC Medicaid operations. These systems are outside of the MMIS / MEDS systems, and SCDHHS has determined that the functionality of the majority of these systems documented in this report will be incorporated into the future Medicaid Enterprise system. A few of the documented PC Applications are used in the Bureau of Fiscal Affairs. The functionality of these systems will be replaced by an SAP implementation that will tentatively occur 11/2/2009.

An overview of each system is provided. Detailed worksheets documenting all aspects of these interfaces can be found in Appendix K. This section provides a short overview of each system.



4.3. *MMIS Interfaces*

MMIS Interfaces Support Owner(s):

Interface	Supported By
Qualis	SCDHHS
DUR 1st IQ	SCDHHS
Companion Health Port	Clemson
EFT	Clemson
HIPAA Mailbox	Clemson
1099s	Clemson
Gov Connect Care Call	Clemson
Thomson Reuters	Clemson
USC	SCDHHS
PDP Part D	Clemson
Data Match	Clemson
MEVS	Clemson
IVRS	Both
MCO's	Clemson
DSS	SCDHHS
DHEC	SCDHHS
Continuum of Care	SCDHHS
Mental Health (DMH)	SCDHHS
MHN	SCDHHS
DDSN	SCDHHS
DOE	SCDHHS
School for Deaf and Blind (SC SD &B)	SCDHHS
SCAN	Clemson
ORS	SCDHHS
FH	Clemson
MMIS to MEDS	Clemson
MCCS	Clemson
ACS	Clemson
Milliman	SCDHHS
TRI-CARE DEERS	Clemson
SSA-8019	SCDHHS
Maximus	Clemson



Interface	Supported By
CMS- MSIS	Clemson
GAFRS	Clemson
Transportation	Both
CCME Encounters	Clemson

Detailed worksheets documenting all aspects of these interfaces can be found in Appendix K. This section provides a short overview of each of the interfaces.

4.3.1. 1099 Process

As required by IRS regulations, SCDHHS provides all non-exempt Medicaid Providers with a 1099 by January 31st of each year for payments (including various types of adjustments) that they received during the previous calendar year. Duplicate information is provided to the IRS via EDI. The current transfer method is FTP to the IRS Web site. This process is a combined effort between SCDHHS and Clemson.

SCDHHS is required by IRS regulations to provide all non-exempt Medicaid Providers with a 1099 by January 31st of each year for payments (less any adjustments) that they received during the previous calendar year.

4.3.2. Affiliated Computer Services (ACS)

SCDHHS contracts with ACS for certain TPL services including following TPL leads, maintaining policy information (except for automated data match done in MMIS), mailing invoices and letters as part of the TPL Recovery functions and posting responses to the TPL Recovery database in MMIS.

4.3.3. First Data Voice Services – Care Call

This is an interface where providers for CLTC can log their time at patients' residences via telephone by calling in and entering information at the beginning of the visit and again at the end of the visit. Care Call takes this information and generates an 837 transaction that comes in through the translator and is then processed like any other claims.

Care Call transmits 837s to Clemson on Thursdays and Sundays so that they can be included in the Tuesday payment run.

4.3.4. Carolinas Center for Medical Excellence (CCME)

SCDHHS contracts with an External Quality Review Organization (EQRO) called Carolinas Center for Medical Excellence (CCME). Through this interface, the BSM transmits monthly encounter files as needed to support the terms of the CCME contract. CCME audits MCOs.

4.3.5. CMS Medical Statistical Information System (MSIS)



The following edited version was taken from the entire document found at the CMS website:
www.cms.hhs.gov/MSIS/

Prior to Federal Fiscal year 1999, the Medical Statistical Information System (MSIS) was a voluntary program and those states participating in the MSIS project provided data tapes from their claims processing systems to CMS in lieu of the hard-copy statistical 2082 tables. However, in accordance with the Balanced Budget Act (BBA) of 1997, all claims processed are submitted electronically through MSIS.

The MSIS Tape Specification and Data Dictionary contains instructions on the file submissions.

Release 3, effective for files submitted on or after February 15, 2009, provided information for the expansion of all four MSIS claims files to collect the NPI, the provider taxonomy code and claims internal control numbers (ICN). In addition, filler space has been added for future data needs. The current version updates references to SCHIP.

To view important MSIS clarifying information concerning file record sizing, data set naming conventions, labeling, and volume/serial requirements is available by clicking on the "MSIS Submission Format" link on the left-side column of the website.

The purpose of MSIS is to collect, manage, analyze and disseminate information on eligibles, beneficiaries, utilization and payment for services covered by State Medicaid programs. States provide CMS with quarterly computer files containing specified data elements for: (1) persons covered by Medicaid (Eligible files); and, (2) adjudicated claims (Paid Claims files) for medical services reimbursed with Title XIX funds. These data are furnished on the Federal Fiscal year quarterly schedule, which begins October 1 of each year.

Each state eligible file contains one record for each person covered by Medicaid for at least one day during the reporting quarter. Individual eligible records consist of demographic and monthly enrollment data. Paid claims files contain information from adjudicated medical service related claims and capitation payments. Four types of claims files representing inpatient, long term care, prescription drugs and non-institutional services are submitted by the states. These are claims that have completed the state's payment processing cycle for which the state has determined it has a liability to reimburse the provider from Title XIX funds. Claims records contain information on the types of services provided, providers of services, service dates, costs, types of reimbursement, and epidemiological variables.

The current uses of MSIS data include

- Health care research and evaluation activities;
- Program utilization and expenditures forecasting;
- Analyses of policy alternatives;
- Responses to congressional inquiries; and
- Matches to other health related databases.

4.3.6. South Carolina Continuum of Care (COC)



After the MARS EOM cycle, an extract file is created for COC (http://www.continuum.sc.gov/directors_message.html) using SAS. This file is used by COC to reconcile claims data. These are claims that are sent to SCDHHS and are eligible for Medicaid reimbursement. The file is extracted based upon sponsor code (COC) and is created in a format defined by COC. COC uses this file to review claims information and to provide an audit trail for these claims. A file is provided to COC that contains monthly data. The file is provided to COC via Connect Direct.

4.3.7. *HealthPort*

The interface involves the transfer of provider and NPI information on a weekly basis and procedure code information on a weekly basis. The provider/NPI and procedure code files are sent to HealthPort and are used to provide high level front-end editing for their customers (providers). Providers send their claims to HealthPort for editing and submission to SCDHHS for claims processing (837 transactions). HealthPort does preliminary edits including edits to determine if the provider number/NPI is valid, and if the procedure code is valid and covered. In addition to these weekly file exchanges, HealthPort utilizes MEVS to exchange 270/271 Inquire Eligibility transactions via a direct line.

4.3.8. *Bureau of Medicaid Systems Management (BMSM) Data Match*

SCDHHS receives recipient data from providers, contractors and authorized consultants (those who work on behalf of a provider) to compare against data in the South Carolina Medicaid Management Information Systems (MMIS) to verify eligibility for the dates of service. This process is only used to request recipient data that is older than 13 months. There are various reasons that providers and authorized consultants would need to validate eligibility prior to 13 months (e.g. disproportionate share, checking PDP eligibility, a lawsuit, checking student eligibility so a school can ensure they got reimbursed properly, an audit reviewing claims denied etc.). If the data being requested is less than 13 months old, the request would go through the normal 270 process.

Currently, this is a manual task. Providers and authorized consultants submit request on CD's, disks or cassettes and eligibility data is returned to them on diskette and, if requested, in hard copy.

BMSM has currently gotten the number of providers who participate in this process to less than 18. The larger number of providers that used this process in the past has changed their business model in order to make requests via a 270 as opposed to waiting 13 months and then using the Data Match process.

4.3.9. *South Carolina Department of Disabilities and Special Needs (DDSN)*

On a monthly basis, SCDHHS produces a data file and two reports for DDSN for recipients in the following programs that are eligible for both Medicaid and Medicare: Department of Mental Retardation Waiver/Established (DMRE), Department of Mental Retardation Waiver/New (DMRN) and the Head and Spinal Cord/New (HSCN). The data file and the reports are created by the 5th working day of the month using Cobol and SAS to extract paid claims data from archives



and to transmit that data to DDSN via C:D. The file and data reports are sent directly from Clemson to DDSN.

4.3.10. Department of Health and Environmental Control (DHEC) – Breast and Cervical Cancer Program (BCCP)

On a monthly basis, SCDHHS produces five data files for DHEC of the claims that were paid during the previous month for recipients in PCAT 71. PCAT 71 is the (BCCP. The Breast and Cervical Cancer Prevention and Treatment Act of 2000 allows states to provide full Medicaid benefits to uninsured women who are found in need of treatment for breast and/or cervical cancer or pre-cancerous lesions (CIN 2/3 or atypical hyperplasia). SCDHHS creates a data file for Professional, Drug, Dental, Nursing Home and Hospital claims. These files are created around the 5th working day of the month and are copied to DHEC via HHCD033 server.

4.3.11. South Carolina Department of Mental Health (DMH)

After the MARS EOM cycle, two extract files are created for DMH using SAS by BMSM. These files are used by DMH to reconcile claims data. These are claims that are sent to SCDHHS and are eligible for Medicaid reimbursement. The files are extracted based upon sponsor code (DMH) and are created in a format defined by DMH. DMH uses these files to review claims information and to provide an audit trail for these claims. A monthly file and a summary file are provided to DMH.

4.3.12. South Carolina Department of Education (DOE)

After the MARS EOM cycle, an extract file is created for DOE using SAS. This file is used by DOE to reconcile claims data. These are claims that are sent to SCDHHS and are eligible for Medicaid reimbursement. The file is extracted based upon sponsor code (DOE) and is created in a format defined by DOE. DOE uses this file to review claims information and to provide an audit trail for these claims. A file is provided to DOE that contains monthly data. The file is provided to DOE via Connect Direct.

4.3.13. South Carolina Department of Social Services (DSS)

After the MARS EOM cycle, two extract files are created for DSS using SAS. These files are used by DSS to reconcile claims data. These are claims that are sent to SCDHHS and are eligible for Medicaid reimbursement. The files are extracted based upon sponsor code (DSS) and are created in a format defined by DSS. DSS uses these files to review claims information and to provide an audit trail for these claims. A monthly file and a summary file are provided to DSS.

4.3.14. Wachovia - Electronic Funds Transfer (EFT)

This interface is used to electronically send an ACH file to Wachovia to transfer funds to the different provider reimbursement accounts.

This interface is also used to electronically send a Med recon (medical reconciliations) file with all paper check payments to Wachovia so that reconciliation can occur when the providers cash the checks.

A provider is only in one file, this is based upon whether or not the provider is enrolled in EFT.



4.3.15. First Health

SCDHHS sends physician claims data to First Health under drug utilization review contract. The jobs/programs are in the SCDHHS libraries and executed from the HHS JCL library.

4.3.16. Government Accounting and Financial Reporting System (GAFRS)

Provider payment information from the weekly claims payment process in MMIS is transmitted to GAFRS, the accounting system used by SCDHHS. The system is physically housed at the Budget and Control Board; the system is maintained by their Chief Information Officer (CIO). SCDHHS's Bureau of Fiscal Affairs is responsible for using GAFRS to track financial transactions at SCDHHS from within GAFRS. Every financial transaction that happens at the agency (e.g. MMIS service payments to providers, administrative expenditures etc.) is entered into this system.

4.3.17. HIPAA Mailbox

The HIPAA Mailbox is the interface for sending and receiving files of HIPAA X12 EDI transactions to/from trading partners and also from the South Carolina Web Claim Submission Tool. The EDI Support Center, provided as part of a contract with MCCS, is involved in setting up the mailboxes.

TPA(s) specifies which transactions are legal for the trading partners to send in. Setting up the mailboxes includes setting these restrictions. The mailboxes are managed as part of a system often referred to as the EDI Translator System. Functions of the Translator System include:

- Archiving all inbound and outbound files
- Acknowledging receipt of X12 Files
- HIPAA X12 Compliancy Checking
- Translation between proprietary and X12 formats
- Repository for incoming transaction data.
- Notifying Trading Partner and/or EDI Support Center of translation/compliancy errors.
- Tracking
- Hourly uploads of 837 transaction files to the mainframe.

4.3.18. First Data Government Solutions - Interactive Voice Response System (IVRS)

Provider uses the phone to create an eligibility query that is sent first to First Data Government Solutions (contractor for SCDHHS), a 270 transactions is created and sent to the Clemson University MEVS server. A response is then sent from MEVS to IVRS with a message containing the eligibility information is played back on the phone for the provider.

4.3.19. Managed Care Organizations (MCOs)

SCDHHS contracts with MCOs to provide medical services for Medicaid recipients using a per member per month fee structure. Recipients are assigned to MCOs by SCDHHS, and MCOs receive an agreed upon amount each month regardless of the number of services provided for a member. For each service, the MCO must submit "encounter" data to SCDHHS. This data include MCO information, recipient information, procedure codes, physician information, dates, times, etc. This interface provides the means by which MCOs can submit files containing encounter data to SCDHHS. This data is submitted using a proprietary format via C:D. SCDHHS validates the data to determine whether it is valid or should be rejected. A number of data files are also



returned to the MCO by SCDHHS for reporting and management purposes. SCDHHS currently has contracts with seven MCOs.

4.3.20. *Maximus (Managed Care Enrollment Counselor)*

SCDHHS contracts with an Enrollment Counselor to manage the outreach to and enrollment of members into Managed Care. MMIS sends 834s to the Enrollment Broker/Counselor for eligible individuals, based on PCAT and RSP. The Enrollment Broker/Counselor sends enrollment decisions to the MMIS, which confirms back to the Enrollment Broker that enrollment decisions have been accepted. After receipt of the 834s, the Enrollment Broker/Counselor sends enrollment packets to managed care eligibles.

4.3.21. *Medicaid Claims Control System (MCCS)*

Providers submit claims to MCCS in paper form as well as on electronic media. MCCS uses a combination of OCR technology and manual data entry to enter the claims. MCCS then groups the claims into batch and transmits them to Clemson via a direct line. They are sent to the internal reader (INTRDR) using remote job entry (RJE), and arrive at Clemson as a batch job to be run.

Weekly, after the MMIS payment process, checks are printed at MCCS. These are merged with paper remittance advices and provider ECFs (which are printed at Clemson and delivered to MCCS) and mailed to the providers.

The file of Medicaid cards originates within the MEDS system (for newly eligible beneficiaries and replacement cards). This file is sent MMIS nightly, where it is further processed and sent to the card vendor (currently MCCS).

4.3.22. *MMIS to MEDS*

The first file is a listing of recipients that MMIS wants included in the Managed Care process. The second file is a read by MEDS to update the RSP indicator on the MEDS member data.

(Note: This interface represents a data exchange between the MMIS and MEDS. It does not send/receive data from an external entity.)

4.3.23. *Medicaid Eligibility Verification System (MEVS)*

This interface creates files by extracting data from MMIS, on a daily basis, to populate the MEVS database. The MEVS database is completely repopulated every day, not updated. Recipient eligibility and some information on eligibility for Medicaid programs are kept. Vendors query via EDI X12 270 transaction as to whether or not on this date the recipient is eligible.

The Translator interfaces with MEVS by X12 270 EDI transactions coming in via mailboxes. It forwards the transactions from the mailboxes to MEVS, via SFTP, for processing. MEVS then makes available the response files so that the translator can retrieve and place them into the mailboxes for pickup.

The Eligibility portion of the SC Medicaid Web Based Submission Tool queries MEVS using EDI X12 270 and 271.

4.3.24. *Medical Homes Network (MHN)*



Provides data for Medical Homes Network sure recipients and boards (last 6 months of any Fee for Service claims for boards eligible recipients) to MHN. The data is used by the plan to coordinate care for the participating recipients.

4.3.25. *Milliman (Actuaries)*

This is an Executive Staff contract for actuarial services and associated reporting.

4.3.26. *South Carolina Budget and Control Board – Office of Research and Statistics (ORS)*

This interface is used to submit ad hoc requests for data that come from ORS. The interface gives ORS data they need to fulfill research request to various agencies requiring Medicaid statistics.

4.3.27. *Medicare Part D GAPS Coverage*

PDP insurance carriers participating in the GAPS Program are required to submit encounter data to SCDHHS. These data are to be submitted monthly along with a paper invoice. The Pharmacy program area processes the paper invoice and compares it to the report from processing the encounters. This report is also posted in D:D. The Pharmacy program area used D:D to save report as a text file when needed for transfer to the PDP. This transfer is made via the SCDHHS Extranet.

Encounter data is submitted to SCDHHS by each PDP. The data is stored on the MMIS mainframe at Clemson. SCDHHS analyzes data and provides a report to the Pharmacy program area. Reports are provided to each PDP when needed.

4.3.28. *First Health – Pharmacy Point-of-Sale (POS)*

SC Medicaid has contracted with a pharmacy POS contractor to adjudicate pharmacy claims and a limited set of DME procedure codes (diabetic testing supplies). Pharmacies can check eligibility, submit claims for drugs and DME procedures codes, and call the help center.

The contractor adjudicates the claims using their FirstSX system. Clemson sends them data (Recipient File, Policy File, and Drug File). The adjudicated claims are placed directly on the mainframe at Clemson once at week, mostly on Wednesday. An e-mail is also sent to Clemson containing the number of claims. Clemson manually verifies this and alerts the contractor. Basic front end processing is then done on the claims.

MMIS only does very basic edits on these claims during claims processing.

4.3.29. *Qualis Health – Quality Improvement Organization (QIO)*

Produces QIO claims data for Qualis Health.

4.3.30. *DHEC – South Carolina Community Access Network (SCAN) – Medicaid Eligibility Module*

SCAN is an interactive data retrieval website provided via the Internet for community assessment, planning and viewing of health information (more specifically, Medicaid eligibility data). This information is used by legislative staff, county officials, planners, researchers, citizens, etc. Users can create tables, charts, and maps according to their interests and specifications. In essence, users can query the system for information related to Medicaid eligibility data.



DHEC manages/maintains the SCAN website. SCDHHS will make available to DHEC two Medicaid eligibility data files via C:D for distribution on this website. The first file will include monthly eligibility data and the second file will include Fiscal year (unduplicated) eligibility data. The website will contain an introduction, list of definitions, list of payment categories, standard queries for frequently requested information, etc.

4.3.31. *South Carolina School for the Deaf and the Blind (SCSD&B)*

After the MARS EOM cycle, two extract files are created for SCSD&B using SAS. These files are used by SCSD&B to reconcile claims data. These are claims that are sent to SCDHHS and are eligible for Medicaid reimbursement. The files are extracted based upon sponsor code (SCSD&B) and are created in a format defined by SCSD&B. SCSD&B uses these files to review claims information and to provide an audit trail for these claims. A monthly file and a summary file are provided to SCSD&B. The files are provided to SCSD&B via C:D.

4.3.32. *Social Security Administration (SSA) through DSS – SSA8019*

Clemson receives files from SSA via DSS and sends a processed file and report to MIVS.

SSA 8019 is a form called the "TPL Information Statement" where by the SSA obtains third party liability information and provides that information to the State agencies that provide Medicaid under the terms of an approved plan in accordance with Title XIX of the Social Security Act. The Medicaid State agencies then use the information provided to attempt to bill any third parties liable for medical care, support or services for a beneficiary for that care, support or services to guarantee that Medicaid remains the payer of last resort.

This interface consists of three weekly jobs which process a data file from SSA via DSS. The jobs verify data, process the file and create a file going to ACS.

The jobs also produce a report to indicate possible leads for ACS of new Medicaid beneficiaries with third party insurance.

This interface is the responsibility (on-call) of SCDHHS, not Clemson, although it runs on the Clemson mainframe.

JOBS:

SSAVERI - VERIFIES 'HHCD010.SSA8019.WCF' from DSS

SSA8019 - PRODUCES 'HHS.FTP2.SSA8019'

SSAHCD - CREATES 'HHCD010.SSA8019' and WCF to ACS

4.3.33. *Thomson Reuters MMIS/MEDS Interface*

The purpose of the interface is to provide agency data to the vendor for the purpose of populating the decision support system and SURS System. These systems are used by the agency for reporting and program integrity research.

A collection of mainframe jobs run on weekly and monthly basis to extract data from MMIS and MEDS databases and the resulting files are transferred to the vendor via C:D.

4.3.34. *Transportation Brokers*

SCDHHS contracts with several Transportation Brokers who provide non-emergency transportation services to Medicaid beneficiaries. This interface exists to support a process for



SCDHHS payment to Transportation Brokers based on a monthly capitation rate for each Medicaid beneficiary residing within an established region. The interface also collects essential Broker and transportation provider encounter data in support of the Transportation Broker Program.

4.3.35. *TRICARE DEERS Data Match*

This is a yearly interface that begins with SCDHHS/Clemson creating a file of SC Medicaid Eligible beneficiary information which is sent to TRICARE. There it is processed against the DEERS data store to identify and extract policy coverage information which is sent to MMIS for processing and updating the MMIS Policy Database.

4.3.36. *University of South Carolina (USC) – Institute for Families in Society (IFS and HEDIS Measures) and the USC School of Pharmacy*

This data is for analyzing the cost effectiveness of Medicaid services provided to Medicaid eligible children and adults residing in South Carolina for SCDHHS. The data is also used for epidemiological research.

4.3.37. *South Carolina Medicaid Web-Based Claims Submission Tool*

The Web Tool allows providers to accomplish tasks quicker and more efficiently than using paper forms.

The Web Tool serves as an alternative method in the creation, editing, submission, and adjustment (void and void/replacement) of CMS-1500, UB-04, and Dental claims. It allows for the creation and modification of personalized lists (provider, recipient, payer, insured etc.), which when used, decrease the claim submitter's need to type repetitive data. It enables a provider to check the status of any submitted claim or to view/copy previously submitted web claims (Reports feature) for refactoring thereby decreasing the time it takes to prepare a claim for processing. Lastly, Medicaid eligibility queries of a single recipient or in batches of up to 50 to provide instant "at a glance" verification of eligibility.

To view or copy previously submitted claims (Reports feature) or to view claims status, the Web Tool server queries the Web Tool SQL Server database and displays the results in the provider's web browser.

For eligibility verification requests the web server sends a 270 transaction to the MEVS Eligibility Processing System. MEVS responds to each of the requests in real time and passes 271 transaction(s) back to the Web Tool for display in the provider's web browser.

For the creation of personalized lists, entering of claims, and the editing of claims no transactions are sent to the mailbox for processing by MMIS. All data is stored on the SQL server for future use. The claims data is kept for submission to claims processing.

For submission of claims, the claim first has to be entered as above. Then the provider may choose to submit the entire batch or selectively submit each claim. When submitted, the Web Tool sends an 837 X12 transaction file to a mailbox for processing by the Translator. The Translator then "pushes" the data to MMIS (for more information on the steps see HIPAA Mailbox MMIS Interface). After the claims have been submitted successfully, the provider receives a confirmation message in the web browser that includes the batch ID number for the



claims. The claims are processed in a claims run (**Edit Claim**) and appear on the provider's monthly remits and payments.



4.4. *MEDS Interfaces*

MEDS Interfaces Support Owner(s):

Interface	Supported by
SC State Retirement System (SCSRS)	Clemson
Employment Security Commission	Clemson
Medicare Modernization Act (MMA)	Clemson
State Data Exchange (SDX)	Clemson
Buy-in	Clemson
Enumeration Verification System (EVS)	Clemson
US DHHS Office of Children and Family Services Public Assistance Reporting	Clemson
MMIS (MEDS to MMIS)	Clemson
State Verification & Exchange System (SVES)	Clemson
Beneficiary Data Exchange System (BENDEX)	Clemson
Department of Social Services Data Sharing (CSE)	Clemson
COB	Clemson

Detailed worksheets documenting all aspects of these interfaces can be found in Appendix J. This section provides a short overview of each of the interfaces.

4.4.1. *Beneficiary Earnings and Data Exchange System (BENDEX)*

The BENDEX interface is part of the IEVS. IEVS is an automated system that matches Medicaid applicants/recipients with the ESC, the SSA, BEER, and the IRS (not implemented). The IEVS is designed to assist in the determination of an applicants' eligibility through the exploration of past and present income. All applicants must be matched at application time. Information obtained through IEVS is highly confidential.

BENDEX is an ongoing nightly data exchange with SSA. For every new Medicaid recipient, an initial request is made to establish the exchange. A request is resent when the SSN, SSCN, Medicare number, disability dates, or date of death changes. There is an online screen where a worker can initiate a request. A worker's request takes priority over a nightly exchange.

Once the exchange is established, initial entitlement and material changes in entitlement to SSA benefits are automatically reported to the state as well as Medicare data and disability information. The benefit information is used to update the Medicaid member's financial information and is used for applications, rebudgets and reviews. Discrepant information and exceptions are reported through alerts and reports. In November of each year, MEDS uses the information from BENDEX to automatically recalculate the countable income for budget groups containing persons that have received the annual cost of living increase in their SSA benefit check (COLA occurs in Jan or March). The BENDEX interface also provides the SSA benefit information to use in recalculating continued eligibility for GAPS on an ongoing basis.



4.4.2. Buy-In Interface

The MEDS Buy-In interface exchanges weekly, in a batch mode, information with CMS in Baltimore to transmit all Buy-In (Part A and Part B) accretions, deletions and changes. It processes the daily Buy-In transactions and monthly billing file received from CMS and generates a monthly file to MMIS for processing of premium payments. It captures and maintains the Medicare claim number to support this interface and also builds a history of the Buy-In eligibility based on the incoming transactions from CMS. Workers are notified of discrepant information through online alerts and reports. The system identifies those who are potentially eligible for Buy-In and those who are ineligible and creates the Buy-In transactions to be sent to CMS according to the schedule defined in user-maintained system table structures.

4.4.3. Coordination of Benefits (COB)

The COB Contractor Interface is a monthly data exchange between states and the COB Contractor to share information related to the Medicare Part D program. The purpose of the COBC process is to coordinate the prescription drug benefits between Medicare Part D plans and the State Pharmaceutical Assistance Programs (SPAP), which serve as supplemental payers. This collection of all prescription drug related benefits will facilitate the tracking of TrOOP (True Out-of-Pocket) expenses incurred by each Medicare beneficiary. MEDS transmits a file of persons enrolled in the SPAP to the COBC monthly. South Carolina's SPAP is the Gap Assistance Pharmacy Program for Seniors (GAPS). It was established to assist low income Medicare beneficiaries with prescription drug costs during the period when Medicare Part D does not pay. Only persons eligible for GAPS (PCAT 92) are sent to COBC.

The COBC notifies the state whether the SPAP recipient is enrolled in Medicare Part D and/or Low Income Subsidy and provides other information related to the prescription drug coverage such as the plan number and enrollment date. Online screens display the information received from the COBC. Certain parts planned to be implemented in MEDS for the COB interface are still outstanding. These are:

- Automated closures with the new notices.
- Automated updates to include but not limited to date of death, LIS dates, Medicare coverage dates, LIS coverage dates, and Part D coverage dates.
- Create Audit and History tables and screens to display audit and history data.
- Purge aged data

4.4.4. Department of Social Services Data Sharing

Once a week an unduplicated file of Medicaid eligibility and enrollment information for all members in active, pending, or closed budget groups is generated and sent to DSS for the purpose of administration including determining eligibility and providing or arranging for services as allowed by SC Code Regs. 126-170 *et seq.* The data is used by the CSE Program under Title IV-D for enforcing medical support obligations. It is used by the Temporary Assistance to Needy Families (TANF) and Supplemental Nutrition Assistance Program (SNAP) programs as lead information for eligibility determinations and for referrals.

DSS has contracted with SABER to implement a new CSE system. The new system is scheduled for implementation in March 2011. Many system changes will be required for SCDHHS to provide the information that the DSS Child Support Enforcement Department is federally mandated to receive from Medicaid. SCDHHS also has future plans to receive information from



DSS that will be used to automatically establish Medicaid eligibility for Title IV E Foster Care and Adoption Assistance children.

4.4.5. *Employment Security Commission (ESC) Interface*

This interface consists of three parts. ESC provides to SCDHHS a full wage file quarterly and changes monthly (1), a weekly file of unemployment compensation benefits (2), and a monthly file of persons receiving special benefits (3). This interface is an unencrypted tape that is delivered to SCDHHS via courier.

The following is a description of what the ESC provides to SCDHHS:

- **ESC-Wage** – The wage file includes the name and address of the employer and up to 6 quarters of wage data for an individual. The ESC wage data is updated to a master file. Workers access the master file through an online screen. Exceptions are reported through reports. Note: ESC provides a separate file of employers that must be used in conjunction with the wage file to identify the employer name and address.
- **Unemployment Compensation Benefits (UCB)** – The weekly file of South Carolina residents receiving UCB is updated to a master file and to the MEDS member's financial record. Up to 52 weeks of UCB data is maintained. Workers access the master file through an online screen. MEDS automatically terminates eligibility if the UCB data received for a person eligible for GAPS (PCAT 92) exceeds the income limit.
- **Special Benefits** – This portion of ESC has not yet been implemented, but the file is currently being received. The monthly file of special benefits identifies South Carolina residents receiving special assistance such as Trade Adjustment. The MEDS plan was to update the amount of the special benefit to the Medicaid member's financial information so that it could be used for initial determinations, re-budgets, and reviews. The receipt of or increase in special benefits would automatically trigger a redetermination and recalculation of countable income. Exceptions would be reported through alerts and reports. Screens would also be available to view the Special Benefit information received from ESC.

4.4.6. *Enumeration Verification System (EVS) Interface*

EVS is a batch interface with SSA that assists Medicaid eligibility workers in verifying and obtaining a valid SSN, particularly for newborns. EVS identifies persons with no SSN and creates a request to SSA to obtain the SSN. SSA matches the name and date of birth to their records and communicates their findings through a verification code. The SSA response is displayed online and the worker is notified through alerts of the result of the match. A notice is sent to the primary individual if SSA was not able to match the states' information to their records. The notice requests they apply for an SSN or notify their eligibility worker if they have already obtained an SSN.

4.4.7. *MEDS to MMIS Interface*

This interface is a nightly transfer (copy) of data from MEDS to MMIS. It includes Budget Group (Family), Member (Recipient), Medicaid Card, and Managed Care information.

4.4.8. *Medicare Modernization Act (MMA) Interface*

The Medicare Modernization Act of 2003 established the Medicare Prescription Drug Program, also known as Medicare Part D, making prescription drug coverage available to Medicare beneficiaries, effective January 1, 2006. The MMA transfers payment responsibility for the



prescription drugs of dually eligible Medicaid and Medicare enrollees from Medicaid to Medicare. The MMA also established the Low-Income Subsidy (LIS) to assist individuals with low income and resources with payment of premiums, deductibles, and co-payments required under Part D.

MMA provides for a continued state contribution to the cost of providing drug benefits for full benefit dual eligibles through a monthly payment from the states to the Federal government. The Secretary determined a per capita amount for each state. In January 2006, states began making monthly payments to the Federal government for each full benefit dual eligible in Part D. The state contribution is reduced each subsequent year by equal amounts to 75% of the calculated per capita amount in 2015 where it remains thereafter. The state contribution is also known as maintenance of effort or clawback.

The MMA interface is a monthly data exchange between states and CMS. States gather information on dual eligibles (full and partial) and potential full dual eligibles and sends to CMS. CMS identifies a full dual as a person having Medicare and full Medicaid benefits. A partial dual is one who is eligible for QMB only, SLMB or QI1. CMS identifies potential eligibles as persons who are not known to be full dual eligibles, but are Medicaid eligibles approaching an age or disability status that is likely to lead to a future determination of full dual eligibility. If CMS can match the state's information to their records, it returns Medicare information related to the Medicare Part D prescription drug plan program, e.g. Medicare Part A, B, C, D, and LIS enrollment dates and the person's Part D plan contract number. This information is updated to the eligibility database and is used in the claims payment process. Online screens are available to display the information received. SCDHHS Bureau of Medicaid Systems Management staff uses the Medicare information provided by MMA to resolve Buy-In rejections.

4.4.9. SC State Retirement System (SCSRS) Interface

The SCSRS provides a monthly file of South Carolina residents who receive retirement benefits. SCDHHS receives this file from SCSRS through DSS via C:D. The information is updated to a master file and is available online for future reference if needed for new applications or when an existing MEDS member becomes a new beneficiary of state retirement income. Receipt of or changes in the state retirement benefit are automatically updated to the Medicaid member record and can be used in eligibility determinations and reviews without an independent verification. Workers are alerted if the change requires a redetermination of eligibility (because of a change in income etc.). The redetermination process is not automated; the process requires manual calculations by a program area worker. For those clients who have state retirement benefits, the file provides documentation of benefit amounts as well as an indicator of other insurance coverage. Annually (May and June), the SCSRS is notified of persons receiving a state retirement benefit and reside in a nursing facility. A cost of living increase is not awarded to residents of nursing homes. For other categories, the eligibility data system automatically recalculates the countable income for budget groups containing persons that have received the annual cost of living increase in their state retirement benefit check.

Automated updates of information and re-budgets, when applicable, are planned to be included in the eligibility data system.

4.4.10. State Data Exchange (SDX) Interface



South Carolina is a 1634 State. See Governing policies (item 8) for definition of 1634 State. The SDX is an interface designed to receive SSI data from the Social Security Administration (SSA) for the purpose of establishing and maintaining Medicaid eligibility. When SSA notifies that an individual is SSI eligible, Medicaid eligibility is automatically established, if there is no current eligibility. If there is current eligibility, the Medicaid eligibility record is updated with the SDX data, if appropriate. When SSA notifies that an individual has lost their SSI, the system automatically updates the Medicaid eligibility record to reflect termination of eligibility. Most recipients losing their Medicaid due to the loss of their SSI benefit are given an additional 30 days to apply for benefits under another Medicaid coverage group before their eligibility is terminated. Updates are applied to MEDS based on the member's current SSI and Medicaid eligibility status and the Medicaid payment category.

The system reports, through online alerts, invalid and discrepant data, special transactions, non-process-able transactions or other conditions as defined. Reports are also generated for information as well as for exceptions. A Client Inquiry screen is available to display the SSI information received from SSA. The SDX transaction is also available online for resolution of discrepant data. SDX transactions are stored for 1 year.

4.4.11. State Verification & Exchange System (SVES)

A data exchange of new and prospective Medicaid recipients that occurs nightly for the purpose of:

- SSN Validation
- SSA Benefits Verification
- SSI Benefits Verification
- Coverage Quarters Verification
- Prisoner Status Verification

This file is transferred to DSS and merged with other SVES requests. DSS transmits to the Social Security Administration through Connect Direct. The SSA processes this request file and sends back a response file with the information based on the request that was made.

The requests for SSN validation are generated automatically whenever a new or prospective Medicaid recipient is entered into MEDS or changes are made to specific personal information. Through online access with appropriate security authority, a user may manually request a SSA, an SSI inquiry, QC40 inquiry, and/or a prisoner inquiry. A QC40 inquiry is used to identify continued employment for 40 quarters); this describes the number of qualifying quarters of social security for the Medicaid recipient. A prisoner inquiry is used to determine if the recipient is in prison for the purpose of informing the worker so they can use it in the eligibility determination process. A SSA-SSI inquiry is for the identification of SSA and SSI benefits. There is only one file returned for SSN validation and SSA-SSI inquiry data.

4.4.12. Paris Interface

The Public Assistance Reporting Information System (PARIS) was created to allow participating states to identify:

- Persons that may be receiving benefits in multiple states (Interstate match)
- Persons receiving VA benefits (VA match)



- Persons receiving military pensions, etc. (Federal match)

Once a quarter, SCDHHS sends Medicaid data for members of active and pending budget groups to the Defense Manpower Data Center (DMDC). The Office of Children and Family Services administers PARIS and contracts with DMDC to receive Medicaid data from participating states and data from the Veterans' Administration and the Department of Defense. DMDC matches the state data with the data received from other states, the Veterans' Administration and the Department of Defense and returns information to the states.

SCDHHS only requests matches with other states and VA at this time. There is not an agreement in place for SCDHHS to receive the Department of Defense matches. Currently, only the interstate match portion of PARIS is operational.

The COM components are used to combine and format the data from the ARS components to be used to generate a PARIS request file.



4.5. PC Applications

PC applications systems (both COTS and developed in-house) that are maintained at SCDHHS for use by various program areas around the agency to support SC Medicaid operations. These systems are outside of the MMIS / MEDS systems, and SCDHHS has determined that the functionality of the majority of these systems documented in this report will be incorporated into the future Medicaid Enterprise system. A few of the documented PC Applications are used in the Bureau of Fiscal Affairs. The functionality of these systems will be replaced by an SAP implementation that will tentatively occur 11/2/2009.

Certain PC Applications (4.5.1 – 4.5.16) will be replaced by the new SAP system and will not be included in the new Medicaid Enterprise system. Included in this list is GAFRS, which is maintained by the South Carolina Budget and Control Board. This system is SCDHHS' primary agency-wide accounting system (that will be replaced by the scheduled SAP implementation), and SCDHHS has technical staff that supports this system. For these reasons SCDHHS has chosen to include it in the documentation.

The functionality of the remaining documented PC Applications (0 – 4.5.22) will be replaced by the new Medicaid Enterprise System.

4.5.1. Accounts Receivable Log (ARL) System

All receivables that have been identified by SCDHHS (i.e. the AR Department) are entered into the Accounts Receivable Log (ARL). Once in the ARL, the receivable is assigned a receivable # (RC #). This RC # is then keyed into the GAFRS system for official tracking with Comptroller General's Office.

Weekly revenue detail reports are submitted to the TPL and Program Integrity program areas at SCDHHS for recovery tracking purpose. Program Integrity utilizes that information to track and reconcile Medicaid overpayment debts that have been submitted from their area.

4.5.2. Approach System

The Approach System is a "Lotus" tool that functions as a database similar to Microsoft Access. The system is housed in the Bureau of Information Technology (BITS). It is located on the network under a specific user directory; however it is not distributed over the network for multiple users. The application resides on a particular machine.

4.5.3. Cash Receipt Log (CRL) System

All checks that are received by the AR program area are entered into the CRL. The CRL assigns a receipt number and captures the check number, payer, date, provider # (if applicable), etc. All of these entries can be searched at a later date if research has to be done on a specific check.

Once a month, SCDHHS sends a floppy disk to MCCC so that they may key the aforementioned receivable checks (RC12's) into the MMIS to capture checks that have been submitted for 1099 reporting. SCDHHS sends a Data Transmission Form and MCCC acknowledges receipt by sending the form and the disk back to SCDHHS (This is a paper report).



Weekly revenue detail reports are submitted to the TPL and PI Divisions for recovery tracking purpose. Program Integrity utilizes that information to track and reconcile Medicaid overpayment debts that have been submitted from their area.

4.5.4. Check Cancellation System

The Check Cancellation System is used to track the deletion and cancellation of checks paid to Medicaid providers (e.g. a provider didn't cash the check within the required period of time etc.). It is also used to track reissued checks to Medicaid providers. Information entered into the Check Cancellation System for deletions and cancellations is transferred to Clemson's mainframe via FTP under a Time Sharing Option (TSO). Clemson uses this information to generate a tape or file to send to the bank to have these items removed from the bank's master file. Cancellation information is also sent to MCCS to process RC18 adjustments that are keyed into MMIS to reduce the provider's 1099.

4.5.5. AdminDays System

The Medicaid Administrative Days database program is used when a Medicaid beneficiary has been discharged from acute care but is still in the hospital waiting on a nursing home bed to become available. This database is used for logging administrative day's claims. Providers send their hardcopy administrative day's claims to SCDHHS. The Hospital Services program area processes these claims. The administrative day's rate is used to calculate what this period of time costs; then the provider files a claim to receive payment for services during that period. These claims, made by providers, are for the period of time in which a Medicaid beneficiary has already been discharged and is awaiting a nursing home bed. The administrative day's rate changes yearly and the new rates are entered into the program area's (Hospital Services) database. Once the claims are entered into the database, the database program will multiply the number of days and the administrative rate at the time service was rendered. After entering all administrative days' claims, a credit adjustment is done for each hospital (provider). When they have been signed, the credit adjustment is forwarded to MCCS for payment. Upon request, a report can be printed (using the actual database program itself) to show the patients and providers that participate or have participated in the program.

4.5.6. Appeals and Hearings System

This is a database system that is used for keeping track of appeal case information. Information such as the name of the person appealing, date received, hearing officer, and case number etc. are all recorded in this database. The system also tracks information for the cases as they flow from a newly opened case all the way to a closed case. However, tracking of the actual correspondence between all parties involved in the appeals process is not tracked in this system (see wish list below). While this database system ultimately achieves the goal of tracking actual appeals, and information related to the appeal process, it is not user friendly.

4.5.7. ApplicationXtender

The ApplicationXtender System is a COTS document imaging solution for scanning and archiving documents from various program areas across the agency. Once archived, documents can be retrieved from this system for review. There is PHI information on many of the documents being scanned (e.g. eligibility, benefits, Managed Care related documents etc.). Documents are retained indefinitely unless a purge is requested. The vendor EMC website for ApplicationXtender is:



http://info.emc.com/mk/get/15711_LAND_STD?reg_src=WEB&P.ctp_program_execution.Source_ID=15711&CMP=KNC-Google

The following describes how each of the six business areas identified as stakeholders use **ApplicationXtender**:

Central Eligibility Processing:

This program area has case files that they need digitally archived. They produce the transmittal letter with Scan Log (described later). The transmittal letter along with the documents needing archival is sent to BITS, which scans the documents into the system. The program areas can then launch ApplicationXtender on their computers and view the archived documents.

Beneficiary & User Services, Program Support:

This program area uses the ApplicationXtender to digitally archive enrollment / disenrollment / transfers for Medicaid patients (Managed Care). They produce the transmittal letter with Scan Log (described later). The transmittal letter along with the documents needing archival is sent to BITS, which then scan the documents into the system. The program areas can then launch ApplicationXtender on their computer and view the archived documents.

Policy / Planning, Eligibility / Policy Oversight:

This program area has case files that they need digitally archived. They produce the transmittal letter with Scan Log (described later). The transmittal letter along with the documents needing archival is sent to BITS, which then scan the documents into the system. The program areas can then launch ApplicationXtender on their computers and view the archived documents.

TPL, Fiscal Affairs:

This program area has checks (cash receivables), case files and correspondence that they need digitally archived. They produce the transmittal letter with Scan Log (described later). The transmittal letter along with the documents needing archival is sent to BITS, which then scan the documents into the system. The program areas can then launch ApplicationXtender on their computers and view the archived documents.

Accounting Operations, Fiscal Affairs:

This program area has checks (cash receivables state recovery, or casualty recover) that they need digitally archived. They produce the transmittal letter with Scan Log (described later). The transmittal letter along with the documents needing archival is sent to BITS, which then scan the documents into the system. The program areas can then launch **ApplicationXtender** on their computers and view the archived documents.

Appeals & Hearings:

This program area has hearing files (old order decisions) that they need digitally archived. They produce the transmittal letter with Scan Log (described later). The transmittal letter along with the documents needing archival is sent to BITS, which then scan the documents into the system.



The program areas can then launch **ApplicationXtender** on their computers and view the archived documents.

Note: The ApplicationXtender system is a COTS scalable to the environment system. Licensing is concurrent and users are named within the system. For detailed hardware requirements contact vendor EMC or check their website <http://www.emc.com/products/family/documentum-applicationxtender-family.htm>

4.5.8. Beneficiary Users System (BUS)

This system is used as a record keeping / tracking tool when SCDHHS receives Managed Care Plan Enrollment / Disenrollment / Change Form (SCDHHS Form 280-2) from members. SCDHHS is able to enter the members' family number, name, address, notes, and other identifying information. Persons who have access to this system are able to read notes and track forms / correspondence to check the status of a member's request.

4.5.9. Community Long Term Care – Case Management System (CLTC CMS)

South Carolina relies upon the CMS for the day-to-day management of three Medicaid waivers (Elderly/Disabled, HIV/AIDS, and Ventilator Dependent). The system is a Microsoft Access application. CMS databases are maintained daily by the state's 13 CLTC regional offices, with updates to the central database occurring nightly.

CMS contains information from assessments, and service plans for the Medicaid home and community-based services waivers listed above. The service plan includes information on the reasons a person may need long-term care services (the "problems"), the preferred result for the person related to the problems (the "goals"), and the means to reach the goals (the "intervention"). Case managers enter the service plans, and information obtained during assessments into the CMS.

In addition to supporting intake, assessment, care planning, and service initiation functions, CMS is also used to support quality management through its report-generation function (e.g. reports on timeliness of assessment, reassessments, care plan development, tracking missed provider visits, identifying participants at risk in the event of an emergency or natural disaster etc.).

4.5.10. Constituent Services System

The simple database system is used to track constituent (e.g. other agencies, legislators etc.) cases (issues) received via direct call, agency email box, legislative referrals, etc. Constituent Services staff uses the system to track the progress and keep record of issues they are handling. The tracker allows this area to quickly find information on individuals within the agency they have assigned to a constituent case in the past (the system keeps record of all past entries). They also use the tracker to log letters that go out under Agency Director or the Deputy Director of Medicaid Eligibility and Beneficiary Services. The tracker is used for ad-hoc reports as well to determine which cases are pending and who in the agency is responsible for handing the case.

4.5.11. Contract Log System (CLS)

The CLS is used to:

- Assign contract numbers by provider type.



- Add/change a provider record.
- Delete a provider record.
- Change a status records.
- Amend a provider record.
- Browse contracts.
- Track review process (i.e. to - from dates).
- Reports include the Renewal list of contracts by Bureau, All Bureaus, and Procurement Specialist.
- Provider the Sole Source/MMO contract.
- HIPAA Report.
- Administrative Cost Sharing Report.

4.5.12. Dental Prior Authorization System (DPAS)

DPAS is used to submit and track approved PA requests as they are processed, and as a beneficiary treatment history resource. PAs that have been denied are kept in the Dental program area filing cabinet (there is no place in the DPAS system to enter a denial).

Process for using DPAS:

1. When the Dental program area receives a request from a provider for PA for services to be performed, the request is either approved or denied. Then, the information for approved PAs (provider number, recipient number etc.) is entered into the DPAS system and a prior authorization (PA) number is assigned to the request.
2. In cases of determination of medical necessity for non covered services or frequency issues, the request (with documentation attached) is then forwarded to the program area's dental consultant for his/her determination of approval or denial of the request. The consultant may also assign an allowable reimbursement rate to the services.
3. Services that are standard frequency issues (e.g. multiple periodic Panorex films taken for treatment of broken mandible outside the once every 3 years limit) and have documentation attached, are entered, approved and returned (mailed) to the provider.
4. The provider will then submit a claim to Medicaid (mailed), with the PA number listed on the claim form and a copy of the approved request for PA. They will list the procedure code "D9999" on the claim and this will result in the claim suspending to the program area with an edit of 507- Manual Pricing required.
5. The program area then enters the reimbursement pricing amount and returns (mails) the suspended claim to MCCS for processing.

4.5.13. Durable Medical Equipment (DME)

This system is an in-house database application that is essentially used to house all of the approved PA information for durable medical equipment. This application is also used to track the DME and supplies. If a PA request is denied, a notice is sent to the provider, and recipient – and hardcopies of the correspondence are archived (there is no electronic imaging). The denied PA request is not kept in this tracking system. Only approved PAs are tracked. The current application is very cumbersome and repetitive; the program area would like to see it



redesigned to be more efficient. The application is used on a daily basis to look up old accepted prior authorizations as a safe guard against duplicating equipment. The application is also used to manually place new information online for this program area's research.

4.5.14. Estate Recovery System

The ER System is a database that is used for tracking ER cases and related information.

An individual must have been on Medicaid and receiving either CLTC services or Nursing Home care in order to be subject to ER The ER System has three primary functions: case management, diary, and reports.

The case management function of the ER System is used to track the returned questionnaire information – and open a case if there is sufficient enough assets (greater than \$10,000) to pursue a claim. The diary function is used to keep track of critical time reminders and deadlines.

An ER Questionnaire is sent to the family or personal representative of all recipients who died that were either in a nursing home or receiving CLTC services. The letter that is sent out with the questionnaire is generated out of the ER System.

Preparing Claims Package

Review case files for all pertinent information and ensure that all information has been posted accurately to the Estate Recovery database. The following is a list of the pertinent information:

- Case Number
- Personal Representative(s) Information (name and address)
- Attorney Information (name and address)
- Date of Death
- Date Notice to Creditor's first ran in the newspaper
- Claim Amount

This information can come from several sources; the Estate Questionnaire, the Probate Inquiry, notes in the log from a telephone conversation with a family member, an attorney, or responsible party.

Note: The ER database receives its data from MMIS differently than the other TPL functions at SCDHHS. BMSM has a data interface with BITS in order to provide the data necessary for the ER database to be operational. BMSM runs jobs to take data off of the MMIS mainframe and interface it over to BITS for the ER System. See **Manage Estate Recovery** for detailed information on the ER business process.

4.5.15. Executive Log System

The Executive Log System is used to keep track of any mail that comes in the Director's Office. This mail can be from several sources, and may include: the Governor's office, other State Agencies, CMS, beneficiaries, etc. After the mail is stamped in, it is then logged to the appropriate Deputy and their assistant will send it to the appropriate functional business area. None of the documents are imaged. This is a simple tracking system. Any correspondence that comes into the Director's Office and requires a response is logged into the system with a suspense date. Turn-around time is five business days for legislative or Governor's office correspondence, seven for regular correspondence, and 10 for FOIA requests.



The information that's entered into the system is: entry date, last update, user name, log number, Fiscal year, correspondence date, subject, category, category description, referred to, date referred, response time, due date, logged to and date cleared (also there is an entry for if it needs the Director's signature).

4.5.16. *Government Accounting and Financial Reporting System (GAFRS)*

GAFRS is the accounting system used for all accounting operations in SCDHHS. The system is physically housed at the Budget and Control Board; the system is maintained by the CIO. The Bureau of Fiscal Affairs is responsible for using GAFRS to track financial transactions at SCDHHS from within GAFRS. Every financial transaction that happens at the agency (e.g. MMIS service payments to providers, administrative expenditures etc.) is entered into this system. No actual money resides in the Fiscal program area (the money is located at the South Carolina Treasury's Office).

SCDHHS receives the Chart of Accounts from the Comptroller General's Office with our annual Appropriations by Mini Code (Budget Unit Code). The Medicaid Finance and Accounting Operations departments prepare an AFI file and send it to the Financial Systems department for loading Appropriations into GAFRS. Appropriations are loaded into GAFRS by Mini Code, Fund and Expenditure Object codes 1100 and 1201.

Based on the approved funding levels, allotments are developed for each Bureau/Division. The information is entered into EXCEL spreadsheets and must be approved by executive staff. When allotments are approved by executive staff, Accounting Operations prepares an AFI file to send to Financial Systems for loading into GAFRS. This is both a manual and electronic process handled through EXCEL, ACCESS, FTP and GAFRS. Allotments are loaded for Other Operating and Salary by Index, PCA and Expenditure Object.

After appropriations and allotments are loaded into GAFRS, beginning cash balances for state 1001 funds are loaded into our Grants. This is done by taking the total amounts allocated by Mini Code and allocating it to each Grant based on the previous year's expenditures. Borrowing limits for Federal funds are loaded into GAFRS. This is both a manual and electronic process handled through EXCEL, ACCESS, FTP and GAFRS.

SCDHHS has a contractor that receives refund payments from insurance companies and providers. Another SCDHHS contractor receives refund checks from pharmaceutical companies. These contractors deposit these monies into a Lock Box account at Wachovia Bank. The State Treasurer's Office sweeps that account daily and posts these funds to J02 (SCDHHS). Each night, the Comptroller General's office sweeps the State Treasurer's Office for transactions completed by SCDHHS. A revenue interface is conducted (based on specific criteria established for the interface) to post funds into GAFRS. The following morning, the batch is available in GAFRS for financial systems staff to release, activate and post.

Funding can be moved around between grants, appropriations, and allotments in several ways. First, funds from a grant can be moved between grants. Appropriations can be moved between Mini Codes. Lastly, allotments can be moved between the program areas. Fiscal Affairs staff monitors the process using GAFRS reports or error messages. After GAFRS processes the weekly MMIS data, the staff reviews the reports and alerts to make sure there is sufficient money



appropriated to each fund to fund the week's MMIS payments. Staff make manual "journal entries" in GAFRS to adjust the source of funds, if necessary.

GAFRS will also flag any errors it finds and provide a description of what happened. A Fiscal Affairs worker can then make a manual adjustment (e.g. journal entry) to bring GAFRS to correct the error. Supervisors will sometimes address the error, or they will email the appropriate division making them aware of the issue requiring action. Supervisors have the ability to monitor every user that is logged into GAFRS; this allows them to ensure that the Fiscal Affairs workers are performing their assigned tasks (e.g. clearing up any errors that GAFRS flagged).

Reports are generated each month from GAFRS and MMIS, and are used to reconcile the two systems. Any errors that are identified are cleared up as quickly as possible. The Fiscal Affairs accounting operation are heavily monitored with reports generated from GAFRS. All financial reports are generated in GAFRS. They are created daily, weekly, monthly, quarterly, annually, and ad-hoc, and are available for viewing electronically in D:D. The primary reports used for monitoring cash, appropriations, allotments, etc., are as follows:

DAFR9424 - Appropriation Summary Status Report; DAFR9427 - Program Structure Appropriation Summary Status Report; DAFR 9428 - GAFRS Financial Data Summary Analysis Report; DAFR 9053 - Allotment Detail by Selected Expend Object & BUC Report; DAFR 9213 - Summary Pre-Encumbrance/Encumbrance Status Report; DAFR

4.5.17. Hospital Services System

SCDHHS contracts with a QIO contractor for reviews of prior/pre-authorizations and support documentation for services rendered by physicians. The remaining hospital services go through agency-internal review. These are reviewed by the hospital services registered nurse and medical directors. Currently, the internal review process is for unlisted drugs and services and for codes not covered under contract with the contractor. Unlisted codes require not only authorization but pricing, which is why they are handled internally. Unlisted codes suspend to the program area for this review.

This system tracks hospitals', and physicians' suspended claims. More specifically, the system is used to track suspended claims (1500 and UB-04) that come in for review by the Hospital Services program area's nurse reviewer.

The system was created to more effectively respond to hospitals', and physicians' inquiries on the status of a suspended claim and whether it has been received and/or processed in the program area's office. This tracking system is located in the Hospital Services program area. As mailed claims/ECFs are received from MCCS, they are date stamped and then forwarded to Hospital Services for keying into the tracking system. The claims/ECFs that are accepted are then sent back to MCCS for edit / payment. Once the claim/ECF is resolved, whether it is rejected, paid, additional information is requested, etc., the system is updated to reflect that action. The provider would have to call MCCS to check on payment status. Only Hospital Services staff performs these reviews and enter data into the tracking system. Physicians' Services staff has read-only access; they have read-only access because 90% of the claims being reviewed by Hospital Services are for doctors who often want to know the status of their claims/ECFs. The remaining 10% of inquires come from hospitals' independent of the physician inquiring about a



claim/ECFs. Giving Physicians' Services read-only access cuts down on inquiries made about claims status to the nurse reviewer in Hospital Services.

4.5.18. *Integrated Personal Care – Case Management System (IPC CMS)*

This system is used for entering assessments completed by IPC nurses on OSS recipients who have been referred to the IPC program for evaluation. If the resident meets requirements the system issues an Authorization for services that is attached to billing documents known as TADs. The system tracks residents in the IPC program.

Below is a description of IPC:

The OSS program pays Community Residential Care Facilities (CRCFs) X dollars per month for Medicaid eligible recipients. This money is a supplement to the residents SS or SSI for room and board.

The amount of the supplement is set by State Government via the SC legislative budgetary process.

The amount does not match what CRCFs actually charge for their rooms.

IPC was created to increase the amount paid to the CRCFs with matching federal funds. To meet the Federal Government requirements the state can pay facilities for "personal care". An example: Bathing, Dressing, Toileting etc.

Not all residents require personal care so SCDHHS RNs must complete an assessment to determine if the resident qualifies for the additional funds (the funds do not actually go to the resident but to the CRCF for providing the care).

Because SCDHHS gets matching federal funds the CRCF has to apply, be approved, and sign a contract with SCDHHS to be an IPC or "Integrated Personal Care" provider.

If a facility is an IPC provider and has a resident that meets the following conditions the nurse that works at the facility and **only that nurse** can make the referral. NO other sources can refer a resident.

1. The resident must be receiving the above described OSS payment.
2. The resident must need help with personal care.
3. The resident must consent to an assessment by the SCDHHS nurse to determine eligibility.

The nurse who goes to the facility and assesses the resident is a SCDHHS employee and is an RN. The RN will enter the assessment criteria described above into the IPC-CMS. Once the SCDHHS RN determines that the facility is indeed providing personal care, and that all other criteria have been met, SCDHHS authorizes the payment of 16.00/day to the facility to provide that care. The form is called an Authorization Service Provision Form or "Authorization" for short.

Monthly-The facility "bills" or "requests payment" for the OSS residents on the TAD. So when they have a resident that qualifies for the EXTRA 16.00/day they simply fill in an extra column on that TAD and attach the Authorization form to request payment. They only attach the



"Authorization" form the first month the resident is determined eligible. After that the payment will continue as long as the resident continues to live in the facility and receives personal care.

The TAD is mailed by the facility to MCCC. MCCC directly deposits the payment into the facilities bank account.

4.5.19. *Medicaid Disability System*

The Department of Disability Determinations receives two types of hardcopy applications (an initial application, and a review application). The initial application is for when an applicant first applies. The information entered (manually keyed) into the system for the hardcopy initial application is the applicant data (name, address, SSN), application date, county, eligibility worker, date received, application category and a brief description of the alleged disability. If an applicant becomes a beneficiary (they are found disabled, and meet eligibility), they are assigned a medical review date (usually within 3-7 years). The medical review is done to see if the beneficiary's medical condition has improved (whether they still need assistance, and remain eligible for that assistance). The information entered into the system for the initial application described above is updated once the review application is completed.

4.5.20. *Partners for Health System (PFH)*

This system is used by Central Eligibility at SCDHHS. The system works in partnership with MEDS.

The PFH Tracking System is an automated logbook that tracks the status of Medicaid applications. The system additionally allows for the printing of a number of letters based on events related to the applications (e.g. acceptance or denial of enrollment in the Medicaid program). The system keeps track of: payees, household members, various applications for each payee, events related to each application, recipients or household members related to various events, and questions or reasons for certain actions taken by the Division of Central Eligibility in line with the Medicaid Policy Manual.

Data in the tracking system is arranged in the form of record entries. Each record entry in the system contains detailed information related to the Medicaid application and its status. These records include information such as payee name, address, household members, application type, pay category, date and time of events, effective dates, termination date, etc.

CEP receives hundreds of pieces of mail each day. The mail consists of Medicaid applications, reviews and information requested by a caseworker and used for approval or denial of a case. The mail is: opened, time stamped, copied, hard copy filed, and then manually keyed into the PFH Tracking System and sent to the appropriate caseworker. MEDS is unable to track the application is this way.

The tracking system is used when mail is received and any action taken by a caseworker is tracked into the system. Also, the system prints letters that are mailed back to the client to request information. This system does not interact with the MEDS system. The system is helpful to the Central Eligibility staff in "tracking the progress" of a case. When they receive calls from clients, they can tell them where their application/review is "in the process".

4.5.21. *Program Integrity Case Management System (PICMS)*



This is a proprietary Microsoft Access application that manages PI cases. The system tracks basic information about the case, including the source of the case, open and closure dates, the reviewer and department conducting the review, provider type under review, type of allegation, outcome of the case (including sanctions), and the amount of the overpayment identified and recouped.

4.5.22. *Third Party Liability – Casualty System (TPL Casualty)*

The MMIS automatically generates accident questionnaires when certain trauma-related codes appear on claim forms. Clemson prints and sends the questionnaires to SCDHHS for mailing to beneficiaries. The beneficiaries mail the completed questionnaires to the TPL Division at SCDHHS, which handles casualty-related recovery efforts. When questionnaires are returned, the response is posted in the tracking file of the TPL subsystem to stop subsequent letters from being mailed. The MMIS has recovery level indicators on the procedure code file that determines whether 1, 2, or 3 questionnaires will be sent.

The TPL Division enters the data from the questionnaire into the, SQL database, TPL Casualty Tracking System. The system tracks events, generates letters, and reports related to accident claims received by the agency's TPL department. The system also tracks case information related to the beneficiary, such as Medicaid number, address, other insurance coverage, etc.

The attorney's info (if applicable) may have been provided by the beneficiary on the questionnaire. The TPL Division sends the attorney the itemization form if it is determined that there are enough accident-related claims to warrant establishing a case.

A questionnaire is not always generated for all of the potential casualty recovery cases. Many attorneys already have the Medicaid itemization form on file. Because many questionnaires are not returned, most cases result from attorney itemization requests. They will fill it out and sent it to TPL; they sometimes do this without ever having received a questionnaire.

The attorney sends the TPL Department the itemization form with case information for the accident.

The TPL department then does research to find out if any claims were paid by Medicaid related to the accident. If Medicaid did pay claims related to the accident and the beneficiary or liable party had insurance coverage that should have paid the claim, the TPL department will make an effort to recoup these funds from the insurance company.



5 Technical Capabilities Assessment

5.1. *Methodology/Approach*

Using the process information contained in the problem statements the SCDHHS team completed the Technical Capability Matrix. The matrix was then reviewed by the Clemson team and in some cases they provided more information. Several supporting statements relating to each technical area or technical function were added in the column "Business Process Support" although this is not an exhaustive list. There is not a direct map from problem statement to matrix section and this is to be expected as technical functions, for example "Workflow Management," will occur in multiple business processes.

Most of the actual analysis needed for the technical capability matrix occurred during the discussion of the business processes. Assessing the "As-Is" technical capability was a matter of finding supporting examples from the research that was conducted to determine the "As-Is" business capability.

The current technical capability is almost entirely at the lowest level. In the areas where it is not at Level 1, the improvement is due to the use of external components to advance the technical capability to address a business pain point (such as access to data or HIPAA compliance), not due to a change to the core MMIS system.



5.2. Results of the Technical Capabilities Assessment

MITA TECHNICAL AREA/ TECHNICAL FUNCTION	ASSOCIATED DOCUMENTATION	BUSINESS PROCESS SUPPORT	AS-IS LEVEL OF TECHNICAL CAPABILITY	MAJOR CONSTRAINTS TO ACHIEVING NEXT LEVEL	TO-BE LEVEL OF TECHNICAL CAPABILITY 3-5 YEARS	TO-BE LEVEL OF TECHNICAL CAPABILITY 6-10 YEARS
				"GAP"		
B.0 Business Enabling Services						
B.1 Forms Management	STATE SPECIFIC Enter Claim, PM Enroll Provider, ME Determine Eligibility, Various PC Applications	Hardcopy CMS-1500, UB-04, and Dental Claim forms are submitted to MCCS for scanning and keying for claims directly into the MMIS for adjudication. The Web Tool and HIPAA Mailbox MMIS Interface also allow for the electronic submission of X12 HIPAA claims. The majority of Medicaid applications utilize electronic forms for input into the system (these however are not online forms).	1	Program policy changes would be required. Beneficiaries lack access to online forms (via internet, kiosk etc.). All claims would need to be available via the Web Tool (some that are not include: Nursing Home, Community Long Term Care etc.).	3	5
B.2 Workflow Management	Partners for Health (PFH) PC Application	MEDS uses ChangeMan to electronically manage the flow of development entities (programs, JCL, screens) from a testing environment, to QA to production. MMIS uses a manual process. Although many SC Medicaid contractors use automated workflow management, the state uses primarily manual workflow. Exceptions include: <ul style="list-style-type: none"> Internal Medicaid application: PFH which is used by Central Eligibility for 	1	Paper files are still heavily used throughout the Medicaid Enterprise. COTS (or internally developed) Workflow Management software would be required.	3	5



MITA TECHNICAL AREA/ TECHNICAL FUNCTION	ASSOCIATED DOCUMENTATION	BUSINESS PROCESS SUPPORT	AS-IS LEVEL OF TECHNICAL CAPABILITY	MAJOR CONSTRAINTS TO ACHIEVING NEXT LEVEL	TO-BE LEVEL OF TECHNICAL CAPABILITY 3-5 YEARS	TO-BE LEVEL OF TECHNICAL CAPABILITY 6-10 YEARS
				"GAP"		
		processing Medicaid applications (see PFH PC Application for technical details).				
B.3 Business Process Management (BPM)	ME Determine Eligibility, OM Edit Claim, Various PC Applications	Nearly all business process management is manual. The current MMIS /MEDS, and other internal Medicaid applications lack full rules engine capabilities. There is very little ability to register, define, classify, and manage all of the rules, verify consistency of rules definitions, define the relationships between the different rules, and relate these rules to the current Medicaid systems.	1	Next level is undefined.	3	5
B.4 Business Relationship Management (BRM)	PM Manage Provider Communication, ME Manage Applicant and Member Information, Various PC Applications	There is no central call center for internal and external inquiries. SCDHHS and its contractors utilize various automated tracking systems that assist in BRM. The SCDHHS internal help desk uses Microsoft Help Desk to assist users. Clemson University's help desk that supports SCDHHS is Tiger Tracks.	1	Next level is undefined.	3	5
B.5 Foreign Language Support	ME Manage Applicant and Member Communication, ME Perform Population and Member Outreach	Beneficiary communication is manually translated by the Office of Public Information. Some Medicaid forms, including applications, are available in Spanish.	1	Next level is undefined.	3	5



MITA TECHNICAL AREA/ TECHNICAL FUNCTION	ASSOCIATED DOCUMENTATION	BUSINESS PROCESS SUPPORT	AS-IS LEVEL OF TECHNICAL CAPABILITY	MAJOR CONSTRAINTS TO ACHIEVING NEXT LEVEL	TO-BE LEVEL OF TECHNICAL CAPABILITY 3-5 YEARS	TO-BE LEVEL OF TECHNICAL CAPABILITY 6-10 YEARS
				"GAP"		
B.6 Decision Support						
B.6.1 Data Warehouse	DSS:PM Manage Program Information;SURS: PI Identify Candidate Case;CLTC Case Management System (CM System)	Data is extracted by the MMIS/MEDS contractor and transferred to the Decision Support System (DSS)/DW contractor, where it is transformed and loaded into the data warehouse. The process of transferring these multiple databases into the data warehouse has several automated features, with some manual. The majority of other internal Medicaid applications do not have the ability to extract, transform and load data from multiple databases into a data warehouse. An exception would be the CLTC CMS.Since the MITA Logical Data Model is undefined in MITA Framework 2.0, SCDHHS cannot be assessed a level 3. Though Level 2 is undefined, SCDHHS meet most of the criteria of Level 3.	Level 2 (though level 2 is undefined, SCDHHS meets most of the criteria of Level 3).	The MITA logical data model is undefined.	3	5
B.6.2 Data Marts	DSS:PM Manage Program Information; SURS: PI Identify Candidate Case; Various PC Applications	The MARS, SURS and DSS data marts are created with Extract, Transform, and Load (ETL) functions using the MMIS data extract transferred from the MMIS/MEDS contractor. We are uncertain as to whether this	Level 2 (though level 2 is undefined, SCDHHS meet most of the criteria of	The MITA logical data model is undefined.	3	5



MITA TECHNICAL AREA/ TECHNICAL FUNCTION	ASSOCIATED DOCUMENTATION	BUSINESS PROCESS SUPPORT	AS-IS LEVEL OF TECHNICAL CAPABILITY	MAJOR CONSTRAINTS TO ACHIEVING NEXT LEVEL	TO-BE LEVEL OF TECHNICAL CAPABILITY 3-5 YEARS	TO-BE LEVEL OF TECHNICAL CAPABILITY 6-10 YEARS
				"GAP"		
		conforms with the MITA Logical Data Model. Since the MITA Logical Data Model is undefined in MITA Framework 2.0, SCDHHS cannot be assessed a level 3. Though Level 2 is undefined, SCDHHS meet most of the criteria of Level 3.	Level 3).			
B.6.3 Ad hoc Reporting	DSS:PM Manage Program Information;SURS: PI Identify Candidate Case;Various PC Applications	The DSS/DW contractor provides a suite of reporting tools for ad hoc reporting (MMIS/MEDS). The majority of internal Medicaid applications outside of MMIS/MEDS have ad hoc reporting capabilities as well.	2	Currently a level 2, the next level is undefined.	3	5
B.6.4 Data Mining	DSS:PM Manage Program Information; SURS: PI Identify Candidate Case; Various PC Applications	SURS is the primary data mining tool used by Program Integrity. The DSS consists of many COTS tools. While the majority of data mining is accomplished via COTS tools, SCDHHS still uses MARS which required very manual coded procedures. The majority of other internal Medicaid applications do not have data mining capabilities.	1	SURS is an effective COTS package from these requirements. However, MARS is still used by many individuals at SCDHHS which is a major constraint to attaining the next level.	3	5
B.6.5 Statistical Analysis	DSS:PM Manage Program Information;SURS: PI Identify Candidate Case;Various PC Applications	DSS and SURS (MMIS/MEDS). The majority of other Medicaid applications do not have the ability to perform a statistical analysis of designated data (this is mostly accomplished manually).	1	The functionality of the internal Medicaid applications would need to be replaced by the new Medicaid Enterprise System.	3	5



MITA TECHNICAL AREA/ TECHNICAL FUNCTION	ASSOCIATED DOCUMENTATION	BUSINESS PROCESS SUPPORT	AS-IS LEVEL OF TECHNICAL CAPABILITY	MAJOR CONSTRAINTS TO ACHIEVING NEXT LEVEL	TO-BE LEVEL OF TECHNICAL CAPABILITY 3-5 YEARS	TO-BE LEVEL OF TECHNICAL CAPABILITY 6-10 YEARS
				"GAP"		
				DSS and SURS are effective at meeting the requirements of this level otherwise.		
B.6.6 Neural Network Tools		SC Medicaid does not use any neural network tools.	1	The technology is currently unavailable in a COTS package.	3	5
A.0 Access Channels						
A.1 Portal Access	ME Manage Applicant and Member Communication, ME Manage Member Grievance and Appeal, PM Manage Provider Communication, PM Manage Provider Grievance and Appeal	Beneficiaries and providers interface with SC Medicaid primarily via manual methods (Level 1). Providers can access SC Medicaid via an IVRS and the web-based claims submission tool (Level 2).	1	A central call center for beneficiaries is a major constraint SCDHHS.	3	5
A.2 Support for Access Devices	ME Manage Applicant and Member Communication; Inquire Payment Status, ME OM Inquire Member Eligibility, IVRS MMIS Interface	Beneficiary access is primarily manual (Level 1). Providers can access SC Medicaid via an IVRS and the web-based claims submission tool (Level 2).	1	A central call center for beneficiaries is a major constraint SCDHHS.	3	5
I.0 Interoperability						
I.1 Service-Oriented Architecture						
I.1.1 Service Structuring and	Various PC Applications	MMIS/MEDS and the other Medicaid applications are not	1	Would require a service oriented	3	5



MITA TECHNICAL AREA/ TECHNICAL FUNCTION	ASSOCIATED DOCUMENTATION	BUSINESS PROCESS SUPPORT	AS-IS LEVEL OF TECHNICAL CAPABILITY	MAJOR CONSTRAINTS TO ACHIEVING NEXT LEVEL	TO-BE LEVEL OF TECHNICAL CAPABILITY 3-5 YEARS	TO-BE LEVEL OF TECHNICAL CAPABILITY 6-10 YEARS
				"GAP"		
Invocation		SOA compliant, therefore SCDHHS does not have 'services' under that definition.		architecture (SOA)		
I.1.2 Enterprise Service Bus		SCDHHS does not have an Enterprise Service Bus.	1	Would require a Enterprise Service Bus	3	5
I.1.3 Orchestration and Composition		MMIS/MEDS Not applicable for internal Medicaid Applications.	1	Next level is undefined.	3	5
I.2 Standards-Based Data Exchange	MMIS Interfaces, MEDS Interfaces, Various PC Applications	MEDS does not use standards-based data exchanges in all interfaces. Some may be regulated, some may be needs-based. Data exchange conforms to HIPAA and other current federal regulations, but may not conform to MITA standards. This places the SC Medicaid Enterprise above the defined Level 1 but below Level 3.	2	Next level is undefined.	3	5
I.3 Integration of Legacy Systems	Various PC Applications	MMIS/MEDS and the other Medicaid applications are point-to-point, not 'service enabled'.	1	Next level is undefined.	3	5
D.0 data Management and Sharing						
D.1 Data Exchange Across Multiple Organizations	MMIS Interfaces, MEDS Interfaces	Electronic data exchange is via secure Connect:Direct, Secure HTTP and Secure FTP. Note we are not using the MITA information hub as defined in the	1	MITA information hub is undefined - a Enterprise Service Bus (ESB).	3	5



MITA TECHNICAL AREA/ TECHNICAL FUNCTION	ASSOCIATED DOCUMENTATION	BUSINESS PROCESS SUPPORT	AS-IS LEVEL OF TECHNICAL CAPABILITY	MAJOR CONSTRAINTS TO ACHIEVING NEXT LEVEL	TO-BE LEVEL OF TECHNICAL CAPABILITY 3-5 YEARS	TO-BE LEVEL OF TECHNICAL CAPABILITY 6-10 YEARS
				"GAP"		
		framework. The MITA hub uses Enterprise Service Busses. We are above level 1 and would be a level 2, were it not for the MITA hub.				
D.2 Adoption of Data Standards		SC Medicaid does not use enterprise-wide data standards.	1	MMIS has defined standards, but MEDS (eligibility) does not have published standards. MITA Model is undefined.	3	5
P.0 Performance Measurement						
P.1 Performance Data Collection and Reporting	Various PC Applications	The MMIS and MEDS databases are monitored by the DBA group for speed in processing. Clemson has no predefined metrics. Internal SC Medicaid: Performance data collection and reporting is ad hoc and not centralized. Many internal business areas at SCDHHS perform collection and reporting differently (using excel or reports from PC Applications etc.). Contracts: Performance monitoring is defined by individual contracts. Many contractors are required to	1	Would need predefined metrics across the Medicaid Enterprise.	3	5



MITA TECHNICAL AREA/ TECHNICAL FUNCTION	ASSOCIATED DOCUMENTATION	BUSINESS PROCESS SUPPORT	AS-IS LEVEL OF TECHNICAL CAPABILITY	MAJOR CONSTRAINTS TO ACHIEVING NEXT LEVEL	TO-BE LEVEL OF TECHNICAL CAPABILITY 3-5 YEARS	TO-BE LEVEL OF TECHNICAL CAPABILITY 6-10 YEARS
				"GAP"		
		submit performance data and obtain it using their own methods.				
P.2 Dashboard Generation	PM Manage Program Information, Various PC Applications	Enterprise-wide performance reporting must be manually aggregated. An executive dashboard tool is available for querying the DSS/DW, but the agency does not use it. The majority of internal Medicaid applications do not have summary-level displays for performance information.	1	Though such a "dashboard" tool is available, SCDHHS does not use it (they rely on many different reports for analysis).	3	5
S.0 Security and Privacy						
S.1 Authentication	Various PC Applications, PG Manage Program Information	Access to MMIS, MEDS, and other internal Medicaid applications is via logon ID and password.	1	Next level is undefined.	3	5
S.2 Authentication Devices		Clemson uses Microsoft's Remote Server and Hummingbird Host Explorer for mainframe access (by The Open Text Connectivity Solutions Group). SC Medicaid does not use any of the above defined authentication devices. SCDHHS and its contractors primarily use card access for physical entry.	Level 1 (levels 1 and 2 are undefined).	Next level is undefined.	3	5
S.3 Authorization and Access	Various PC Applications, PG Manage Program	SC Medicaid uses role-based security access. Users request access to the various internal	2	Next level is undefined.	3	5



MITA TECHNICAL AREA/ TECHNICAL FUNCTION	ASSOCIATED DOCUMENTATION	BUSINESS PROCESS SUPPORT	AS-IS LEVEL OF TECHNICAL CAPABILITY	MAJOR CONSTRAINTS TO ACHIEVING NEXT LEVEL	TO-BE LEVEL OF TECHNICAL CAPABILITY 3-5 YEARS	TO-BE LEVEL OF TECHNICAL CAPABILITY 6-10 YEARS
				"GAP"		
Control	Information	Medicaid applications via the OAC Request Form.				
S.4 Intrusion Detection		SCDHHS and its contractors employ substantial intrusion detection, prevention and blocking measures, including firewalls, monitoring probes, 24x7 offsite monitoring and alerting. Because no levels have been defined SCDHHS will default to level 1.	1	Next level is undefined.	3	5
S.5 Logging and Auditing	Various PC Applications	MEDS has a data tracking process that logs access to beneficiary Interface data by worker user-id. The MMIS online tracks and logs worker access to certain beneficiary data. These logs are stored on tape. Not all access is logged. SCDHHS tracks login attempts (including logon approvals and disapprovals) to the various internal Medicaid applications.	1	MEDS has these capabilities, while MMIS does not.	3	5
S.6 Privacy	Various PC Applications	SC Medicaid employs procedural controls in accordance with state and federal privacy laws. There are role-based access restrictions for internal Medicaid applications delivered over the agency's secure network. However, access is not defined at the data element level.	1	Next level is undefined.	3	5
F.0 Flexibility -						



MITA TECHNICAL AREA/ TECHNICAL FUNCTION	ASSOCIATED DOCUMENTATION	BUSINESS PROCESS SUPPORT	AS-IS LEVEL OF TECHNICAL CAPABILITY	MAJOR CONSTRAINTS TO ACHIEVING NEXT LEVEL	TO-BE LEVEL OF TECHNICAL CAPABILITY 3-5 YEARS	TO-BE LEVEL OF TECHNICAL CAPABILITY 6-10 YEARS
				"GAP"		
Adaptability and Extensibility						
F.1 Rules- Driven Processing	Case Management System (CM System) PC Application, Partners for Health (PFH) PC Application	Rules are designed and applied manually and inconsistently for internal Medicaid applications. Exceptions include the CM System, and the PFH PC Applications which have rules engine functions.	1	Next level is undefined.	3	5
F.2 Extensibility	Various PC Applications, MEDS and MMIS Interfaces	Extensibility requires heavy coding changes for the majority of internal Medicaid applications.	1	Next level is undefined.	3	5
F.3 Automate Configuration and Reconfiguration of Services	Various PC Applications, PG Manage Program Information	Most MMIS/MEDS changes require hard coding and are managed through a structured change management process. Internal Medicaid applications are coded in various programming languages, so the ease and speed of configuration and reconfiguration varies across the Medicaid Enterprise. There is little or no configuration management. Changes are disruptive.	1	Next level is undefined.	3	5
F.4 Introduction of New Technology	Various PC Applications	Integrating new technology with MMIS/MEDS is edifficult due to the hard-coded nature of these systems. Internal Medicaid applications are coded in various programming languages, so the ease of adopting new technology varies.	1	Next level is undefined.	3	5



6 Preliminary Plans

6.1. *Executive Goals and Objectives*

SCDHHS sees two major development areas for South Carolina Medicaid over the next several years. A reconfigured Medicaid Enterprise is closely linked to both these areas

- 1) Continued expansion of managed care
- 2) Health Information Technology

6.1.1. *Managed Care*

Over the past few years, South Carolina Medicaid has expanded its managed care offerings exponentially. Five health plans and one MHN operate throughout the state. Managed care is now considered the default option for most categories of beneficiaries, with a managed care Enrollment Counselor providing counseling and performing auto-enrollments when necessary. SCDHHS' strategic document, the South Carolina Health Connections Medication Transformation plan, details this expansion, among other efforts (see Appendix I).

The state plans to continue providing care management primarily by enrolling beneficiaries into managed care organizations. These organizations supply clinical attention and care coordination. We are also interested in expanding the care management offerings of our contracted managed care organizations.

An effort is underway to use encounter data rather than fee-for-service data to set managed care capitated rates. Currently the task force is working to ensure that Medicaid is receiving an encounter record for every service provided and that the data are complete and accurate; this data can then be used to set more appropriate reimbursements for providers and MCOs.

Managed care will also be improved by enhanced health information technology and a health information exchange: combining clinical data and claims data can help providers and MCOs better manage care.

6.1.2. *Health Information Technology (HIT)*

As we submit this report, SCDHHS is deeply immersed in the Health Information Technology provisions (also known as HITECH) of the American Recovery and Reinvestment Act of 2009 (ARRA). The purpose of these provisions is to encourage the adoption and meaningful use of certified EHR technology. The ultimate goals are to promote health care quality and health information exchange through the use of certified EHR technology.

As the state Medicaid agency, SCDHHS will assume primary responsibility for promoting, measuring, and reporting on the meaningful use of HIE. CMS is currently working to define meaningful use for Medicare, while meaningful use for Medicaid will be defined by the State Medicaid agency. We anticipate that South Carolina's Medicaid meaningful use definition will be similar to Medicare's with the exception being additional requirements for the special populations served by the Medicaid program. Because Medicaid's qualifying providers will be predominantly pediatric providers, the special Medicaid meaningful use guidelines will likely concern pediatric care and reporting.



The agency anticipates that meaningful use reporting will be done through the DSS/SURS MARS data warehouse. The data will be passed from providers' EHRs through the state's SCHIE interface to the DSS/SURS MARS data warehouse.

The agency intends to set up a Division of meaningful use tasked with defining and explaining meaningful use, processing reports, measuring meaningful use and administering the entitlement payments as specified in the ARRA legislation. The division will be a multidisciplinary team made up of clinical, actuarial and programmatic experts qualified to advise the agency on meaningful use.

To fulfill other HITECH provisions, SCDHHS has been coordinating with ORS of the state Budget & Control Board, which developed a scalable HIE currently in use by Medicaid providers.

When ARRA was first signed, SCDHHS, ORS, and a nonprofit organization called Health Sciences South Carolina (HSSC) came together to form an e-Health group, which follows the Markle Foundation's Connecting for Health Common Framework and is participating in the National Governor's Association State Alliance for e-Health. The e-Health group has held a series of HIT Summits where the private sector, state government, non-profits, and universities are working to assess the current state of HIT in South Carolina and to develop a cohesive plan to move forward.

SCDHHS has submitted a Letter of Intent to act as the HIE grantee for the Cooperative Agreement and the full grant application. As part of the application, SCDHHS is working with other state HIT stakeholders to develop a strategic plan and an operational plan laying out a detailed path to statewide HIE deployment and meaningful use.

In addition, the agency is developing a Medicaid Strategic Plan for HIT in accordance with the State Medicaid Director's Letter dated September 1, 2009 (SMD #09-006 ARRA HIT #1). This MITA State Self-Assessment will inform the Medicaid Strategic Plan, which in turn will have effects on MITA and the development of the future Medicaid Enterprise.

SCDHHS is well positioned to meet the requirements of the HITECH Act. It remains to be seen exactly how HITECH will affect the future requirements of the South Carolina Medicaid Enterprise system. However, the MITA Framework and this SS-A report allow for revision and flexibility as we move forward.



6.2. Template #3

MITA BUSINESS AREA	STATE BUSINESS AREA	MITA BUSINESS PROCESS	STATE BUSINESS PROCESS	AS-IS LEVEL OF BUSINESS CAPABILITY	MAJOR CONSTRAINTS TO ACHIEVING NEXT LEVEL	TO-BE LEVEL OF BUSINESS CAPABILITY 3-5 YEARS	TO-BE LEVEL OF BUSINESS CAPABILITY 6-10 YEARS
					"GAP"		
Member Management	Beneficiary Management	ME Determine Eligibility	Determine Eligibility	1	* Manual eligibility decisions * Paper applications	3	5
	Beneficiary Management	ME Enroll Member	Enroll Member	1	* Siloed program areas handle special enrollments * Paper applications	3	5
	Beneficiary Management	ME Disenroll Member	Disenroll Member	1	* Data transfers between agencies, contractors, and programs not real-time	3	5
	Beneficiary Management	ME Manage Member Information	Manage Member Information	1	* Paper eligibility files * Poor system audit trail * No automated file maintenance	3	5
	Beneficiary Management	ME Inquire Member Eligibility	Inquire Member Eligibility	1	* No Member Registry * Eligibility not real-time * MITA data exchange standards not yet fully defined	3	5
	Beneficiary Management	ME Perform Population and Member Outreach	Perform Population and Member Outreach	1	* Resources limit translation, distribution, and materials * Siloed outreach efforts * No way to measure	3	5



MITA BUSINESS AREA	STATE BUSINESS AREA	MITA BUSINESS PROCESS	STATE BUSINESS PROCESS	AS-IS LEVEL OF BUSINESS CAPABILITY	MAJOR CONSTRAINTS TO ACHIEVING NEXT LEVEL	TO-BE LEVEL OF BUSINESS CAPABILITY 3-5 YEARS	TO-BE LEVEL OF BUSINESS CAPABILITY 6-10 YEARS
					"GAP"		
					success * Contact information often outdated		
	Beneficiary Management	ME Manage Applicant and Member Communication	Manage Applicant and Member Communication		* No contact tracking * No Member Registry * Minimal web communication	3	5
	Beneficiary Management	ME Manage Member Grievance and Appeal	Manage Member Grievance & Appeal	1	* No contact tracking * No web portal * Limited beneficiary data store and audit trail in MEDS * Paper eligibility files	3	5
Provider Management	Provider Management	PM Enroll Provider	Provider Enrollment	1	* Paper applications * No web portal * Manual credentials verification	3	5
	Provider Management	PM Disenroll Provider	Disenroll Provider	1	* Little interagency / interstate communication	3	5
	Provider Management	PM Manage Provider Information	Manage Provider Information	1	* System crosswalks NPI to legacy ID * Limited provider information fields in system * Limited info sharing with	3	5



MITA BUSINESS AREA	STATE BUSINESS AREA	MITA BUSINESS PROCESS	STATE BUSINESS PROCESS	AS-IS LEVEL OF BUSINESS CAPABILITY	MAJOR CONSTRAINTS TO ACHIEVING NEXT LEVEL	TO-BE LEVEL OF BUSINESS CAPABILITY 3-5 YEARS	TO-BE LEVEL OF BUSINESS CAPABILITY 6-10 YEARS
					"GAP"		
					data partners		
	Provider Management	PM Inquire Provider Information	Inquire Provider Information	1	* System crosswalks NPI to legacy ID * No web portal for enrollment and confirmation	3	5
	Provider Management	PM Manage Provider Communication	Manage Provider Communication	BCM not published		3	5
	Provider Management	PM Manage Provider Grievance and Appeal	Manage Provider Grievance and Appeal	1	* No central complaint tracking * No web portal	3	5
	Provider Management	PM Perform Provider Outreach	Perform Provider Outreach	1	* No web portal * Limited provider data store in MMIS * Few efforts to ID potential providers	3	5



MITA BUSINESS AREA	STATE BUSINESS AREA	MITA BUSINESS PROCESS	STATE BUSINESS PROCESS	AS-IS LEVEL OF BUSINESS CAPABILITY	MAJOR CONSTRAINTS TO ACHIEVING NEXT LEVEL	TO-BE LEVEL OF BUSINESS CAPABILITY 3-5 YEARS	TO-BE LEVEL OF BUSINESS CAPABILITY 6-10 YEARS
					"GAP"		
Contractor Management	Contractor Management	CO Award Admin or HS Contract	Award Contract	1	* At agency, no automated contract administration * Coordination but no automated exchange between agency and ITMO/MMO	3	5
	Contractor Management	CO Close Admin or HS Contract	Close out Contract	1	* Monitoring of turnover/termination is manual * Older contracts may not have detailed turnover procedures	3	5
	Contractor Management	CO Manage Admin or HS Contract	Manage Contract	1	* Contracts and records are stored on paper * Older contracts may lack performance standards	3	5
	Contractor Management	CO Manage Contractor Information	Manage Contractor Information	1	* Contracts are paper	3	5
	Contractor Management	CO Inquire Contractor Information	Inquire Contractor Information	1	* Inquiries are manual and require research of paper files * Siloed programs may lack access to correct information	3	5



MITA BUSINESS AREA	STATE BUSINESS AREA	MITA BUSINESS PROCESS	STATE BUSINESS PROCESS	AS-IS LEVEL OF BUSINESS CAPABILITY	MAJOR CONSTRAINTS TO ACHIEVING NEXT LEVEL	TO-BE LEVEL OF BUSINESS CAPABILITY 3-5 YEARS	TO-BE LEVEL OF BUSINESS CAPABILITY 6-10 YEARS
					"GAP"		
	Contractor Management	CO Manage Contract Communication	Manage Contract Communication	1	* No tracking system for contractor communication * Siloed programs may lack access to correct information	3	5
	Contractor Management	CO Perform Contractor Outreach	Perform Contractor Outreach	1	* Minimal identification of potential contractors	3	5
	Contractor Management	CO Support Contractor Grievance and Appeal	Support Contractor Grievance and Appeal	1	* No communication tracking	3	5
	Contractor Management	CO Produce Admin or HS RFP	Produce RFP	1	* MITA standards not integrated into RFPs * Contracts data not centrally stored and standardized	3	5
Operations Management	Operations Management	OM Authorize Referral	N/A	N/A	N/A	N/A	N/A
	Operations Management	OM Authorize Service	Authorize Service	1	* Multiple tracking systems and manual processes * Manual verification of PA numbers	3	5
N/A	N/A	OM Authorize Treatment Plan	N/A	N/A	N/A	N/A	N/A



MITA BUSINESS AREA	STATE BUSINESS AREA	MITA BUSINESS PROCESS	STATE BUSINESS PROCESS	AS-IS LEVEL OF BUSINESS CAPABILITY	MAJOR CONSTRAINTS TO ACHIEVING NEXT LEVEL	TO-BE LEVEL OF BUSINESS CAPABILITY 3-5 YEARS	TO-BE LEVEL OF BUSINESS CAPABILITY 6-10 YEARS
					"GAP"		
	Operations Management	OM Apply Attachment	Apply Attachment	1	* System cannot accept EDI attachments * System cannot associate imaged paper attachments with original claim	3	5
	Operations Management	OM Apply Mass Adjustment	Apply Mass Adjustment	1	* Affected claims must be identified through manual reports and jobs * Agency staff cannot perform adjustment themselves * Providers notified of adjustment via paper mailing	3	5
N/A	N/A	OM Audit Claim-Encounter	N/A	N/A	N/A	N/A	N/A
	Operations Management	OM Edit Claim/Encounter	Edit Claim/Encounter	1	* Edits are hard-coded, difficult to test and change * Much resolution is manual, on paper	3	5
	Operations Management	OM Price Claim/Encounter	Price Claim/Encounter	1	* Encounters are not priced/valued * System requires manual pricing updates * Minimal audit trail and price history	3	5



MITA BUSINESS AREA	STATE BUSINESS AREA	MITA BUSINESS PROCESS	STATE BUSINESS PROCESS	AS-IS LEVEL OF BUSINESS CAPABILITY	MAJOR CONSTRAINTS TO ACHIEVING NEXT LEVEL	TO-BE LEVEL OF BUSINESS CAPABILITY 3-5 YEARS	TO-BE LEVEL OF BUSINESS CAPABILITY 6-10 YEARS
					"GAP"		
	Operations Management	OM Prepare COB	Prepare COB	1	* Paper invoicing for retro and pay-and-chase	3	5
	Program Integrity	OM Prepare EOB	Prepare EOB	1	* No PHRs or portal to integrate with EOB * EOBs and responses are paper.	3	5
N/A	N/A	OM Prepare HCBS Payments	N/A	N/A	N/A	N/A	N/A
	Operations Management	OM Prepare Premium EFT/check	Prepare Premium EFT/check	1	* HIPP and Medicare checks are manual and do not use the 820 transaction * HIPP is not tied to MMIS	3	5
	Operations Management	OM Prepare Provider EFT/check	Prepare Provider EFT/Check	1	* EFT requirement not enforced. * Payments are not coordinated with other agencies.	3	5
	Operations Management	OM Prepare Remittance Advice-Encounter Report	Prepare Remittance Advice/Encounter Report	1	* No web portal * Many providers are not equipped to receive EDI remits * Weekly processing cycle means adjudication data cannot be immediately available	3	5



MITA BUSINESS AREA	STATE BUSINESS AREA	MITA BUSINESS PROCESS	STATE BUSINESS PROCESS	AS-IS LEVEL OF BUSINESS CAPABILITY	MAJOR CONSTRAINTS TO ACHIEVING NEXT LEVEL	TO-BE LEVEL OF BUSINESS CAPABILITY 3-5 YEARS	TO-BE LEVEL OF BUSINESS CAPABILITY 6-10 YEARS
					"GAP"		
	Operations Management	OM Prepare Capitated Premium Payment	Prepare Capitated Premium Payment	1	* Revising payment rates is difficult, manual	3	5
	Operations Management	OM Prepare HIPP	Prepare HIPP	1	* HIPP calculations must be done manually. * Program is not well promoted. * Contractor cuts manual check; no 820 transaction.	3	5
	Operations Management	OM Prepare Medicare Premium Payment	Prepare Medicare Premium Payment	1	* MMIS check often differs from Medicare billed amount; requires manual intervention * Buy-In data is via periodic file transfers, not real-time	3	5
	Operations Management	OM Inquire Payment Status	Inquire Payment Status	1	* No web portal * Many providers still call program area	3	5
	Operations Management	OM Manage Payment Information	Manage Payment Information	1	* Large proportion of manual claims and other paper * DSS is robust but needs wider user base * Adjudication is not real-time.	3	5



MITA BUSINESS AREA	STATE BUSINESS AREA	MITA BUSINESS PROCESS	STATE BUSINESS PROCESS	AS-IS LEVEL OF BUSINESS CAPABILITY	MAJOR CONSTRAINTS TO ACHIEVING NEXT LEVEL	TO-BE LEVEL OF BUSINESS CAPABILITY 3-5 YEARS	TO-BE LEVEL OF BUSINESS CAPABILITY 6-10 YEARS
					"GAP"		
N/A	N/A	OM Calculate Spend Down	N/A	N/A	N/A	N/A	N/A
N/A	N/A	OM Prepare Member Premium Invoice	N/A	N/A	N/A	N/A	N/A
	Operations Management	OM Manage Drug Rebate	Manage Drug Rebate	1	* No interfaces with manufacturers	3	5
	Operations Management	OM Manage Estate Recovery	Manage Estate Recovery	1	* Inconsistent sources of death information * ER database not tied to MMIS * Claims history in MMIS limited * Slow, manual communication with courts, families, lawyers, etc.	3	5
N/A	N/A	OM Manage Recoupment	N/A	N/A	N/A	N/A	N/A
	Operations Management	OM Manage Cost Settlement	Manage Cost Settlement	1	* Calculations are manual * Most cost reports are submitted manually * Large backlog of settlements	3	5



MITA BUSINESS AREA	STATE BUSINESS AREA	MITA BUSINESS PROCESS	STATE BUSINESS PROCESS	AS-IS LEVEL OF BUSINESS CAPABILITY	MAJOR CONSTRAINTS TO ACHIEVING NEXT LEVEL	TO-BE LEVEL OF BUSINESS CAPABILITY 3-5 YEARS	TO-BE LEVEL OF BUSINESS CAPABILITY 6-10 YEARS
					"GAP"		
	Operations Management	OM Manage TPL Recovery	Manage TPL Recovery	1	* Providers bear burden for cost avoidance * Many policy leads are manually verified * Automated data exchange with other payers lacking	3	5
Program Management	Program Management	PG Manage 1099s	Manage 1099s	BCM not published		3	5
	Program Management	PG Perform Accounting Functions	Perform Accounting Functions	1	<i>Cannot be assessed until new accounting system implementation is further along.</i>	3	5
	Program Management	PG Designate Approved Services and Drug Formulary	Designate Approved Services and Drug Formulary	BCM not published		3	5
	Program Management	PG Develop and Maintain Benefit Package	Develop and Maintain Benefit Package	BCM not published		3	5
	Program Management	PG Manage Rate Setting	Manage Rate Setting	1	* No automated rate uploads * Minimal audit trail and price history	3	5
	Program Management	PG Formulate Budget	Formulate Budget	1	* No modeling or forecasting tools	3	5



MITA BUSINESS AREA	STATE BUSINESS AREA	MITA BUSINESS PROCESS	STATE BUSINESS PROCESS	AS-IS LEVEL OF BUSINESS CAPABILITY	MAJOR CONSTRAINTS TO ACHIEVING NEXT LEVEL	TO-BE LEVEL OF BUSINESS CAPABILITY 3-5 YEARS	TO-BE LEVEL OF BUSINESS CAPABILITY 6-10 YEARS
					"GAP"		
					* Siloed programs develop own budgets		
	Program Management	PG Draw & Report FFP	Draw & Report FFP	1	*Process is only partially automated	3	5
	Program Management	PG Manage FFP for MMIS	Manage FFP for MMIS	1	*Relies heavily on manual processes *Data are not centralized	3	5
	Program Management	PG Manage FFP for Services	Manage FFP for Services	1	*Relies heavily on manual processes *Data are not centralized	3	5
	Program Management	PG Manage F-MAP	Manage F-MAP	1	* Have not adopted MITA standard interfaces *Uses a mix of manual and automated processes	3	5
	Program Management	PG Manage State Funds	Manage State Funds	1	<i>Cannot be assessed until new accounting system implementation is further along.</i>	3	5
	Program Management	PG Develop Agency Goals & Objectives	Develop Agency Goals & Objectives	BCM not published		3	5
	Program Management	PG Develop and Maintain Program Policy	Develop and Maintain Program Policy	BCM not published		3	5



MITA BUSINESS AREA	STATE BUSINESS AREA	MITA BUSINESS PROCESS	STATE BUSINESS PROCESS	AS-IS LEVEL OF BUSINESS CAPABILITY	MAJOR CONSTRAINTS TO ACHIEVING NEXT LEVEL	TO-BE LEVEL OF BUSINESS CAPABILITY 3-5 YEARS	TO-BE LEVEL OF BUSINESS CAPABILITY 6-10 YEARS
					"GAP"		
	Program Management	PG Maintain State Plan	Maintain State Plan	1	* Current plan is on wiki but not versioned * Updates require passing paper around agency, long wait periods	3	5
	Program Management	PG Generate Financial and Program Analysis Report	Generate Financial and Program Analysis Report	BCM not published		3	5
	Program Management	PG Maintain Benefits/Reference Information	Maintain Benefits/Reference Information	BCM not published		3	5
	Program Management	PG Manage Program Information	Manage Program Information	1	* DSS is robust but needs wider user base	3	5
	Program Management	PG Develop & Manage Performance Measures & Reporting	Develop & Manage Performance Measures & Reporting	1	* Siloed programs set and monitor performance measures * No dashboard for performance monitoring	3	5
	Program Management	PG Monitor Performance and Business Activity	Monitor Performance and Business Activity	1	* Performance monitoring tools not built in to systems	3	5



MITA BUSINESS AREA	STATE BUSINESS AREA	MITA BUSINESS PROCESS	STATE BUSINESS PROCESS	AS-IS LEVEL OF BUSINESS CAPABILITY	MAJOR CONSTRAINTS TO ACHIEVING NEXT LEVEL	TO-BE LEVEL OF BUSINESS CAPABILITY 3-5 YEARS	TO-BE LEVEL OF BUSINESS CAPABILITY 6-10 YEARS
					"GAP"		
Business Relationship Management	Business Relationship Management	BR Establish Business Relationship	Establish Business Relationship	BCM not published		3	5
	Business Relationship Management	BR Manage Business Relationship Communication	Manage Business Relationship Communication	BCM not published		3	5
	Business Relationship Management	BR Manage Business Relationship	Manage Business Relationship	BCM not published		3	5
	Business Relationship Management	BR Terminate Business Relationship	Terminate Business Relationship	1	* No systematic review or termination procedures across contractor and trading partner relationships	3	5
Program Integrity	Program Integrity	PI Identify Candidate Case	Identify Candidate Case	2	* MITA data standards not yet thoroughly defined * Audit trails and system history limited	3	5
	Program Integrity	PI Manage Case	Manage Case	1	* MITA data standards not yet thoroughly defined * Audit trails and system history limited	3	5
Care Management	Care Management	CM Establish Case	Establish Case	BCM not published		3	5



MITA BUSINESS AREA	STATE BUSINESS AREA	MITA BUSINESS PROCESS	STATE BUSINESS PROCESS	AS-IS LEVEL OF BUSINESS CAPABILITY	MAJOR CONSTRAINTS TO ACHIEVING NEXT LEVEL	TO-BE LEVEL OF BUSINESS CAPABILITY 3-5 YEARS	TO-BE LEVEL OF BUSINESS CAPABILITY 6-10 YEARS
					"GAP"		
	Care Management	CM Manage Case	Manage Case	1	* Little care coordination between agencies * Insufficient system resources for tracking and monitoring care	3	5
N/A	N/A	CM Manage Medicaid Population Health	N/A	BCM not published	N/A	N/A	N/A
N/A	N/A	CM Manage Registry	N/A	BCM not published	N/A	N/A	N/A
N/A	State Specific Business Area	N/A	Enter Claim	1	* Many providers not equipped to bill electronically	3	5
N/A	State Specific Business Area	N/A	Perform Adjustment	1	* Intensive, manual process for both claim-level and gross-level adjustments	3	5
N/A	State Specific Business Area	N/A	Manage Edit Correction Forms	1	* Paper-based process * No online resolution of suspended claims (internal or external)	3	5



6.3. *MMIS Survey Results*

MMIS User Survey

BMSM conducted an agency-wide survey in May 2009 to determine what problems users have with the MMIS. Users were asked what kinds of MMIS training and improvements are most important to them.

The survey also collected information on the most commonly used MMIS screens, which will be helpful during development of a new system and business processes but is not included here.

The survey was sent only to MMIS users. 441 users completed the survey.

According to the survey, the MMIS is frequently used throughout the agency. 36% of respondents access the system multiple times a day. Another 27% access it at least once per day.

The survey also found a fairly large proportion of long-term MMIS users within the agency:

How long have you been a MMIS user?	Response Percent	Response Count
6 months or less.	17.1%	75
Up to 12 months.	21.7%	95
Up to three years	17.6%	77
Up to five years	7.8%	34
More than five years	35.8%	157

The following are common MMIS user concerns, along with some representative comments for each.

- Login process is cumbersome.
 - “Have to enter password too many times. Once should be sufficient.”
 - “Entering passwords twice is annoying.”
 - “Too many steps to get into system.”
 - “Very confusing to new employees- Having to log in two places, one mistake in the log in and you have to start over from the beginning.”
 - “Dissatisfied with duplication of login & password required to get into the system. The system “times out” rather quickly and then you have to re-enter everything again.”
- Passwords must be changed frequently.
 - “I wish that it would not prompt you to change your password so often.”
 - “I do not like to have to change my password so frequently. I am running out of ideas for passwords. I have used my children, pets, spouse, etc.”



- Certain mistakes require the user to exit the system and start over again.
 - “It is hard to navigate to each screen and if you press the wrong button you have to exit out and start all over. It can be very frustrating.”
 - “It is very basic. It works, but it locks up if you put something in the wrong place when trying to get where you're going. It doesn't let you fix your error and go on. You have to go out and start over. Kind of time consuming, but not a major problem. I guess it could be construed as a security feature.”
 - “have experienced freezing up of system if you accidentally click in the wrong place or enter an incorrect key & have to close out & go back in.”
 - “When you get to 2nd screen & have to press "s" for select-if you've been using MMIS several times during the day and you slip up and press "X" instead of "S", then have to quit all the way out-waste of time? I know it has to be a "sensitive system" for security but sometimes it seems a little too sensitive...?”
 - “slow to get in @ times and will quickly throw you out if you hit the wrong key”
 - “I hate that it will disconnect if you click a button by error.”
- Navigation between screens is difficult or cumbersome.
 - “Also, it is difficult and sometimes impossible to go back one screen.”
 - “I actually use MMIS less than 2-3 times per month. I feel intimidated by it because I have trouble navigating through the screens to find the data that I need.”
 - “It is not a user friendly system because a lot of the pages are like dead end roads you have to go all the way back [...]”
 - “I would like to see fewer screens, with less duplication of data having to be keyed across multiple lower-level screens.”
 - “Please have your CICS programmers cut down the number of wasted screens we have to go through to get to the data we need. I don't need to select essentially the same option on 2-3 introductory menus in order to get to 4 screens I need to print for the CLTC charts.”
- Users haven't received enough training.
 - “Need training because I am teaching myself how to navigate through and assisting with consumer requests/executive staff requests. Also, have had to rely on other staff members for direction and would prefer obtaining necessary training.
 - “MMIS is very useful but I don't know how efficiently navigate through it because I was never trained. I taught myself how to use it for checking third party liability, diagnosis codes, and provider info.”
- There is no MMIS user guide or key.
 - “It would be great if there was a MMIS User Training Manual like the MEDS one. Because I do not use the system often, I sometimes have to look back over notes and old e-mails to remember how to find the information I need.”
 - “[I need] a little guidebook with all of the acronyms for the managed care plans and provider types, etc... The F13 option does not always open up the screen which shows us what the code represents and that would be helpful.”
- MMIS and MEDS do not interact well.
 - “I also think that it is confusing when CLTC workers use MMIS and ME workers use MEDS and the two programs don't always match.”
 - “I wish the interaction between meds and mmis was easier.”
 - “I just really do not like using it, you have to toggle between MEDS and MMIS and if your forget a RCP number then you have to go back, if you have more than one family



- member you have to pull the RCP number individually then toggle it just does not flow well at all.”
 - “I have to continue to click back and forth thru the screens to get all the information that I need. It would be nice to have the same information as Eligibility has since we occasionally run into problems with the hospital concerning eligibility.”
- Users would like to open more than one MMIS screen at the same time.
 - “[I hope] a system can be implemented where we can have more than one screen opened. e.g. if we are checking a claim and an issue comes up regarding a code, we do not have to leave the screen we are in and exit out to view information and come back to the same screen. instead have the ability to open a total separate screen on the required page (basically have two or more screens of the MMIS open).”
 - “When you need medical information and have determined that they have insurance you have to navigate back and forth through several screens to get needed information. And then for a new query you have to go back again.”
 - “would be helpful if two screens could be used at the same time. for instance eligibility screen at the same time you are researching claims data. As it stands now, you have to remember or write down info from one screen to carry over to the other search.”
- “Sound Alike” search does not work well.
 - “I hate that the "sound alike" will not pull up all providers even though you know they should be listed.”
 - “Several people have trouble finding a provider through ‘Provider Sound Alike’.”
- The user interface is poor.
 - “I prefer a GUI program.”
 - “[I] prefer a user-friendly web-based tool that supports notes, history, on-line assistance/ glossary/ training resources. As MMIS currently stands, users must simply rely on rote memorization.”
 - “I have to reset my font size/color daily because it does not save. I need a slightly larger font size.”

Other requests include:

- Have all beneficiary information on one screen (insurance, managed care plans, and phone numbers are not on main screen).
- Ability to search on variety of fields and factors (especially for claims and beneficiaries)
- Ability to fix typing errors when accessing screens.
- Daily reports on beneficiaries that become ineligible
- Add a notes section to document calls and other contact information.
- Stop tape feeds (interfaces) from automatically overriding record details. (A user may have corrected an error and then the feed data overrides the correction.)
- Reduce exact matches for keying in different values. Instead, provide a listing of possible matches to reduce trial and error typing.
- Provide an audit trail.

These results and comments will inform discussions of future system improvements and the design of the Medicaid Enterprise.



6.4. Summary of Required Functionality

It is clear from the business analysis that our goal must be to implement a system that encourages use through clarity and good design, is flexible and adaptable to address the changing needs of the agency, and is capable of supporting increasing demands through streamlined, agile and reusable application components that can be developed, deployed, and maintained efficiently while eliminating redundancy and duplication throughout the system. The technology must support the processes of the agency, rather than requiring the process to conform to the limits of technology.

The summary of required functionality is a description of what the new system must be able to do (in addition to what the current system does today). This summary has been drawn from user requests made during the problem statement interviews and thus represents deficiencies and opportunities from the user perspective. The functionality requests fall into four major areas: locus of control, standardization, relationship management, and general system improvements.

6.4.1. Locus of Control

Improve reporting, decision support, and business intelligence within the system. Users want the ability to retrieve data without relying on the intervention of technical staff. Relying on other agency areas (or technical staff) to provide data introduces delays and slows business processes. Users need to be able to develop interfaces for entities outside the agency but have those interfaces supported centrally.

Agency users need greater control over how the business works. It should be possible to change parts of the system without changing the whole and the system should change more quickly. It should be possible to make the technical changes necessary to support the process changes as well as regulation or policy changes.

While requesting the ability to make substantial changes, the users recognize the need to prevent or reduce fraud. In conjunction with the need to support change, the system must also maintain a record of all user changes. Ideally this would include a way for the user to comment on a change so that there would be some record of the rationale behind a decision. To facilitate audit and investigation, the system should be able to expose the claims payment process (when appropriate) to external auditors to demonstrate compliance.

6.4.2. Standardization

Manual data entry and process steps should be automated wherever possible, reducing or eliminating opportunities for fraud or error. Data fields should pre-populate (e.g., complete a beneficiary's name and address fields based on beneficiary ID) and screens should be tailored to the situation so that the user is guided and supported through the process.

If a process relies on certain events, the next step in the process should automatically occur in response to the trigger. For example, entering a new age bracket may change a beneficiary's eligibility. Currently monitoring this change is done manually and therefore could be missed. In addition, some steps may need to trigger yet require approval to complete, so the process workflow also should address approval workflow as well.



The system should automatically validate data using external sources for that validation. For example, addresses should be validated using United States Postal Service data. Automated licensing checks should be possible against external review boards. Data matches with credit bureaus could be used in determining eligibility. Prior authorization checks could be automated and validated. In all cases where a manual check is made, time is lost and there is a potential for miss-keying the data.

Moving forward, there is an increasing demand for consistency among state agencies. The system must comply with all applicable standards to ensure consistency and allow for the common exchange of health information, as well as simplifying the audit process which is currently manual, time-consuming, and prone to error. It should be possible to send and receive data and necessary electronic communication between SCDHHS and other state agencies, providers, and recipients where appropriate.

6.4.3. Relationship Management

The system needs to provide cohesive views of beneficiaries and providers, tracking, facilitating, and in some cases even initiating communication when required by the agency's business processes. Wherever possible, use of hard copies should be eliminated and replaced by seamless, electronic access to data.

The system should facilitate and automate the necessary communication for each process to ensure consistency and reduce the reliance on manual intervention. A new system should improve the communication media, either allowing format changes to the current printed output or replacing printing where appropriate with more cost effective communications media. A unified electronic record of all communications must be available to system users. This unified record needs to accommodate attaching multiple formats of supporting documentation.

The system should show all available services for a beneficiary. The system should facilitate case management, customizing screens to the workflow for that process for that beneficiary rather than a generic flow that may not apply. Processes should be revealed as wizard-driven, guiding interviews and assisting in information-gathering conducted by agency staff. Calculations required during the process should be done for the user. Standard business rules should apply to the processes to ensure consistency.

Access to the system should be made available to recipients. Currently, the web interface for the system is only available to providers.

The system should support monitoring customer satisfaction and make it possible for customers to provide feedback. Some part of this should be automated, so that system performance that impacts user experience will be monitored, tracked, and reported on, including metrics such as response time and end to end process time.

Relationship management will include online, self-paced training for new providers or those providers who want to review materials. The provider manuals should be standardized and maintained centrally. Furthermore, while this is currently expressed only as a need for provider materials, there are likely opportunities to handle beneficiary education in a similar manner.



6.4.4. General System Improvements

Through the problem statements there are general issues with the current environment that could be addressed if the system were easier to change. The issues may be smaller in scope than the overt functionality requests (such as automate data validation with external agencies). While not precisely missing functionality, they are a source of frustration for users and are examples of how the system is seen as an obstacle rather than a tool.

Searching capability should be improved and made easier to use. Navigation options should make it easier to move from screen to screen, or view multiple screens if necessary. Several of the data codes in use could be mapped to a human-readable label. The systems used by the agency should be consistent and share necessary data, such as indicators used in both MMIS and MEDS. Data should be available longer, with the retention policy matched to the needs of all agencies using that data.

6.5. Technical Constraints

It is impossible to meet the current business needs of SCDHHS within the context of the current system in place today. While system changes are possible, the expense of changes and the time required to make them reduce the agency's ability to adapt and function in an agile manner. Changes have been made and continue to be made to the core MMIS system; however, users have also been forced to arrive at alternate solutions to meet the needs of the agency.

An example workaround is the Microsoft Access database used to workflow for one of the business processes: there was a need for workflow tracking and enforcement, but no easy way to add that to the existing system. The result is a series of shadow systems that may not be secure, that may not be able to share data without manual re-entry, and that almost certainly do not comply with any agency-wide disaster recovery policy for the core MMIS.

An additional complication is the record space available within the current MMIS. There is no additional space available within many of the record fields. If there is a requirement to expand a field (such as making a name field longer than 28 characters) or add a field, there are three possible approaches: substantial rewrites (involving time and cost), storing the data elsewhere and linking to it (increasing the complexity of the system and making future changes more difficult), or denying the request.

6.6. Future Environment

The future MMIS system will likely be implemented and delivered as a hybrid approach that will combine COTS applications with solutions that can be tailored to fit the needs of the agency and components that custom-developed. A hybrid solution will allow the selection of best-of-breed solutions and is supported by the component-based Service Oriented Architecture approach of the MITA framework.

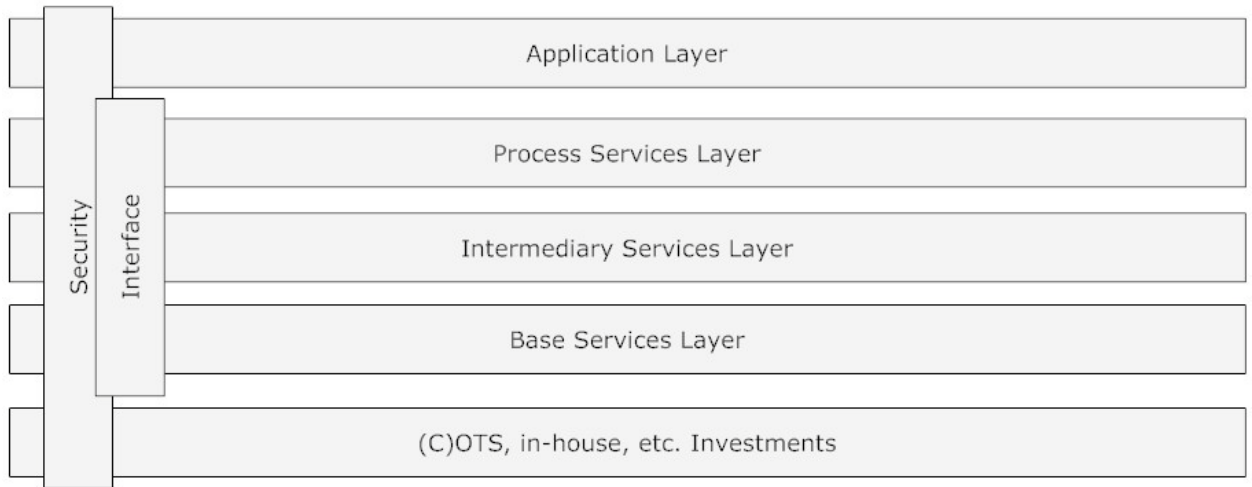
Development of solution requirements and detailed reference architectures are activities of the forthcoming DDI planning project. However, based on information from SSA activities and the MITA Framework, a conceptual meta-architecture can be developed.

Concerns -- gaps from the BCM and TCM analysis as well as from the comprehensive "wish list" developed during the SSA business process interviews -- can be categorized into "themes." The themes can be super-imposed on a SOA layered meta-architecture. Any solution architecture



developed during DDI planning will derive from this meta-architecture (or revision if necessary) to ensure solutions cover all identified technology needs to support SC Medicaid business transformation.

The following layered SOA model is based on the process-enabled SOA model from Enterprise SOA by Krafzig/Banke/Slama.



Security features and services must permeate the solution.

The interface layer represents features that are present at service boundaries for all services.

Base Services are atomic services or service wrappers that expose features of infrastructure IT investments, such as existing in-house or off-the-shelf applications.

The Intermediary Services Layer provides adapters, gateways, facades, and composite services that facilitate interoperability or more efficient use and re-use of base services and core IT investments.

The Process Services Layer is responsible for service and process orchestration, reasoning and decision-making, service and process control and state management features.

The Application Layer provides simple and composite applications, user interface, and other presentation features.

The choice of themes for grouping concerns is admittedly arbitrary. The precise taxonomy of themes is not particularly important – themes simply serve as a means to make a very long, repetitive list of concerns manageable. The following table describes the chosen themes and notes the layer or layers in which they seem most likely to be addressed.



Layer(s)	Name	Description
Process	Rules-driven	Policy, rates, compliance, etc., are enforced through business-editable rules. The rules engine supports time-bounded reasoning so that rules are applied only for decisions made during the period the rules are applicable.
Application	Electronic Forms Management	The solution provides electronic forms construction and management.
Application	Business-oriented User Interface	The solution provides a user interface configurable by business administration staff
Intermediary, Interface	Real-time Data Access	Data is accessible in real-time by outside agencies, states, etc.
Interface	Audit Support	Activity is logged and reports are available for administrative and auditing purposes. Also see "Reporting"
Interface	Business Monitoring	Automation is provided throughout the solution for performance and quality monitoring
Application	ERP Functions	The solution supports the usual ERP functions, such as financial management (FM), customer relationship management (CRM), business relationship management (BRM), supply chain management (SCM), human capital management (HCM), etc., to facilitate provider, recipient, contract, business relationship, etc. activities.
Base	Case Management	Case management features are provided in addition to ERP functions
Base	Document Management	The solution provides electronic document management and document imaging services. OCR features for binding imaged documents to beneficiary, provider, etc., records are provided.
Base, Intermediary	Real-time Adjudication and Eligibility	The solution supports claims adjudication, eligibility determination, and credential (re)verification processing in real-time. These features have cradle-to-grave visibility
Base, Intermediary	Entity Single-view	The solution provides unified, "single-views" of information entities
Application	Portal Services	"Self-help", "self-serve," and "one-stop-shopping" portal services are provided
Process, Application	BAM Support	Business activity monitoring (BAM) portal and support are provided. Also see "Reporting")
Base	Fraud detection	Pro-active, front-end fraud detection as well as "pay and chase" detection are provided
Interface, Intermediary	Standardized IFaPs	Standard and standardized information entities, formats, and protocols are utilized in information exchange at least at solution boundaries IFaPs
Interface, Intermediary	B2B Support	The solution supports business-to-business exchanges (interoperability) between agencies, payers, states, etc.



Layer(s)	Name	Description
Base, Intermediary	Messaging Services	The solution provides enterprise messaging, transaction transformation, and gateways
Base, Intermediary	Information Model	The solution utilizes a comprehensive canonical information model
Application, Base	Incident Tracking	Support for incident and issue tracking is provided
Interface	Standardization	Standardization of business processes, information entities, technology standards, etc., are supported across all domains
(Not Applicable)	Multiple Environments	Multiple execution environments are supported for development, testing, etc.
(Not Applicable)	Business Continuation and Recovery	The solution provides for disaster recovery and business continuity support
Base	SSO	The solution supports single sign-on, identity management, and role-based entitlements
Interface	HIE Support	The solution is HIE-ready, for example by being NHIN CONNECT compliant
Application	Education Portal	The solution provides self-serve education resources
Process	Process and Workflow	Components to manage process orchestration and workflow management are provided
Base, Intermediary	Informatics	The solution provides data warehouse, business intelligence, data analysis, and associated reporting features
Base, Intermediary	Reporting	The solution provides ad-hoc reporting features wherever applicable
Interface	Internationalization	Support for multiple languages is provided
Base	SOA Support	Technologies required to deliver features as services in support of a Service Oriented Architecture are provided
(see "SOA Support")	Agility	The solution is relatively easy to adapt to changing requirements over time
Base, Intermediary	5010/ICD-10	The solution is HIPAA/Code set change ready
(see "Informatics," et. al.)	Health Outcomes	The solution helps Medicaid to improve benefit recipient health outcomes
(Not Applicable)	Efficiency and Effectiveness	The solution is designed to improve productivity and overall effectiveness of Medicaid administration

“Not Applicable” indicates that the theme is not really implemented but more a guiding principle.

The future state MMIS is intended to address all of the themes listed through a service-oriented solution that re-uses existing IT investments wherever possible and innovates where necessary.



As solution architectures are devised and evaluated, they can be compared against the meta-architecture and proposed solution components fit to layers and finally back to themes to ensure all concerns are covered.

6.6.1. *Change*

Due to the demands placed on the agency to adapt to change, there must be some way for the agency to have greater control over how the system works. Two components that would address this requirement are incorporating a business rules engine and business process orchestration. Making a business rules engine available to SCDHHS would allow program changes such as eligibility limits to be made without requiring intervention of technical programming staff. Providing information about business processes through some sort of orchestration tool would allow users to see areas for improvement and potentially make those improvements without having to rely on technical staff. In both cases, greater information about the impact of a change would assist in prioritizing and approving changes.

6.6.2. *Sharing*

The system must comply with standards to support interagency work as well as improving healthcare quality and beneficiary health outcomes. The system must also be flexible to interact with other systems within the state and the National Health Information Network (NHIN). It is not possible today to predict and document all the data exchange needs that develop and change on a daily basis; therefore standards compliance is the only possible way to address that requirement.

6.6.3. *Assessment*

The new system must be written with CMS certification in mind, with the certification process as the fundamental source of requirements. The development must be documented well enough to demonstrate compliance with state and federal law and policy, be measureable and repeatable, and have the ability to report at the executive dashboard level for both state and federal organizations. This will require new tools to support a structured development process.



7 Conclusion

SCDHHS intends to use the SS-A as a guide as requirements are developed for the new MMIS, MEDS, and other MMIS sub-systems. Information from this report will also serve as a tool in the ARRA HIT project.

The SS-A will continuously evolve as SCDHHS moves towards implementing the MITA framework in its systems. As SCDHHS develops its strategic planning efforts, the SS-A will prove to be an invaluable resource in planning for the years to come.

Also, it is SCDHHS' hope that developments incorporated in meeting new levels of MITA maturity will also promote the purpose of the HIT provisions under ARRA which are to promote health care quality and health information exchange through the use of certified EHR technology.

South Carolina Department of Health and Human Services



Appendices A-H: Business Capabilities Self-Assessment Report for the Medicaid Information Technology Architecture State Self-Assessment



Medicaid
Information
Technology
Architecture

November 2009



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Appendix A: List of Acronyms

ABD	Aged, blind and disabled (PCAT 32)
ACH	Automated Clearing House; the network/system utilizing the Federal Reserve Banking System for transferring money to and from accounts. It is overseen by the NACHA agency (Electronic Payments Association).
ADA	American Dental Association
AG	Attorney General
ALC	Administrative Law Court
APD	Advanced Planning Document
ARL	Accounts Receivable Log
ASO	Administrative Service Organization
BCCP	Breast and Cervical Cancer Program (PCAT 71)
BCM	Business Capability Matrix
BENDEX	Beneficiary Earnings and Data Exchange
BITS	Bureau of Information Technology Systems
BMSM	Bureau of Medicaid Systems Management
BPM	Business Process Model
BRMP	Bureau of Reimbursement Methodology and Policy
Budget Group	Grouping of members based on family and financial responsibility
BUS	Beneficiary Users System
C:D	Connect Direct
CCB	Change Control Board
CCME	Carolina Center for Medical Excellence
CCN	Claim Control Number
CEP	Central Eligibility Processing
CFR	Code of Federal Regulations
CHAMPUS	Original fee-for-service healthcare for military and dependants
CIO	Chief Information Officer
CLS	Contract Log System
CLTC	Community Long Term Care
CLTC CMS	Community Long Term Care Case Management System
CMS	Centers for Medicare and Medicaid Services; Case Management Sheet/System
COB	Coordination of Benefits
COBC	Coordination of Benefits Contractor
COC	Continuum of Care
COU	Community Long Term Care Assessment (level of care assessment)
CPT	Current Procedure Terminology
CRCF	Community Residential Care Facility
CRL	Cash Receipt Log
CSE	Child Support Enforcement
D:D	Document Direct
DDSN	Department of Disabilities and Special Needs
DEERS	Defense Enrollment Eligibility Reporting System (Military)



DHEC	South Carolina Department of Health and Environmental Control
DME	Durable Medical Equipment
DMH	Department of Mental Health
DMRE	Department of Mental Retardation Waiver/Established
DMRN	Department of Mental Retardation Waiver/New
DOB	Date of Birth
DOD	Date of Death
DOE	South Carolina Department of Education
DOU	DDSN assessment sent (level of care)
DPAS	Dental Prior Authorization System
DRG	Diagnosis-related group
DRU	Department of Recipient Utilization
DSS	South Carolina Department of Social Services; Decision Support System
EC	Electronic Commerce
ECF	Edit Correction Form
EDI	Electronic Data Interchange
EFT	Electronic Funds Transfer
EOM	End of Month
EPMS	Employee Performance Management System
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
ER	Estate Recovery
ESC	South Carolina Employment Security Commission
EVS	Enumeration Verification System
FFP	Federal Financial Participation
FFS	Fee-for-service
FMAP	Federal Medical Assistance Percentages
FOIA	Freedom of Information Act
FPW	Family Planning Waiver (PCAT 55)
FQHC	Federal Qualified Health Center
FTP	File Transfer Protocol
GAFRS	Government Accounting and Financial Reporting System
GAGAS	Generally Accepted Government Auditing Standards
GAP	Senior prescription drug benefit (PCAT 92)
GAR	Grant Application Request
HCBS	Home and Community-based Services
HCFA	Health Care Financing Administration
HCK	Healthy Connections Kids (PCAT 88, 99)
HCPCS	Healthcare Common Procedure Coding System
HEDIS	Health Employer Data and Information Sets
HIIRF	Health Insurance Information Referral Form
HIPAA	Health Insurance Portability and Accountability Act
HIPP	Health Insurance Premium Payment
HMO	Health Maintenance Organization
HOA	Health Opportunity Account
Household	Grouping of budget groups based on family relationship and living arrangement
HSCN	Head and Spinal Cord/New



ICF	Intermediate Care Facility
ICF/MR	Nursing Homes-Intermediate Care Facilities/Mentally Retarded
IDT	Interdepartmental Transfer
IEVS	Income Eligibility Verification System
IFB	Invitation for Bids
IFS	Institutes for Families in Society
IPC	Integrated Personal Care
IRS	Internal Revenue Service
ITMO	Information Technology Management Office
IVRS	Integrated Voice Response System
JAD	Joint Application Design
LIF	Low Income Family (PCAT 59)
LIS	Low-Income Subsidy
LOE	Level of Effort
MARCi	Medicaid Application Response Center and Customer Interface
MARS	Management and Administrative Reporting System
MBES	Medicaid Budget and Expenditure System
MCAC	Medical Care Advisory Committee
MCCS	Medicaid Claims Control System
MCIS	Managed Cared Information System
MCO	Managed Care Organization
Med Recon	Medical Reconciliations
MEDS	Medicaid Eligibility Determination System
Member	MEDS name for what will become an MMIS recipient.
MEVS	Medicaid Eligibility Verification System
MFCU	Medicaid Fraud Control Unit
MGC	Managed Care
MHN	Medical Homes Network
MIVS	Medicaid Insurance Verification Services
MLE	Member Listing Eligibility
MMA	Medicare Modernization Act of 2003
MMIS	Medicaid Management Information Systems
MMO	Materials Management Office
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding
MRFU	Medicaid Recipient Fraud Unit
MSIS	Medical Statistical Information System
NDC	National Drug Code
NPI	National Provider Identifier
OCWI	Pregnant Woman (PCAT 12, 87)
ORS	Office of Research and Statistics
OSS	Optional State Supplementation
PA	Prior authorization, Program area
PARIS	Public Assistance Reporting, Office of Children and Family Services
PCA	Program Cost Account
PCAT	Payment Category (Program Code/Identifier)



PDL	Preferred Drug List
PDP	Preferred Drug Provider
PEP	Physician Enhanced Program
PFH	Partners for Health
PHI	Protected Health Information
PI	Program Integrity
PICKLE	Plan for Achieving Self Support (also known as PASS)
PMPM	Per-member-per-month
POC	Plan of Care
POS	Point of Sale
PS	Production Support
QA	Quality Assurance
QI	Qualified Individuals (PCAT 46)
QIO	Quality Improvement Organization
QMB	Qualified Medicare Beneficiaries
RAI	Request Additional Information
REOMB	Recipient Explanation of Medical Benefits Program
RFC	Request for Change
RFI	Request for Information
RFP	Request for Proposal
RFS/RFC process	Request for service/Request for change
RHC	Rural Health Clinic
RJE	Remote Job Entry
RSP	Recipient Special Program
SAS	Statistical Analysis System.
SC B&CB	South Carolina Budget and Control Board
SCAN	South Carolina Community Access Network
SCBO	South Carolina Business Opportunity Letter
SCEIS	South Carolina Enterprise Information System
SCMSA	South Carolina Medical Service Area
SCSD&B	South Carolina School for the Deaf and Blind
SCSRS	SC State Retirement System
SDLC	Software Development Life Cycle
SDX	State Data Exchange
SFTP	Secure File Transfer Protocol
SLMB	Specified Low Income Medicare Beneficiaries
SOP	Standard Operating Procedure
SPAP	State Pharmaceutical Assistance Programs
SSA	Social Security Administration
SSI	Supplemental Security income
SSP	State supplementary payment
SURS	Surveillance and Utilization Review System
SVES	State Verification & Exchange System
Sybase EC Gateway	Software that supports electronic messaging. EC is Electronic Commerce.
TAD	Turnaround Document
TEFRA	Tax Equity and Fiscal Responsibility Act of 1982 (PCAT 57)



TCP/IP	Transmission Control Protocol/Internet Protocol
TigerTracks	Clemson University Incident Tracking System
Title XVI	Supplemental Security Income for the Aged, Blind, and Disabled
TPA	Trading Partner Agreement
TPL	Third Party Liability
TRC	Technical Review Committee
TrOOP	True Out-of-Pocket
TSO	Time Sharing Option
UCB	Unemployment Compensation Benefits
USC	University of South Carolina
X12	Standards Organization responsible for the HIPAA EDI X12 Transactions for healthcare
X12 270	EDI Eligibility, Coverage or Benefit Inquiry transactions
X12 271	Eligibility, Coverage or Benefit Information transactions
Zeke	Mainframe Job scheduling software/tool utilized by Clemson University



Appendix B: BCMs

Member Management: Determine Eligibility: Business Capabilities				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions				
The Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				
How does the applicant complete and submit the application?	Applicant completes application on paper with submissions being faxed, hand-delivered, or mailed.	Applicant may use paper application but also has choices of data entry at government offices and kiosks. Electronic submissions are available and used.	Applicants may complete and submit electronic applications from any location that has internet access; there is a uniform application process for multiple programs, including Medicaid.	
	Refer to business process write-up.			
Does the application use standardized format and data content?	Data and format are indeterminate. Requirements are locally defined.	Application data are standardized within the Medicaid enterprise.	Application data are standardized using MITA standard interface and data content specifications across multiple programs.	
		Application is standardized across state Medicaid. Refer to business process write-up.		



How are application data validated?	Information is manually validated. Staff contact external and internal document verification sources via phone, fax, USPS. Decisions on data verifications take several days.	Many application data validations are automated (SSA, address, birth certificate, etc.).	Electronic messages and automatic data matching are sent to external entities such as banks for financial verification, employers for wage verification and employment dates, to state and federal tax authorities, insurance companies to verify TPL using MITA standard interfaces.	
		Many sources are automated, though some verification (e.g., citizenship) is still manual and in person.		
How consistent are the decisions?	Decisions have a degree of inconsistency due to individual interpretation and application of policies.	Consistency improves with the automation of some processes.	With increased automation, rules are consistently applied and decisions are uniform. Exceptions are minimal and reviewed for quality improvement to reduce future need.	
	Refer to business process write-up.			
How integrated is the eligibility determination process?	There are many pathways for determining eligibility. Eligibility determination may occur in silos without sharing or coordination, i.e., different processes for each type of eligibility.	Eligibility determination is automated to assist staff in processes. For example, social services staff could access web portal to begin process of Medicaid application or single application form may be used across agencies.	Different types of eligibility pathways are merged into a single electronic standard process through interagency agreements for multiple benefit assistance programs.	



	Refer to business process write-up.			
Business Capability Quality: Timeliness of Process				
How timely is the End to End process?	The process can require many days to receive the application, validate key data, determine eligibility and transfer information to the MMIS.	The process time is reduced due to applications being received on-line and some automation, but may continue to require many days to validate key data, determine eligibility and transfer information to the MMIS.	The process time is generally reduced to 24 hours due to on-line application processes using MITA standard interface and validations.	
	Refer to business process write-up.			
Business Capability Quality: Data Access and Accuracy				
How accurate is the information used in this process?	Data is entered by hand into the application and keyed in by staff. There are inconsistencies and errors that need correction.	Information in the member data store conforms to business rules. Information gathered externally is subject to errors.	Information conforms to MITA standards including interfaces with external data sources.	
	Refer to business process write-up.			
How accessible is the information used in this process?	Access to bank account, residence requirements, citizenship information all require manual contact via phone, fax, or United States Postal Service (USPS).	Information in the member data store is instantly accessible. External validations may still be via phone, fax, or USPS.	Internal and external data is instantly available via messaging.	
	Refer to business process write-up.			



Business Capability Quality: Cost-Effectiveness				
What is the ratio for the cost of eligibility determination compared to the value of the results?	Process is labor intensive and takes away from personal interactions with applicants.	Automation of business rules for eligibility determination improves the effectiveness of the process and allows staff to focus on difficult cases.	Use of MITA aligned business service interfaces and messaging with external entities streamlines this process allowing staff more time with applicants.	
	Refer to business process write-up.			
Business Capability Quality: Effort to Perform; Efficiency				
How do you describe the efficiency of the Determine Eligibility process?	Manual workflow is burdensome. Some applicants experience delays in obtaining eligibility.	Automation increases efficiency and reduces delays in obtaining eligibility.	Use of national MITA standards and uniform data and processes among participating entities improves efficiency and further reduces delays in obtaining eligibility.	
	Refer to business process write-up.			
Business Capability Quality: Accuracy of Process Results				
What is the quality of the results of the process?	Manual processes can result in inaccurate eligibility determinations.	Accuracy of results is higher than at Level 1	Accuracy of the results is 98% or higher.	
	Refer to business process write-up.			
Business Capability Quality: Utility or Value to Stakeholders				



How satisfied are the stakeholders?	Stakeholder satisfaction is low, with few resources dedicated to improvement and few measurements in place, e.g. reliance on complaints, legal mandates for action regarding improving stakeholder satisfaction.	States begin to identify gaps in levels of satisfaction and stakeholder expectations and priorities. Improvements are made strategically, increasing stakeholder satisfaction over Level 1.	Medicaid Enterprise conducts internal and external audits/focus groups which take into consideration the results of its previous research along with other national standards to identify additional stakeholder expectations and priorities. Improvements are made based on national and MITA best practices, improving stakeholder satisfaction over Level 2.	
	We have not conducted a cost benefit analysis.			

Enroll Member				
Capability Question	Level 1	Level 2	Level 3	Levels 4 & 5
Business Capability Descriptions				
The Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				
What Is the Access Channel for Receipt of Enrollment Application Form?	Applicants submit paper application forms to each program separately.	Application process is more automated. Some applications may be submitted on paper via. telephone or, web-based.	Applicants may initiate an eligibility/enrollment application online from home or a community location receive some responses in real time. Paper applications are still an option for those without computer access.	
	Refer to business process write-up			
What Is the Level of Collaboration with Other Programs?	There is no cross program coordination.	Staff collaborate within the agency.	Collaborating agencies use MITA standard interface for the enrollment data exchange. ("No Wrong	



			Door")	
	Refer to business process write-up; Specific program areas are responsible for certain programs.			
Are Verification and Validation Activities manual or automated?	Approximately 20% of the verification and validation of enrollment data is performed automatically.	Approximately 50% or more of the verification and validation of enrollment data is automated; some information requires manual processing.	90% of the verification and validation of enrollment data is automated and is based on MITA HL7 data standards. Some categories of eligibility may be exceptions.	
		See Determine Eligibility draft. Verification and Validation are not part of Enroll Member, but these interfaces are a form of automation.		
How Are Business Rules Applied?	Enrollment policies, procedures, benefits and application forms are program specific and may be prone to error due to manual application of policies.	Some business rules are automated resulting in consistent application of these rules.	Maximizes number of automated business rules which accommodate business rules for multiple programs.	
	Refer to business process write-up			
BUSINESS CAPABILITY QUALITIES (Examples only excerpted from total list)				
[Qualities are capabilities that are measurable]				
Timeliness of Process				
What Is the Timeliness of End to End Process?	From Mail Room In to Mail Room Out:	From Mail Room In to Mail Room Out:	Manual processes are the exception and do not significantly impact performance of the business process.	
<i>Manual Process</i>	Completion of the Enroll Member process is measured in months.	Completion of the Enroll Member process is measured in weeks		



		Refer to business process write-up.		
<i>Electronic Process</i>	[no electronic]	From Electronic In to Out: No more than 14 days	From MITA Business Service Trigger to Result: timeliness improves over Level 2	
	There is no electronic application submission.			
Data Access and Accuracy				
Are data and format standardized?	Enrollment data and format are non-standard	Enrollment data are standardized. Enrollment applications are standardized and electronic. Data can be used to support HIPAA transaction needs without crosswalking.	Enrollment and exchange data use MITA standard interfaces, improving accuracy, reusability, and interoperability.	
	Refer to business process write-up. Applications are not electronic.			
How accurate are the data?	Data accuracy is measured as sufficient to support operation of the business process	Data accuracy is noticeably improved over level 1.	Data accuracy is measured as 98% of total data stored and 98% of occurrences of data accessed.	
	Refer to business process write-up. Wish list items to improve data accuracy.			
Effort to Perform; Efficiency				
What Level of Effort is required?	The enrollment process required is labor intensive and inefficient due to manual processes.	The enrollment process requires less effort than at Level 1 due to increased efficiencies.	The enrollment process requires less effort than Level 2 due to increased efficiencies.	
	Refer to business process write-up			
Cost-Effectiveness				
Is the cost of the enrollment process balanced by the results?	No. Siloed and manual enrollment processes are expensive and result in redundant effort and costs.	Fewer applicants and members are enrolled in the wrong program, reducing program costs and eliminating redundancy.	Shared services and inter-agency collaboration contribute to streamline the process.	



	Have not conducted a cost-benefit analysis			
Accuracy of Process Results				
What are acceptable Error Rates?	Much of the application information is manually validated may be difficult resulting in increased error rates and potential for fraud. Decisions may be inconsistent.	Automation of data edits and business rules improves accuracy of validation and verification. Automated application of enrollment business rules improves consistency.	Use of MITA standard interface and automation of enrollment and verification data interchange improves consistency and accuracy of enrollment results. Error rate is 0.5% or higher.	
	See Enroll Member and Determine Eligibility drafts. Eligibility workers may not be informed of all options available to a potential member.			
Stakeholder Satisfaction				
What is the level of stakeholder satisfaction?	Satisfaction level is described as adequate.	Satisfaction level is noticeably improved over level 1 and can be described as sufficient.	Satisfaction level is noticeably improved over level 2 and can be described as very good.	
	Have not conducted a satisfaction survey			

Dis-enroll Member				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
General Description				
Is this business process primarily manual or automated?	The process is primarily manual. Disenrollment information is manually entered and automatically updates to the eligibility/enrollment data store.	The process is a mix of manual and automated activities. Data may still be manually entered. Rules are automatically applied.	The process is primarily automated. Required data are delivered via MITA standard interface. Rules are configurable.	



		Refer to business process write-up		
Does this business process use standards?	Required data are entered into State-specific disenrollment forms. Rules are manually applied and verified.	Local standards based on HIPAA definitions are applied to the disenrollment process.	The process uses the MITA standard interface which is aligned with HIPAA and any other applicable standards.	
	Refer to business process write-up. No disenrollment forms are used.			
Does the Medicaid enterprise collaborate with other agencies or entities in performing this process?	Each agency manages its own disenrollment process. Member data, including ID, demographics and health status is not comparable across programs, reducing ability to monitor program outcomes or detect fraud and abuse.	Information on disenrollment is shared among agencies. Members are disenrolled based on State business rules or Federal regulations. Members are also disenrolled from Waiver and Managed Care programs.	There is collaboration across the Medicaid enterprise on the exchange of disenrollment information.	
		Refer to business process write-up		
Business Capability Quality: Timeliness of Process				
How timely is this end-to-end process?	Disenrollments may take multiple business days.	Disenrollments are completed in 1 business day.	Turnaround time on disenrollment decision can be immediate. Average time to complete a disenrollment process is measured in seconds.	
	Refer to business process write-up. Data transfer from Enrollment Broker to MMIS is daily.			
Business Capability Quality: Data Access and Accuracy				



How accurate is the information used in this process?	Disenrollment data and format are indeterminate. Disenrollment forms are not standardized and may be hard copy. Manual processes can adversely impact accuracy.	Disenrollment requests and exchange data use local versions of HIPAA standards, improving access and accuracy.	Disenrollment requests and exchange data use MITA standard interfaces, further improving access and accuracy to 90% or better.	
	Refer to business process write-up			
How accessible is the information used in this process?	Information may be stored in disparate systems and may need to be accessed manually.	Data may be stored separately but can be accessed and aggregated as needed.	Data may be stored in either a single member registry or federated Enterprise member registries that can be accessed by all applications. Providers, members, and state enrollment staff have secure access to appropriate and accurate data on demand.	
	Refer to business process write-up			
Business Capability Quality: Cost Effectiveness				
What is the ratio of the cost to perform this process compared to the benefits of the results?	Disenrollment occurs in silos without coordination, i.e., different processes and multiple pathways for each type of disenrollment. Considerable staff effort required to keep up with disenrollments within each month.	Cost-effectiveness improves with automation. The Disenroll Member process meets State cost containment guidelines.	Shared services, MITA standard interfaces, and inter-agency collaboration further improve cost-effectiveness over Level 2. The process demonstrates further improvement and value desired by the Medicaid enterprise.	
	Have not conducted a cost-benefit analysis.			
Business Capability Quality: Effort to Perform; Efficiency				



How efficient is this process?	Manual processes create inefficiencies.	Introduction of automation improves efficiency over Level 1.	Use of MITA standard interfaces further increases efficiency over Level 2.	
	Refer to business process write-up			
Business Capability Quality: Accuracy; Usefulness of Process Results				
How accurate are the results of this process?	Decision making for the process is manual and therefore may result in inconsistent decisions. Complies with State guidelines for error rate.	Automation of business rules and standardization of disenrollment data improves accuracy of results. Decision making for the process is based on Medicaid enterprise policy which has been partially automated resulting in uniform decisions most of the time.	Adoption of MITA standard interface and Sharing of data with other agencies improves results. The process consistently applies business rules resulting in uniform decisions.	
		Refer to business process write-up. Loss of eligibility resulting in disenrollment is rule-governed.		
Business Capability Quality: Utility or Value to Stakeholders				
How satisfied are the stakeholders?	Stakeholder satisfaction is low, with few resources dedicated to improvement and few measurements in place, e.g. reliance on complaints, legal mandates for action regarding improving stakeholder satisfaction.	States begin to identify gaps in levels of satisfaction and stakeholder expectations and priorities. Improvements are made strategically, increasing stakeholder satisfaction over Level 1.	Medicaid Enterprise conducts internal and external audits/focus groups which take into consideration the results of its previous research along with other national standards to identify additional stakeholder expectations and priorities. Improvements are made based on national and MITA best practices, improving stakeholder satisfaction over Level 2.	



	Have not conducted a satisfaction survey			
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Member Management: Manage Member Information: Business Capabilities				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions				
The Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				
Does the process meet or exceed legal, regulatory, or agency requirements or expectations?	At this level, the Manage Member Information business process meets the needs of the FFS Medicaid program and MMIS certification requirements such as MARS and MSIS reporting and is validated via OIG reports, staffing and error reports	At this level, the Manage Member Information business process meets the needs of programs beyond FFS and continues to be validated by external measures	At this level, the Manage Member Information business process improves and benefits from member-centric, No Wrong Door initiatives, and will include things such as rules engines to enhance accuracy. Validation to external measures is automated.	
		Refer to business process write-up. Have information stores for programs beyond FFS.		
How do you handle updates of member information from different sources?	There are delays loading data generated from multiple sources and supplied by multiple media including hand delivery	Updates are automated; paper or hand-delivered files are the exception	Updates are fully automated with triggers from multiple sources.	
	Refer to business process write-up. Enrollment applications are hard copy though there are many automated interfaces.			



Can duplicate entries be detected?	Duplicate entries may go undetected	Better internal controls improve level of identification of duplicates	Use of national (ex:HL7) standards and vocabulary for entity identification improves ability to detect and handle duplicates	
		Refer to business process write-up		
Are eligible update notifications sent to stakeholders?	Irregular update notification to interested users and processes	Notification to interested users and processes is immediate (as soon as update occurs)	Standardized update notifications to stakeholders adheres with service level agreements and are sent via preferred communication method.	
	Unsure whether this refers to notifications to eligibility workers requiring redetermination or notifications to potential eligibles			
Do you perform daily eligibility updates?	Legacy member files, lack of integration with the eligibility system, and mailing paper IDs limit Agencies to monthly eligibility periods vs. day-based eligibility/enrollment	Integration with eligibility system supports day based eligibility/enrollment	Daily eligibility updates are available in real time at point of service.	
	Refer to Determine Eligibility draft.			
Are there standard formats for updates?	Data updates are received from disparate sources in indeterminate formats	Data updates are standardized; requested and scheduled data extraction is increasingly automated	Member information is integrated via a Member Registry, which may either contain integrated records of member eligibility data or provide federated access to other Member Registries as appropriate	
		Refer to business process write-up and MEDS interfaces.		



Are the data updates accurate?	Validation of data is inconsistent and not rules-based	Rule-based validation and data reconciliation is more consistent and improves integrity of data repository	Standard interfaces (trigger event and results; messages to external entities), standardized data, consistent business rules and decisions, easy to change business logic	
	Refer to business process write-up and MEDS interfaces.			
Is there an audit trail for updates?	Updates are inconsistently tracked	Updates are automated with date stamp and audit trail	Manage Member Information is handled by a business service with built-in tracking	
	Refer to business process write-up and wish-list items.			
Business Capability Quality: Timeliness of Process				
How timely are the member updates?	Manual and semi-automated steps delay updates; updates take from one week to one month	Update schedule improves over Level 1. On the average, updates occur daily (within 24 hours)	Updates and data extractions can be immediate	
	Refer to business process write-up and MEDS interfaces.			
How timely are the notifications regarding updates?	Notifications are inconsistent in regards to time, and in general, are not timely, i.e., 5 or more days later than the update	Timelier member updates and data extractions; available on the day of the update	Data exchange partners receive update notifications instantly	
		Refer to business process write-up and MEDS interfaces. Notifications to eligibility workers from MEDS are automated.		
Business Capability Quality: Data Access and Accuracy				
How accurate are the updates?	Updates are made to individual files manually. Manual updates result in inconsistency and mistakes.	Automated updates are made to individual files and databases. Applied edits reduce inaccuracy.	Updates, notifications, and data extractions (e.g., MSIS eligibility reports and MCO enrollment rosters) are standardized	



	Refer to business process write-up and MEDS interfaces.			
How are records stored?	Data stores may be multiple; there are issues of duplicate identifiers, discrepancies between data stores, and information quality and completeness	Databases may be relational	Member records are stored in either a single Member Registry or federated Member Registries that can be accessed by all authorized applications	
	Refer to business process write-up and MEDS interfaces.			
Business Capability Quality: Cost-Effectiveness				
What is the ratio of level of effort to results achieved?	Requires numerous data entry staff to key new and updated information, and reconcile duplicates and data inconsistencies; IT staff needed to load member information generated from other systems	Automation leads to greater productivity and cost effectiveness than at level 1.	Distributed update notifications to federated member registries further increases productivity and cost effectiveness over level 2.	
	Refer to business process write-up and MEDS interfaces.			
Business Capability Quality: Effort to Perform; Efficiency				
What is the level of efficiency for this process?	Numerous staff required to support mostly manual processes. Staff must key new information; make updates manually; reconcile and validate data manually.	Automation results in improved process efficiency over level 1. Updates are automatically processed	Standardization adds to level of efficiency greater than level 2. Updates are distributed to data sharing partners immediately.	
	Refer to business process write-up and MEDS interfaces.			
Business Capability Quality: Accuracy of Process Results				



Are the member update results consistent, accurate, and useful to users?	Member information is maintained and available, primarily on a scheduled or request basis to other business processes and users	Automated maintenance of member information ensures that timely, accurate data are available to support all processes needing member information	Use of national standards support federated access to data; business rules and standards result in high level of accuracy	
	Refer to business process write-up and MEDS interfaces.			
Business Capability Quality: Utility or Value to Stakeholders				
What is the level of satisfaction of stakeholders regarding the Member Information update process?	Updates and reconciliations must be manually validated. Stakeholder satisfaction with results is low.	Automation improves accuracy of validation, verification, and reconciliation of database updates. Stakeholder satisfaction improves	Stakeholder satisfaction improves because data accessibility increases the efficiency, speed, and accuracy of member information management processes.	
	Have not conducted a satisfaction survey			



Member Management: Inquire Member Eligibility: Business Capabilities				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions				
The Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				
In general, how acceptable is the eligibility verification process?	Process meets State guidelines but there are problems with timeliness and accuracy.	Automation greatly increases the ability to deliver timely and accurate eligibility information.	Use of MITA interface standards and the full range of X12 functionality increases the usefulness of this process.	
		Refer to business process write-up		
What formats are used for the eligibility request and response?	Inquiries about member's eligibility/enrollment in a program, coverage of benefits, etc. are received in non-standard formats. Media, data format and content differ by program	Eligibility Verification Requests and Responses are communicated using HIPAA X12 270/271 and NCPDP standards.	MITA standard interfaces incorporate full HIPAA data schemas and functionality.	
		Refer to business process write-up		
How collaborative is the inquiry process?	The sources of eligibility information are siloed within different programs; member data is not integrated and not semantically interoperable across programs. Therefore, inquirers must send inquiries to each agency.	Sources of eligibility begin to be integrated resulting in inquirers not having to send inquiries for multiple programs a member is eligible.	Agencies collaborate to establish a one stop shop eligibility inquiry process.	
		Refer to business process write-up		



What media are used to send and receive eligibility information?	Inquiries are sent via telephone, fax, and USPS.	Routine inquiries for member information are automated within the agency via AVRS, point of service devices, Web portal, EDI.	Member information is integrated via a Member Registry, which may either contain integrated records of member eligibility data or provide federated access to other Member Registries as appropriate	
		Refer to business process write-up		
How consistent are eligibility inquiry responses?	Responses vary by individual responder. Level of consistency is moderate.	Automation greatly improves consistency of response. Level of consistency is good.	Using MITA standard interface data ensures increase in consistency of response. Level of consistency is high.	
		Refer to business process write-up		
How accurate are the responses to requests for eligibility verification?	Providers often depend on paper member ID cards that can be inaccurate.	Automation improves accuracy.	Use of MITA interface standards achieves maximum accuracy.	
		Refer to business process write-up		
Business Capability Quality: Timeliness of Process				
How timely are responses to eligibility inquiry?	Most requests for verification of member information are received and responded to manually via phone, fax, USPS.	Member eligibility/ enrollment verification is automated via AVRS, point of service devices, Web portal, EDI.	Using national standards for transport of request/ response and MITA standard interface and messaging, responses can be immediate. Response time is 30 seconds or less.	
		Refer to business process write-up		
How timely is the eligibility information?	Eligibility file is refreshed weekly.	Eligibility file is refreshed daily.	Eligibility file is real time.	
		Refer to business process write-up		



Business Capability Quality: Data Access and Accuracy

How accurate are the responses to eligibility verification?	Information is researched manually. There may be inconsistencies in responses.	Automation improves access and accuracy.	Member eligibility/ enrollment, program, and benefit data and messaging formats adhere to MITA standard interfaces, improving verification and research accuracy.	
	Access and Accuracy is adequate to support the business process.	Access and Accuracy is noticeably improved over Level 1.	Responses are accurate 99% of the time.	
		Refer to business process write-up		

Business Capability Quality: Cost-Effectiveness

What is the ratio for the cost of eligibility verification versus the number of responses?	Generating ID cards for members monthly is expensive and cannot be guaranteed to block false claims of eligibility for service.	Electronic verification lowers cost to providers and State, and reduces denied claims for ineligible members and non-covered services.	Use of MITA standard interfaces and full X12 functionality increase cost effectiveness by reducing staffing and increasing speed.	
	20% of the eligibility verifications result from human intervention; 80% of eligibility verifications are performed electronically without human intervention.	10% of eligibility verifications result from human intervention; 90% are performed electronically without human intervention.	2% of eligibility verifications result from human intervention; 98% are performed electronically without human intervention.	
		Refer to business process write-up		

Business Capability Quality: Effort to Perform; Efficiency



How do you rate the efficiency of the eligibility inquiry process?	Manual workflow is burdensome. Newly eligible members must wait to receive mailed ID cards or the provider must verify eligibility by telephone. Efficiency rating is low.	Automation increases efficiency. Efficiency is rated as adequate.	Use of national MITA standards and one stop shop among participating agency gives providers access to all cross-agency eligibility information including programs and benefits for which members are eligible. Efficiency rating is high.	
		Refer to business process write-up		
Business Capability Quality: Accuracy of Process Results				
What is the quality of the results of the Inquire Eligibility process?	Results quality is adequate.	Results are accurate and timely.	Results are accurate and timely 99% of the time and include eligibility for specific benefits and services.	
		Refer to business process write-up		
How is the quality of the result measured?	Responses are manually validated, e.g., call center audits; stakeholder satisfaction survey.	Automated processes include audit trails.	Business services standardize requests and responses nationally; tracking of response results is automatic.	
		Refer to business process write-up		
Business Capability Quality: Utility or Value to Stakeholders				



How satisfied are stakeholders who have the authority to request eligibility verification?	Stakeholders are somewhat satisfied with results of inquiry.	Stakeholders have no delay in obtaining responses and are very satisfied.	Stakeholders have a one stop shop to access collaborating agencies to obtain information. Stakeholders experience fewer claim denials based on non-covered services. Providers are extremely satisfied.	
	Have not conducted a satisfaction survey			

Member Management: Perform Population and Member Outreach: Business Capabilities

Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions				
The Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				



Does the State Medicaid agency coordinate outreach to the general population and Medicaid eligibles in a coordinated, efficient, and timely way that meets result expectations?	At this level, the Perform Applicant and Member Outreach business process is likely uncoordinated among multiple, siloed programs and not systematically triggered by agency-wide processes or is non-existent.	At this level, the Perform Applicant and Member Outreach business process is more coordinated and populations are targeted more effectively because programs are able to share analysis of current and prospective member demographics, socioeconomic status, functional and health needs based on increased standardization of administrative data, and improved data manipulation for decision support.	At this level, the Perform Applicant and Member Outreach business process is organized around the no wrong door concept, which ensures that regardless of outreach campaign, current and prospective members will be able to access information about all programs that member may be eligible to receive.	
	Refer to business process write-up			
How do you rate the quality and consistency of outreach activities?	Quality and consistency of outreach and education efforts are difficult to measure.	Better demographic data helps agency target populations and measure results.	Use of standards and inter-agency collaboration improves quality and consistency.	
	Refer to business process write-up			
Do outreach materials reach targeted audience?	The agency may encounter obstacles to delivery, e.g., incorrect address or lack of contact information.	Better data are available to connect with targeted populations.	Outreach and education materials are targeted more effectively due to improved data availability. Materials are available via web portals and are shared with other collaborating agencies; Member registries use standardized contact data, including USPS address standards, to alleviate postal delivery failures.	
	Refer to business process write-up			



Can stakeholders easily access information about programs?	Current and prospective members have difficulty locating needed information because of siloed programs.	Help lines and public advertising reaches a broader population.	Current and prospective members are easily able to access information regardless of their channel of inquiry or the program about which they need information. (No Wrong Door)	
		Refer to business process write-up		
Do you address the needs of populations that have functional, linguistic, cultural, and competency challenges?	Functionally, linguistically, culturally, and competency appropriate outreach and education materials are lacking because they are difficult and costly to produce.	Outreach material is functionally, linguistically, culturally, and competency appropriate, but at great expense, or may be limited by State defined parameters (ex: only two languages used).	Use of electronic communications makes provision of functionally, linguistically, culturally, and competency appropriate outreach material more cost-effective.	
	Refer to business process write-up; Wish list includes increasing Spanish (and other languages) communication and outreach.			
How efficient are the outreach operations?	Outreach is primarily manual and conducted by paper or phone.	In addition to phone and paper, states may use Websites, TV, radio and advertisements to distribute outreach information to targeted members.	Better collaboration and standards ensures agency-wide outreach coordination and greater ability to measure the efficacy of outreach and the percentage of targeted populations reached. Agencies support deployment of internet access points, such as kiosks and low cost telecommunication devices such as cell phones for distribution to mobile communities, to alleviate communications barriers.	
		Refer to business process write-up		



What is the basis for the outreach approach?	Outreach to prospective members is sporadic and lacks analysis needed for targeting populations based on demographics, socioeconomic status, functional and health needs.	Access to improved demographic data supports more targeted outreach.	Access to standardized electronic clinical data via registries, electronic prescribing, claims and service review attachments and electronic health records, as well as use of GIS and socio-economic indicators support targeting populations for outreach.	
	Refer to business process write-up			
Business Capability Quality: Timeliness of Process				
How timely are the outreach activities	From end to end, outreach mailings take 3 or more months to produce and send.	Educational materials are distributed, end to end, in 1 to 2 weeks in a combination of written and electronic formats.	Outreach and education information are immediately available to members and the general population via agency portals.	
	Refer to business process write-up; Less than 3 months, but greater than 1-2 weeks.			
Business Capability Quality: Data Access and Accuracy				
What is accuracy of mailing information?	Mailings are not delivered because contact data in members records do not meet USPS standards.	Increased adoption of USPS standards automated mail merges increases accuracy of mailings.	Exclusive use of USPS standards and automated addressing for member data improves accuracy for mailing purposes.	
	Refer to business process write-up			
What is accuracy of content information?	Preparation of materials is manual and subject to error; Information is subject to inaccuracies and inconsistencies.	Increasing use of functionally, linguistically, culturally, and competency appropriate outreach and education materials improves content accuracy.	Use of standardized data to create messages improves accuracy.	
	Refer to business process write-up			



What is accuracy of population and member targeting?	Some ability to target members with certain diagnoses; very difficult to target other populations.	Increased standardization of administrative data, and improved data manipulation for decision support improves accuracy of population targeting.	Standards enhance ability to target populations; Member information is accessed via federated Member Registries that can be accessed by all authorized entities within the state.	
	Refer to business process write-up			
How easy is access to the outreach material?	Lack of outreach and education materials likely limit members access to information.	Outreach materials are developed and stored in electronic format and made available to members via a Web portal, public media, or kiosks, somewhat improving current and prospective member's ability to locate needed information.	Current and prospective members are easily able to access information regardless of their channel of inquiry or the program about which they need information. (No Wrong Door)	
		Refer to business process write-up		
Business Capability Quality: Cost-Effectiveness				
How cost effective is the outreach process?	Process is labor-intensive; high costs reduce frequency of outreach.	Automation results in proficiency in targeting populations needing outreach and education.	Collaboration, data sharing, and shared services increase cost-effectiveness.	
	Have not conducted a cost-benefit analysis			



How cost effective is the media used?	Paper materials are expensive to produce and incur postal expenses and cost of undelivered mail.	Availability of online materials reduces paper and mailing costs Part of the cost is achieving the outcome and these measures are not addressing the outcome of the process. It is not cost effective if people can't read and access it or not actually receiving the data. Need to define and measure effectiveness that web is more efficient.	Predominant use of electronic and public media communication channels lowers cost of paper materials and improves message delivery; USPS standard member contact information decreases undelivered mailings.	
	Have not conducted a cost-benefit analysis			
Business Capability Quality: Effort to Perform; Efficiency				
What is the degree of efficiency in the creation of the outreach materials?	Staff develops and maintains materials manually; this is a labor intensive operation.	Populations are targeted more effectively because programs are able to share analysis of current and prospective member demographics, socioeconomic status, functional and health needs based on increased standardization of administrative data, and improved data manipulation for decision support.	National standards are developed for creation of education and outreach materials. Evidence-based medicine guidelines are used in targeting.	
	Refer to business process write-up			
How efficient is the ability to target populations?	Considerable effort is required to research current and target prospective populations and track mailings.	Better demographics captured in member data stores and external databases, improves ability to target over level 1.	Business services are developed and shared nationally to support target population identification.	
	Refer to business process write-up			



How efficient are distributions to targeted populations?	Mailings are not delivered because of inaccurate, nonstandard contact information, resulting in need to follow up with members by other means or missing outreach and education opportunities.	Mailings are more accurate, transitioning to electronic distribution.	Mailings are now the exception. Electronic distribution is efficient and accurate.	
	Refer to business process write-up			
Business Capability Quality: Accuracy of Process Results				
How accurate are the outreach results? [i.e., does the outreach reach the intended audience and is it read?	Current measures do not accurately reflect outreach results.	Automated tracking yields some statistics. Use of portal by members is monitored to ensure that a sufficient number of the targeted populations are actively engaged in downloading information.	Automated tracking and surveys provide accurate feedback regarding accuracy of outreach.	
	Refer to business process write-up			
Business Capability Quality: Utility or Value to Stakeholders				
Do the efforts reach the targeted population and result in stakeholder satisfaction?	Difficult to measure.	Better tracking and feedback processes over level 1 result in better measurements; stakeholders are found to be generally satisfied.	Member satisfaction is collected as part of the process and shows improvements over Level 2.	
	Refer to business process write-up; Have not conducted a satisfaction survey			

Member Management: Manage Applicant and Member Communication: Business Capabilities

Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
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Business Capability Descriptions

The Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.

What is the medium of communication?	Member communications are primarily conducted via paper and phone	Member communications are conducted via paper and phone; some electronic communication is available e.g., fax, scanned documents, uploads from the web portal, email.	Member communications are primarily electronic, with paper used only as needed to reach populations	
		Refer to business process write-up		
Is there intra-agency collaboration for communication?	Member and applicant communication is likely uncoordinated among multiple, siloed programs and not systematically triggered by agency-wide processes; lacks data to appropriately target populations; of inconsistent quality; not always linguistically, culturally or competency appropriate.	States begin using Websites to provide member information on providers and health plans, and responses to inquiries that can be responded to online or by phone General program information is available to applicants via websites.	Member and applicant communication is organized around the no wrong door concept, which ensures that regardless of point of entry, current and prospective members will be able to access information about all programs	
	Refer to business process write-up			
Are standards used in communications?	No. Requests are received from members and applicants in non-standard formats	Member communications are linguistically, culturally, and competency appropriate, but require considerable manual intervention for paper communications	Yes. Standards ensure coordination and greater ability to measure the efficacy of member communications	
	Refer to business process write-up			



How timely are the responses?	Most requests are sent via telephone, fax, or USPS; standard response within 2 days	Routine requests from members are standardized and automated within the agency via AVRS, Web portal	Agencies support deployment of internet access points, such as kiosks and low cost telecommunication devices such as cell phones for distribution to mobile communities, to alleviate communications barriers	
	Refer to business process write-up			
Are responses timely, accurate?	Research is performed manually and responses are often inconsistent; delays are common	Research and response for these standardized communications are immediate or within batch response parameters; Responses are consistent and timely	Use of electronic communications makes provision of linguistically, culturally, and competency appropriate member communications more feasible and cost-effective Member Registries use standardized contact data, including USPS address standards, to alleviate postal delivery failures MITA standard interfaces (trigger event and results; messages to external entities), are used by Medicaid agency and collaborating sister agencies	
	Refer to business process write-up			
Business Capability Quality: Timeliness of Process				
What is the timeliness of the response?	Manual and semi-automated steps may require some days to complete response.	Member requests and responses are automated via Web, AVRS with date stamp and audit trail. Responses available on the average within 2 days	Member information is accessed via either a single Member Registry or federated Member Registries; Response is immediate; Inquiries can be made to multiple agencies via collaboration	



	Refer to business process write-up			
Business Capability Quality: Data Access and Accuracy				
What is accuracy of response?	Responses are made manually and there may be inconsistency and inaccuracy (within agency tolerance level).	Access is via Web portal; Automated responses increase accuracy	Requests and responses are standardized among Medicaid's, improving accuracy	
	Refer to business process write-up			
Business Capability Quality: Cost-Effectiveness				
Do the benefits of the operation justify the costs?	Requires numerous staff and high cost to meet demands of member communication	Improvements in member services and automation result in higher cost effectiveness than level 1.	Use of standards and collaboration and shared services further increases cost effectiveness.	
	Have not conducted a cost-benefit analysis			
Business Capability Quality: Effort to Perform; Efficiency				
What level of effort is required to manage member communications?	Staff research and respond to requests manually.	Some responses to member requests are automated.	Collaboration among agencies achieves a one-stop shop for member inquiries; Information requested by member is continuously refreshed	
	Refer to business process write-up			
Business Capability Quality: Accuracy of Process Results				
How accurate are the results of communications?	Responses are manually validated, e.g., via call center audits; member satisfaction survey.	Automation improves accuracy of responses.	MITA standard interfaces improve requests and responses nationally.	
	Refer to business process write-up			
Business Capability Quality: Utility or Value to Stakeholders				
Are stakeholders satisfied with responses?	Stakeholders receive information but there may be delays and inconsistent results.	Stakeholders have no delay in obtaining responses and information is accurate.	Stakeholders have a one stop shop to access collaborating agencies to obtain information.	



	Have not conducted a satisfaction survey			
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Member Management: Manage Member Grievance and Appeal: Business Capabilities

Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions				
The Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				
What media are used to collect and store case documents?	This is an all-manual process. Grievances and appeals are filed via fax and USPS. Confidential documents are transferred by certified mail.	Documents are scanned and the case file is automated and can be shared among case workers.	MITA standard interfaces are used for Grievance and Appeal triggers (grievance and appeal application data) and results (case resolution).	
	Refer to business process write-up			
Are standards used in development of case documents?	No standards beyond general requirements for establishing a case.	Local documentation standardization is established.	MITA standard interfaces are used to initiate and develop the case, e.g., Request documentation; Validate credentials; Maintain case	
	Refer to business process write-up			
How are requests for additional documentation handled?	Requests for documents are managed manually.	Some review steps are automated using agency specific standards.	Case file is Web-enabled; information is shared among staff managing the case.	
	Refer to business process write-up			
How timely is the End to End process?	Indeterminate, lengthy	Time required to develop the case is reduced. Staff increased productivity by 50% from Level 1.	Additional streamlining of case process due to adoption of standard interfaces. Staff increased productivity by 50% from Level 2.	
	Refer to business process write-up			



How is case information verified?	Verification of information is handled manually. There may be inconsistencies between cases of the same type.	There is more consistency in the steps taken in the review and resolution process	Medicaid collaborates with other health and human services agencies that manage appeals to create a one-stop shop model for both member and consumer appeals, increasing accuracy of data by verifying multiple sources of information.	
	Refer to business process write-up			
Business Capability Quality: Timeliness of Process				
What is the timeliness of the End to End (E2E) process? [Note: this measure does not include legal steps to stop the process.]	This is an all-manual process; Cases typically require months to complete. Duration of process is 180 business days or longer.	Automation in development of case file, scheduling hearings, storing documents results in reduction in E2E time. Duration of process is 100 business days or less.	Standardized MITA interfaces further streamline the E2E process. Duration of process is 45 business days or less.	
	Refer to business process write-up			
What is the timeliness of requests for information associated with the case?	Requests are dependent on telephone, fax, and mail service. May take weeks to receive information. Duration of request/ response is 20 business days or longer.	Requests for member information are automated via AVRS, Web portal, EDI within an agency. Duration is 10 business days or less.	Standard interface messages between the agency and the member or business associated are used. Responses to research questions are immediate across all data sharing partners within the state. Duration of process is 4 hours or less.	
	Refer to business process write-up			
Business Capability Quality: Data Access and Accuracy				



How accurate are the case data?	Information is researched manually resulting in inconsistencies among case files; there are no standards for case data. It is difficult to measure accuracy.	Automation of case files improves accuracy. Business rules are used to validate origin data. Case information is more accurate than Level 1. A standardized grievance definition is determined within State Medicaid e.g., eligibility, MCOs.	Standard MITA interfaces improve accuracy of content. Case information is accurate 98% of the time.	
	Refer to business process write-up			
How accessible are case files (to authorized viewers)?	Requests are managed manually resulting in delays. Accessibility is rated as Poor	Access to available information is facilitated via Web portal and EDI channels using standard formats. Accessibility is rated as Good.	Access uses standard MITA interface and messaging. Accessibility is rated as Excellent	
	Refer to business process write-up			
Business Capability Quality: Cost-Effectiveness				
What is the ratio of cost of operations to number of cases managed?	Process is labor-intensive.	Automation of some research steps increases productivity levels of staff required to manage caseloads.	Collaboration with sister agencies that may conduct parts of the appeals cases increases cost-effectiveness.	
	Have not conducted a cost-benefit analysis			
Business Capability Quality: Effort to Perform; Efficiency				



What is the level of efficiency in this process?	Staff research and maintain manually. Highly inefficient due to manual processes.	Responses to requests to collect and verify member case information, and case management activities, are automated. Meets goals for efficiency improvements from Level 1.	Standardization of input and case results allows staff to focus on analytical activities. MITA standard interfaces standards are used for creation of a case, acquisition of information, and publication of results. Improved efficiency from Level 2 processes.	
	Refer to business process write-up; Process is not highly inefficient.			
Business Capability Quality: Accuracy of Process Results				
What is the level of accuracy in the case results?	There may be inconsistencies in results between similar cases.	Results are documented and recorded automatically and can be accessed and reviewed as needed.	MITA standard interface improves accuracy of case results.	
	Refer to business process write-up			
Business Capability Quality: Utility or Value to Stakeholders				
What is the degree of satisfaction to the member regarding the process? [Note: does not ask about satisfaction with the Result]	Low level of satisfaction due to demands of and delays in the process.	State has determined standardized measurement improving member access, communication, and implementation of the grievance and appeal process. The member benefits from introduction of automation to speed up the case resolution. Satisfaction level is higher than Level 1	Members benefit from consistency and predictability of the process. Satisfaction level is higher than Level 2	
	Have not conducted a satisfaction survey			



What is the degree of satisfaction to stakeholders?	Business process complies with agency and state requirements for a fair hearing and disposition. However, stakeholders are not satisfied with the burden of research and delays.	The agency benefits from introduction of automation to speed up the case resolution. Stakeholders are satisfied.	Agencies benefit from introduction of MITA standard interfaces. Stakeholders are very satisfied.	
	Have not conducted a satisfaction survey			

PM Enroll Provider: Business Capabilities				
Enroll Provider				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions				
Does enrollment process meet State and federal regulations or policies?	Meets state and federal requirements for processing applications timely and accurately.	Exceeds state and federal requirements for processing applications timely and accurately.	Exceeds state and federal requirements for processing applications timely and accurately including one-stop collaboration across the Medicaid enterprise.	
	Yes-OIG audit, state legislation?			
What is the mode of receipt of enrollment applications?	Staff receive and process paper enrollment applications submitted via USPS.	Provider enrollment staff receive and process mix paper and Web-based applications adhering to state Medicaid agency specific standards.	Majority of Provider applications are on-line and use MITA standard interfaces for data content or are submitted via standard messages.	
	Reference Enroll Provider ps			



How are enrollment rules applied and information verified?	Staff manually apply the agency's business rules (including verifying information, assigning ID, and associating rates).	Some business rules (e.g., verify information supplied, assign ID, associate rates, and map provider attributes to program needs, e.g., linguistic, specialty care) are automated.	Most verification and validation of application information are automated [Manual intervention is required on an exception basis.]	
	Reference Enroll Provider ps			
How are credentials verified? (a.k.a., Credentialing) (e.g., college degree, license, certification, NPI, EIN, SSN)	Staff verify credentials by use of phone, fax, USPS.	Some automated data exchange is established with credentialing organizations and ID sources.	Communications with credentialing organizations and ID sources are performed as business service messages. MITA standard interfaces are used to validate credentials and verify or obtain ID numbers.	
		Reference Enroll Provider ps-dhec		
What ID number is used?	Uses local identifier assigned by the state.	Receives NPI and cross-references (or translates) to state ID	The NPI is the ID of record for all healthcare providers. Atypical providers are enumerated differently. Legacy identifiers may be retained for some business purposes, but newly enrolled providers will not require them.	
		Reference Enroll Provider and Manage Provider Information-Use of NPI and legacy		
Is there a process for Revalidation of Credentials?	Providers are re-enrolled as needed; credentials are revalidated, manually, at that time.	Providers are re-enrolled periodically; credentials are revalidated via a mix of manual and automated processes (consistent with enrollment process).	Credentials are automatically re-validated and staff receive alerts when adverse results occur (e.g., provider license is terminated; provider is added to a criminal investigation list).	
	No; Wish List Item for reverification			



Business Capability Quality : Timeliness				
What is the End-to-end Process Time?	Decisions on application may take several days but within State regulations. Average end-to-end process is completed in 30-60 days.	Average end-to-end process is completed in 15-30 days.	Turnaround time on application decision for 85% of enrollments is no more than 24 hours. Exceptions may be those requiring extensive credentialing or site visits.	
		Reference Enroll Provider ps; 5 day standard		
Business Capability Quality: Data Access and Accuracy				
Are enrollment data standardized?	Application data and format are non standard.	Application data and format are standardized within the agency.	Application data interfaces are standardized nationally using MITA standards.	
		Reference Enroll Provider ps		
What is the ID of record? (Not applicable to atypical providers)	Provider data, including ID and taxonomy, are not comparable across provider types and programs, reducing ability to monitor performance or detect fraud and abuse.	NPI is used, but crosswalked to legacy identifiers.	The NPI is the identifier of record across all programs except for atypical providers and others who may not qualify for an NPI.	
		Reference Enroll Provider and Manage Provider Information ps		
Business Capability Quality: Cost-effectiveness				
Are enrollment processes shared across agencies? [a.k.a., one-stop shop]	There is no cross agency enrollment process.	Shared batch processes and inter-agency collaboration contribute to streamline the process.	Centralized provider registry is used by multiple agencies with a high level of technology minimizing manual data entry and file maintenance.	
	No			
Business Capability Quality: Effort to Perform; Efficiency				



How efficient is the credentialing process?	Staff contact external and internal credentialing and verification sources via phone, fax.	Enrollment verification processes continue to be handled by siloed programs according to program-specific rules.	Electronic applications adhere to MITA standard interface requirements. Manual steps may continue only for exceptions.	
		Reference Enroll Provider ps, based on provider type		
Business Capability Quality: Accuracy of Process Results				
How accurate and consistent are enrollment results?	Much of the application information is manually validated resulting in inconsistency of decisions and some amount of inaccuracy in verification of credentials.	Automation of some business rules improves accuracy of validation and verification results.	All verifications can be automated and conducted via standardized interfaces increasing the level of consistency and accuracy.	
	Reference Enroll Provider ps; procedure manuals			
Are external databases used to prevent enrollment of sanctioned providers?	Inconsistent, manual access to external databases, sanctioned providers may continue to be enrolled.	The agency requests and sends verification inquiries to any other agency regarding the status of a provider.	Sanctioned provider information is shared across state boundaries.	
			Reference Enroll Provider, Manage Provider Information, Disenroll Provider	
Business Capability Quality: Utility or Value to Stakeholders				
What is the level of Stakeholder Satisfaction?	Stakeholders are often frustrated by delays and errors in the enrollment process. Low level of satisfaction	Stakeholders are more satisfied with the enrollment process over level 1.	Stakeholders are very satisfied with the enrollment process. Stakeholder satisfaction is rated at 75% or better.	



	We have not conducted a satisfaction survey.			
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Disenroll Provider				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
General Description				
Is this business process primarily manual or automated?	This is a manual process.	The process is a mix of manual and automated activities.	The process is primarily automated.	
	See Disenroll Provider draft			
Does this business process use standards?	There is a disenrollment request form but no data and format standards. There may be multiple disenrollment steps based on provider type.	There are local standards and State regulations for the disenrollment request format.	MITA interface standards are adopted.	
	See Disenroll Provider draft			
Does the Medicaid enterprise collaborate with other agencies or entities in performing this process?	Disenrollment is a standalone process within Medicaid enterprise.	Disenrollment process is coordinated with other agencies who agree to share data with Medicaid. Notifications of Medicaid disenrollment may be paper based.	The Medicaid enterprise and other agencies and entities collaborate on common disenrollment process. Messages regarding disenrollment are communicated via information exchange. Disenrollments may be done via web portal.	
		See Disenroll Provider draft		
Business Capability Quality: Timeliness of Process				
How timely is this end-to-end process?	This process is completed within 10 working days or more.	The process is completed within 5 working days or less.	This process is completed in 24 hours or less.	



	See Disenroll Provider draft			
Business Capability Quality: Data Access and Accuracy				
How accurate is the information used in this process?	Disenrollment data are manually entered and subject to inconsistencies.	Consistent format for capture of disenrollment information improves accuracy.	Use of MITA interface standard improves accuracy to 99%.	
	See Disenroll Provider draft			
How accessible is the information used in this process?	Information is available within one working day.	Information is available within one hour.	Information is immediately available.	
	See Disenroll Provider draft; access to exclusions list is immediate, other sources may take several days.			
Business Capability Quality: Cost Effectiveness				
What is the ratio of the cost to perform this process compared to the benefits of the results?	Lack of automation and data standards negatively impact cost-effectiveness.	Automation improves cost-effectiveness.	Collaboration among agencies and use of MITA interface standards further improves effectiveness.	
	See Disenroll Provider draft			
Business Capability Quality: Effort to Perform; Efficiency				
How efficient is this process?	Lack of automation and data standards negatively impact efficiency.	Automation allows staff to focus on quality assurance of the process.	Focus shifts from processing of disenrollment requests to monitoring the performance and improving efficiency of the process, and maintaining adequate provider network.	
	See Disenroll Provider draft			
Business Capability Quality: Accuracy; Usefulness of Process Results				



How accurate are the results of this process?	Lack of automation and data standards negatively impact accuracy.	Disenrollments are accurate most of the time due to automation and data standards.	Results are more accurate than Level 2 due to MITA standard interfaces.	
	See Disenroll Provider draft			
Business Capability Quality: Utility or Value to Stakeholders				
How satisfied are the stakeholders?	Stakeholder satisfaction is low, with few resources dedicated to improvement and few measurements in place, e.g. reliance on complaints, legal mandates for action regarding improving stakeholder satisfaction.	States begin to identify gaps in levels of satisfaction and stakeholder expectations and priorities. Improvements are made strategically, increasing stakeholder satisfaction over Level 1.	Medicaid Enterprise conducts internal and external audits/focus groups which take into consideration the results of its previous research along with other national standards to identify additional stakeholder expectations and priorities. Improvements are made based on national and MITA best practices, improving stakeholder satisfaction over Level 2.	
	See Disenroll Provider draft			



Provider Management: Manage Provider Information: Business Capabilities				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions This Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels. NOTE: Manage Provider Information includes uploads to and downloads from Provider Information data stores.				
How are changes to provider information data stores (databases, registries) handled?	Changes to provider registry are managed manually.	Changes to provider registry are standardized within the agency and automated.	MITA standard interfaces are used for changes to provider registry.	
	Some changes are automated; Reference Manage Provider Information ps			
How are changes verified for accuracy?	Accuracy of data is manually verified.	Validation of data is automated.	Validation of data is built into the business service.	
	TAD, Reference Manage Provider Information ps			
Are there standards for data stored, uploaded, or changed?	Local standards apply. There is inconsistency in types of provider data stored. Hardcopy documents are scanned and stored.	NPI is used but is translated to local IDs if needed for internal processing Atypical providers continue to use proprietary identifiers, unless a national standard has been established.	Other agencies statewide can collaborate with Medicaid and accept the MITA standard interface. NPI is the ID of record and this standard is used by all downstream business processes. Atypical providers continue to use proprietary identifiers, unless a national standard has been established.	



		Reference Manage Provider Information ps; Level 1 also applies		
How timely is the data management process including updates and notifications of change?	Updates are completed on different schedules based on source of updated information. Notification to users regarding changes to registry is nonstandard.	Updates are timely, e.g., within 24 hours. Changes are immediately available to users and business processes that need to use this information.	Changes are immediately available and standardized across multiple agencies.	
	Reference Manage Provider Information ps			
How accurate is the stored data?	Duplicate entries may go undetected. There are known inaccuracies in the stored data.	Data improves due to automation of process, including verification of data with outside entities such as the National Provider Identifier registry or Council for Affordable Quality Healthcare (CAQH) Universal Provider Data source (UPD).	Data are standardized and routine data verification with external entities further improves accuracy.	
	Reference Manage Provider Information ps			
Business Capability Quality: Timeliness of Process				
How timely is the End to End data management process?	Manual and semi-automated steps require some days to complete update and maintenance process.	Provider updates are automated with date stamp and audit trail.	Updates are immediate.	
	Reference Manage Provider Information ps			
How timely is the process of notifications regarding updates?	Manual notifications are sent according to local standards.	Notifications are automatically generated following the update.	Data exchange partners receive update information instantly.	



	Providers are not notified; Reference Manage Provider Informaiton ps			
Business Capability Quality: Data Access and Accuracy				
How accurate is the data management process?	Updates are made to data manually. Inconsistencies and inaccuracies can go undetected.	Automated updates are consistent according to agency standards. Edits are consistent.	Data conforms to MITA standard interfaces.	
	Reference Manage Provider Information ps			
Business Capability Quality: Cost-Effectiveness				
What is the ratio of cost of staff to number of updates handled?	Requires significant amount of manual data entry resulting in a low level of cost effectiveness.	Automation leads to higher cost effectiveness.	Distributed updates of changes to provider registry improve cost effectiveness over level 2.	
	We have not done a ratio study of cost of staff to number of updates; Data entry is manual.			
Business Capability Quality: Effort to Perform; Efficiency				
How efficient is the data management process?	Staff perform file updates manually.	Updates are automatically processed; requires fewer staff to support the process.	Updates are available to data sharing partners; Centralized, validated information can be shared among entities when providers serve more than one state agency.	
	Reference Manage Provider Information ps			
Business Capability Quality: Accuracy of Process Results				



How accurate are the results of the data management process?	Updates are manually validated.	Automation improves accuracy of validation and verification of database updates. Automated maintenance of provider information ensures that timely, accurate data are available to support member assignment.	NPI is the ID of record and standardizes ID and taxonomy updates; Atypical providers continue to use proprietary identifiers, unless a national standard has been established; MITA standardized data increases level of accuracy.	
	Reference Manage Provider Information ps			
Business Capability Quality: Utility or Value to Stakeholders				
How satisfied is agency staff with the Manage Provider Information process?	Staff experience delays, difficulty in retrieving information, and inaccuracy of information leading to low level of satisfaction.	Staff is generally satisfied with timeliness and accuracy of data stored and access to it.	Staff is very satisfied with timeliness and accuracy of data stored and access to it.	
	We have not conducted a satisfaction survey.			
How satisfied are providers with the data management process?	Providers routinely complain about the accuracy of their information in the Medicaid system, as well as challenges in the update process.	Provider complaints are fewer and seem generally satisfied with timeliness and accuracy of data stored.	Provider complaints are rare and most seem very satisfied with timeliness and accuracy of data stored.	
	We have not conducted a satisfaction survey.			

Provider Management: Inquire Provider Information: Business Capabilities

Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions The Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				



Is there a standard format used for inquiries about provider information?	Inquiries are received from different sources to obtain information about a provider (e.g., status, location, specialty, status) in nonstandard formats.	Routine inquiries for provider information are standardized and automated within the agency.	MITA standard interfaces are used for inquiries regarding provider registry information. NPI is the ID of record used in the inquiry except for providers that do not qualify for NPI.	
	Business Process states it is limited to enrollment inquiries.			
What is the mode of communication used for inquiries?	Most requests are sent via telephone, fax, or USPS	Responses are submitted via AVRS, Web portal, EDI, via PC or terminal connection or within batch response parameters	Other agencies statewide and interstate can adopt MITA standard interfaces and participate in the inquiry process.	
	Reference Inquire Provider Information			
How are responses to inquiries managed?	Research is performed manually.	Research and responses are automated.	Research and responses are automated across multiple agencies, intra and interstate.	
	Reference Inquire Provider Information			
What is the quality of the results of inquiries?	Manual responses have a higher probability of being inconsistent.	Responses are consistent and timely.	Responses are consistent and timely across multiple agencies intra and interstate.	
	Reference Inquire Provider Information			
Business Capability Quality: Timeliness of Process				
How timely is the End to End inquiry process?	Most requests for verification of provider information are received and responded to manually via phone, fax, USPS.	Requests for provider information are automated via AVRS, Web portal, EDI within an agency using agency standards for messages. Timeliness improves from Level 1	Responses are immediate. [Requires 10 seconds or less]	
	Reference Inquire Provider Information			



Business Capability Quality: Data Access and Accuracy				
How accurate are the responses to inquiries?	Information is researched manually and may lead to inconsistencies in responses.	Automation improves access and accuracy over Level 1.	Inquiry messages use MITA standard interfaces, improving accuracy. Inquiry response accuracy is rated at 95% or better.	
	We have not done a study to determine accuracy			
Business Capability Quality: Cost-Effectiveness				
What is the cost effectiveness of this business process?	Requires high degree of manual intervention resulting in relatively low cost effectiveness.	Automation leads to staff working exceptions only and increased cost effectiveness over Level 1.	Use of MITA standard interfaces streamlines the inquiry process leading to increased cost effectiveness over Level 2.	
	We have not done a study to determine cost-effectiveness			
Business Capability Quality: Effort to Perform; Efficiency				
How efficient is the inquiry process?	Staff research and respond to requests manually.	Responses to requests to inquiries are automated.	Provider information is continuously refreshed. One stop shop for agencies who share providers.	
	Reference Inquire Provider Information			
Business Capability Quality: Accuracy of Process Results				
What is the level of quality of the results of this process?	Responses are manually validated, e.g., via call center audits; stakeholder satisfaction survey.	Periodic review of audit logs verifies that Automation improves accuracy of responses.	MITA standard interfaces produce consistent and accurate responses to inquiries.	
	We have not done a study to determine quality.			
Business Capability Quality: Utility or Value to Stakeholders				



How satisfied are stakeholders with the inquiry process?	Stakeholders receive the information they need.	Stakeholders receive immediate responses. Satisfaction improves over Level 1.	Stakeholders have access to collaborating agencies to obtain information on a provider. Audit trail helps to quantify satisfaction. Satisfaction is rated at 95% or better.	
	We have not done a study to determine satisfaction.			

Provider Management: Manage Provider Grievance and Appeal: Business Capabilities

Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
<p align="center">Business Capability Descriptions</p> <p align="center">The Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.</p>				
What media are used to collect and store case documents?	This is an all-manual process. Grievances and appeals are filed via fax and USPS. Confidential documents are transferred by certified mail.	Documents are scanned and the case file is automated and can be shared among case workers.	MITA standard interfaces are used for Grievance and Appeal triggers (grievance and appeal application data) and results (case resolution).	
		Reference Manage Provider Grievance and Appeal ps		
Are standards used in development of case documents?	No standards beyond general requirements for establishing a case.	Local documentation standardization is established.	MITA standard interfaces are used to initiate and develop the case, e.g., request documentation; validate credentials; maintain case.	
		Reference Manage Provider Grievance and Appeal ps		



How are requests for additional documentation handled?	Requests for documents are managed manually.	Some review steps are automated using agency specific standards.	Case file is Web-enabled; information is shared among staff managing the case.	
	Reference Manage Provider Grievance and Appeal ps			
How is case information verified?	Verification of information is handled manually. There may be inconsistencies between cases of the same type.	There is more consistency in the steps taken in the review and resolution process.	Medicaid collaborates with other health and human services agencies that manage appeals to create a one-stop shop model for both provider and consumer appeals.	
	Unclear on what case information is verified			
Business Capability Quality: Timeliness of Process				
What is the timeliness of the End-to-End (E2E) process? [Note: this measure does not include legal steps to stop the process.]	This is an all-manual process; Cases typically require months to complete.	Automation in development of case file, scheduling hearings, storing documents results in reduction in E2E time. Duration of process is 100 days or less.	Standardized MITA interfaces further streamline the E2E process. Duration of process is 45 days or less.	
		Reference Manage Provider Grievance and Appeal ps		
What is the timeliness of requests for information associated with the case?	Requests are dependent on telephone, fax, and mail service. May take weeks to receive information.	Requests for provider information are automated via AVRS, Web portal, EDI within an agency. Duration is 10 days or less.	Standard interface messages between the agency and the provider or business associated are used. Responses to research questions are immediate across all data sharing partners within the state. Duration of process is 4 hours or less.	
	Reference Manage Provider Grievance and Appeal ps			



Business Capability Quality: Data Access and Accuracy				
How accurate are the case data?	Information is researched manually resulting in inconsistencies among case files; there are no standards for case data. It is difficult to measure accuracy.	Automation of case files improves accuracy.	Standard MITA interfaces improve accuracy of content. Case information is accurate 98% of the time.	
	Reference Manage Provider Grievance and Appeal ps			
How accessible are case files (to authorized viewers)?	Requests are managed manually resulting in delays. Accessibility is rated as poor.	Access is via Web portal and EDI channels using standard formats. Privacy and legal restrictions are complied with when posting data, including appeal information. Accessibility is rated as good.	Access uses standard MITA interface and messaging. Privacy and legal restrictions are complied with when posting data, including appeal information. Accessibility is rated as excellent.	
	Case files are imaged (see ApplicationXtender and Scan Log). Accessibility is good.	What are standard formats for a case file?		
Business Capability Quality: Cost-Effectiveness				
What is the ratio of cost of operations to number of cases managed?	Process is labor-intensive.	Automation of some research steps increases efficiency in managing a case.	Collaboration with sister agencies that conduct appeals cases increases cost-effectiveness.	
	Reference Manage Provider Grievance and Appeal ps			
Business Capability Quality: Effort to Perform; Efficiency				



What is the level of efficiency in this process?	Manual responses have a higher probability of being inefficient.	Responses to requests to collect and verify provider case information, and case management activities, are automated. Efficiency is verified by periodic audit log reviews.	Standardization of input and case results allows staff to focus on analytical activities. MITA standard interfaces standards are used for creation of a case, acquisition of information, and publication of results.	
	Reference Manage Provider Grievance and Appeal ps			
Business Capability Quality: Accuracy of Process Results				
What is the level of accuracy in the case results?	Manual processes may result in inconsistencies in results between similar cases.	Results are documented and recorded automatically and can be accessed and reviewed as needed. Accuracy is verified by periodic audit log reviews.	MITA standard interface improves accuracy of case results. Quality improvement processes are in place to analyze results and modify processes to reduce future grievances and appeals.	
	Reference Manage Provider Grievance and Appeal ps			
Business Capability Quality: Utility or Value to Stakeholders				
What is the degree of stakeholder satisfaction?	Low level of stakeholder satisfaction due to demands of and delays in the process.	<p>The provider benefits from introduction of automation to speed up the case resolution.</p> <p>The agency benefits from introduction of automation to speed up the case resolution.</p> <p>Satisfaction level is moderate.</p>	<p>Providers benefit from consistency and predictability of the process.</p> <p>Agencies benefit from introduction of MITA standard interfaces (reduced learning curve, clearer guidelines, ability to monitor/id problem areas in instructions/manuals etc)</p> <p>Satisfaction level is high</p>	
	We have not conducted a stakeholder satisfaction survey.			



Provider Management: Perform Provider Outreach: Business Capabilities				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
The Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				
In general, how is the provider outreach process performed?	The Perform Provider Outreach and Education business process is primarily manual. It is labor intensive and time consuming. At this level there is no targeting of providers.	Increased use of agency standards for provider data improves identification of targeted, enrolled providers; and aids in identification of provider network gaps in specialty, location, cultural and linguistic needs.	Outreach benefits from national MITA standard interfaces, improving the ability to identify target populations.	
	Reference Perform Provider Outreach ps			
What media are used for outreach?	Agencies use ad hoc, nonstandard communication methods which may include scheduled mailings, training workshops, TV, radio, hardcopy posters for public transportation and community centers and clinics, and newspaper advertisements to distribute outreach and educational information to targeted providers.	Standard educational and policy information for enrolled providers is maintained electronically by the agency and is distributed to the providers via improved communication mechanisms such as electronic media or web portal.	Agencies within the State collaborate on creation and distribution of information via provider portal using standardized data. Agencies establish Web 2.0 presence to increase interaction with provider and among providers.	
		Reference Perform Provider Outreach ps Description for Level 1 appears to reference Member.		



How is population for outreach targeted?	Identification of targeted providers is based on provider registry data and claims history. Outreach to non-enrolled population, when/if conducted, is random.	Better demographic data improve ability to target. Provider registries use standardized contact data, including NPI address standards, to alleviate postal delivery failures.	Tools such as geographic Information Systems (GIS) and socioeconomic indicators support targeting providers for outreach.	
	Reference Perform Provider Outreach ps			
Is there collaboration in outreach activities?	Outreach is uncoordinated among multiple, siloed programs.	Some inter-agency coordination on provider outreach among siloed programs.	Outreach and education materials are available via state Medicaid portal. Materials are developed and distributed collaboratively with other agencies.	
		Reference Perform Provider Outreach ps		
How well does Outreach accommodate linguistic, cultural, and other differences?	No ability to identify linguistic and cultural differences.	Improvements in identifying different populations based on use of external data stores, however, Linguistically, culturally-appropriate material requires significant manual intervention.	Automated translation and repositories of cultural and competency appropriate statements makes provision of appropriate outreach material more feasible and cost-effective.	
Business Capability Quality: Timeliness of Process				



What is the timeliness of the End to End process? [i.e., from creation of outreach material and distribution rules to perform outreach to execution and result.]	This is primarily an all manual process. Outreach may require weeks or months.	The provider portal and agency citizen portal make outreach information available on demand. Length of time needed to conduct outreach and achieve desired result is reduced.	Agencies collaborate to identify outreach goals and materials. Outreach and education information are immediately and consistently available to providers across collaborating agencies. Collaboration increases reusability of materials and improved, shared distribution methods result in significant reductions in time required.	
	Development of materials may vary. There is no way to automate the development of outreach materials. However, access is automated.			
Business Capability Quality: Data Access and Accuracy				
How accurate are data used in the outreach process?	Material is manually developed and disseminated. Accuracy level is rated as adequate.	Increased quality assurance and quality control measures within the Medicaid agency improve data accuracy. Use of Web portal and EDI channels may also increase accuracy. Accuracy level is satisfactory.	Use of MITA standards and collaboration for shared quality assurance and quality control measures among agencies increases accuracy. Accuracy level is high.	
		Material must be manually developed. Reference Perform Provider Outreach ps		
Business Capability Quality: Cost-Effectiveness				
What is the cost effectiveness of outreach processes?	Higher cost to lower number of outreach processes.	Moderate cost to higher number of outreach processes.	Lower cost to higher number of outreach processes.	



		Reduced cost via e-bulletins, manuals. Reference Perform Provider Outreach ps		
Business Capability Quality: Effort to Perform; Efficiency				
How efficient are outreach processes?	Staff is burdened by manual research to determine target audience(s), outreach goals, material development, etc....	Use of improved data analytics increases efficiency of process including identification of target audience(s), outreach goals, material development, etc... More automated methods of packaging and delivery increase efficiency.	Outreach is developed using standardized data and analytics and is disseminated via collaborating agencies.	
		Reference Perform Provider Outreach ps; No targeting of audience.		
Business Capability Quality: Accuracy of Process Results				
How accurate are the outreach results? [i.e., does the outreach reach the intended audience and is it read?	Provider information is maintained and available, primarily on a scheduled or request basis to other business processes and users.	Automated tracking yields some statistics regarding measurable outcomes based on outreach goals and results.	Communications are standardized within the Medicaid agency resulting in better coordination and greater ability to measure the efficacy of provider outreach such as monitoring whether the outreach nets intended results.	
	We don't track whether materials are accessed.			
Business Capability Quality: Utility or Value to Stakeholders				



How satisfied are stakeholders with the outreach process?	Level of stakeholder satisfaction may be measured by provider's surveys, but is not likely monitored on a regular basis.	Increased interaction with providers yields more consistent information about their level of satisfaction. Business Process improvements net increased levels of satisfaction over Level 1.	Interaction with multiple agencies is streamlined and more consistent, resulting in increased provider satisfaction. Stakeholder opinions are regularly solicited in a standardized and automated manner. Level of stakeholder satisfaction is High.	
		Provider Outreach satisfacton survey results are high. Reference Perform Provider Outreach ps		

Award Administrative or Health Services Contract

Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions				
This Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				
Is the process manual or automated?	The Award Contract process is manual. The paper proposal(s) are mailed to the Agency. Manual validation, verification, and assessment of proposal data are required.	Submission of proposals is via electronic medium (e.g., Web portal). Centrally accessible electronic storage of proposal materials and internal electronic communication has been implemented. Assessment of proposal data is manual.	The process is automated using electronic mechanisms for submitting proposals and MITA standards for the data content.	



	Reference Award Contract ps: some contracts are paper form			
What is the primary mechanism for receipt of proposals and communication with respondents?	Receipt of proposals and communication with respondents is via paper, phone, face-to-face, and fax.	Receipt of proposals and communication with respondents utilizes electronic means of communication (e.g., submission of proposals via a Web portal, e-mail, or CD). Paper, phone, face-to-face, and fax is used for communications.	Receipt of proposals and communication with respondents are automated. Some face-to-face communication is still required.	
	Reference Award Contract ps: some paper-based, electronic at state-level, not at agency			
Are data and format standardized?	The business process utilizes non-standard data and format. Proposals conform to State requirements.	Proposals conform to State requirements including instructions for electronic submissions.	Proposals conform to MITA standards for data content and any additional requirements imposed by the State.	
	Reference Award Contract ps			
How are proposal data verified?	Staff contacts external and internal document verification sources via USPS, telephone, or fax.	Some automated verifications of Contractor information are available such as EIN, status of tax payment.	MITA standard interfaces enable more automated data verification.	
	No automated verification			
Business Capability Quality: Timeliness of Process				
What Is the Timeliness of End to End Process?	The process may require several months.	Centrally accessible electronic storage of proposal materials and internal electronic communication reduces total work effort within the agency. The process requires less time than Level 1.	The process, on average, requires less time than at Level 2 due to MITA standard interfaces.	



	Length of time varies, contracts are not available electronically			
Business Capability Quality: Data Access and Accuracy				
How accurate is the information available to the process?	Manual processes allow gaps in the accuracy and completeness of proposal content.	Use of standards set by the State procurement office, implementation of internal data standards, implementation of centrally accessible electronic storage of proposal materials, and electronic communication mechanisms all contribute to increased accuracy of data.	Implementation of MITA data standards and interfaces, electronic mechanisms for tracking and sharing proposal materials, and automation of the steps further reduces data inaccuracies.	
	We do have manual processes, but these do not allow for gaps in the accuracy and completeness of proposal content.			
Is the data necessary to the process readily accessible?	Accessing information to verify, validate, and assess proposal data is challenging due to data being stored in disparate locations and manual recovery processes are necessary.	Increased standardization by the State procurement office, and increased use of electronic storage of proposal materials and electronic communication mechanisms simplify data access.	MITA data standards and interfaces, electronic mechanisms for receiving, tracking and sharing proposal materials, and automation of routine access to proposal information have been implemented.	
	See Award Contract ps; many manual processes			
Business Capability Quality: Cost-Effectiveness				
What is the relationship of the cost of this process to the benefit of its results?	The process complies with state and federal regulations however, manual processes adversely affect cost effectiveness.	State defined data and content standards; centralization reduces process costs and allows staff to shift some attention to cost management and ongoing quality improvement.	The reduced cost of a primarily automated process allows staff to focus on an improved approach to managing the process.	



	We have no evidence that manual processes negatively impact cost effectiveness.			
Business Capability Quality: Effort to Perform; Efficiency				
How efficient is this End-to-End process?	This process requires a large commitment of manual effort.	Increased automation creates more efficiency and reduces duplicative/ repetitive process steps and duplication of effort.	Introduction of MITA standards and reusable services facilitates automation of the process and maximizes staff efficiency.	
	See Award Contract ps; many manual processes			
Business Capability Quality: Accuracy of Process Results				
How accurate is the process?	The manual process introduces opportunities for error and additional oversight is required to ensure compliance with State and Federal procurement rules.	Introduction of standards and automation reduce opportunity for error and level of oversight required.	Alignment with MITA standards introduces greater quality control, reduces manual intervention, and improves the overall accuracy of the process results.	
	See Award Contract ps; many manual processes			
Business Capability Quality: Utility or Value to Stakeholders				
What is the level of satisfaction of staff with this process?	The level of manual effort to validate, verify, and assess the proposal data, duplication of efforts across the agency, and the frequency with which decisions are appealed adversely affect staff satisfaction.	Partially automated processing; increased use of electronic communication mechanisms; and implementation of State standards improve staff ability to validate, verify, and assess the proposal data, thus increasing staff satisfaction with the process.	Introduction of MITA standards and reusable services, the implementation of centralized, automated tracking of the Award Contract process, and ongoing automation of the process enable staff to maximize their effectiveness in managing the process.	
	See Award Contract ps; many manual processes			



How satisfied are respondents with the process?	Respondents are dissatisfied with the burden of the process and the length of time.	Respondent satisfaction improves due to the ability to electronically submit proposals, increased consistency in decisions and the reduction in turnaround time.	Respondent satisfaction increases as a correlation with the implementation of MITA data and interface standards and consistent and timely decisions are achieved.	
	We have not conducted a satisfaction survey.			

Close Out Administrative or Health Services Contract				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions				
This Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				
How integrated or centralized is the process?	There is no centralized oversight of the contract close out within the Medicaid enterprise. There is no coordination among agency programs or between the Medicaid agency and other State agencies in relation to closing out contracts.	The Medicaid enterprise has introduced centralized tracking of contracts. Policies have been introduced to oversee the close out process, and coordinate efforts between agency programs.	The Medicaid enterprise's centralized tracking is fully automated. The contract close-out process is coordinated with other agency/agencies' programs.	
	See Close Out Contract ps; various entities could initiate this process			
Is the process manual or automated?	The close out contract process consists primarily of manual, paper-based steps.	The close out contract process uses electronic storage of contract information and internal electronic communications.	The implementation of MITA standards and electronic mechanisms for storing and communicating contract information, have enabled all feasible steps of closing out contracts to be automated.	



	See Close out Contract ps			
What is the primary mechanism for exchange of contract information?	Exchange of contract information is primarily via USPS, phone, face-to-face, and fax.	Exchange of contract information utilizes some electronic means (e.g., e-mail, web-based portals to push information) but USPS, phone, face-to-face, and fax based communication remains a significant part of the process.	Automation using MITA standard interfaces have been implemented to the extent feasible.	
		See Manage Contractor Communication ps		
Are data and formats standardized?	The business process utilizes non-standardized data and formats from multiple sources.	Local data and format standards are utilized.	MITA standard interfaces have been implemented.	
	Not all close out data is standardized			
Business Capability Quality: Timeliness of Process				
What Is the Timeliness of the End-to-End Process?	The fully manual contract close-out process can exceed 3 months or more.	Mixed automation and manual contract close-out processes can be completed in significantly less time than Level 1.	The contract close-out process can be completed in significantly less time than Level 2.	
	Length of time varies/dependence on ITMO/MMO; see Close Out Contract ps			
Business Capability Quality: Data Access and Accuracy				



How accurate is the information available to the process?	The fully manual contract close-out process improves accuracy and completeness of contract information.	Implementation of data and formats standards, centralization of contract data, increased internal and external electronic communication improves accuracy and completeness of contract information as compared to Level 1.	Implementation of MITA data standards, electronic data, formats and interfaces, electronic mechanisms for tracking and storing contracts, and automation of the contract close-out process reduces contract information inaccuracies. Accuracy improves over Level 2.	
	No metrics are provided for rating possible improvements.			
Is the data necessary to the process readily accessible?	The manual nature of the process causes delays in information retrieval, e.g., information in off-site storage may take up to two weeks to retrieve.	Implementation of data, format, and interface standards and centralized contract close-out data simplify data access. Information retrieval takes significantly less time than Level 1.	MITA data standards and interfaces, centralized electronic mechanisms for storage and tracking of contracts, and automation of routine access to contract information have been implemented. Access to information is immediate.	
	Contracts are paper-based in agency.			
Business Capability Quality: Cost-Effectiveness				
What is the relationship of the cost of this process to the benefit of its results?	A primarily manual process results in a contract close-out focus restricted to meeting compliance thresholds dictated by State and Federal regulations.	Implementation of local format and content standards, centralized tracking of contracts; and coordination among agency programs reduces contract close out costs and allows staff to shift attention to cost management and ongoing quality improvement.	The fully automated contract close-out process allows staff to focus on an outcome-oriented approach to closing out contracts.	



	No cost benefit analysis has been completed.			
Business Capability Quality: Effort to Perform; Efficiency				
How efficient is this End-to-End-process?	The primarily manual contract close-out process is often inefficient and results in disputes and delays in resolution.	Efficiency increases with automation, centralized tracking of contracts, coordination among agency programs, and interface data exchange standards. Staff is able to follow consistent steps in the close-out process.	High efficiency levels are achieved with the introduction of MITA standards. Reusable services facilitate full coordination between the Medicaid agency and other State agency programs. The automation of the centralized tracking of contracts eliminates duplication of effort.	
	No proven correlation between manual contract close out and disputes/delays in resolution.			
Business Capability Quality: Accuracy of Process Results				
How accurate are the process results?	Lack of data accuracy and completeness, process integration, and manual processing adversely affect the quality, consistency, and accuracy of the contract close-out process.	Implementation of local data, format, and interface standards and the centralized tracking of the contracts simplify data access increasing the quality and consistency of the contract close-out process.	Implementation of MITA standard interfaces, electronic mechanisms for communication, automation of the centralized tracking of contracts, and automation of the contract close-out steps process improve the consistency with which business rules are applied. This results in a highly uniform contracts close-out process.	
Business Capability Quality: Utility or Value to Stakeholders				



What is the level of stakeholder satisfaction?	<p>A primarily manual process adversely affects the ability to close-out contracts with minimal effort. Delays and disputes over close-out issues are common.</p> <p>Stakeholder satisfaction is generally low.</p>	<p>Implementation of local standards and the centralized tracking of the contracts data increase the ability to close out contracts.</p> <p>Stakeholder satisfaction levels improve over Level 1.</p>	<p>Implementation of MITA standards and reusable services; automation of the centralized tracking of contracts; full interfacing between agency programs; and automation of the contract close-out process maximizes the effectiveness in closing out contracts.</p> <p>Stakeholder satisfaction levels increase over Level 2.</p>	
	We have not conducted a satisfaction survey and do not know if it is generally low.			

Manage Administrative or Health Services Contract

Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions				
This Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				
How integrated or centralized is the process?	<p>Contract management is not centralized. Each agency may interface with a State's procurement office but oversight of the management of a contract lies with the agency who requested the contract. There is little or no coordination among agency programs for procurement or management of contracts.</p>	<p>The Medicaid enterprise has introduced centralized tracking of contracts. Coordination between agencies reduces silos and increases efficiency in contract management. Coordination among agency programs for procurement or management of contracts is improved.</p>	<p>MITA standards have been implemented; there is full coordination among agencies in relation to the management of contracts. The centralized contract tracking is automated, thus reducing duplication and increasing quality in managing contracts.</p>	



	see Manage Contract ps			
Is the process manual or automated?	The contract management process consists primarily of manual, paper based steps.	Contract information is stored electronically. Contract management reports are also automated.	The implementation of MITA standards and the centralized tracking of contracts are automated. Electronic mechanisms for storing and communicating contract information enable contract management activities. Some manual steps continue.	
	See Manage Contract ps			
What is the primary mechanism for exchange of contract information?	Exchange of contract information is primarily a manual process via USPS, phone, face-to-face, and fax.	Exchange of contract information utilizes some electronic means (e.g., e-mail, web-based portals to push information) but USPS, phone, face-to-face, and fax based communication remains a significant part of the process.	Automation using MITA standard interface has been implemented to the extent feasible.	
		See Manage Contract ps		
Are data and format standardized?	The business process utilizes non-standardized data and format from multiple sources.	State standardizes contract format and content with local standards to achieve uniformity.	MITA interface standards have been implemented.	
	See Manage Contract ps			
Business Capability Quality: Timeliness of Process				



What Is the Timeliness of this End to End Process?	<p>Fully manual operations cause delays in contract management activities.</p> <p>Obtaining information to monitor or review contract and interactions with contractors may require several working days.</p>	<p>Centralization of contract and use of local standards for data format and content reduce end to end time.</p> <p>Obtaining information to monitor or review contract and interactions with contractors may require less time than at Level 1.</p>	<p>MITA standards and reusable services have been implemented. The centralized tracking of contracts is automated.</p> <p>Obtaining information to monitor or review contract is immediate.</p>	
	see Manage Contract ps			
Business Capability Quality: Data Access and Accuracy				
How accurate is the information available to the process?	<p>Manual management of contracts results in inaccurate and/or incomplete data.</p>	<p>Centralization of contract information and implementation of local standards improve accuracy of content.</p>	<p>MITA standards and reusable services further improve data accuracy.</p>	
	see Manage Contract ps			
Is the data necessary to the process readily accessible?	<p>Access to data is limited by inconsistent and untimely receipt of and updates to information from both internal and external sources. Multiple data sources must be accessed and verified.</p> <p>Accessing information may take several working days.</p>	<p>Centralization of contract information and local standards improve accessibility.</p> <p>Accessing information takes significantly less time than at Level 1.</p>	<p>MITA standards and reusable services have been implemented. The centralized tracking of contracts is now automated and supports complete coordination between agency programs and eliminates duplication of effort.</p> <p>Access to information takes significantly less time than at Level 2.</p>	
	see Manage Contract ps			
Business Capability Quality: Cost-Effectiveness				



What is the relationship of the cost of this process to the benefit of its results?	A primarily manual process results in uncoordinated contract management. The focus is limited to meeting compliance thresholds dictated by State and Federal regulations.	Contract information is centralized and automated. Coordination among agency programs reduces contract management costs. Staff focuses on cost management and implementation of a higher quality improvement process within the contract management process.	MITA standards and reusable services have been implemented. The centralized tracking of contracts is automated and supports complete coordination between agency programs, eliminating duplication of effort. Staff focuses on an improved approach to managing contracts.	
	see Manage Contract ps			
Business Capability Quality: Effort to Perform; Efficiency				
How efficient is this End to End process?	A primarily manual contract management process results in duplication of effort across the agency. There are many opportunities to create or improve efficiency.	Centralization of contract information and introduction of standards increases efficiency over Level 1.	MITA standards and reusable services have been implemented. The centralized tracking of contracts is automated and supports complete coordination between agency programs, eliminating duplication of effort.	
	This process is not centralized.			
Business Capability Quality: Accuracy of Process Results				
How satisfactory are the results of the process?	Lack of data accuracy and completeness, lack of process integration, and manual processing adversely affect the quality, consistency, and accuracy of managing contract data. <i>Application of business rules is generally inconsistent.</i>	Standardization allows more efficient cost management, quality improvement, and contract performance measurements to be enhanced. Application of business rules is more consistent than at Level 1.	MITA standards and reusable services have been implemented. The centralized tracking of contracts eliminates duplication of effort and increases efficiency. Application of business rules is consistent 99% of the time.	



	Monitoring data is not standardized.			
Business Capability Quality: Utility or Value to Stakeholders				
How satisfied are the stakeholders with the process?	Fully manual contracts management is extremely frustrating to stakeholders who encounter lack of data accuracy and completeness due to manual processing and communication mechanisms. Duplication of efforts across the agency adversely affects stakeholders' ability to manage contracts. Slow turnaround time and inaccuracies or inconsistencies in information reported also frustrates Stakeholders. Stakeholder satisfaction is generally low.	Centralization and automation of contract information, use of local standards for format and content, more consistent application of business rules, and improved turnaround time improve stakeholder satisfaction. Stakeholder satisfaction is higher than at Level 1.	MITA standards and reusable services have been implemented. The centralized tracking of contracts is automated. Stakeholder satisfaction is higher than at Level 2.	
	We have not conducted a satisfaction survey and do not know whether satisfaction is low.			

Produce Administrative or Health Services RFP				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions				
This Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				



How integrated or centralized is the process?	The process is re-invented each time an RFP is deemed necessary. The data from one procurement to another is stored manually and is siloed.	Contract data are centralized and maintained electronically. There is coordination between agencies. Requirements tracking and maintenance are centralized.	Centralized contract data are automated. MITA standards are fully integrated into the RFP process. Coordination between agencies eliminates duplication of contracted services.	
		Refer to business process write-up; Coordination with ITMO and MMO		
Is the process manual or automated?	Production of an RFP consists primarily of manual, paper based steps. Manual compilation of data is required.	Contract data are, electronic, centralized and coordinated between agencies. Manual compilation of data remains a requirement in some cases. Publication of the RFP uses electronic medium (e.g., Web portal).	The centralized contracts data are automated. MITA standards are fully integrated into the produce RFP process.	
		Refer to business process write-up; Coordination with ITMO and MMO		
What is the primary mechanism for publication of the RFP and communication with potential respondents?	Publication of the RFP and communication with potential respondents is primarily via paper, face-to-face, e-mail and fax. Publication of the RFP may be via electronic medium. Potential respondents can use phone, fax, face-to-face e-mail, or paper as a way to keep current on any updates during the produce RFP process.	Contract data are centralized and there is coordination between agencies. Publication of the RFP and communication concerning updates and RFP status with potential respondents are automated.	MITA standards are fully integrated into the Produce RFP process. The process is fully automated. Some face-to-face communication remains a part of the process.	
	Refer to business process write-up			



Are data and format standardized?	The business process utilizes non-standardized data and formats from multiple sources.	State adopts some standards promulgated by federal and/or State agencies.	Data and format are based on MITA standard interfaces.	
		Refer to business process write-up		
Business Capability Quality: Timeliness of Process				
What Is the Timeliness of End to End Process?	Manual RFP development and communication mechanisms (both internal and external) result in an extended timeline to produce RFP. The process may require 6 or more months to issue the RFP.	Contract data are centralized and coordinated between agencies. The State uses web portals, email distribution and tracking, for respondent communications. The process normally requires fewer than 6 months.	Contract data are centralized. MITA standards are fully integrated into the process. The process supports outcome oriented program management, ensures MITA compliance, and supports the shift to shared business services in both the production of RFPs and their content. The process normally requires fewer than 3 months.	
	Refer to business process write-up			
Business Capability Quality: Data Access and Accuracy				
How accurate is the information available to the process?	Due to the highly manual nature of this process the resulting RFP can contain inaccuracies and inconsistencies.	Contract data is centralized and coordinated between agencies. Local standards for RFP content are used. The development of Medicaid specific policies and procedures for the RFP process reduces confusion and provides more accurate data within the RFP.	The centralized contract uses MITA standard interfaces. This ensures accuracy of data.	
	Refer to business process write-up			



Is the data necessary to the process accessible?	<p>Access to data is limited by constraints of the manual process and updates to information.</p> <p>Accessing information to research/compile RFP content can take more than 6 months.</p>	<p>Contracts data are centralized and there is coordination between agencies. The development of Medicaid specific policies and procedures reduces confusion and provides more accurate data within the RFP. Increased use of electronic storage of RFP materials and electronic communication mechanisms simplify data access.</p> <p>Accessing information to research/compile RFP content, on average, takes less than 3 months.</p>	<p>The centralized contracts data is now automated. MITA standards are fully integrated into the produce RFP process. The process has been enhanced to support outcome oriented program management, ensure MITA compliance and support the shift to shared business services in both the production of RFPs and their content. Exceptions can be researched through real-time access to data via MITA interfaces.</p> <p>Access to information to research/compile RFP content is accomplished in less than 1 month.</p>	
	Refer to business process write-up			
Business Capability Quality: Cost-Effectiveness				
What is the relationship of the cost of this process to the benefit of its results?	<p>The focus of the manual process is on meeting compliance thresholds dictated by State and Federal regulations.</p>	<p>Use of tools to structure and capture the RFP requirements improves the cost/effectiveness relationship.</p>	<p>The process has been enhanced to support improved program management, ensure MITA compliance, and support the shift to shared business services in both the production of RFPs and their content. The primarily automated, standardized process allows staff to focus on managing the production of RFPs and effectively communicating with potential respondents.</p>	



	Have not conducted a cost-benefit analysis			
Business Capability Quality: Effort to Perform; Efficiency				
How efficient is this End to End process?	Manual processing, lack of coordination with other processes and programs, duplicative work, and lack of standards produce many opportunities to create or improve efficiency.	Contract data are centralized. Shared electronic work space and version control improve efficiency of this process.	The centralized contract data are automated. MITA standards are fully integrated into the Produce RFP process. The process has been enhanced to support improved program management, ensure MITA compliance and support the shift to shared business services in both the production of RFPs and their content.	
		Refer to business process write-up		
Business Capability Quality: Accuracy of Process Results				
How satisfactory are the results of the process?	Manual processing and lack of complete information adversely affects the quality and accuracy of RFP content. Inconsistencies and ambiguities increase the number of respondent questions and can lead to post award protests.	Contracts data are now centralized and coordination between agencies is implemented. The development of Medicaid specific policies and procedures for the Produce RFP process reduces confusion and provides more accurate data within the RFP.	The centralized contracts data is automated. MITA standards are fully integrated into the Produce RFP process. The process has been enhanced to support improved program management, ensure MITA compliance and support the shift to shared business services in both the production of RFPs and their content.	
	Have not conducted a satisfaction study			
Business Capability Quality: Utility or Value to Stakeholders				



What is the level of stakeholder satisfaction?	The level of manual effort involved in the process affects satisfaction. Stakeholder satisfaction is negatively impacted due to inconsistent and inaccurate RFP content and manual communication mechanisms.	RFP information is centralized and coordination between agencies is implemented. The development of Medicaid specific policies and procedures for the Produce RFP process reduces confusion and provides more accurate data within the RFP. Stakeholder satisfaction is higher than at Level 1.	The centralized contracts data is automated. MITA standards are fully integrated into the Produce RFP process. The process has been enhanced to support improved program management, ensure MITA compliance and support the shift to shared business services in both the production of RFPs and their content. Satisfaction is higher than at Level 2.	
	Have not conducted a satisfaction survey			

Manage Contractor Information

Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions				
This Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				
Is this process manual or automated?	Staff receives instructions to update the contractor master file from many sources via paper and fax.	Requests are standardized locally and automated. Automation of rules maintains integrity of data repository.	Manage Contractor Information is fully automated.	
	Refer to business process write-up			



How is the information regarding the Contractor information validated?	Validation is manual and subjective.	Validation is consistent and rules based.	Validation is consistent, rules-based, and uses MITA standard interfaces.	
	Refer to business process write-up			
Does this process use standards?	Requests are received from disparate sources in indeterminate formats.	State and Federal standards are used in this process.	MITA standards are used in this process.	
	Refer to business process write-up			
Business Capability Quality: Timeliness of Process				
How timely is this End to End process?	Maintenance of contract files, contract amendment, and related documents is a manual process.	Contracts, amendments, and related documents are scanned and stored. Timeliness is increased over Level 1.	All contractor and contract information is managed via MITA standard interface requirements. Timeliness is increased over Level 2.	
	Refer to business process write-up			
Business Capability Quality: Data Access and Accuracy				
How accurate is the information used in this process?	Contractor information is contained in written documents. Information maintenance requires manual processes that adversely affect the ability to access the data and data accuracy.	Electronic data sources increase the ability to access data and the accuracy of the information over Level 1.	MITA standards are used for this process.	
			Data accuracy is 98% or better.	
	Refer to business process write-up			
How accessible is the information used in this process?	Staff accesses the record and complete the process manually.	The update is automatically applied and available to all staff.	The update is automatically applied, using MITA standard interface.	
	Refer to business process write-up			
Business Capability Quality: Cost-Effectiveness				



What is the ratio of the cost of this process compared to the benefits of the results?	Minimum State process requirements and agency performance standards are met.	Automation improves process and allows focus on exception case resolution, increasing cost-benefit ratio of process.	Adoption of MITA standard interfaces further increasing cost-benefit ratio of process.	
	Have not conducted a cost-benefit analysis			
Business Capability Quality: Effort to Perform; Efficiency				
How efficient is this process?	Process meets minimum State process guidelines and agency performance standards. Manual processes create inefficiencies.	Staff benefit from automation on exception case resolution improving the efficiency of the process.	Use of MITA standard interfaces improves efficiency over Level 2.	
	Refer to business process write-up			
Business Capability Quality: Accuracy of Process Results				
How accurate are the results of this process?	Contractor information is maintained in manual files. Manual processes introduce opportunity for error. Overall, the agency is relatively satisfied that information is correctly maintained.	Contractor information is stored electronically. Accuracy of results is improved over Level 1.	Contractor information is stored electronically using MITA standard interface. Accuracy of results is improved over Level 2.	
	Refer to business process write-up			
Business Capability Quality: Utility or Value to Stakeholders				



How satisfied are the stakeholders?	Stakeholder satisfaction is low, with few resources dedicated to improvement and few measurements in place, e.g. reliance on complaints, legal mandates for action regarding improving stakeholder satisfaction.	States begin to identify gaps in levels of satisfaction and stakeholder expectations and priorities. Improvements are made strategically, increasing stakeholder satisfaction over Level 1.	Medicaid Enterprise conducts internal and external audits/focus groups which take into consideration the results of its previous research along with other national standards to identify additional stakeholder expectations and priorities. Improvements are made based on national and MITA best practices, improving stakeholder satisfaction over Level 2.	
	Have not conducted a satisfaction survey			

Inquire Contractor Information				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions				
This Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				
Is this process manual or automated?	This is a manual process. The inquirer contacts the Agency by telephone, fax, or USPS and receives responses via the same modes.	Agencies provide portals for inquiries and responses. Inquirers have access under the State mandatory requirements for access to public information regarding the Contractor/Contract.	MITA standard interface is used for the inquiry and response. Portals are integrated to improve access to Contractor information.	
	Refer to business process write-up			
Does this process use standards?	There are no standards.	Each agency has its own standards for the inquiry and response.	MITA standards are used to define the request data and the response data.	



		Refer to business process write-up		
What information does the inquiry and response convey?	Inquiries include but are not limited to: Does this entity have a current contract? What services does the contract cover? What is the end date of the contract?	Inquiries are framed by the profiles available on the portal. The profile includes contractor name, address, start and end date, major services provided, contact information.	The inquiry response data set is established by the MITA Trigger and Result specifications that have been approved by MITA governance.	
	Refer to business process write-up			
How formalized is the process?	The process is informal and inconsistent.	The process is formal across state agencies with proper reviews to ensure correctness and legality. Accurate logs are kept of all inquiries.	The process now utilizes automated workflow to ensure accuracy and proper reviews. The documents are transferred and stored electronically.	
	Refer to business process write-up			
Business Capability Quality: Timeliness of Process				
What is the timeliness of this process?	Inquiries are answered within several working days.	Responses are available immediately via the portal.	Responses are available immediately and include MITA standard data.	
	Refer to business process write-up			
Business Capability Quality: Data Access and Accuracy				
How accurate is the data used by this process?	Accuracy depends on availability of the data and staff to respond to the inquiry. Manual processes affect negatively impacts accuracy.	Accuracy depends on maintenance of the portal data. Accuracy is improved over Level 1.	Accuracy is further improved by use of MITA specified data. Accuracy is improved over Level 2.	
	Refer to business process write-up			
How accessible is the data?	Responders need to consult paper files. Access to information is limited to business hours.	The portal is accessible according to its scheduled availability. Portal is functional beyond the normal hours of the business day.	Accessibility is almost 24 hours per day, excepting maintenance windows.	



	Refer to business process write-up			
Business Capability Quality: Cost-Effectiveness				
What is the ratio of the cost to support this process to the value of its results?	Results are within Agency performance standards.	Agency demonstrates cost-effectiveness of the portal. Cost of maintenance is low and usage is high.	The cost-effectiveness measurement is built into the business service which improves over Level 2 due to MITA standard interfaces.	
	Have not conducted a cost-benefit analysis			
Business Capability Quality: Effort to Perform; Efficiency				
How efficient is this process?	The manual process results in low efficiency, meeting minimal agency performance guidelines.	The portal solution meets agency performance guidelines introducing more efficiency than Level 1.	Alignment to MITA Standards in the portal solution further improves efficiency.	
	Refer to business process write-up			
Business Capability Quality: Accuracy of Process Results				
What is accuracy of the results of this process?	Manual processes results in greater opportunity for human error.	Automation and business rules reduce error and improve accuracy of process results.	Alignment to MITA Standards further reduces errors and improves efficiency of business results.	
	Refer to business process write-up			
Business Capability Quality: Utility or Value to Stakeholders				



How satisfied are the stakeholders?	Stakeholder satisfaction is low, with few resources dedicated to improvement and few measurements in place, e.g. reliance on complaints, legal mandates for action regarding improving stakeholder satisfaction.	States begin to identify gaps in levels of satisfaction and stakeholder expectations and priorities. Improvements are made strategically, increasing stakeholder satisfaction over Level 1.	Medicaid Enterprise conducts internal and external audits/focus groups which take into consideration the results of its previous research along with other national standards to identify additional stakeholder expectations and priorities. Improvements are made based on national and MITA best practices, improving stakeholder satisfaction over Level 2.	
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Manage Contractor Communication				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions				
This Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				
Is the process manual or automated?	This process is primarily conducted via paper, fax, and phone.	The process increases the use of electronic methods. The enterprise accepts inquiries that can be responded to online or by phone.	At this level, the process is primarily electronic.	
	Refer to business process write-up			



Is the process coordinated or managed in disparate, uncoordinated locations?	Contractor communications are uncoordinated among multiple, siloed programs and not systematically triggered by agency-wide processes; lacks data to appropriately target contractors, may encounter obstacles to delivery, e.g., incorrect or lack of contact information.	Contractor communications processes are centralized via Websites to provide contractor information.	Communications are centralized ensuring enterprise coordination with greater ability to measure the efficacy of contractor communications.	
	Refer to business process write-up			
Are standards used?	There are no standards for these communications.	Standards are developed for common on-line queries. A formal Communications Management Plan has been established following Project Management guidelines.	MITA standards for the communication interface are required. The project is managed by a comprehensive Project Management Plan following Project Management guidelines.	
	Refer to business process write-up			
Business Capability Quality: Timeliness of Process				
How timely is the End to End process?	Staff log and manually research the request. Requests may take several working days.	Contractors access Help services via a portal. Many common inquiries are answered on-line. Most requests can be answered in 24 hours or less. Multiple portals may exist as contractors may work with multiple agencies.	Contractor inquiries use MITA standard interface. Most common inquiries are responded to in real-time. Exceptions may require 24 hours or less. Portals are integrated so contractors have consistent way of communicating.	
	Refer to business process write-up			
Business Capability Quality: Data Access and Accuracy				
How accurate is the information accessed to support this process?	Responses are subjective, based on manual research.	Responses are standardized using portal.	Responses are standardized via MITA interface requirements.	
	Refer to business process write-up			



Can the information be accessed easily?	Staff manually researches policy manuals, contracts, and other documents.	Automated responses improve ease of access.	Accessing information is integrated among systems. Single sign-on exists to access all necessary information.	
	Refer to business process write-up			
Business Capability Quality: Cost-Effectiveness				
What is the cost of this process compared to the benefits of the results?	The process meets State expectations for costs.	Automation increases the benefit of the process.	Automation and use of MITA standards further increase the benefit of the process.	
	Have not conducted a cost-benefit analysis			
Business Capability Quality: Effort to Perform; Efficiency				
How efficient is this process?	The manual nature of this process invites improvements to increase efficiency.	The process is able to receive and send communications more efficiently.	Use of MITA standards increases efficiency.	
	Refer to business process write-up			
Business Capability Quality: Accuracy of Process Results				
How accurate are the process results?	Process results are minimally accurate; most legal and contractual requirements are met.	Formal process uses some automation to ensure that all legal and contractual requirements are met.	Use of MITA standard vocabulary and further automation results in a more accurate result than at Level 2.	
	Refer to business process write-up			
Business Capability Quality: Utility or Value to Stakeholders				
How satisfied are the stakeholders with this process?	Stakeholders rely on a manual communication process. Satisfaction is generally low.	The communication process is formalized and available to all. Stakeholder satisfaction improves over Level 1.	The communication process is formalized and utilizes MITA standard interfaces. Stakeholder satisfaction improves over Level 2.	
	Have not conducted a satisfaction survey			



Perform Contractor Outreach				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions				
This Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				
Is this process manual or automated?	<p>The process is primarily conducted via United States Postal Service (USPS) and telephone for individual communications; flyers, radio, TV, newspapers, and publications that post contractor RFPs.</p> <p>At this level there is no targeting of contractors.</p>	The process is conducted via an Internet portal for existing contractors and by newspapers, publications, and on-line advertising services that post contractor RFPs.	The process is electronic; attachments can be downloaded and saved or printed. Publications are also used if required by law to post RFPs. Use of electronic communications and MITA standard interfaces makes outreach material more feasible and cost effective.	
	See Perform Contractor Outreach draft			
Is this process coordinated with other entities performing similar activities?	<p>Outreach is uncoordinated among multiple, siloed programs; lacks data to appropriately target populations.</p>	Outreach is better coordinated because programs are able to share analysis/ performance measures based on increased standardization of administrative data, somewhat standardized clinical data available via registries, and improved data manipulation for decision support.	Use of MITA interfaces result in coordination with other entities.	
	See Perform Contractor Outreach draft			



Are standards used?	Minimal standards exist.	The Medicaid enterprise has policy for communications with the public.	MITA standard interfaces are used for common outreach activity.	
		See Perform Contractor Outreach draft		
How formalized is the process?	The process is informal and inconsistent.	The process is formal across the Medicaid enterprise with proper reviews to ensure correctness and legality. Accurate logs are kept of all outreach initiatives.	The process now utilizes automated workflow to ensure accuracy and proper reviews. The documents are transferred and stored electronically.	
	See Perform Contractor Outreach draft			
Business Capability Quality: Timeliness of Process				
How timely is this process End-to-End?	Timeliness depends on the type of outreach. It is ad hoc in nature. Outreach activity duration is relatively lengthy.	Timeliness is improved due to electronic modes of dissemination (i.e., via a communication portal). Outreach activity requires less time than at Level 1.	Timeliness is further improved due to use of MITA standard interfaces which result in launching outreach alerts and other communications immediately.	
	See Perform Contractor Outreach draft			
Business Capability Quality: Data Access and Accuracy				
How accurate is the information used in this process?	Staff manually verify that the information is accurate.	Electronic communications have built-in verifications of accuracy.	Use of MITA standard interfaces increases accuracy of data to 95% or better.	
	See Perform Contractor Outreach draft			
How accessible is the information needed for this process?	Information for the outreach is manually accessed. This adds to the time requirements for this process.	Some information for the process is accessible electronically. This reduces the time requirements for launching the outreach.	Information for contractor outreach is accessible from various electronic sources. Such information improves the basis for policy directives and support targeting contractors for outreach.	



	See Perform Contractor Outreach draft			
Business Capability Quality: Cost-Effectiveness				
What is the cost of this process compared to the benefit of the results?	Cost meets budget expectations.	Costs decline based on automation and standardization of data.	Use of MITA standard interfaces further decreases cost.	
	We have not conducted a cost benefit analysis.			
Business Capability Quality: Effort to Perform; Efficiency				
How efficient is this process.	Meets State expectations for a manually-based process.	Less effort required to launch outreach.	Efficiency of launching outreach is further improved by use of MITA standards.	
		Minimal outreach requires minimal effort.		
Business Capability Quality: Accuracy of Process Results				
How accurate are the results of this process?	Outreach is launched to a general audience but cannot be aligned with targeted audience negatively impacting accuracy.	Capability to match outreach with target audience improves the accuracy of the process.	Sophisticated methods ensure targeted outreach to contractors who are qualified to respond to specific needs of the Medicaid enterprise.	
	See Perform Contractor Outreach draft; no outreach targeting.			
Business Capability Quality: Utility or Value to Stakeholders				



How satisfied are the stakeholders with this process?	Stakeholder satisfaction is low, with few resources dedicated to improvement and few measurements in place, e.g. reliance on complaints, legal mandates for action regarding improving stakeholder satisfaction.	States begin to identify gaps in levels of satisfaction and stakeholder expectations and priorities. Improvements are made strategically, increasing stakeholder satisfaction over Level 1.	Medicaid Enterprise conducts internal and external audits/focus groups which take into consideration the results of its previous research along with other national standards to identify additional stakeholder expectations and priorities. Improvements are made based on national and MITA best practices, improving stakeholder satisfaction over Level 2.	
	We have not conducted a satisfaction survey.			

Support Contractor Grievance and Appeal				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions				
This Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				
How automated is the process?	The process is entirely paper based, which results in cumbersome document management and process inefficiencies.	The process conducts some of its activities electronically, except where paper documents are required by law. In this case, the documents are scanned for electronic data capture.	The process conducts the majority of its activities electronically, except where paper documents are required by law. In this case, the documents are scanned for electronic data capture.	
		Refer to business process write-up		



How centralized is the grievance and appeals process?	Grievances and appeals are filed, managed, and resolved by siloed programs, leading to inconsistent application or relevant laws and administrative policies and inhibiting performance monitoring.	Agencies begin to centralize or standardize the administration of this process to achieve economies of scale, thereby increasing coordination and improving consistency by which rules are applied and appeals disposed.	Use of MITA interface standards further increases coordination and reuse of standardized Grievance & Appeal services.	
	Refer to business process write-up; appeals are centralized, but grievances are not.			
Do contractors know how to access the grievance and appeals process?	Contractors have difficulty finding the right door for filing grievances and appeals.	The process is clearly identified. A Review Board has been established to review cases.	The process is standardized across the Medicaid Enterprise. MITA interface standards are used by all.	
		Refer to business process write-up; Do not use a review board, but have a Division of Appeals and Hearings.		
How is this process managed?	Agency guidelines are followed for opening, documenting, and resolving the case.	A formal Management Plan has been established.	The process is administered as part of the Medicaid enterprise and is managed by a comprehensive Management Plan.	
	Refer to business process write-up; no formal plan for resolving grievances.			
Business Capability Quality: Timeliness of Process				
How timely is this End-to-End process?	This process may require months due to lack of automation.	Introduction of automation to manage case files and capture information reduces process time as compared to Level 1.	Introduction of automation to manage case files and capture information plus use of MITA interfaces reduces process time as compared to level 2.	
	Refer to business process write-up			



Business Capability Quality: Data Access and Accuracy				
How accurate is the information used in this process?	There are minimal standards for the content of the case file and solicited documentation.	Local standards are used for data stored in the case file thereby improving accuracy of data stored.	MITA standards define interfaces thereby further improving accuracy of data stored.	
		Refer to business process write-up		
How accessible is the information required for this process?	Contractors have difficulty accessing program rules to discern the merit of their grievance or appeal.	Contractors have limited access to program rules to discern whether their grievances or appeals have merit.	Access to administrative data needed to review and dispose of the grievances and appeals is readily available and standardized, improving consistency and timeliness of dispositions. Contractors can electronically access program rules to discern whether their grievances or appeals have merit.	
		Refer to business process write-up; contract language provides necessary information		
Business Capability Quality: Cost-Effectiveness				
What is the cost to perform this process compared to the benefit of the results?	The process meets agency expectation for costs and benefits.	Process demonstrates increase in benefit due to lower cost of operations through automation.	Process demonstrates increase in benefit due to further reduction in cost of operations through automation and use of MITA standards.	
	We have not conducted a cost benefit analysis.			
Business Capability Quality: Effort to Perform; Efficiency				



How efficient is the process?	The process consumes a great deal of staff time. Cases may require months to complete.	The process is more efficient and allows staff to focus more time on improving the process and working on exceptions. Most cases require less time than at Level 1.	The process is consistent, orderly, and allows staff to spend even more time on quality outcomes and process improvement. Most cases can be resolved in less time than at Level 2.	
	Refer to business process write-up			
Business Capability Quality: Accuracy of Process Results				
What is the value of the results of this process?	Meets agency goals for managing cases.	Formal process is in place ensuring that all legal and program requirements are satisfied. These changes support business activity monitoring of performance measures, which in turn provide data needed for process improvements.	Formal, efficient, and electronic process is in place ensuring that all legal and program requirements are satisfied. The process is designed to collect data about the types of grievance and appeal it handles. This data is used to discern program improvement opportunities that may reduce the issues that give rise to grievances and appeals.	
	Refer to business process write-up; no agency-specific goals for case management.			
Business Capability Quality: Utility or Value to Stakeholders				
How satisfied are the stakeholders?	The process is entirely manual and informal. Stakeholder satisfaction is negatively impacted due to the length of time required to resolve the case.	Stakeholder satisfaction is rated higher than at Level 1 because the average cases are resolved in shorter period of time.	Stakeholder satisfaction is rated higher than at Level 2 because the average cases are resolved in shorter period of time.	
	We have not conducted a satisfaction survey.			



Authorize Service				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions				
This Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				
How are the Authorize Service request and response transmitted?	Authorize Service request and response are primarily submitted via paper, telephone, or fax.	Authorize Service request is a mix of paper/phone/fax and electronic media.	The Authorize Service process is automated using MITA standard interfaces.	
	Reference Authorize Service ps (One area does offer providers web-based submission)			
Do the format and data content adhere to standards?	Each state has developed its own unique paper forms to support this process; there may be different forms per provider type.	State has implemented the X12 278 standard transaction. Web portals may support error free submissions with data validations, client-side edits, and pre-populated fields, thereby facilitating the process.	MITA standard interactions are used.	
	Reference Authorize Service ps			
What method is used to process the request?	Authorize Service requests are manually validated against state specific business rules.	Although there are improvements in automation of sending and receiving, and use of HIPAA data standards, the approval process may remain manual.	The Authorize Service process is completely automated, reducing the need for manual review to exceptions.	
	Reference Authorize Service ps			



What method is used if additional information is required to process the request?	If an Authorize Service request requires additional information, the reviewer must manually contact the submitter/provider and await the response.	Authorize Service process may generate an electronic request for additional information via an X12 277 or letters may be generated.	Authorize Service process generates an electronic request for additional information via an X12 277 using the standard MITA interface.	
	Reference Authorize Service ps			
How easy is it to change the rules of Authorize Service?	Manual rule changes require many days for approval and implementation.	Although there may be some automation of rules, changes and maintenance are labor intensive, especially in legacy applications.	Authorize Service processing is highly flexible so that rule changes can be made quickly.	
		Reference Manage Program Information/Authorize Service		
Business Capability Quality: Timeliness of Process				
How timely is this End to End business process?	The Authorize Service request may take many days.	The process requires less time than at Level 1.	The process requires 60 seconds or less.	
	Reference Authorize Service ps			
Business Capability Quality: Data Access and Accuracy				
How easy is the access to information needed to make the decision on the request?	Accessing the data required to make the decision may take days.	Access requires less time than at Level 1.	Access is immediate for most requests.	
	Reference Authorize Service ps			
How accurate is the data used in this process?	The data sources are accurate but the manual decision-making may lead to inconsistencies in results	HIPAA standard transactions improve accuracy of data but the decision-making process may remain manual. Accuracy is higher than at Level 1	Decisions are automated and based on MITA data standards. Accuracy is rated at 95%.	
	Reference Authorize Service ps			
Business Capability Quality: Cost-Effectiveness				



What is the ratio of cost to support this process to the benefits of the result?	Manual process is labor intensive. High cost to produce desired results.	Automation of the receiving and sending process and use of HIPAA standard data allows staff to focus on the decision-making process, increasing cost effectiveness.	Use of MITA standard interface along with HIPAA standard data and automation of the workflow allow staff to focus on exceptions, process improvement and outcome measures.	
	Reference Authorize Service ps			
Business Capability Quality: Effort to Perform; Efficiency				
How efficient is this process?	Labor intensive. Efficiency is low.	Efficiency increases over Level 1.	Efficiency is measured at 85% or better.	
	Reference Authorize Service ps			
Business Capability Quality: Accuracy of Process Results				
How accurate are the results of this process?	Accuracy of results is low.	Accuracy of results is rated better than at Level 1.	Accuracy of results is rated at 90% or better.	
	A lot of data is not verified; Reference Authorize Service ps			
Business Capability Quality: Utility or Value to Stakeholders				
How satisfied are the stakeholders?	Satisfaction is low.	Satisfaction is higher than at Level 1.	Satisfaction is rated at 90% or better.	
	We have not conducted a satisfaction survey			



Apply Attachment				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions				
This Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				
How is clinical data requested and received when this information is required to process a transaction (claim, service authorization request, treatment plan) or for other business processes?	Medical and dental records are requested via telephone or USPS and copies are delivered in paper format (including X-rays) via USPS certified mail and fax.	The agency receives a mix of paper and electronic attachments and returns a mix of electronic and paper formats.	The majority of transactions and attachments are received electronically. Agency continues to accept paper attachments from a small number of providers who still submit paper transactions.	
	See Apply Attachment draft			
What standards apply to the clinical records?	There are limited, agency specific requirements for the clinical documents.	Electronic attachments meet HIPAA standards with additional, agency-specific Implementation Guide instructions. Paper attachments still adhere to limited agency specific requirements.	Electronic attachments meet MITA standard interface requirements.	
	See Apply Attachment draft; no electronic attachments.			
Does the clinical information accompany the transaction?	Paper attachments (i.e., clinical records) are sent separately from the transaction; the two documents are matched up, requiring manual intervention.	Electronic attachments are automatically matched to corresponding claim. Paper attachments may be scanned but are still manually associated with the applicable transaction.	Electronic attachments are required for electronically submitted transactions and accompany the transaction.	
	See Apply attachment draft; attachments are only accepted if submitted with a claim, at the same time as a claim in hard copy.			



Are validation activities manual or automated?	Validation that the attachment provides the necessary information is a primarily manual process.	Some validation is automated.	The implementation of the process as a service per MITA standard interface requirements allows automated validation of attachments.	
	See Apply Attachment draft			
Business Capability Quality: Timeliness of Process				
How timely is the End to End process for requesting and receiving clinical records and matching them to the transaction?	Manual requests and USPS certified delivery result in delays. It requires 30 or more days for receipt of the requested records and associating them with the transaction.	Electronic attachments shorten time required to receive the clinical information and to match with the transaction. Paper attachments may be scanned, reducing the distribution time within the agency. It requires 24 hours or less to receive clinical attachment and associate with correct transaction.	Use of MITA national standards for attachments improves speed of processing. Clinical data is available concurrently with the transaction.	
	See Apply Attachment draft			
Business Capability Quality: Data Access and Accuracy				
Can the clinical record be accessed easily?	Clinical information must be kept in locked storage. Authorized personnel retrieve records for use in review of the transaction. Accessing clinical records generally requires 48 or more hours.	Electronic attachments improve access to clinical information by authorized personnel. Security and privacy rules apply. Clinical records can be accessed in about 1 hour or less.	Electronic attachments are required for electronic transactions and are immediately available to authorized requesters. Routine access to clinical information needed to process a transaction is totally automated.	
	See Apply Attachment draft			
Is the clinical data associated accurately?	Manual matches and reviews result in inconsistency and errors.	Use of electronic attachments automates matching of attachment with associated information and improves accuracy.	Use of MITA standards and use of nationally standardized data results in 99.9% accuracy of clinical information matching.	



	See Apply Attachment draft			
Business Capability Quality: Cost-Effectiveness				
What is the ratio of the cost of this process to the benefit of its results?	The process is manually intensive but meets agency goals for ensuring appropriateness of payment.	Automation improves cost to benefit ratio.	Use of the MITA standard interface further improves cost to benefit ratio.	
	See Apply Attachment draft			
Business Capability Quality: Effort to Perform; Efficiency				
How efficient is this End to End process?	The process is manually intensive creating inefficiencies.	Electronic attachments and use of business rules improve process efficiency.	Use of MITA national standards for the Claim Attachment facilitates performance. Efficiency is rated at 90%.	
	See Apply Attachment draft			
Business Capability Quality: Accuracy of Process Results				
How accurate are the results of the process?	There are inconsistencies in results in the manual matching and processing of attachment records	Consistency is improved over Level 1 through automation and use of X12 standard.	Consistency and accuracy of results improves over level 2 and reaches 95% or better.	
	See Apply Attachment draft			
Business Capability Quality: Utility or Value to Stakeholders				
How satisfied are the stakeholders with the process?	Stakeholder satisfaction is relatively low due to the manual burden of complying with the request and the delays involved in the decision.	Stakeholder satisfaction improves due to automation of the process and reduction in delay time.	Stakeholder satisfaction increases to 90% or better in correlation with the consistent application of business rules to MITA and industry standard data.	
	See Apply Attachment draft			



Apply Mass Adjustment				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions				
This Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				
What process is used to identify claims affected by a mass adjustment?	Agency staff manually produce reports to identify the claims affected by the adjustment.	Claims affected by the mass adjustment are identified through an automated application.	The Apply Mass Adjustment process utilizes MITA standards for its interfaces and for processing and has the flexibility to easily change the criteria for identification of claims and application of the adjustment.	
	See Apply Mass Adjustment draft			
How is the adjustment applied to the claims?	Agency staff manually apply the adjustment to each claim identified.	Application of the adjustment is automated and the process includes an audit trail.	The process uses automation and MITA standard interfaces to apply adjustments.	
		See Apply Mass Adjustment draft		
Business Capability Quality: Timeliness of Process				
What is the timeliness of this End to End process?	The Apply Mass Adjustment process may take many working days.	The Apply Mass Adjustment process can be completed, on the average, in fewer working days than at Level 1.	The Apply Mass Adjustment process can be completed, on the average, in 8 hours or less.	
	See Apply Mass Adjustment draft			
Business Capability Quality: Data Access and Accuracy				



Are data and format standardized?	Non-standardized data adds to the time and effort necessary identifying all claims affected by the adjustment.	The introduction of data standards enables automation and on-line access to the data.	The Apply Mass Adjustment process is implemented as a service and is supported by MITA data and interface standards.	
		See Apply Mass Adjustment draft; claims data is standard.		
How easy is it to access the data necessary to complete this process?	Access to data is controlled manually. Data access may take several days.	The Apply Mass Adjustment process uses on-line access to data. Data access takes no more than 1 hour for smaller batches (fewer than 1,000 claims) or 4 hours for large batches (more than 1,000).	The Apply Mass Adjustment process has immediate access to standardized data. Data access takes a maximum of 1 hour for the largest batches.	
	See Apply Mass Adjustment draft; May take several days as Clemson gathers data and routes to program areas to verify.			
How accurate is the identification and adjustment process?	Manual identification results in subjective selection of claims to be used and manual application of adjustment results in inconsistency and errors, impacting accuracy.	Data accuracy is improved over Level 1.	Use of MITA standardized interfaces and data representations ensures accuracy of data. Data accuracy is measured as 99% or better.	
		See Apply Mass Adjustment draft		
Business Capability Quality: Cost-Effectiveness				
What is the ratio of cost to perform this process to the benefit of the result?	The Apply Mass Adjustment process relies primarily on staff to perform actions, resulting in high cost to achieve results.	Automation reduces staff levels required to achieve the same or better results as Level 1.	The Apply Mass Adjustment process maximizes resources and demonstrates increased Return on Investment. Automation allows State to focus on exceptions and process improvement.	
	See Apply Mass Adjustment draft			



Business Capability Quality: Effort to Perform; Efficiency

How efficient is this process?	Labor intensive process is characterized as low efficiency.	Efficiency is better than at Level 1.	Efficiency is rated at 90% or higher.	
	See Apply Mass Adjustment draft			

Business Capability Quality: Accuracy of Process Results

How accurate are the results of this process?	Decision making for the Apply Mass Adjustment process is manual and therefore subjective resulting in inconsistent decisions.	Decision making for the Apply Mass Adjustment process is based on Agency policy which has been automated resulting in higher consistency than at Level 1.	Use of MITA interface standards increases accuracy and consistency to 95% or better.	
		We're unclear as to how "decision making" relates to accuracy of this process. Agency does use some automation and feels it is an accurate process (see Apply Mass Adjustment bp). This has been audited internally.		

Business Capability Quality: Utility or Value to Stakeholders

How satisfied are stakeholders?	Stakeholder satisfaction is low due to the delays and inconsistencies in producing the adjustment and the way in which the results are communicated.	Stakeholder satisfaction is improved over Level 1.	Stakeholder satisfaction is rated at higher than 95%.	
	We have not conducted a satisfaction survey. However, communication methods are not inconsistent.			



Edit Claim Encounter				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions				
This Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				
How does the agency receive the claim or encounter information?	The agency receives paper claims and summary encounter data. Claims are scanned or manually entered into an electronic record format.	The agency continues to accept paper claims, but most providers submit claims electronically. All encounter data is transmitted electronically.	All claims are submitted electronically and comply with HIPAA and MITA standards. Encounters are submitted as HIPAA compliant transactions from managed care organizations and any other external processor, e.g., a PBM, mental health, dental processor, or other agency.	
		Refer to Enter Claim; Still currently have more providers that submit paper claims		
Are the claim and encounter records standardized?	The agency specifies formats for claims and encounter records, adhering in general to National paper format specifications.	Electronic claims transactions meet HIPAA data standards. Encounter data is received electronically or is posted to Web sites and may use state specified, non-HIPAA compliant formats or the X12 837 and NCPDP standards.	Electronic transactions use MITA standard interfaces nationally in addition to compliance with HIPAA transaction and code set standards.	
		Refer to Enter Claim		



Do sister agencies use the Medicaid claim or encounter claim edit process?	No. Sister agencies and waiver programs manage their own Edit Claim process.	Medicaid agency can accept sister agency and waiver program claims and load other agency data into an enterprise data warehouse by supporting multiple formats and mapping nonstandard data elements.	Medicaid agency coordinates with other agencies and programs to accept, process, and access standard data elements through MITA interfaces.	
		Refer to Enter Claim; DSS, DMH, etc.		
Does the agency use the data of record from the submitter or does it translate the data to its internal specifications?	State keys or scans the data of record into its internal format.	Automated Data Translators convert national data standards to state specific data to support business processes.	The Edit Claim/ Encounter business process uses MITA standard data with no translation required.	
	Refer to Edit Claim			
How integrated is the Claim edit process across the Medicaid enterprise?	Not integrated across programs at Level 1.	Some integration of Claims Edit processing is across the Medicaid enterprise.	The process is integrated across the enterprise and employs MITA standard interfaces.	
		Refer to Edit Claim		
Business Capability Quality: Timeliness of Process				
How timely is the End to End process?	Manual processing steps may require days to complete a claim edit process. Suspended claims require lengthy manual resolution.	Electronic claim processing and POS adjudication greatly increase timeliness. The claim edit process is completed within 24 hours to 30 seconds respectively.	Use of MITA data interface standards supports processing in less than 30 seconds.	
	Refer to Edit Claim			
Business Capability Quality: Data Access and Accuracy				



How accurate is the claim or encounter data?	Key fields are validated against databases. However, it is difficult for reviewers to consistently interpret and apply adjudication rules manually. Attachment data is unstructured which increases inconsistency of the review process.	For EDI claims/encounters, edits are automated for many steps, but may be manual for attachments and suspended claims/ encounters. Data accuracy is higher than Level 1.	All claim and encounter data meets MITA standards. Data accuracy is rated at 99%.	
		Refer to Enter Claim and Edit Claim		
Business Capability Quality: Cost-Effectiveness				
What is the ratio of cost of the claim edit process to the benefit of the results?	Manual operations and maintenance result in high cost of processing. Rules lack flexibility and are costly to change.	Significant automation improves the cost/benefit ratio.	Edit processing is highly flexible so that edit rules and code set changes can be made quickly and inexpensively.	
		Refer to Edit Claim		
Business Capability Quality: Effort to Perform; Efficiency				
How automated is the Claim edit process for Medicaid claims?	Edited fields are validated against standard and state specific code sets. Attachments and suspended claims/encounters are processed manually.	Edit rules programs support complex algorithms which maximize automated adjudication and minimize the need for manual intervention. The process is more automated than at Level 1 but may have manual components.	MITA standard interfaces and the use of configurable business rules limit exceptions. Average changes take fewer than 8 hours or less.	
	Refer to Edit Claim			



How easy is it to change edit rules and criteria?	Manual rules and automated validations are hardcoded. Changes are difficult, lengthy, and costly.	Despite progress, related processes continue to be tightly integrated, so that changes to edits can result in unintended downstream processing consequences. Average change takes fewer days than Level 1.	Related processes are decoupled, allowing changes to be made in the Edit Claim/ Encounter process independently without affecting downstream processes. Average changes take less time than Level 2.	
	Refer to Edit Claim			
Business Capability Quality: Accuracy of Process Results				
What is the quality of the results?	Results meet agency requirements for accuracy.	Automation greatly improves the quality and accuracy of results. Results are increasingly accurate as compared to Level 1.	The Edit Claim/Encounter process is completely automated and only rare edit exceptions must be manually reviewed. Results are accurate and timely 99% of the time.	
		Refer to Edit Claim		
Business Capability Quality: Utility or Value to Stakeholders				
How satisfied are stakeholders with the process?	Stakeholder satisfaction is low, with no resources dedicated to improvement and few measurements in place. (Reliance on complaints, legal mandates for any action)	Medicaid Enterprise begins to identify <i>gaps</i> between levels of satisfaction and stakeholder expectations and priorities. Improvements are made strategically increasing stakeholder satisfaction over Level 1.	Medicaid Enterprise conducts internal and external audits/focus groups which take into consideration the results of its previous research along with other national standards to identify additional stakeholder expectations and priorities. Improvements are made based on national and MITA best practices. Stakeholder satisfaction is rated 90% or better.	



	Have not conducted a satisfaction survey			
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Price Claim/Value Encounter				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions				
This Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				
Is this process manual or automated?	Some Medicaid services are automatically priced using rate and fee reference data. Many require manual pricing.	A majority of Medicaid services are automatically priced.	The agency uses MITA standard interfaces and the MITA business service to automatically price claims.	
		See Price Claim-Value Encounter draft		
How are encounter records priced?	There is no Level 1 pricing for encounter transactions.	States use fee-for-service reference data or other sources to assign a price or value to an encounter.	The agency uses MITA standard interfaces and the MITA business service to automatically apply a value to the encounter.	
How are waiver program and other agency claims priced?	Waiver program and atypical provider services may be manually priced separately from Medicaid claims.	Waiver programs and other agencies may use the automated Medicaid claims processing and pricing services.	Medicaid agency coordinates with sister agencies and waiver programs to present a multi-agency automated claim adjudication and pricing process to providers.	
		See Price Claim-Value Encounter draft		



How easy is it to change prices?	It is difficult and time consuming to change pricing tables. This is a manual process.	Pricing updates are automated.	Business rules allow maximum flexibility in changing pricing algorithms.	
	See Price Claim-Value Encounter draft			
Business Capability Quality: Timeliness of Process				
How timely is the End to End business process?	The process is completed within the State's standard payment cycle.	The process is automated and requires 24 hours or less.	The process is accomplished in real time.	
	See Price Claim-Value Encounter draft			
Business Capability Quality: Data Access and Accuracy				
How easy is it to access data required for pricing?	Access to data is controlled manually. Data access may take up to 1 day.	The process uses on-line access to pricing data. Data access takes no more than 30 seconds.	The process has immediate access to standardized data. Data access takes no more than 1 second.	
	See Price Claim-Value Encounter draft			
How accurate are the data used for pricing?	Manual operation results in subjective selection of data to be used, negatively impacting accuracy.	Accuracy and consistency of data used in the process is higher than at Level 1 due to increased automation.	Use of MITA standardized interfaces and data definitions ensures accuracy of data. Data accuracy is measured as 99%.	
	See Price Claim-Value Encounter draft; pricing tables are manually updated.			
Business Capability Quality: Cost-Effectiveness				
What is the ratio of cost to support this process compared to the benefits.	The process is primarily manual and is relatively low in cost effectiveness.	Automation of processes increases and cost effectiveness is higher than found at Level 1.	Further automation of processes increases cost efficiency. Cost effectiveness is higher than found at Level 2.	



		See Price Claim-Value Encounter draft		
Business Capability Quality: Effort to Perform; Efficiency				
How efficient is this process?	Manual processing, lack of coordination with other processes, duplicative work, and lack of standards results in relatively low efficiency.	Increased automation, coordination with other processes, and introduction of standards creates more efficiency than at Level 1.	Introduction of MITA standards and reusable services creates even greater efficiency than at Level 2.	
	See Price Claim-Value Encounter draft; manual pricing can be duplicative.			
Business Capability Quality: Accuracy of Process Results				
How accurate are the process results?	Decision making for the process is manual and therefore subjective, resulting in some inconsistent decisions. There is a minimal audit trail relating to the pricing methodology and accuracy is negatively impacted.	Decision making for the process is based on Agency policy which has been automated resulting in uniform decisions. The pricing methodology is tracked but only minimal information is available. Accuracy is higher than found at Level 1.	The process consistently applies business rules resulting in uniform decisions. A full audit trail of the pricing methodology is available indicating the values present at the time of adjudication. Accuracy of results is rated at 98%.	
	See Price Claim-Value Encounter draft			
Business Capability Quality: Utility or Value to Stakeholders				
How satisfied are the stakeholders?	Stakeholder satisfaction is relatively low due to error prone manual processes.	The process measures utility by tracking percent successful completion of the process, supplemented by periodic surveys. Stakeholder satisfaction is higher than found at Level 1.	The process measures utility based on Enterprise-wide standards. Stakeholder satisfaction is higher than found at Level 2.	
	We have not conducted a satisfaction survey.			



Prepare COB				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions				
This Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				
How automated or manual is this process?	<p>COB is a manual process. Cost Avoidance is described as Payer to Provider.</p> <p>Example If a claim is identified with other primary payer responsibility, it is denied and returned to the provider indicating there is a requirement to bill the other payer(s) first.</p>	<p>COB is an automated approach to the sharing in payment for a billed service.</p> <p>Cost Avoidance is described as Payer to Payer.</p>	<p>The process is completely automated and only in rare exceptions requires manual intervention.</p> <p>Uses MITA standard interface for Cost Avoidance is described as Payer to Payer information exchange.</p>	
		Refer to business process write-up		
How coordinated is the COB process?	<p>Coordination with the provider to have the provider file with other payer(s) uses manual and non HIPAA standard automated processes.</p>	<p>COB uses the HIPAA claim transaction to exchange data with the other payer.</p>	<p>The majority of COB is coordinated among data sharing partner agencies in the State.</p>	
	Refer to business process write-up			
Are standards used?	<p>Payer uses proprietary standard remittance advice to communicate need for provider to submit claim to other payer(s) of first resort.</p>	<p>COB is identified as a HIPAA standard transaction.</p>	<p>COB uses the MITA standard interface in addition to latest HIPAA data content standard.</p>	
	Refer to business process write-up			



Business Capability Quality: Timeliness of Process				
What is the timeliness of this End to End process?	COB is performed in payment cycles.	COB may be performed outside of regular payment cycles.	COB is performed in real time.	
			Refer to business process write-up	
Business Capability Quality: Data Access and Accuracy				
What is the level of data access and accuracy for this process?	Appropriate data is maintained within data stores and must be accessed independently and may be manual. Application of automation exists to some extent using proprietary standards in an attempt to ensure accuracy.	Using the HIPAA standard claim transaction improves access to and accuracy of data.	Combining HIPAA standard claim data and MITA standard interface specifications maximizes access and accuracy.	
	Refer to business process write-up			
Business Capability Quality: Cost-Effectiveness				
What is the ratio of cost to support this process compared to the desired results?	A partially automated COB process is not the most cost effective.	A fully automated coordination of benefits is the most cost-effective way to apply the rules of other (eg. primary and secondary) payment.		
	Refer to business process write-up; Invoicing is not automated, otherwise, this process is automated.			
Business Capability Quality: Effort to Perform; Efficiency				
How efficient is this process?	Manual processes result in relatively low efficiency.	Automation, coordination with other processes and introduction of standards reduces duplicative work and improves efficiency.	Use of MITA standard interfaces results in more efficient process than Level 2.	



		Refer to business process write-up		
Business Capability Quality: Accuracy of Process Results				
How accurate or useful are the results?	COB is a standard process using some level of automation. Accuracy levels are acceptable despite the payer to provider coordination methodology.	Usefulness and accuracy of COB results is notably improved over Level 1.	COB is successfully executed 99% of time.	
		Refer to business process write-up		
Business Capability Quality: Utility or Value to Stakeholders				
What is the value to the stakeholders?	Stakeholders are somewhat satisfied regarding the fact that their A/R files receive quick response of denial from Medicaid, and the need to re-direct the claim to another payer.	Stakeholders are satisfied that benefit coordination is automated from payer to payer and based on business rules.	Stakeholders are satisfied that benefit coordination is automated from payer to payer and based on business rules and MITA standards.	
	Have not conducted a satisfaction survey			

Prepare EOB				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions				
This Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				



Is the process manual or automated?	The sampling and generation of Explanation of Benefits (EOBs) is manually identified. Distribution is via the USPS.	The Medicaid enterprise uses sampling enhancements to target selected populations. Generation of EOB is automated; distribution is via USPS.	EOBs may be integrated with Personal Health Records (PHRs). When PHRs are used the sampling process is enhanced to target selected populations. Distribution may be via USPS. EOBs are generated automatically and are available via web portal.	
		See Prepare EOB draft		
Are data and format standardized?	Data standards are agency specific.	Data standards benefit from HIPAA data standards for procedure codes.	The agency uses MITA standard interfaces for the EOB.	
		See Prepare EOB draft		
If sampling is used, what sampling algorithm is used?	Medicaid enterprise complies with federal regulations to produce random samples of EOBs monthly.	Medicaid enterprise enhances the sampling process to target selected populations.	In addition to the targeted populations, sampling is dynamically generated based on provider billing patterns and SURS results.	
		See Prepare EOB draft		
Are the EOBs culturally, linguistically, and capability appropriate and available in alternate formats?	The process does not employ alternate formats, cultural and linguistic adaptations.	Alternate formats, cultural and linguistic adaptations are introduced on a limited basis.	Alternate formats, cultural and linguistic adaptations are automatic.	
	See Prepare EOB draft			
Business Capability Quality: Timeliness of Process				



What is the timeliness of this End to End process?	The process meets the timelines for producing EOBs.	The process meets the timelines for producing EOBs. Electronic copies of all outgoing letters are available online to all authorized users.	The majority of the electronic copies of EOBs are available online to all authorized users. Outgoing letters utilize barcodes or other automated tools for faster processing and indexing upon return.	
	See Prepare EOB draft			
Business Capability Quality: Data Access and Accuracy				
Is the data necessary to the process accessible?	Data required for the EOB is accessed via hardcoded instructions.	Data are selected via table-driven parameters.	Data are selected via user interface screens. Members can review data online and report on a questionable service through a web interface.	
		See Prepare EOB draft		
Business Capability Quality: Cost-Effectiveness				
What is the ratio of the cost of this process to the benefit of its results?	Costs are primarily associated with postage, return postage, and screening of responses. Effectiveness is rated at 50% or below, associated with responses to the EOB that lead to program savings.	Results are based on the number of quality responses, cases opened, and Medicaid funds recovered. Flexibility in targeting EOBs over manually identifying the sample improves effectiveness of responses to 75% or better. Automation increases effectiveness.	The targeting of certain populations has increased the useful responses over manually identifying the sample and the amount of funds recovered has increased as a result. Integration with Personal Health Records and the use of MITA standard interface may increase effectiveness to 85% or better.	
	See Prepare EOB draft			
Business Capability Quality: Effort to Perform; Efficiency				



How efficient is this End to End process?	The Prepare EOB process is primarily manual, including the printing and distribution processes.	The job and printed material are generated routinely on a production schedule using standard forms and materials.	The EOBs can be returned electronically or responded to on the web.	
		See Prepare EOB draft; distribution process is manual.		
Business Capability Quality: Accuracy of Process Results				
How accurate are the results of this process?	The process meets State and Federal expectations regarding results.	The process produces more accurate results than at Level 1 due to introduction of automation and targeting.	The use of more automation produces accurate results 99% of the time or better.	
	See Prepare EOB draft			
Business Capability Quality: Utility or Value to Stakeholders				
How satisfied are the stakeholders?	Stakeholder satisfaction is low, with few resources dedicated to improvement and few measurements in place, e.g. reliance on complaints, legal mandates for action regarding improving stakeholder satisfaction.	States begin to identify gaps in levels of satisfaction and stakeholder expectations and priorities. Improvements are made strategically, increasing stakeholder satisfaction over Level 1.	Medicaid Enterprise conducts internal and external audits/focus groups which take into consideration the results of its previous research along with other national standards to identify additional stakeholder expectations and priorities. Improvements are made based on national and MITA best practices, improving stakeholder satisfaction over Level 2.	
	We have not conducted a satisfaction survey.			



Prepare Premium EFT				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions				
This Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				
Are payment transactions prepared in paper format (checks) or electronic funds transfer (EFT)?	Medicaid enterprise or Department of Finance uses an automated process to produce a paper check. At Level 1, there is no EFT.	Medicaid enterprise complies with state or industry standards for EFT and conforms to HIPAA standards.	The Medicaid enterprise uses MITA standard interfaces for EFT transactions. All payment is via EFT.	
		Refer to business process write-up; some paper checks are also printed.		
What standards are used for the payment process?	State specific standards are used in completing this process.	HIPAA standard transactions are used for electronic payments. . Medicaid enterprise employs banking automated clearinghouse (ACH) transactions for the movement of funds.	MITA standards are used for EFT interfaces and incorporate HIPAA data content.	
	Refer to business process write-up			
Is the payment process integrated across agencies, or siloed per agency?	Each State agency has its own payment process. This often is a manual process with paper checks and other financial documents.	Automation improves integration throughout the Medicaid enterprise. EFTs are common.	Through inter-agency coordination, multiple agencies share the same EFT process.	
		Refer to business process write-up		
Business Capability Quality: Timeliness of Process				
How timely is this End to End process?	The process may require weeks to complete a cycle.	The process may require days to complete a cycle.	The process may complete in hours or near real-time.	



		Refer to business process write-up		
Business Capability Quality: Data Access and Accuracy				
How easy is it to access data needed for this process?	The process accesses data automatically but human intervention is required in the preparation and mailing of checks.	The process uses on-line access to data. Response time is measured in less than a minute.	The process has immediate access to standardized data. Data access is real time, with few exceptions.	
	Refer to business process write-up			
How accurate are the data used in this process?	The process uses State-specific data standards and formats developed by State agencies.	The process uses its version of national data standards (e.g., HIPAA) for interfaces.	Use of MITA standardized interfaces and data representations ensures accuracy of data. Data Accuracy is rated at 99%.	
	Refer to business process write-up			
Business Capability Quality: Cost-Effectiveness				
What is the ratio of the cost of this process to its benefits?	The process meets State budget guidelines.	Increased automation, coordination with other processes, and introduction of standards reduces duplicative work and creates cost effectiveness.	The Prepare Premium EFT process consistently applies business rules resulting in uniform, automated outcomes. The process is described as highly efficient.	
		Refer to business process write-up		
Business Capability Quality: Effort to Perform; Efficiency				
How efficient is this process?	Manual processes reduce efficiency	Increased automation, coordination with other processes, and introduction of standards reduces duplicative work and creates more efficiency.	The Prepare Premium EFT process consistently applies business rules resulting in uniform, automated outcomes. The process is described as highly efficient.	



		Refer to business process write-up		
Business Capability Quality: Accuracy of Process Results				
How accurate are the results of this process?	Process results may result in errors due to manual processes.	Process results improve over Level 1 due to automation.	Process results are rated at 95% accuracy or better.	
	Refer to business process write-up			
Business Capability Quality: Utility or Value to Stakeholders				
How satisfied are the stakeholders?	Stakeholder satisfaction is low, with few resources dedicated to improvement and few measurements in place, e.g. reliance on complaints, legal mandates for action regarding improving stakeholder satisfaction.	States begin to identify gaps in levels of satisfaction and stakeholder expectations and priorities. Improvements are made strategically, increasing stakeholder satisfaction over Level 1.	Medicaid Enterprise conducts internal and external audits/focus groups which take into consideration the results of its previous research along with other national standards to identify additional stakeholder expectations and priorities. Improvements are made based on national and MITA best practices, improving stakeholder satisfaction over Level 2.	
	Have not conducted a stakeholder satisfaction survey			

Prepare Provider EFT/Check				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions				
This Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				



What format is used for payments?	Medicaid agency or Department of Finance uses an automated check write process to produce a paper check which is mailed to the provider. There is no EFT at Level 1.	Medicaid enterprise complies with state or industry standards for electronic funds transfer (EFT) and conforms to HIPAA requirements. Paper checks are sent to some submitters. Medicaid enterprise encourages electronic billers to adopt EFT payment.	The Medicaid enterprise uses MITA standard interfaces for EFT transactions. All submitters receive EFT payment.	
		See Prepare Provider EFT-Check draft		
What standards are used for the payment process?	State-specific standards are used in completing this process.	HIPAA standard transactions for EFT are used. Medicaid enterprise employs maximum use of banking ACH transaction for the movement of funds.	National MITA standards are used for EFT interfaces.	
		See Prepare Provider EFT-Check draft		
Is the payment process integrated across agencies, or siloed per agency?	Each State agency has its own payment process.	Medicaid enterprise manages its own process for Medicaid billers.	Through inter-agency coordination, multiple agencies share the same EFT process.	
	See Prepare Provider EFT-Check draft; SAP may move system to Level 2.			
How secure is this process?	Staff maintains control over secure check stock.	Staff maintains oversight and control of payment processes. All components of the check and EFT processes are dual-controlled, following standard accounting practices.	Use of MITA standards further automates payment preparation and improves security over Level 2.	
		See Prepare Provider EFT-Check draft		
Business Capability Quality: Timeliness of Process				



How timely is this End to End process?	The process may require weeks to complete a cycle.	The process requires no more than a week to complete a cycle.	The process is immediate (however, State policy may delay release of funds).	
		See Prepare Provider EFT-Check draft		
Business Capability Quality: Data Access and Accuracy				
How accurate are the data used in this process?	The process uses State-specific data standards and formats developed by State agencies. Data may include many errors.	The process uses national data standards. Data accuracy is higher than found at Level 1.	Use of MITA standardized interfaces and data representations ensures accuracy of data. Data accuracy is rated at 99%.	
	See Prepare Provider EFT-Check draft			
Business Capability Quality: Cost-Effectiveness				
What is the ratio of the cost of this process to its benefits?	The process meets State budget guidelines, but is relatively low in cost effectiveness.	The process meets State cost containment guidelines, and is more cost effective than found at Level 1.	The process demonstrates improved Return on Investment projected by the Medicaid Enterprise and is more cost effective than found at Level 2.	
		A cost benefit analysis demonstrates encouraging use of EFT has increased cost-effectiveness.		
Business Capability Quality: Effort to Perform; Efficiency				
How efficient is this process?	The process meets State and Federal expectations regarding results, but is relatively low in efficiency	Increased automation, coordination with other processes, and use of standards creates more efficiency than seen at Level 1.	The process consistently applies business rules resulting in uniform, automated outcomes. The process is described as highly efficient.	



		Use of some automation-- Refer to business process write-up		
Business Capability Quality: Accuracy of Process Results				
How accurate are the results of this process?	Due to manual processes results may include errors.	Process results are more accurate than found at Level 1.	Process results are improved over Level 2. Accuracy is rated at 98%.	
	Use of some automation, but manually stuffing checks may lead to errors--Refer to business process write-up			
Business Capability Quality: Utility or Value to Stakeholders				
How satisfied are the stakeholders?	Stakeholder satisfaction is low, with few resources dedicated to improvement and few measurements in place, e.g. reliance on complaints, legal mandates for action regarding improving stakeholder satisfaction.	States begin to identify gaps in levels of satisfaction and stakeholder expectations and priorities. Improvements are made strategically, increasing stakeholder satisfaction over Level 1.	Medicaid Enterprise conducts internal and external audits/focus groups which take into consideration the results of its previous research along with other national standards to identify additional stakeholder expectations and priorities. Improvements are made based on national and MITA best practices, improving stakeholder satisfaction over Level 2.	
		Encouraging EFT was a strategic improvement to improve satisfaction.		



Prepare Remittance Advice/Encounter Report				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions				
This Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				
Is the process manual or automated?	Medicaid agency produces a paper Remittance Advice using state Medicaid agency specific format and data content and a mixture of manual and automated processes.	The Medicaid Enterprise complies with HIPAA to supply an electronic RA. Medicaid agency continues to provide paper RAs to some providers. Most processes are automated.	The RA and encounter report are fully automated. All Providers and encounter submitters receive electronic transactions with some exceptions.	
	Refer to business process write-up; plans in progress to implement electronic RA			
How detailed is the information in the RA or encounter report?	The RA contains data and is formatted according to state specifications.	RA and encounter report are replaced by HIPAA compliant transactions which use standard codes.	The agency uses MITA standard interfaces for the RA and encounter report.	
	Refer to business process write-up			
What standards are used for the RA or encounter report?	State-specific standards. Explanations of codes may be comprehensive and are agency specific.	HIPAA standard is required for the electronic RA.	HIPAA standard is required for the electronic RA; MITA standard interface is used for the business service.	
	Refer to business process write-up			
Business Capability Quality: Timeliness of Process				
How timely is this process?	The paper RAs are mailed to the providers within the standards set by the State's business process.	The RA lag is reduced from Level 1. More reliance is on electronic versus paper.	MITA Standard interfaces make adjudication results available real time.	



	Refer to business process write-up			
Business Capability Quality: Data Access and Accuracy				
How accurate are the data used in the process?	Manual intervention and siloed data sources may result in relatively low accuracy of data.	Data is based on the HIPAA standard for electronic RA. Data is more accurate than found at Level 1.	Use of MITA standardized interfaces and data definitions ensure a robust data set. Data accuracy is 98 percent or better.	
	Refer to business process write-up			
How accessible is the information used in this process.	Access to data is controlled manually. It may require a few days to locate information.	The process uses online access to data. Data access takes no more than 1 hour.	The process has immediate access to standard data. Data access takes no more than 60 seconds.	
		Refer to business process write-up		
Business Capability Quality: Cost-Effectiveness				
What is the ratio of the cost to support the process compared to its benefit?	The process has a relatively high cost due to manual intervention.	The process is more cost effective than found at Level 1 due to increased automation and HIPAA standards.	The process is more cost effective than found at Level 2 due to MITA standard interfaces.	
	Have not conducted a cost-benefit analysis			
Business Capability Quality: Effort to Perform; Efficiency				
How efficient is the process?	The process is entirely paper and sent via the United States Postal Service and is relatively inefficient.	A portion of the RAs are delivered electronically; the efficiency is higher than found at level 1.	With few exceptions, all RAs are electronically produced and delivered; the efficiency is higher than found at level 2.	
	Refer to business process write-up			
Business Capability Quality: Accuracy of Process Results				



How accurate are the results of the process?	Manual processes negatively impact accuracy.	The process is significantly more accurate than found at Level 1 due to increased automation and HIPAA standards.	Accuracy of process results achieves 98 percent or better due to MITA standard interfaces.	
	Refer to business process write-up			
Business Capability Quality: Utility or Value to Stakeholders				
How satisfied are the stakeholders?	Stakeholder satisfaction is low, with few resources dedicated to improvement and few measurements in place, e.g. reliance on complaints, legal mandates for action regarding improving stakeholder satisfaction.	States begin to identify gaps in levels of satisfaction and stakeholder expectations and priorities. Improvements are made strategically, increasing stakeholder satisfaction over Level 1.	Medicaid Enterprise conducts internal and external audits/focus groups which take into consideration the results of its previous research along with other national standards to identify additional stakeholder expectations and priorities. Improvements are made based on national and MITA best practices, improving stakeholder satisfaction over Level 2.	
	Have not conducted a stakeholder satisfaction survey			

Prepare Capitation Premium Payment				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions				
This Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				



What methodology is used to prepare the Capitation Premium payments?	The agency identifies members who are assigned to a managed care organization, a benefit manager, or a primary care physician, and matches them to appropriate rate cells in order to calculate monthly payments.	The calculation process may be more automated than at Level 1 and produces the dataset necessary to produce a HIPAA compliant transaction.	The agency uses MITA standard interfaces which incorporate HIPAA premium payment schema for identification of managed care program enrollees, and preparation of the capitation premium payments.	
		Refer to business process write-up		
How easy is it to change premium payment algorithms?	This is a manual activity and requires strong testing/quality control effort to ensure changes are correct.	Business rules are automated on a State-specific basis.	The agency has the flexibility to easily change the criteria for rate cells using a User Interface.	
	Refer to business process write-up			
Business Capability Quality: Timeliness of Process				
How timely is the payment calculation process?	The calculation may require days at Level 1.	The calculation may be completed in hours at Level 2 due to increased automation.	Payments can be calculated within minutes.	
			Refer to business process write-up; errors require manual corrections.	
Business Capability Quality: Data Access and Accuracy				
How easy is it to access data needed for this process and how accurate is the data?	Capitation payments may be treated as FFS claims that access Provider and Member data stores. Monthly prepayment cycle can be out of synch with member and provider information.	Automated synchronization of Provider and Member data stores improves access to and accuracy of data over Level 1.	Using MITA standard interface to Provider and Member stores improves access to and accuracy of data over Level 2.	
		Refer to business process write-up		
Business Capability Quality: Cost-Effectiveness				



What is the ratio of the cost to support this process to the benefits it produces?	Manual intervention is required to manage adjustments and reconciliations.	Automation improves productivity and focus shifts to oversight and quality control of this process.	Automation and MITA standard interface further improves this process and frees staff to focus on oversight and quality control.	
	Refer to business process write-up			
Business Capability Quality: Effort to Perform; Efficiency				
How efficient is this process?	Data sets are maintained manually. Manual intervention reduces efficiency.	Automation increases efficiency. Data sets are generated automatically through the internal assignment process.	Automation and MITA standard interface further improves this process over Level 2.	
		Refer to business process write-up		
Business Capability Quality: Accuracy of Process Results				
How accurate are the results of this process?	Manual processes may result in errors requiring manual intervention.	Automation and improved access to data reduces errors and improves accuracy of the process.	Automation and use of MITA standard interfaces improves accuracy to 95% or better.	
		Refer to business process write-up		
Business Capability Quality: Utility or Value to Stakeholders				
How satisfied are the stakeholders?	Stakeholder satisfaction is relatively low due to error rate of Level 1 process.	Satisfaction has improved over Level 1 because errors are infrequent.	Satisfaction has improved over Level 2 because errors are rare.	
	Have not conducted a stakeholder satisfaction survey			

Prepare Health Insurance Premium Payment



Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions				
Is the process manual or automated?	Premium payments are manually generated.	Premium payments are automated utilizing HIPAA standard transactions.	MITA standards are implemented for automated health insurance premium payments.	
	Refer to business process write-up			
Are data and format standardized?	Non-standard data is used to generate premium payment.	The Medicaid enterprise implements HIPAA-compliant standards for electronic premium payments.	The process utilizes national MITA standards for its interfaces and for processing.	
	Refer to business process write-up			
Business Capability Quality: Timeliness of Process				
What Is the Timeliness of End to End Process?	The process requires more than 30 days.	The process requires less time than at Level 1.	The process requires less than 24 hours to complete.	
	Refer to business process write-up			
Business Capability Quality: Data Access and Accuracy				
Is the data necessary to the process accessible?	Access to data is controlled manually. Data access may take several days.	Access to data may be a mix of manual and automated processes. Data access takes less time than required at level 1.	The process is fully automated and data access is immediate via MITA standard interfaces	
	Refer to business process write-up			
How accurate are the data used in the process?	Manual operation results in subjective selection of data to be used. Accuracy is negatively impacted due to manual process.	Accuracy and consistency of data used meets State expectations. Accuracy is greater than at level 1.	Use of MITA standardized interfaces and data definitions ensures accuracy of data. Data accuracy is higher than at level 2.	
	Refer to business process write-up			
Business Capability Quality: Cost-Effectiveness				



What is the ratio of the cost of this process to the benefit of its results?	The process meets State budget guidelines. Manual processes negatively impact cost effectiveness.	Improved data quality and automation improve cost effectiveness over Level 1.	The process demonstrates Return on Investment projected by the Medicaid enterprise.	
	Have not conducted cost-benefit analysis			
Business Capability Quality: Effort to Perform; Efficiency				
How efficient is this End to End process?	Manual processing, lack of coordination with other processes, duplicative work, and lack of standards results in many opportunities to create or improve efficiency.	Increased automation, coordination with other processes, and introduction of standards reduce duplicative work and creates more efficiency.	Introduction of MITA standards and reusable services creates even greater efficiency.	
	Refer to business process write-up			
Business Capability Quality: Accuracy of Process Results				
How accurate are the results of this process?	Accuracy is negatively impacted due to manual processes.	Automation improves accuracy of results over Level 1.	Use of MITA standard interfaces improves accuracy of results to over 98%.	
	Refer to business process write-up			
Business Capability Quality: Utility or Value to Stakeholders				



How satisfied are the stakeholders?	Stakeholder satisfaction is low, with few resources dedicated to improvement and few measurements in place, e.g. reliance on complaints, legal mandates for action regarding improving stakeholder satisfaction.	States begin to identify gaps in levels of satisfaction and stakeholder expectations and priorities. Improvements are made strategically, increasing stakeholder satisfaction over Level 1.	Medicaid Enterprise conducts internal and external audits/focus groups which take into consideration the results of its previous research along with other national standards to identify additional stakeholder expectations and priorities. Improvements are made based on national and MITA best practices, improving stakeholder satisfaction over Level 2.	
	Have not conducted a stakeholder satisfaction survey			

Prepare Medicare Premium Payment				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions				
Is the process manual or automated?	Some information is exchanged using electronic communication but verification of members meeting the criteria is manual.	Agencies use automated and manual business rules to improve identification of buy-in candidates, prepare the premium payment calculation, and track the data exchange.	The process is fully automated. The agency has the flexibility to easily change the criteria for identification of buy-in candidates.	
		Refer to business process write-up		



What is the mechanism for data exchange between process stakeholders?	The agency exchanges information via tape with the SSA using electronic communication standards specified by SSA.	The agency exchanges information with SSA via electronic interfaces based on HIPAA standards.	Medicaid agencies and CMS use a MITA standard interface for the premium payment.	
		Refer to business process write-up		
Business Capability Quality: Timeliness of Process				
What Is the Timeliness of End to End Process?	The process requires 1 month to complete.	The process requires fewer than 10 days to complete.	The process requires less than 24 hours to complete.	
	Refer to business process write-up			
Business Capability Quality: Data Access and Accuracy				
Is the data necessary to the process accessible?	Access to data is controlled manually. Data access may take 1 day or more.	Access to data is a mix of manual and automated processes. Data access may take up to 4 hours.	The process is fully automated and data access is immediate.	
		Refer to business process write-up		
How accurate are the data used in the process?	Manual operation results in subjective selection of data to be used negatively impacting accuracy.	Accuracy and consistency is higher than Level 1 due to increased automation.	Use of MITA standardized interfaces and data definitions ensures accuracy of data. Data accuracy is measured at 98% or better.	
		Refer to business process write-up		
Business Capability Quality: Cost-Effectiveness				
What is the ratio of the cost of this process to the benefit of its results?	Manual processes may not be measured/analyzed for cost effectiveness.	The Medicaid enterprise considers cost effectiveness when making improvements.	The process demonstrates the improvement value projected by the Medicaid enterprise.	
	Have not conducted a cost-benefit analysis			
Business Capability Quality: Effort to Perform; Efficiency				



How efficient is this End to End process?	Manual processing, lack of coordination with other processes, duplicative work, and lack of standards results in many opportunities to create or improve efficiency.	Increased automation, coordination with other processes, and introduction of standards reduce duplicative work and creates more efficiency.	Introduction of MITA standards and reusable services creates even greater efficiency.	
		Refer to business process write-up		
Business Capability Quality: Accuracy of Process Results				
How accurate are the results of this process?	Accuracy is negatively impacted due to manual processes.	Automation improves accuracy of process results over Level 1.	The process produces acceptable results 98% of the time.	
		Refer to business process write-up		
Business Capability Quality: Utility or Value to Stakeholders				
How satisfied are the stakeholders?	Stakeholder satisfaction may not be measured.	States begin to identify gaps in levels of satisfaction and stakeholder expectations and priorities. Improvements are made strategically, increasing stakeholder satisfaction over Level 1.	Medicaid Enterprise conducts internal and external audits and takes into consideration stakeholder expectations and priorities, improving stakeholder satisfaction over Level 2.	
	Have not conducted a stakeholder satisfaction survey			

Inquire Payment Status				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions				
This Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				



Is the process manual or automated?	The claim status inquiry process is primarily a manual process and is associated with a specific claim document.	Programs employ a mix of automated and manual mechanisms: Automated Voice Response systems, legacy direct data entry, web enabled direct data entry, point of service devices for electronic claim status responses, and submission of HIPAA X12 transactions.	All programs use a centralized automated electronic claim status process based on MITA standard interface. This business process is implemented as a business service.	
		See Inquire Payment Status Draft		
What parameters limit searches?	Search may be based on the claim ICN, date of service, or patient name	Search parameters are expanded and some mechanisms utilize HIPAA X12 transaction standards.	Search parameters adhere to MITA interface standards and allow from broad to very specific search criteria.	
		See Inquire Payment Status Draft		
How is the data requested/relayed?	Providers inquire about the current adjudication status of a claim by phone, fax, or mail and Staff responds by the same medium.	Providers inquire and receive responses via a mix of automated and manual processes. HIPAA X12 inquiry standard is adopted.	Providers use the latest HIPAA X12 inquiry format. The process uses the MITA standard interface.	
		See Inquire Payment Status Draft		
How is information accessed in order to perform the response?	Staff performs search on the payment information for claims in process or the payment information repository for claims that have been adjudicated.	Information is automatically accessed, rules are applied, answer is prepared for response.	The MITA Inquire Payment Status business service workflow manages the information access process.	
		See Inquire Payment Status Draft; some staff still perform manual searches.		
How integrated is the process?	Depending on the type of claim, providers must contact different portions of the organization (e.g. provider call center, pharmacy call center, waiver programs).	The agency begins to centralize the process providing a more centralized point of access for all types of claims.	The MITA standard interface is used by collaborating agencies, offering a single point of contact for the provider.	



	See Inquire Payment Status Draft.			
Business Capability Quality: Timeliness of Process				
What Is the Timeliness of End to End Process?	The manual process is time consuming for providers and resource intensive for agency. The process is completed in 2 days.	The process is completed in 1 day or less.	Most inquiries and responses are processed immediately.	
		See Inquire Payment Status Draft.		
Business Capability Quality: Data Access and Accuracy				
Are data and format standardized?	Data is not standardized and content and format may vary by data source.	Internal and HIPAA X12 data standards are introduced.	MITA data standards are used for this business service in addition to the latest X12 data standards.	
		See Inquire Payment Status Draft.		
Can the data be accessed easily?	Accessibility is limited by business hours and legacy process cycles.	Centralization improves accessibility for both staff and providers. Some mechanisms available close to 24x7.	Access is 24x7, and is completely automated for the provider.	
		See Inquire Payment Status Draft.		
Business Capability Quality: Cost-Effectiveness				
What is the ratio of the cost of this process to the benefit of its results?	High cost needed to support and meet response goals.	Moderate cost meeting increased response goals.	Fully automated process is used. Only exceptions are reviewed.	
		See Inquire Payment Status Draft.		
Business Capability Quality: Effort to Perform; Efficiency				



How efficient is this End to End process?	Manual process takes many working days.	Increased automation with some manual processing existing, resulting in fewer working days to complete.	The process is fully automated and takes place in real-time.	
		See Inquire Payment Status Draft.		
Business Capability Quality: Accuracy of Process Results				
How satisfactory are the results of the process?	Application of business rules is consistent the majority of the time.	Application of business rules improves over Level 1.	Application of business rules is consistent 99% of the time.	
		See Inquire Payment Status Draft.		
Business Capability Quality: Utility or Value to Stakeholders				
How satisfied are the stakeholders?	Satisfaction is rated low due to limited accessibility and response turn-around time.	Satisfaction improves over Level 1 due to automation, easier access, and improvements in response time.	Satisfaction improves over Level 2 as a correlation with the automation of the process and MITA standard data and interfaces. Satisfaction is rated at 95% or higher.	
		See Inquire Payment Status Draft.		

Manage Payment Information				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions				
This Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				



How well does the process meet State and Federal statutes?	At this level, the Manage Payment Information business process is focused primarily on meeting traditional FFS program needs as reflected in MMIS certification requirements such as SURS and MARS reporting.	At this level, the Manage Payment Information business process is more responsive to meeting the needs of managed care and waiver programs.	At this level, the Manage Payment Information business process is now an enterprise resource that provides real time access to quality, complete and semantically interoperable data via record locator services that federate all programs' payment information. It is implemented as a business service using the MITA standard interface.	
	Refer to business process write-up			
What is the level of automation?	The process is rigidly tied to legacy technology governing maintenance of data stores.	Data sources are primarily electronic interchange such as EDI, POS and Web portals, and now include electronic encounter, managed care and Medicare premium, COB, TPL, waiver program and member payment data.	The process is fully automated as a MITA business service, using MITA standard interfaces.	
		Refer to business process write-up and Manage Program Information draft		
How integrated is the process?	Encounter, other agency, and waiver program payment data are stored in different places, separately from Medicaid payment data.	Although the internal data must be mapped to these different data sources, the ability to compare data across programs has improved, broadening the usefulness of payment history, e.g., program and provider performance monitoring.	All payment history data, including that not required to meet HIPAA, such as member payments, are stored internally in accordance with a standards-based UML data model that improves comparability across programs.	
		Refer to business process write-up and Manage Program Information draft		



What is the source of the data?	The source of the data is a mix of manual updates, data entry, Optical Character Recognition (OCR), and proprietary EDI processed by the Edit, Audit, and Payment business processes.	Data sources are increasingly HIPAA 837 claims. Encounter and waiver program payment history data is a mix of HIPAA compliant and proprietary.	Claims attachments are compliant with the X12 275; Premium payment data is compliant with the HIPAA 834, in addition to MITA standard interface.	
	Refer to business process write-up; see Enter Claim and fiscal-related processes			
Are data and format standardized?	Data is non-standardized and varies by siloed programs. As a result, output data used for reporting lacks comparability.	Agencies begin centralizing and coordinating payment processes and standardizing internal payment history data.	All programs use HIPAA 837 data for claims history records, including COB and encounter data, in addition to MITA standard interface.	
	Refer to business process write-up			
Business Capability Quality: Timeliness of Process				
What Is the Timeliness of End to End Process?	Payment data is not captured timely because batch updates are scheduled around legacy system production cycles, OCR and data entry of paper claims, and the manual nature of claim resolution within the adjudication process.	Adjudication process automation improves timeliness of compiling payment history. However, with the exception of Pharmacy POS, payment history updates continues to be scheduled around legacy system production cycles.	Electronic claims are processed in real time; and automation of most adjudication and premium processes, including the processing of structured data within claims attachment markedly improves the availability, quality, completeness and timeliness of payment data.	
		Refer to business process write-up		
Business Capability Quality: Data Access and Accuracy				



Can the data be accessed easily?	Data availability is limited by siloed systems reporting capabilities. Using payment data for profiling members, providers, program analysis, or outcome measures requires costly and untimely statistical manipulation.	Rudimentary decision support, reporting and analysis tools, and data mart capabilities improve users ability to reliably and cost effectively access the payment history they require for purposes beyond compliance with MMIS certification requirements.	Decision support and sophisticated analytic tools enable users to compile member, provider, service or condition specific profiles and perform complex ad hoc analysis and reporting in real time Data accuracy is measured as 98% of total data stored and 98% of occurrences of data accessed.	
		Refer to business process write-up and Manage Program Information draft		
Business Capability Quality: Cost-Effectiveness				
What is the ratio of the cost of this process to the benefit of its results?	Cost of processes needed to support and meet payment information needs of the enterprise is relatively high.	Cost of meeting payment information needs of the enterprise improves over Level 1.	Cost of meeting payment information needs of the enterprise improves over Level 2.	
	Have not conducted a cost-benefit analysis			
Business Capability Quality: Effort to Perform; Efficiency				
How efficient is this End to End process?	Manual workflow yields relatively low level of efficiency.	Standardization of data and increased automation reduces the time it takes to update or access data, improving efficiency.	Updates and access to data are immediate, further improving efficiency over Level 2.	
	Refer to business process write-up and Manage Program Information draft			
Business Capability Quality: Accuracy of Process Results				



What is the accuracy of the results of the process?	Application of business rules may be inconsistent due to manual processes, leading to relatively low quality of results.	Automated application of business rules leads to improved consistency over Level 1 and higher quality of process results over Level 1.	Use of MITA standard interfaces yields improved quality of process results. Application of business rules is consistent 99% of the time.	
	Refer to business process write-up and Manage Program Information draft			
Business Capability Quality: Utility or Value to Stakeholders				
What is the level of stakeholder satisfaction?	Inconsistent results and manual processes lead to relatively low stakeholder satisfaction.	Improved results and processes lead to higher satisfaction than at Level 1.	Use of MITA standard processes leads to stakeholder satisfaction of 95% or higher.	
	Have not conducted a stakeholder satisfaction survey			

Manage Drug Rebate				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions				
This Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				
Is the process manual or automated?	At this level, the Manage Drug Rebate business process is primarily a manual paper based invoice process.	At this level, the Manage Drug Rebate business process uses electronic interchange and automated processes; for example, information from legacy processes support the generation of rebate information.	At this level, the Manage Drug Rebate business process is automated as a MITA business service using the MITA interface standard. If manufacturer payment is equal the invoice, then automation is possible. If there are any discrepancies manual intervention may be necessary.	
	Refer to business process			



	write-up			
How integrated is the process?	Programs are siloed so rebate process may be uncoordinated, e.g., mental health, waiver, and shared programs with health departments pay for drugs but may not participate in the Medicaid drug rebate program.	Data from siloed programs are pooled as inputs to the drug rebate process thus centralizing the process to increase coordination.	The drug rebate process is fully centralized and the use of MITA standard interfaces support integration and interoperability for all programs that pay for drugs.	
		Refer to business process write-up		
Business Capability Quality: Timeliness of Process				
What Is the Timeliness of End to End Process?	Reporting, analysis, and responses to pharmaceutical companies and CMS inquiries are largely a manual process. The manual generation of invoices relies on paper based claim files for the necessary information.	Centralization of data and automation of much of the process has improved the time to execute the end to end process. Improvements in CMS processes allow more timely completion of this process by the States.	Communications are consistent, timely and appropriate. Invoices may be posted on WEB portals for pharmaceutical company retrieval; data files may be electronically transmitted.	
		Refer to business process write-up		
Business Capability Quality: Data Access and Accuracy				
Are data and format standardized?	CMS mandated hardcopy formats and electronic data files are used for Medicaid drug rebate program.	Agencies are centralizing drug utilization data from siloed programs as inputs to the drug rebate process. Application data are standardized within the agency.	The Agency supports data and technology integration and interoperability Application data are standardized using MITA interface and data content specifications across multiple programs.	
		Refer to business process write-up		



How accurate are the data?	The data used for reporting, analysis, and responses to pharmaceutical companies and CMS inquiries contains some inaccuracies.	Centralization and increased automation improves access and accuracy. Data accuracy is improved over Level 1.	The use of MITA data standards results in few inaccuracies. Data accuracy is measured as 98% of total data required for invoicing and backup documentation.	
		Refer to business process write-up		
Can the data be accessed easily?	Access to data is limited by siloed legacy systems.	Centralization creates a single source for drug utilization data, removing the need to access multiple data sources.	Data is standardized for automated electronic interchanges (interfaces) between agencies and drug manufacturers.	
		Refer to business process write-up		
Business Capability Quality: Cost-Effectiveness				
What is the ratio of the cost of this process to the benefit of its results?	Cost-effectiveness is impacted by lack of data standards, accuracy and completeness (missing data from siloed programs), manual processing, and need for CMS quarterly reporting of rebate information Relatively high cost of process needed to support and meet rebate level goals.	Centralization of drug utilization data from siloed programs and increased automation lower resource requirements, achieve economies of scale, and increase rebates. Process costs lower than at level 1.	Automation and use of MITA data standards and standard interfaces increase cost effectiveness and allows staff to focus on exceptions and process improvement. Support for the automated process further reduces costs from Level 2.	
	Have not conducted a cost-benefit analysis			
Business Capability Quality: Effort to Perform; Efficiency				



How efficient is this End to End process?	Non-standardized data and format makes any type of cross program management reporting and analysis for drug rebate purposes difficult and costly. Manual processing is relatively inefficient.	Data standards and increased automation improve efficiency through better access to data and increased rebates. Increased automation improves efficiency over Level 1.	Automation reduces manual involvement to handling exceptions. Staff is focused on resolving disputes. Automation improves efficiency over Level 2.	
	Refer to business process write-up			
Business Capability Quality: Accuracy of Process Results				
How satisfactory are the results of the process?	Lack of data standards, accuracy and completeness and manual processing contribute to inconsistencies in business rule application.	Centralization of drug utilization data from siloed programs and increased automation improve the consistency of business rule application.	Automation and use of MITA data standards and standard interfaces results in consistent application of business rules 99% of the time.	
		Refer to business process write-up; Data is centralized.		
Business Capability Quality: Utility or Value to Stakeholders				
What is the level of satisfaction of stakeholders?	Satisfaction is low due to manual processes required, lack of standardized data and poor data accuracy.	Better than Level 1 due to automation of the process, use of standards and improved data accuracy.	Stakeholder and CMS satisfaction increases to 80% or better as a correlation with the consistent application of business rules and MITA standard data and interfaces.	
	Have not conducted a satisfaction survey			

Manage Estate Recovery				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions				



This Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.

Is the process manual or automated?	At this level the Manage Estate Recovery business process is a manual paper based process. Non-standardized data and format from multiple sources requires manual compilation of data.	At this level, the Manage Estate Recovery business process uses electronic interchange and automated steps, for example, receiving data from Community or County Offices, date of death matches, probate petition notices and reports of death from nursing homes.	At this level, the Manage Estate Recovery business process has automated most activities in the workflow.	
	Reference Manage Estate Recovery ps; some electronic interchange			
What is the medium of communication with stakeholders involved in the recovery?	Communications to stakeholders and members' personal representatives are accomplished via phone, fax, e-mail and mail.	Communication to stakeholders and members personal representatives is a mix of phone, fax, and mail, plus the use of e-mail and electronic interchange for exchange of larger or standardized sets of data.	Communications to stakeholders are primarily electronic, paper becomes the exception.	
	Reference Manage Estate Recovery ps			



How integrated is the process?	There is little coordination with other entities that are data sources. Data is not standardized and is often paper based.	Agencies are standardizing data to increase coordination and consistency. Other stakeholders, including families, attorneys, funeral homes, and others, will be encouraged to use standard data elements. This improves the ability to complete recovery and allows application to application updates (e.g., automated updates of the Member Information and Payment Information data stores.)	MITA standard interfaces are used for electronic interchanges (interfaces) between agencies and other entities that are sources of information. MITA data standards have enabled complete application to application integration.	
	Reference Manage Estate Recovery ps			
Business Capability Quality: Timeliness of Process				
What Is the Timeliness of End to End Process? Note: due to the variables involved in estate recovery (wills, lawsuits, claims and other procedural steps inherent in the probate process) it is difficult to estimate the end to end timeline.	Manual communications and processing are not timely. Generating correspondence, e.g., demand of notice to probate court to members' personal representatives and notices of intent to file claim, are not timely.	At this level, the Manage Estate Recovery business process uses electronic interchange and automated steps which improves timeliness for stakeholders involved in the process. Agencies are standardizing data to increase coordination and consistency, therefore improving the timeliness.	Communications to stakeholders and members' personal representatives are timely. Application to application integration reduces manual processing to exceptions.	
	Reference Manage Estate Recovery ps; Central agency is timely			
Business Capability Quality: Data Access and Accuracy				



Are data and format standardized?	At this level the Manage Estate Recovery business process is supported by proprietary EDI and non-standardized data and format from multiple sources.	Agencies are standardizing data. Some data will remain non-standard e.g., real estate appraisals, financial statements, valuation of personal property.	MITA standard interfaces are used for electronic interchanges (interfaces) between agencies.	
	Reference Manage Estate Recovery ps			
How accurate is the information available to the process?	There is lack of data accuracy and completeness. Necessary records at the county and local level are difficult to find and are often not available.	Internal standardization of data, use of data exchange standards, and increased use of automation reduces inaccuracies.	Implementation of MITA data standards and interfaces and automation of the steps to the extent feasible greatly reduces inaccuracies. Data accuracy is measured as 90% of total data collected for recovery case files.	
	Reference Manage Estate Recovery ps			
Is the data necessary to the process accessible?	Access to data is limited by the sporadic, inconsistent, and untimely receipt of data and updates to Member Information and Payment Information, as well as requests for data from external entities. Multiple data sources must be accessed.	Agencies are standardizing data. Multiple data sources must still be accessed.	MITA data standards allow automation of routine access to estate recovery information. Exceptions can be researched via real-time access to data via MITA standard interfaces.	
	Reference Manage Estate Recovery ps			
Business Capability Quality: Cost-Effectiveness				



What is the ratio of the cost of this process to the benefit of its results?	Cost effectiveness is impacted by lack of data accuracy and completeness, and manual processing. High cost of process needed to support and meet recoupment goals.	Agencies are standardizing data to increase coordination and consistency, therefore allowing automation of some steps and ensuring recovery is completed. Moderate cost of meeting increased recoupment goals.	At this level, the Manage Estate Recovery business process has almost eliminated its use of non-electronic interchange and has automated most steps to the extent feasible. <i>Lower cost to support a more automated process.</i>	
	Program area says process is not cost-effective compared to other states.			
Business Capability Quality: Effort to Perform; Efficiency				
How efficient is this End to End process?	Manual processing results in relatively low efficiency.	Increased automation improves efficiency over Level 1.	Use of MITA standard interfaces improves efficiency over Level 2.	
	Reference Manage Estate Recovery ps			
Business Capability Quality: Accuracy of Process Results				
How accurate are the results of the process?	Lack of data accuracy, completeness, and manual processing adversely affects the accuracy and amount of recovery.	Use of electronic interchange and automated steps increases coordination and improves consistency and access for stakeholders involved in the process. Standardization of data increases consistency, enhancing data usefulness for determining the value of estate liens and improving the accuracy of the case follow-up, ensuring recovery is completed and Member Information and Payment Information data stores are updated timely.	The process has almost eliminated its use of non-electronic interchange and has automated most steps to the extent feasible reducing inaccuracies and improving accuracy of results. Communications to stakeholders and members personal representatives are consistent and appropriate. Application of business rules is consistent 99% of the time.	



	Reference Manage Estate Recovery ps			
Business Capability Quality: Utility or Value to Stakeholders				
What is the level of satisfaction of stakeholders?	Lack of data accuracy and completeness and, manual processing adversely affects the accuracy and amount of recovery resulting in relatively low satisfaction with the process.	The use of electronic interchange and automated processes, increases coordination, improves access, timeliness and consistency. Stakeholder satisfaction is higher than at Level 1.	By minimizing the use of non-electronic interchange and automating most steps, exchanges with members' personal representatives are consistent and appropriate. Resulting in a process effectiveness that maximizes estate recoveries. This results in stakeholder satisfaction rating of 80% or higher.	
	We have not conducted a satisfaction survey.			

Manage Cost Settlement				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions				
This Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				



How integrated is the process?	There is no coordination among programs and between the agency and other intermediaries that produce the Medicare Cost Report.	The Medicaid enterprise is centralizing common processes to achieve economies of scale, increase coordination, and improve the consistency of rule application. This improves the ability to process cost settlements. Application-to-application updates are possible in some cases (e.g., automated updates of the Payment Information data store.)	MITA standard interfaces are used for electronic interchanges (interfaces) between agencies and other entities that are sources of information. MITA data standards have enabled complete application to application integration.	
	Refer to business process write-up; Some coordination occurs with certain provider types.			
Is the process manual or automated?	The process utilizes primarily paper based processing.	The process is a mix of manual and automated steps. There is some use of electronic interchange.	MITA standard interfaces are used for electronic interchanges and most activities in the workflow are automated.	
	Refer to business process write-up			
Are data and format standardized?	The process is non-standard (or State-specific.)	The Medicaid enterprise uses State-specific data standards to increase coordination and consistency and to increase its usefulness for performance monitoring, management reporting and analysis.	MITA data standards interfaces are used.	
	Refer to business process write-up			
Business Capability Quality: Timeliness of Process				



What is the timeliness of End to End process?	Manual communications (with providers and external data sources) and processing are not timely. The process requires 4 or more months per settlement.	Electronic interchange and automated steps improve timeliness for stakeholders involved in the process. Agencies are standardizing data to increase coordination and consistency, therefore improving the timeliness. The process requires 4 or fewer weeks per settlement.	Communications with providers are timely and electronic interchange minimizes time frames for receipt/exchange of data. Application to application integration reduces manual processing to exceptions. The process requires 10 or fewer days.	
	Refer to business process write-up			
Business Capability Quality: Data Access and Accuracy				
How accurate is the information available to the process?	Data consistency is relatively low due to the manually completed, paper-based documents.	Internal standardization of data, use of HIPAA data exchange standards, and increased use of automation reduces inconsistencies in data sources. Data accuracy is higher than found at level 1.	Implementation of MITA data standards and interfaces and automation reduces inaccuracies. Data accuracy is higher than found at level 2.	
	Refer to business process write-up			
Is the data necessary to the process accessible?	Access to data is limited by inconsistent and untimely receipt of data and updates to Provider Information and Payment Information. Multiple data sources must be accessed.	Agencies are standardizing data and use of HIPAA standard format for electronic interchanges simplifies data access. Multiple data sources must still be accessed.	MITA data standards allow automation of routine access to cost settlement information. Exceptions can be researched via real-time access to data via MITA interfaces.	
	Refer to business process write-up			
Business Capability Quality: Cost-Effectiveness				



What is the ratio of the cost of this process to the benefit of its results?	Cost effectiveness is impacted by lack of data accuracy, completeness, and consistency, and manual processing.	Agencies are standardizing data to increase coordination and consistency, therefore allowing automation of some steps and ensuring cost settlement is completed on time.	At this level, the Manage Cost Settlement business process has automated most steps to the extent feasible.	
	Refer to business process write-up. Length of time spent on cost reports negatively impacts cost.			
Business Capability Quality: Effort to Perform; Efficiency				
How efficient is this End to End process?	Manual processing, lack of coordination with other processes, duplicative work, and lack of standards adversely affect efficiency.	Increased automation, coordination with other processes, and introduction of standards reduce duplicative work and creates more efficiency.	Introduction of MITA standards and reusable services creates even greater efficiency.	
	Refer to business process write-up			
Business Capability Quality: Accuracy of Process Results				
How accurate are the results of the process?	Lack of data accuracy and completeness, lack of process integration, and manual processing adversely affects the accuracy and amount of cost settlement.	Process centralization, use of electronic interchange, standardization of data, and automated steps improves consistency and accuracy.	The process uses MITA standardized interfaces and has automated most steps improving accuracy of results. Communications to stakeholders, external data sources, and providers are accurate, consistent, and appropriate. Accuracy of process results are rated at 90% or higher.	
	Refer to business process write-up			
Business Capability Quality: Utility or Value to Stakeholders				



What is the level of satisfaction of stakeholders?	Lack of data accuracy, completeness, and manual processing adversely affects the accuracy and amount of cost settlement resulting in relatively low satisfaction with the process.	Electronic interchange and automated processes increases coordination and improves timeliness, consistency, and access. Satisfaction is higher than found at level 1.	By eliminating use of non-electronic interchange and automating most steps to the extent feasible staff can maximize their effectiveness in processing cost settlements and ensuring the exchanges with providers are consistent and appropriate.	
	Have not conducted a satisfaction survey			

Manage TPL Recovery				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions				
This Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				
Is the process manual or automated?	The process is primarily manual utilizing a mix of paper, phone, fax, and some proprietary EDI.	The process is a mix of manual and automated steps; the use of electronic interchange has been implemented where possible.	The process is mostly automated and uses MITA standard interfaces for payer-to-payer COB process reducing the burden to providers and optimizing timeliness.	
		Refer to business process write-up		
How is TPL information validated?	Information regarding third-party resources is manually validated.	Electronic data from other payers are used for data matches and validation of member TPL data.	MITA interface standards support completely automated validation of TPL data.	
		Refer to business process write-up		



How integrated is the process?	Programs are siloed so the recovery processes are uncoordinated.	Common processes have been centralized to achieve economies of scale and increase coordination.	The process is fully integrated within the agency with MITA standard interfaces used for electronic interchanges between agencies and other entities that are sources of TPL information. E.g., COB data is available via the RHIO (Regional Health Information Organization) or NHIN (National Health Information Network).	
		Refer to business process write-up		
Are data and format standardized?	The process uses non-standard data and formats.	The agency has implemented internal data standards and the format for electronic interchanges is HIPAA compliant.	MITA data and interface standard have been implemented.	
		Refer to business process write-up		
Between which stakeholders is COB carried out?	TPL recovery is accomplished primarily via payer-to-provider COB.	Some TPL recovery is payer-to-provider and the remaining is payer-to-payer COB.	TPL recovery is accomplished primarily via payer-to-payer COB. Communication is made available electronically to members and providers.	
	Refer to business process write-up; DHHS invoices providers, not other payers.			
What is the mechanism for data exchange between process stakeholders?	Communication with providers, members, and other payers is primarily manual utilizing a mix of mail, phone, and fax.	Communication with providers and other payers regarding TPL is automated based on automated claim submission via HIPAA compliant electronic interchanges.	MITA standard interfaces are used for electronic interchanges between agencies and other entities that are sources of TPL information.	
	Refer to business process write-up			
Business Capability Quality: Timeliness of Process				



What is the timeliness of the End to End process	Manual processing and communications to and from stakeholders are not timely. The timeliness of the process is measured in months.	Centralization of the process and the use of data standards, electronic interchange, and some automated steps improve timeliness. The timeliness of the process is measured in weeks.	Communications with stakeholders are timely and electronic interchange minimizes time frames for receipt/exchange of data. The timeliness of the process is measured in days.	
	Refer to business process write-up; Have many automated processes-- Invoicing providers occurs on a multi-quarter schedule.			
Business Capability Quality: Data Access and Accuracy				
How accurate is the information available to the process?	Data is non-standard, inconsistent, and untimely. Data accuracy is relatively low.	Internal standardization of data, use of HIPAA data exchange standards, and increased use of automation reduces inaccuracies. Data accuracy is higher than found at level 1.	Implementation of MITA data standards and interfaces, payer to payer data exchange, and automation of the workflow further reduces inaccuracies. Data accuracy is measured as 95% of total data collected for TPL recovery.	
		Refer to business process write-up		
Is the data necessary to the process accessible?	Access is limited by inter-agency, provider, and other payer legacy systems and incompatibility of data matches.	Agency use of HIPAA standard format for electronic interchanges simplifies data access. Multiple data sources must still be accessed.	MITA data standards allow automation of routine access to TPL information. Exceptions can be researched via real-time access to data via MITA interfaces.	
		Refer to business process write-up		



Business Capability Quality: Cost-Effectiveness

What is the ratio of the cost of this process to the benefit of its results?	Cost effectiveness is impacted by lack of data accuracy, completeness, and consistency, and by manual processing. High cost to support and meet TPL recovery goals.	Agencies standardize data to increase coordination and consistency, therefore allowing automation of some steps and ensuring cost settlement is completed. Moderate cost of meeting increased TPL recovery goals.	At this level, the Manage TPL Recovery business process has automated most steps to the extent feasible. States benefit from a uniform ROI calculation. <i>Low cost to support a more automated process.</i>	
		Refer to business process write-up		

Business Capability Quality: Effort to Perform; Efficiency

How efficient is this End to End process?	Manual processing, lack of coordination with other processes, duplicative work, and lack of standards results in many opportunities to create or improve efficiency.	Increased automation, coordination with other processes, and introduction of standards reduce duplicative work and creates more efficiency.	Introduction of MITA standards and reusable services creates even greater efficiency.	
		Refer to business process write-up		

Business Capability Quality: Accuracy of Process Results



How accurate are the results of the process?	Lack of data accuracy and completeness and process integration, and manual processing adversely affects the accuracy and amount of cost settlement. Inconsistency in the rules applied to TPL recoveries from agency to agency results in relatively low accuracy.	Process centralization, use of electronic interchange, standardization of data, and automated steps increases coordination, improves consistency, and simplifies data access ensuring TPL recoveries are completed successfully and Member and Payment Information data stores are accurately updated. The accuracy level is higher than found at level 1.	The process has almost eliminated its use of non-electronic interchange and has automated most steps to the extent feasible improving accuracy of results. Communications to stakeholders, external data sources, and providers are consistent and appropriate The accuracy level is higher than found at level 2. Application of business rules is consistent 99% of the time.	
		Refer to business process write-up		
Business Capability Quality: Utility or Value to Stakeholders				
What is the level of satisfaction of stakeholders?	Lack of data accuracy and completeness and manual processing adversely affects the accuracy, amount of TPL recovery, and the response turn-around time resulting in relatively low satisfaction with the process.	Electronic interchange and automated processes increase coordination and improve timeliness and consistency. Additionally, improved response turn-around time improves the ability to carry out the process. Satisfaction is higher than found at level 1.	By almost eliminating the use of non-electronic interchange and automating most steps, staff can maximize their effectiveness in processing TPL recoveries. Satisfaction is 90% or higher.	
	Have not conducted a satisfaction survey			



Perform Accounting Function				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions				
This Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				
Is this business process primarily manual or automated?	The accounting function is a mix of manual and automated activities using locally developed applications.	The accounting function uses a mix of manual processes and Commercial Off The Shelf (COTS) products.	Periodic reporting is highly automated.	
	See Perform Accounting Functions ps			
Does this business process use standards?	Complies with CFR 45, Cash Management Act, Governmental Accounting Standards Board (GASB) standards.	Complies with CFR 45, Cash Management Act, GASB standards and Generally Accepted Accounting Principles (GAAP) COTS packages are certified compliant with these standards.	Complies with CFR 45, Cash Management Act, GASB standards and GAAP. Uses MITA standard interface.	
		See Perform Accounting Functions ps; no COTS package but meets these principles.		
Does the Medicaid enterprise collaborate with other agencies or entities in performing this process?	Collaboration includes manual processes and is limited and ad hoc. Collaboration with other agencies is limited to the sharing of reporting results. The MMIS operational functions are shared across all Medicaid enterprise agencies.	Collaborative efforts are more structured and widespread and strategic in nature.	Collaboration is further improved by the use of data definitions and MITA standard interfaces.	
	Post-SAP will be Level 2			
Business Capability Quality: Timeliness of Process				



How timely is this end-to-end process?	The semi-automated process struggles to meet deadlines.	Less time is required than at Level 1. automated processes.	Less time is required than at Level 2. standard interface.	
		Process is timely, though manual		
Business Capability Quality: Data Access and Accuracy				
How accurate is the information used in this process?	Manual operation results in subjective selection of data to be used. Conflicts of data occur frequently. Validation is via locally developed applications. Error detection and correction is manual.	Accuracy and consistency of data used in the process are improved due to the use standards and increased automation.	Use of MITA standardized interfaces and data definitions ensures even greater improvement in the accuracy of data. Data is easily reconciled among various reports. Data accuracy is measured at 99%.	
	See Perform Accounting Functions ps			
How accessible is the information used in this process?	Access to data is controlled manually. Data access is limited and not readily shared with stakeholders.	The process uses on-line access to data. Real-time data access may be limited creating timeliness issues.	The process has real time access to standardized data.	
	Access is limited to Fiscal staff.			
Business Capability Quality: Cost Effectiveness				
What is the ratio of the cost to perform this process compared to the benefits of the results?	The process meets State budget guidelines. Cost benefit ratio may not be able to be calculated.	Through the use of automation and other process improvements, the cost benefit ratio improves.	The process demonstrates further improvement value desired by the Medicaid enterprise.	
	We have not conducted a cost benefit analysis.			
Business Capability Quality: Effort to Perform; Efficiency				
How efficient is this process?	The process relies primarily on staff to perform actions.	Automated processes results in higher efficiency.	Meets Medicaid enterprise goals for improvement in efficiency and complies with MITA conformance standard for this process.	



	See Perform Accounting Functions ps			
Business Capability Quality: Accuracy; Usefulness of Process Results				
How accurate are the results of this process?	The process meets minimal State and Federal expectations regarding accuracy of results.	Reduction in errors and improved consistency of results increase usefulness of the process.	Accuracy and consistency are further improved with use of MITA standard interface.	
	Unable to determine current accuracy level because of SAP implementation.			
Business Capability Quality: Utility or Value to Stakeholders				
How satisfied are the stakeholders?	Stakeholder satisfaction is low, with few resources dedicated to improvement and few measurements in place, e.g. reliance on complaints, legal mandates for action regarding improving stakeholder satisfaction.	States begin to identify gaps in levels of satisfaction and stakeholder expectations and priorities. Improvements are made strategically, increasing stakeholder satisfaction over Level 1.	Medicaid Enterprise conducts internal and external audits/focus groups which take into consideration the results of its previous research along with other national standards to identify additional stakeholder expectations and priorities. Improvements are made based on national and MITA best practices, improving stakeholder satisfaction over Level 2.	
	We have not conducted a stakeholder satisfaction survey.			

Manage Rate Setting				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions				



This Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.

Is this business process primarily manual or automated?	The process is primarily manual.	The process is a mix of manual and automated activities. Information is received from multiple sources.	The process is primarily automated. Messages are exchanged with trading partners to obtain information.	
	See Manage Rate Setting draft			
Does this business process use standards?	Standards are limited to the data standards enforced by the Medicaid enterprise.	Adoption of HIPAA standards improves standardization of data used for rate setting which supports comparability with other payers.	MITA standard interface ensures the comparability of data used for rate setting across entities accepting the standard.	
	See Manage Rate Setting draft			
Business Capability Quality: Timeliness of Process				
How timely is this end-to-end process?	The process meets State target dates for periodic updates to reimbursement rates.	Increased automation shortens the time required to complete rate setting functions, improving timeliness over Level 1.	Use of MITA standard interface and data standards further reduces time required for rate setting, improving timeliness over Level 2.	
	See Manage Rate Setting draft			
Business Capability Quality: Data Access and Accuracy				
How accurate is the information used in this process?	Manual operation results in subjective selection of data to be used.	Accuracy and consistency of data used in the process improves over Level 1 due to increased automation and HIPAA and other data standards.	Use of MITA standardized interfaces and data standards ensures accuracy of data. Data accuracy is measured as 99%.	
	See Manage Rate Setting draft			



How accessible is the information used in this process?	Access to data is controlled manually. Data is stored in multiple locations and different standards may apply.	Access to data improves over Level 1 due to increased automation and introduction of HIPAA and other data standards. The process uses on-line access to data.	The process utilizes MITA standards for its interfaces and for processing. The process has immediate access to standardized data.	
	See Manage Rate Setting draft; current rates are accessible in MMIS.			
Business Capability Quality: Cost Effectiveness				
What is the ratio of the cost to perform this process compared to the benefits of the results?	Manual processes and lack of standards negatively impact cost-effectiveness.	Automation and HIPAA and other data standards increase cost-effectiveness over Level 1.	The process demonstrates improvement value projected by the Medicaid enterprise. Use of data standards in researching and analyzing rate data results in development of appropriate rates using appropriate resources.	
	See Manage Rate Setting draft			
Business Capability Quality: Effort to Perform; Efficiency				
How efficient is this process?	Manual processes create inefficiencies.	Use of automation, HIPAA, and other data standards increase efficiency over Level 1.	Use of MITA standard data improves comparability of data used in the setting of rates. Automation allows staff to focus on strategic aspects of rate setting and Medicaid enterprise policy regarding rates.	
	See Manage Rate Setting draft			
Business Capability Quality: Accuracy; Usefulness of Process Results				



How accurate are the results of this process?	Manual inputs into system and payment rates are manually validated resulting in potential inconsistency or invalid rates.	Improvements in the rate setting process, including automation, results in more accurate rates that encourage provider participation while helping to maintain cost controls.	Use of MITA standards improves ability to compare information used in rate setting with other data which in turn further improves the appropriateness of State rates.	
	See Manage Rate Setting draft			
Business Capability Quality: Utility or Value to Stakeholders				
How satisfied are the stakeholders?	Stakeholder satisfaction is low, with few resources dedicated to improvement and few measurements in place, e.g. reliance on complaints, legal mandates for action regarding improving stakeholder satisfaction.	States begin to identify gaps in levels of satisfaction and stakeholder expectations and priorities. Improvements are made strategically, increasing stakeholder satisfaction over Level 1.	Medicaid Enterprise conducts internal and external audits/focus groups which take into consideration the results of its previous research along with other national standards to identify additional stakeholder expectations and priorities. Improvements are made based on national and MITA best practices, improving stakeholder satisfaction over Level 2.	
	Satisfaction is low.			

Formulate Budget				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions				
This Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				



How manual or automated is this business process?	The process is a mix of manual and automated processes to gather financial data. State-specific applications are used for expenditure forecasting calculations, budget models, and forecasting projections.	This is an automated process supported by Commercial off the shelf (COTS) predictive modeling and expenditure forecasting tools that may be implemented in the decision support system (DSS).	State has implemented use of automated COTS forecasting packages that comply with MITA standard interfaces.	
	See Formulate Budget draft			
What standards are used by this process?	The process meets all state and federal requirements for budget development. There are no specific standards.	Medicaid enterprise has selected COTS tools that impose internal standards.	MITA standard interfaces are used in the budget development process.	
	See Formulate Budget draft			
Is collaboration with other agencies or entities used by this process?	Collaboration is limited to a manual effort to gather information from other entities that have input to the budget.	Medicaid enterprise utilizes some collaboration with stakeholders and other agencies to develop an enterprise-wide budget.	Collaboration improves as other agencies and entities adopt MITA standard interface for updating the budget.	
	See Formulate Budget draft			
Are data and format standardized?	Data is entered in standard formats from multiple sources.	The process is supported by standard financial COTS offering more automation and standardization than Level 1. Data maintained in the data warehouse is accessed with DSS tools meets local standards.	Process uses the MITA standard interface.	
	Data is not in standard formats. See Formulate Budget draft.			
How are data used in this process verified?	The process is primarily a manual effort to gather and verify financial information and cost projections.	The process is a mixture of automation and manual intervention to gather and verify financial information and cost projections.	Adherence to MITA standard interface specifications ensures accuracy of data.	



	See Formulate Budget draft			
Business Capability Quality: Timeliness of Process				
How timely is this end-to-end process?	This business process is required to meet federal and State requirements to occur annually with quarterly updates. Preparation of quarterly updates can require up to three months.	Monitoring and updates to the budget occur daily. Automation improves timeliness of updates over Level 1.	Automation and use of MITA standard interface improves timeliness of updates over Level 2.	
	This is an annual process that requires several months.			
Business Capability Quality: Data Access and Accuracy				
How accurate is the information used in this process?	The information is based on financial cost data and cost estimates with standard inflation factor projection for future. Meets State requirements for accuracy.	The information is gathered from financial cost data and from the DSS. Automation of data capture and availability of predictive modeling and forecasting tools improves accuracy.	Use of MITA standard interface further improves accuracy of information; data accuracy is measured at 98%. Information can be shared with other agencies and States that adhere to MITA standards.	
	See Formulate Budget draft			
How accessible is the information used in this process?	The information is stored within Medicaid enterprise business units and is manually gathered and entered. Personnel information is stored within a human resources system; equipment within IT records, and supplies data within purchasing records.	Benefit information is stored within the MMIS and the state accounting system. Other operating expenses are stored in the state accounting system. More automation improves ability to access budget information.	Greater automation and use of MITA standard interface further improves accessibility to information.	
	No budget data is housed in MMIS.			
Business Capability Quality: Accuracy; Usefulness of Process Results				



How useful or accurate are the results of this process?	This business process is a mix of manual and automated activities and is dependent upon accuracy of data extracted from systems and accuracy of formulas within spreadsheet	Increased automation improves accuracy of data extracted from systems and accuracy of predictive modeling and forecasting tools.	Results improve over Level 2 with the use of MITA standard interface. Accuracy is measured at 98% or better.	
	See Formulate Budget draft			
Business Capability Quality: Utility or Value to Stakeholders				
How satisfied are the stakeholders?	Use of financial spreadsheet and automated processes for calculating and forecasting meets State goals for timeliness and accuracy of budget outcome. Satisfaction is negatively impacted by the number of manual processes.	Standardized COTS predictive modeling and forecasting tools for calculating and forecasting improves timeliness and accuracy of budget outcome and improves the ability of staff to carry out process. Satisfaction is higher than at Level 1.	Use of MITA standard interfaces and COTS that use the MITA data standards further increases stakeholder satisfaction with the process. Satisfaction is higher than at level 2.	
	See Formulate Budget draft			

Manage FFP for MMIS				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions				
This Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				



How manual or automated is this business process?	This process relies on significant manual collection and handling of data obtained from various sources. Sources of data contain details of expenditures for the Design, Development and Installation (DDI) or operation of the MMIS. Sources include Human Resources, data center, and accounts payable.	The State Medicaid enterprise has implemented increased automation in the storage and retrieval of data regarding costs for DDI or operation of the MMIS and preparation of the data needed to request Federal Funding Participation (FFP) or write and Advance Planning Document (APD).	At this level, the Medicaid enterprise has automated most activities to the extent feasible and uses MITA standard interfaces.	
		See Manage FFP for MMIS draft; data stored in GAFRS.		
What standards are used by this business process?	State uses local standards for accessing and extracting data. Much of the information is non-standard.	State has implemented standard methodologies to enable organized development and management of FFP reporting requirements.	The process uses MITA standard interface for extracting data and producing results.	
		See Manage FFP for MMIS draft		
Is collaboration with other agencies or entities used by this process?	The Medicaid agency is a siloed organization and must request information individually from other agencies or external entities.	Agencies have a Memorandum of Understanding (MOU) governing requests for information. Data is standardized per State specifications to better collaborate with other agencies and external entities.	Other agencies and external entities agree to accept MITA standard interfaces, which further support collaboration.	
	We are a siloed state. We are unclear as to how this relates to this bp.			



How adaptable is this process to change?	The process relies heavily on manual manipulation of information and does not adapt easily to change in reporting requirements.	The Medicaid enterprise has introduced automation and standardization and is able to handle some changes via flexible table updates.	Programs are agile and able to adjust business rules quickly in response to Medicaid changes and when output monitoring indicates that the business rules are no longer yielding desired results.	
	See Manage FFP for MMIS draft; changes are manual.			
Business Capability Quality: Timeliness of Process				
How timely is this end-to-end process?	Timeliness of responses to inquiries and data reporting is indeterminate. It takes several weeks to extract and manipulate data to produce standard reports requesting FFP for MMIS (e.g., CMS 64) or for APD.	The Medicaid enterprise has implemented centralization and standardization of the information needed to manage computation of the FFP for MMIS. Process requires less time than Level 1.	Use of MITA standard interfaces streamlines access to data and computations needed to produce data for reporting of FFP for MMIS. Produces useful output in 8 hours or less.	
		See Draw and Report FFP draft		
Business Capability Quality: Data Access and Accuracy				
How accurate is the information used in this process?	The manage FFP business process is a manual process that can lead to inaccuracies in data.	Data centralization and standardization provide more accurate information to manage the reporting of FFP for MMIS.	Data centralization and standardization is in place providing more fully automated and accurate information to manage the reporting of FFP for MMIS. Accuracy is measured at 98% or better.	
		See Draw and Report FFP draft		



How accessible is the information used in this process?	The process is a cyclical process that requires multiple efforts to access information from many sources.	The data centralization and standardization of the information for determining FFP is more accessible.	Data centralization and use of MITA standard interface improves access to data needed to determine the FFP for MMIS.	
		See Manage FFP for MMIS draft		
Business Capability Quality: Cost Effectiveness				
What is the ratio of the cost to perform this process compared to the benefits of the results?	The manual nature of the process is time consuming and requires multiple iterations for documenting the FFP for MMIS.	The centralization and standardization of the information and automation of access reduce the effort of documenting the FFP for MMIS.	Data centralization and use of MITA standard interfaces provide a cost effective and streamlined process for documenting the FFP for MMIS.	
		See Draw and Report FFP draft		
Business Capability Quality: Effort to Perform; Efficiency				
How efficient is this process?	The business process results meet State and federal requirements but require continuous manual efforts throughout the period of production of information for the report.	The data centralization and standardization of the information increases the efficiency of documenting FFP for MMIS.	Data centralization and use of MITA standard interfaces provide a more efficient and streamlined process for the management of the FFP for MMIS over Level 2.	
		See Draw and Report FFP draft		
Business Capability Quality: Accuracy; Usefulness of Process Results				
How accurate are the results of this process?	The manual nature of the process negatively impacts accuracy and may cause inaccuracies in the calculation of FFP for MMIS. State and federal audits discover errors in the process results.	The data centralization and standardization of the information increases the accuracy of the data used in managing the FFP and the error rates are reduced.	Data centralization and use of MITA standard interfaces provide an accurate and streamlined process for managing the FFP for MMIS. The error rates are less than 2%.	
		See Draw and Report FFP draft		



Business Capability Quality: Utility or Value to Stakeholders

How satisfied are the stakeholders?	Stakeholder satisfaction is negatively impacted by manual processes, with few resources dedicated to improvement and few measurements in place, e.g. reliance on complaints, legal mandates for action regarding improving stakeholder satisfaction.	Medicaid Enterprise begin to identify gaps in levels of satisfaction and stakeholder expectations and priorities. Improvements are made strategically, increasing stakeholder satisfaction over Level 1.	Medicaid Enterprise conducts internal and external audits/focus groups which take into consideration the results of its previous research along with other national standards to identify additional stakeholder expectations and priorities. Improvements are made based on national and MITA best practices, improving stakeholder satisfaction over Level 2.	
	We have not conducted a satisfaction survey. We're unsure of who the stakeholders are for this bp.			

Draw and Report FFP

Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions				
This Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				



How manual or automated is this business process?	The process is mostly manual. Staff uses reports generated by the MMIS to manually enter data into state accounting system. Staff uses reports generated by the state accounting system to determine the amount of Federal Financial Participation (FFP) to request.	The process is partially automated. There is an automated update between the MMIS and the state accounting system for most accounts payable and accounts receivable activity in both systems. Automated reporting is used to complete federal expenditure reports. Staff uses reports generated by the state accounting system to determine the amount for each draw.	The process is fully automated There is an automated nightly update between the MMIS and the state accounting system for all accounts payable and accounts receivable activity in both systems. A full audit trail between the MMIS and the state accounting system is maintained.	
		Refer to business process write-up		
What standards are used by this business process?	State complies with CMS regulations concerning quarterly expenditure reporting and the requirements for the Federal Cash Management Improvement Act (CMIA).	Beyond compliance with CMS regulations, some national standards have been adopted.	MITA standard interfaces are used for this process.	
	Refer to business process write-up			
How adaptable is this process to change?	The process is difficult to change because rules must be manually updated and actions are tightly coupled.	The process is easier to change than Level 1 because data is stored on the claim line and the automated update processes are two-way between the MMIS and the financial management payment system.	The process is agile and responds quickly to change through use of business rules and loosely coupled applications.	
	Refer to business process write-up; Exchange is one-way from MMIS to GAIRS			
Business Capability Quality: Timeliness of Process				



How timely is this end-to-end process?	Process is completed as required by CMS, but requires considerable staff time for data entry and report preparation.	Data is updated for each pay cycle and process is completed as required by CMS with moderate staff involvement.	Data is updated nightly and process is completed as required by CMS.	
		Refer to business process write-up		
Business Capability Quality: Data Access and Accuracy				
How accurate is the information used in this process?	Data is reasonably accurate but can be improved.	Data is more accurate than at Level 1.	Data is governed by MITA standard interfaces and accuracy is measured at 98% or better.	
	Refer to business process write-up			
How accessible is the information used in this process?	Obtaining data and preparing reports is mostly a manual process.	Automated reports are available upon completion of each pay cycle.	MITA standard interfaces facilitate access to data needed for this process. Intermediate reports can be produced in real time.	
		Refer to business process write-up		
Business Capability Quality: Cost Effectiveness				
What is the ratio of the cost to perform this process compared to the benefits of the results?	Process depends heavily on manual support.	Automation allows staff to focus on validation and reconciliation of data.	MITA standard interface further improves effectiveness of the process and enables staff to focus on quality control functions.	
		Refer to business process write-up		
Business Capability Quality: Effort to Perform; Efficiency				
How efficient is this process?	Manual steps lead to many iterations of data collection, analysis, and manipulation until final report is ready.	Process is efficient, but still requires staff involvement for activities that could be automated.	MITA standard interfaces and automated processes make this more efficient than at level 2.	
	Refer to business process write-up			



Business Capability Quality: Accuracy; Usefulness of Process Results				
How accurate are the results of this process?	Results are accurate and meet the needs of the agency for the draw of FFP.	Automation of processes increases accuracy over Level 1.	Accuracy of process results improves over Level 2 due to use of MITA standard interfaces.	
	Refer to business process write-up			
Business Capability Quality: Utility or Value to Stakeholders				
How satisfied are the stakeholders?	Stakeholder satisfaction is low, with few resources dedicated to improvement and few measurements in place, e.g. reliance on complaints, legal mandates for action regarding improving stakeholder satisfaction.	States begin to identify gaps in levels of satisfaction and stakeholder expectations and priorities. Improvements are made strategically, increasing stakeholder satisfaction over Level 1.	Medicaid Enterprise conducts internal and external audits/focus groups which take into consideration the results of its previous research along with other national standards to identify additional stakeholder expectations and priorities. Improvements are made based on national and MITA best practices, improving stakeholder satisfaction over Level 2.	
	Have not conducted a satisfaction survey			

Manage FFP for Services				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions				
This Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				



How manual or automated is this business process?	The Federal Financial Participation (FFP) for services funding request is automatically calculated for mandated fee for service claims paid in this time period. All other calculations are manually calculated and applied.	The FFP for services funding request is automatically calculated for mandated fee for service claims and Managed Care Organization (MCO) capitation paid in this time period. Additional calculations are automated. Some manual calculations are still required.	The process uses MITA interface standards and is fully automated except for adjustments.	
		Refer to business process write-up		
What standards are used by this process?	State complies with federal rules for Federal Medical Assistance Percentage (FMAP) calculations.	Medicaid enterprise adheres to national data standards where applicable.	Automated process utilizes MITA standard interfaces.	
	Refer to business process write-up			
How adaptable to change is this process?	The process is difficult to change because rules must be manually updated and actions are tightly coupled.	The process is easier to change than Level 1 because applications are table-driven.	The process is agile and responds quickly to change through use of automated business rules, loosely coupled applications and MITA standard interfaces.	
	Refer to business process write-up			
Business Capability Quality: Timeliness of Process				
How timely is this end-to-end process?	The manual processes require reiterative calculations and verifications until the FFP for services request is completed. This process takes the full time allotted by federal standards (i.e., one quarter) to prepare.	Automation of calculations and introduction of some interfaces with other agencies improves timeliness.	Use of MITA standard interface further improves timeliness.	
	Refer to business process write-up			



Business Capability Quality: Data Access and Accuracy

How accurate is the information used in this process?	The use of manual processes negatively impacts accuracy.	Accuracy increases over Level 1 due to process automation.	MITA standard interfaces further improve accuracy over Level 2.	
		Refer to business process write-up		
How accessible is the information used in this process?	Due to manual processes, information is difficult to access.	Due to increased automation, it is easier to access information than at Level 1.	Information adhering to MITA standard interface requirements improves accessibility over Level 2.	
		Refer to business process write-up		

Business Capability Quality: Cost Effectiveness

What is the ratio of the cost to perform this process compared to the benefits of the results?	Meets budget expectations for management of FFP.	This process is more efficient than Level 1 due to greater automation of access to data and calculations.	Use of MITA standard interfaces allows for better verification and better control of FFP calculations increasing cost efficiency over Level 2.	
	Have not conducted a cost-benefit analysis			

Business Capability Quality: Effort to Perform; Efficiency

How efficient is this process?	Manual intervention reduces efficiency.	Efficiency improves over Level 1 with greater automation and data validation.	Efficiency improves over Level 2 with MITA standard interfaces.	
	Refer to business process write-up			

Business Capability Quality: Accuracy; Usefulness of Process Results

How accurate are the results of this process?	State meets its goals for obtaining FFP for services.	The Medicaid enterprise meets its goals for obtaining FFP for services with few adverse audit results due to process automation.	The Medicaid enterprise meets its goals for obtaining FFP for services with corrective actions rarely needed.	
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	Refer to business process write-up			
Business Capability Quality: Utility or Value to Stakeholders				
How satisfied are the stakeholders?	Stakeholder satisfaction is low, with few resources dedicated to improvement and few measurements in place, e.g. reliance on complaints, legal mandates for action regarding improving stakeholder satisfaction.	The Medicaid enterprise begins to identify gaps in levels of satisfaction and stakeholder expectations and priorities. Improvements are made strategically, increasing stakeholder satisfaction over Level 1.	Medicaid Enterprise conducts internal and external audits/focus groups which take into consideration the results of its previous research along with other national standards to identify additional stakeholder expectations and priorities. Improvements are made based on national and MITA best practices, improving stakeholder satisfaction over Level 2.	
	Have not conducted a satisfaction survey			

Manage FMAP				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions				
This Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				



Is this business process primarily manual or automated?	This process relies significantly on manual activities to develop, maintain, and monitor rules used to assign the correct Federal Medical Assistance Percentages (FMAP) rate to service expenditures and recoveries documented by the Medicaid enterprise.	The process uses a mix of manual and automated activities to develop, maintain, and monitor rules used to assign the correct FMAP rate to service expenditures and recoveries.	The process is primarily automated based on Medicaid enterprise policies for assigning FMAP rates.	
		Refer to business process write-up		
Does this business process use standards?	The Medicaid enterprise uses data that is based on State standards.	The Medicaid enterprise adopts HIPAA standards for data where applicable.	Use of MITA standard interface adds additional standardization to the process.	
	Refer to business process write-up			
Does the Medicaid agency collaborate with other agencies or entities in performing this process?	The Medicaid enterprise focuses on the primary Medicaid services. There is no collaboration with other entities in this process.	The Medicaid enterprise coordinates with other agencies which share in the delivery of services to the Medicaid population.	The Medicaid enterprise coordinates with other agencies with which it has signed Service Level Agreements regarding care of the Medicaid population.	
		Refer to business process write-up; Other agencies bill for Medicaid services through DHHS.		
Business Capability Quality: Timeliness of Process				
How timely is this end-to-end process?	The process meets State and Federal guidelines for timeliness.	The process improves on timeliness of automated access to analyze information.	The process further improves on timeliness through use of MITA standard interface data as the basis for determining the correct FMAP.	
	Refer to business process write-up			
Business Capability Quality: Data Access and Accuracy				



How accurate is the information used in this process?	Inconsistencies in data definitions lead to errors in correctly assigning FMAP rates; errors are detected and corrected.	Enhanced data definitions, through collaborations of Stakeholders, improve accuracy of data used to assign FMAP rates.	Use of MITA standardized interfaces and data definitions maximizes accuracy of data.	
	Refer to business process write-up			
How accessible is the information used in this process?	Staff access multiple data sources that employ indeterminate standards. This adds difficulty to the process.	Data accessibility improves due to automation.	Adoption of MITA standard interface improves access to information needed for this process.	
		Refer to business process write-up		
Business Capability Quality: Cost Effectiveness				
What is the ratio of the cost to perform this process compared to the benefits of the results?	The process meets State expectations.	The process meets State cost containment guidelines due to introduction of standards and automation.	The process demonstrates the improvement value projected by the Medicaid enterprise due to MITA standard interfaces.	
	Have not conducted a cost-benefit analysis			
Business Capability Quality: Effort to Perform; Efficiency				
How efficient is this process?	The process relies primarily on manual processes to collect data, analyze, and assign FMAP rates to services and recoveries, and monitor compliance.	Introduction of automated processes results in improved efficiency.	Due to MITA standard interfaces, efficiency further increases over Level 2.	
		Refer to business process write-up		
Business Capability Quality: Accuracy; Usefulness of Process Results				



How accurate are the results of this process?	Manual processes can negatively impact accuracy. The process meets State and Federal expectations regarding results.	Accuracy of results improves through automation and standardized data.	Monitoring of the results is built in to the process. MITA standard interfaces increase accuracy and usefulness of the result over Level 2.	
		Refer to business process write-up		
Business Capability Quality: Utility or Value to Stakeholders				
How satisfied are the stakeholders?	Stakeholder satisfaction is low, with few resources dedicated to improvement and few measurements in place, e.g. reliance on complaints, legal mandates for action regarding improving stakeholder satisfaction.	States begin to identify gaps in levels of satisfaction and stakeholder expectations and priorities. Improvements are made strategically, increasing stakeholder satisfaction over Level 1.	Medicaid Enterprise conducts internal and external audits/focus groups which take into consideration the results of its previous research along with other national standards to identify additional stakeholder expectations and priorities. Improvements are made based on national and MITA best practices, improving stakeholder satisfaction over Level 2.	
	Have not conducted a satisfaction survey			

Manage State Funds				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions				
This Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				



Is this business process primarily manual or automated?	The process is primarily manual. Data is stored in electronic format, but the analysis and application of decisions regarding allocations and reporting are manual.	A mixture of manual and automated process is used. Use of Commercial Off The Shelf (COTS) products to support Medicaid enterprise financial functions improves ability to access information, analyze, and make decisions regarding allocation and reporting.	The process is primarily automated due to improvements in COTS products and use of MITA standardized data.	
	See Manage State Funds draft			
Does this business process use standards?	Standards may be siloed within systems.	The Medicaid enterprise develops standards.	Management of State funds improves over Level 2 with the use of MITA standard interfaces.	
	See Manage State Funds draft			
Does the Medicaid agency collaborate with other agencies or entities in performing this process?	Some collaboration is required in the allocation of federal funds where non-Medicaid agencies are involved.	Memorandum of Understanding (MOU) with other agencies provides a legal basis for allocation of funds.	MITA aligned Service Level Agreements with other agencies improve collaboration.	
	See Manage State Funds draft			
Business Capability Quality: Timeliness of Process				
How timely is this end-to-end process?	The manual process requires the full amount of time available, i.e., month, quarter, annual.	Less time is required than Level 1.	The process takes less time than Level 2.	
	See Manage State Funds draft			
Business Capability Quality: Data Access and Accuracy				
How accurate is the information used in this process?	The manual methodology builds in redundancy to validate allocation formulas and totals. Errors may occur due to the primarily manual process.	Some automation improves accuracy and reduces errors.	Use of MITA standard interface further improves accuracy.	
	See Manage State Funds draft			



How accessible is the information used in this process?	The process requires significant manual access to data in a variety of sources.	Data is readily available to authorized users.	Data is immediately accessible.	
	See Manage State Funds draft			
Business Capability Quality: Cost Effectiveness				
What is the ratio of the cost to perform this process compared to the benefits of the results?	Meets Medicaid enterprise goals for completing allocation of state funds. Cost benefit ratio may not be able to be calculated.	Automation frees some time for staff to focus on analysis of the data, projections, and recommendations for improvements in allocation formulas.	MITA standard interfaces and improvements in COTS further increase the cost-effectiveness over Level 2.	
	We have not conducted a cost-benefit analysis.			
Business Capability Quality: Effort to Perform; Efficiency				
How efficient is this process?	Minimally meets federal requirements for management of state funds. Manual processes create inefficiencies.	Automated processes results in improvements in utilization of staff who are proactively managing state funds. Automation increases efficiency over Level 1.	Efficiency improves further through use of MITA standard interface which ensures consistency among the various State funds.	
	See Manage State Funds draft			
Business Capability Quality: Accuracy; Usefulness of Process Results				
How accurate are the results of this process?	Manual processes can negatively impact accuracy.	Automation reduces error rates and makes it easier to detect and correct errors.	MITA standard interfaces further increase the accuracy over Level 2.	
	See Manage State Funds draft			
Business Capability Quality: Utility or Value to Stakeholders				



How satisfied are the stakeholders?	Stakeholder satisfaction is low, with few resources dedicated to improvement and few measurements in place, e.g. reliance on complaints, legal mandates for action regarding improving stakeholder satisfaction.	States begin to identify gaps in levels of satisfaction and stakeholder expectations and priorities. Improvements are made strategically, increasing stakeholder satisfaction over Level 1.	Medicaid Enterprise conducts internal and external audits/focus groups which take into consideration the results of its previous research along with other national standards to identify additional stakeholder expectations and priorities. Improvements are made based on national and MITA best practices, improving stakeholder satisfaction over Level 2.	
	We have not conducted a stakeholder satisfaction survey.			

Maintain State Plan				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions				
This Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				
How manual or automated is this business process?	The process is primarily a manual function.	The process is a mixture of manual and automated and/or electronic functions. The base document and updates are stored electronically and are transmitted to CMS.	MITA standard interface standardizes updates to the State Plan.	
		See Maintain State Plan draft		



What standards are used by this business process?	This is a free-form paper document update process.	The Medicaid enterprise has developed standard methodologies and information centralization to respond to changes in the State Plan. State Plan is under configuration and version control on the State's portal.	The Medicaid enterprise adopts State MITA standard interfaces. This means its State Plan is interoperable with other State Plans.	
	See Maintain State Plan draft; document exists electronically, but updates are free-form.			
Is collaboration with other agencies or entities used by this process?	The Medicaid agency is a siloed organization and does not collaborate with other agencies and/or external entities.	The Medicaid enterprise has introduced intra-agency collaboration and external entity interfaces to centralize all data necessary to maintain the State Plan. Local interface rules are used.	All participating agencies adopt MITA standard interface for maintenance of the State Plan.	
	No need to collaborate with other entities.			
How adaptable is this process to change?	All changes are manually processed. The process is slow and most changes are shown as addendum.	Electronic updates to State Plan are easier to adapt to change.	MITA standard interface changes are determined by MITA Governance. State-specific changes are easy to implement.	
	See Maintain State Plan draft			
Business Capability Quality: Timeliness of Process				
How timely is this end-to-end process?	All updates are manual and difficult to implement. Maintenance of State Plan is a year-round activity.	The electronic State Plan can be updated as necessary.	Standard MITA interface shortens the time required for updating State Plan.	
	See Maintain State Plan draft			



Business Capability Quality: Data Access and Accuracy

How accurate is the information used in this process?	The manual nature of this process increases the risk of unreliable and inaccurate information.	Implementation of standardized methodologies and centralized data allow for more accurate information.	Uses of standardized methodologies and centralized data have allowed information to be reliable and up-to-date. Accuracy is measured at 98% or better.	
	See Maintain State Plan draft			
How accessible is the information used in this process?	Information resides in multiple locations requiring time and effort to locate necessary information.	The Medicaid enterprise has introduced intra-agency collaboration and external entity interfaces to centralize all data necessary to maintain the State Plan. This provides for more accessible data.	Parties providing updates to State Plan use the MITA standard interface requirements.	
	See Maintain State Plan draft			

Business Capability Quality: Cost Effectiveness

What is the ratio of the cost to perform this process compared to the benefits of the results?	This is a manual effort and requires time and effort to complete. Cost to benefit ratio is relatively high.	A mixture of manual and automated processes reduces the effort to maintain the State Plan as compared to Level 1. Cost to benefit ratio improves over Level 1.	Use of MITA standard interface results in most effective update process. Cost to benefit ratio improves over Level 2.	
	Have not done a cost benefit analysis.			

Business Capability Quality: Effort to Perform; Efficiency

How efficient is this process?	Process meets state objectives for maintaining State Plan.	Electronic creation and versioning provides more efficient maintenance of the State Plan.	Use of standardized MITA interface further improves efficiency.	
	See Maintain State Plan			



Business Capability Quality: Accuracy; Usefulness of Process Results

How accurate are the results of this process?	The State Plan update process meets State and federal guidelines.	Updates are better controlled, more timely, and accurate as compared to Level 1.	MITA standard interface ensures accuracy of maintenance and allows for sharing of this information.	
	See Maintain State Plan			

Business Capability Quality: Utility or Value to Stakeholders

How satisfied are the stakeholders?	Stakeholder satisfaction is negatively impacted by manual processes, with few resources dedicated to improvement and few measurements in place, e.g. reliance on complaints, legal mandates for action regarding improving stakeholder satisfaction.	Medicaid enterprise begins to identify gaps in levels of satisfaction and stakeholder expectations and priorities. Improvements are made strategically, increasing stakeholder satisfaction over Level 1.	Medicaid enterprise conducts internal and external audits/focus groups which take into consideration the results of its previous research along with other national standards to identify additional stakeholder expectations and priorities. Improvements are made based on national and MITA best practices, improving stakeholder satisfaction over Level 2.	
		Satisfaction has been increased by posting to intranet.		

Manage Program Information

Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
General Description of Capabilities				



Is this process manual or automated?	Reports used to manage program information are not automatically distributed. Technical staff are required as an interface for information requests.	Some automation has been implemented resulting in business users having the capability of accessing information directly.	Business users have direct and dynamic access to centralized and federated data.	
		See Manage Program Information draft		
Does this process use standards?	Local data standards are often duplicative. Data requests and results require manipulation to compensate for data variances.	State adoption of HIPAA data requirements increases the uniformity of data.	Adoption of MITA data models increases standardization of data. Requests for information can be sent to other states that also adhere to MITA standards.	
	See Manage Program Information draft			
Does the Medicaid enterprise collaborate with other agencies or entities in performing this process?	No collaboration. The Medicaid enterprise focuses on accessing information in its domain.	The Medicaid enterprise collaborates with other state agencies who agree on standards for a common data store, access rights, and security.	The Medicaid enterprise collaborates with any other entity that enters into agreements to adhere to MITA interface requirements, security protocols, and privacy rules.	
		Use a common datastore, but not technically collaboration		
Business Capability Quality: Timeliness of Process				



How timely is this end-to-end process?	<p>The process is subject to long delays depending on the complexity of the request and the availability of technical staff.</p> <p>Since most requests have to be processed by a limited number of technical staff, requests may take several weeks to complete.</p>	<p>Use of Commercial Off The Shelf (COTS) products and tools dramatically improves the turnaround time to produce program information.</p> <p>Since business staff is able to perform some of their own inquiries, timeliness is generally improved over Level 1.</p>	<p>Use of MITA standards further reduces the time required to produce the desired result.</p> <p>Simple results created by individual business users require 30 minutes or less. Complex request created by business or technical staff require 1 day or less.</p>	
		See Manage Program Information draft		
Business Capability Quality: Data Access and Accuracy				
How accurate is the information used in this process?	<p>Manual operation results in subjective selection of data to be used. There are many known discrepancies in the data. Data must either be scrubbed prior to the processing, or analysis is required after result is produced to explain discrepancies.</p>	<p>Accuracy and consistency of data used in the process improve over Level 1. Use of COTS packages and HIPAA data standards increases reliability of data.</p>	<p>Use of MITA standardized interfaces and data standards ensures accuracy of data. Data accuracy is measured as 95%.</p>	
	See Manage Program Information draft			
How accessible is the information used in this process?	<p>This process relies on information stored in operational and historical data stores. Information is not readily available. Requests must be scheduled to fit into the operational schedule.</p>	<p>The process uses on-line access to data. Use of COTS packages, tools, and HIPAA compliant data improves accessibility.</p>	<p>Immediate access to standardized data is available further improving accessibility over Level 2.</p>	
	See Manage Program Information draft, some requests must be scheduled.			



Business Capability Quality: Cost Effectiveness

What is the ratio of the cost to perform this process compared to the benefits of the results?	The process meets State budget guidelines.	Cost-effectiveness improves over Level 1 through the use of automation and HIPAA data standards.	The process maximizes time of tactical and strategic staff to obtain answers critical to planning and policy decisions. The process demonstrates the improvement value projected by the Medicaid enterprise. Cost-effectiveness improves over Level 1.	
	We have not conducted a satisfaction survey.			

Business Capability Quality: Effort to Perform; Efficiency

How efficient is this process?	The process relies primarily on staff to manually perform actions. There is inherent inefficiency in submitting business requests to technical staff to produce results. Data inconsistency results in need to request a repeat of the inquiry.	Process efficiency greatly improves through automation and HIPAA data standards. In addition, business areas can manage many of their own inquiries.	Process efficiency further improves due to use of MITA interface standards which significantly reduces data errors and redundancies.	
	See Manage Program information draft; wish-list includes increasing program area tool use.			

Business Capability Quality: Accuracy; Usefulness of Process Results



How accurate are the results of this process?	<p>The process meets State and Federal expectations regarding results.</p> <p>Workarounds are applied to compensate for inconsistencies in data.</p> <p>Lack of data standards and manual processes can adversely impact accuracy.</p>	Additional automation produces more accurate results than at Level 1.	Use of MITA interface standards further improves accuracy of results over Level 2.	
	See Manage Program Information			
Business Capability Quality: Utility or Value to Stakeholders				
How satisfied are the stakeholders?	<p>Stakeholder satisfaction is low, with few resources dedicated to improvement and few measurements in place, e.g. reliance on complaints, legal mandates for action regarding improving stakeholder satisfaction.</p>	States begin to identify gaps in levels of satisfaction and stakeholder expectations and priorities. Improvements are made strategically, increasing stakeholder satisfaction over Level 1.	Medicaid Enterprise conducts internal and external audits/focus groups which take into consideration the results of its previous research along with other national standards to identify additional stakeholder expectations and priorities. Improvements are made based on national and MITA best practices, improving stakeholder satisfaction over Level 2.	
	We have conducted a stakeholder satisfaction survey, which indicated low satisfaction.			



Develop and Manage Performance Measures Reporting

Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions				
This Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				
How manual or automated is this business process?	The process is manual and duplicated in multiple areas within the organization.	The process is a mix of manual and automated processes to gather data and perform calculated outcomes measures.	The process is fully automated with few exceptions.	
	Refer to business process write-up			
Does this process use standards?	Standardized measures developed by the federal or state governments have been applied to a few Medicaid processes and programs. There may be inconsistencies among agency divisions.	Standardized industry performance measures in addition to federal or state performance measures have been applied to many of the Medicaid enterprise processes and programs.	The process uses MITA standardized interfaces and data definitions to standardize performance measures for all Medicaid enterprises and programs.	
	Refer to business process write-up			
How are data used in this process verified?	Data is manually verified prior to release.	Data verification prior to release is a mix of manual and automated processes.	Data verification is fully automated.	
	Refer to business process write-up			
Are performance measures published?	Measures are produced manually and distributed to other parties responsible for the activity.	Measurements are electronically published.	Based on use of MITA standard interfaces and data definitions States may share outcome measures with other States and federal agencies..	
	Refer to business process write-up			



Business Capability Quality: Timeliness of Process

How timely is this end-to-end process?	This process occurs periodically (weekly, monthly, quarterly, and annually) to meet state and federal timeliness requirements.	Automated receipt of data insures a more timely availability of information than found at level 1.	Information can be refreshed daily on dashboard. Periodicity of posting is up to the state.	
	Refer to business process write-up			

Business Capability Quality: Data Access and Accuracy

How accurate is the information used in this process?	There are some issues regarding data accuracy and completeness and some calculation errors occur.	Internal standardization of data, use of HIPAA data exchange standards, and increased use of automation reduces inaccuracies in data.	Use of standard MITA interface further reduces data errors.	
	Refer to business process write-up			
How accessible is the information used in this process?	Access to data to perform measurement is primarily a manual process. Communication is limited to paper, email, Compact Disc (CD) or publications.	Access to data to perform measurement is primarily through an automated process. Communication occurs through email, Compact Disc (CD) or publication on State's website.	Performance measurement is built into individual business processes and also consolidated into state-level dashboards. Access to data using MITA standard interface which increases accessibility.	
	Refer to business process write-up			

Business Capability Quality: Cost Effectiveness

What is the ratio of the cost to perform this process compared to the benefits of the results?	The business process is manual and may take several weeks to gather specified data for calculation. Accuracy of calculations is manually verified. Publication of outcomes measurement is valuable to State in monitoring efforts.	The business process is mix of automated and manual processes with reduced cost to produce data and increased value to the State as result of publication of outcomes to public. Automation improves effectiveness of performance measures.	Use of MITA standard interfaces and inclusion of performance measures in individual business processes increases cost-effectiveness of this process.	
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	Have not conducted a cost-benefit analysis			
Business Capability Quality: Effort to Perform; Efficiency				
How efficient is this process?	Manual processing, lack of coordination with other processes, duplicative work may result in many opportunities to create or improve efficiency.	Increased automation, coordination with other processes, and introduction of standards reduce duplicative work and create more efficiency.	Use of MITA standards increases efficiency of this process.	
	Refer to business process write-up			
Business Capability Quality: Accuracy; Usefulness of Process Results				
How accurate are the results of this process?	Manual review and verification of accuracy of calculations is needed prior to publication. Manual processes may be error prone.	Less manual review and verification of accuracy of calculations is needed prior to publication due to automation resulting in improved accuracy of the results.	Accuracy increases over level 2 due to the use of MITA standard interfaces.	
	Refer to business process write-up			
Business Capability Quality: Utility or Value to Stakeholders				
How satisfied are the stakeholders?	Stakeholder satisfaction is negatively impacted by manual processes, with few resources dedicated to improvement and few measurements in place, e.g. reliance on complaints, legal mandates for action regarding improving stakeholder satisfaction.	Medicaid enterprise begins to identify gaps in levels of satisfaction and stakeholder expectations and priorities. Improvements are made strategically, increasing stakeholder satisfaction over Level 1.	Medicaid enterprise conducts internal and external audits/focus groups which take into consideration the results of its previous research along with other national standards to identify additional stakeholder expectations and priorities. Improvements are made based on national and MITA best practices, improving stakeholder satisfaction over Level 2.	



	Have not conducted a satisfaction survey			
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Monitor Performance and Business Activity

Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions				
This Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				
Is this business process primarily manual or automated?	The process is primarily a manual operation. Staff self report on some measures. Reports are produced on key operational indicators, e.g., number of claims paid per time period. Ad hoc data requests are issued to collect performance data.	Improvements in data collection provide better base for monitoring performance. The process is a blend of manual and automated steps.	Tracking of the end to end business process execution is built into the MITA standard interface. The process is primarily automated.	
	See Monitor Perf and Bus Activity draft			
Does this business process use standards?	The agency uses locally developed standards and methodologies. There may be inconsistencies among agency divisions.	The Medicaid enterprise uses a performance-based standardized methodology to monitor staff activities.	MITA standard interface data are used in the monitoring process.	
	See Monitor Perf and Bus Activity draft			



Does the Medicaid agency collaborate with other agencies or entities in performing this process?	The process is focused on Medicaid operations and structuring mechanisms to meet baseline requirements.	The Medicaid enterprise shares performance information with other entities with which it has an agreement, e.g., Waiver programs.	The Medicaid enterprise expands performance management systems to other entities.	
	See Monitor Perf and Bus Activity draft			
Business Capability Quality: Timeliness of Process				
How timely is this end-to-end process?	There is no standard approach to monitoring; timeliness is uncoordinated across process steps.	Establishing a structure and guidelines for performance monitoring improves results. Timely, periodic reporting is used to monitor the process.	Use of the MITA standard interface enables real-time performance reporting.	
	See Monitor Perf and Bus Activity draft			
Business Capability Quality: Data Access and Accuracy				
How accurate is the information used in this process?	Manual operation results in subjective selection of data to be used. Information is inconsistent and requires manual adjustments.	Accuracy and consistency of data used in the process improves based on use of standard reports.	Use of MITA standardized interfaces and data definitions improves accuracy of data.	
	See Monitor Perf and Bus Activity draft			
How accessible is the information used in this process?	Access to data is controlled manually. There are challenges in determining what data to use for monitoring and how to retrieve and analyze the data.	Accessibility improves along with strengthening the performance monitoring process and establishing periodic performance reports.	The process utilizes MITA interface standards for reporting. Accessibility improves.	
	See Monitor Perf and Bus Activity draft			
Business Capability Quality: Cost Effectiveness				



What is the ratio of the cost to perform this process compared to the benefits of the results?	Manual processes are not measured/analyzed for cost effectiveness.	The Medicaid enterprise considers cost effectiveness when making improvements to performance monitoring based on results demonstrated in scheduled reports.	The process demonstrates the improvement value projected by the Medicaid enterprise. Performance monitoring data is routinely collected from MITA standard interfaces.	
	See Monitor Perf and Bus Activity draft			
Business Capability Quality: Effort to Perform; Efficiency				
How efficient is this process?	The process relies primarily on staff to perform actions. Agency recognizes that it needs to improve efficiency.	Automated processes results in increased efficiency and allows staff to focus on process improvement.	Efficiency improves further through use of MITA standard interface which ensures consistency of data reported.	
	See Monitor Perf and Bus Activity draft			
Business Capability Quality: Accuracy; Usefulness of Process Results				
How accurate are the results of this process?	The process is in its early stage of development and is not considered mature. Results are judged to be inconsistent and not fully reliable.	The process produces acceptable results and covers the majority of core operations most of the time.	The Medicaid enterprise is able to rely on the monitoring reports and uses the results to assess individual performance and performance of the business process as a whole.	
	See Monitor Perf and Bus Activity draft			
Business Capability Quality: Utility or Value to Stakeholders				



How satisfied are the stakeholders?	Stakeholder satisfaction is low, with few resources dedicated to improvement and few measurements in place, e.g. reliance on complaints, legal mandates for action regarding improving stakeholder satisfaction.	States begin to identify gaps in levels of satisfaction and stakeholder expectations and priorities. Improvements are made strategically, increasing stakeholder satisfaction over Level 1.	Medicaid Enterprise conducts internal and external audits/focus groups which take into consideration the results of its previous research along with other national standards to identify additional stakeholder expectations and priorities. Improvements are made based on national and MITA best practices, improving stakeholder satisfaction over Level 2.	
	We have not conducted a satisfaction survey. It is unclear who the stakeholders are.			

Terminate Business Relationship				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions				
This Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				
Is this business process primarily manual or automated?	A fully manual process exists.	Some automation is used to gather, record, communicate, and distribute information to agency leadership, other state agencies, and participating providers regarding termination of the business relationship.	The Medicaid enterprise and its trading partners (other agencies, entities, and providers) sign Service Level Agreement (SLA) including terms and conditions for termination of agreement.	
	Refer to business process write-up			



Does this business process use standards?	Minimal standards are employed at this level.	The Medicaid enterprise has a methodology that includes a termination process for business relationship and EDI agreement termination using local standards.	The process uses the standard MITA interface for termination of agreement.	
		Refer to business process write-up		
Business Capability Quality: Timeliness of Process				
How timely is this end-to-end process?	The process requires up to 30 days.	The process can be completed, on the average, in no more than 10 days.	The process can be completed in 1 day or less.	
	Refer to business process write-up; time period varies.			
Business Capability Quality: Data Access and Accuracy				
How accurate is the information used in this process?	Manual operation results in subjective selection of data to be used. Accuracy and consistency in the agreement termination may be generally low.	Standards based agreements result in higher accuracy in the terms and conditions. Accuracy and consistency in EDI and business partner agreement termination are higher than at Level 1.	Use of MITA standardized interfaces and data ensures accuracy of data. Accuracy and consistency in the SLA and business partner agreement termination are rated at 99% or better.	
	Refer to business process write-up			
How accessible is the information used in this process?	Information is accessed manually.	There is some automation in accessing the information.	MITA standard interfaces are used to access information.	
	Refer to business process write-up			
Business Capability Quality: Cost Effectiveness				



What is the ratio of the cost to perform this process compared to the benefits of the results?	The process meets State budget guidelines.	The process meets State cost containment guidelines due to increased automation.	The process demonstrates the improvement value projected by the Medicaid enterprise. Cost effectiveness improves over Level 2.	
	Have not conducted a cost-benefit analysis			
Business Capability Quality: Effort to Perform; Efficiency				
How efficient is this process?	The process relies primarily on manual activities.	There are greater efficiencies due to automation of data exchange.	Efficiency is further improved due to use of standardized agreements and use of MITA standard interfaces.	
	Refer to business process write-up			
Business Capability Quality: Accuracy; Usefulness of Process Results				
How accurate are the results of this process?	Contractual agreements meet state policy and legal requirements for termination.	Decision making is more accurate due to automated Medicaid enterprise policy resulting in uniform terms and conditions. Accuracy improves over Level 1.	The process consistently applies business rules within the SLA resulting in optimal decisions 99% of the time.	
	Refer to business process write-up			
Business Capability Quality: Utility or Value to Stakeholders				



How satisfied are the stakeholders?	A primarily manual process adversely affects the ability to terminate the business relationship with minimal effort. Delays and disputes over termination issues are common. Stakeholder satisfaction is negatively impacted.	Implementation of local standards and the centralized tracking of the data increase the ability to terminate the business relationship. Stakeholder satisfaction improves over Level 1.	Implementation of MITA standards and reusable services; automation of the centralized tracking of the business relationship; full interfacing between agency programs; and automation of the process maximizes the effectiveness in terminating the business relationship. Stakeholder satisfaction improves over Level 2.	
	Have not conducted a satisfaction survey			

PI Identify Candidate Case				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions				
How integrated or centralized is the process?	The process is duplicated in multiple parts of the organization (siloed). There is little coordination among agency programs or between the Medicaid Enterprise and other stakeholders (e.g., other State agencies, CMS, intermediaries, other payers) in relation to this process.	The process is integrated within the Medicaid Enterprise. There is improved coordination between the Medicaid Enterprise and other stakeholders in relation to this process.	MITA data standards enable data exchanges between the Medicaid Enterprise and other stakeholders in relation to this process.	
		Refer to business process write-up		



Is the process manual or automated?	The process is a mix of manual and automated steps. Parameters for identification of cases are manually entered. Exception processing is automated.	Increased automation and enhanced parameters are used for case identification.	The process automates most activities in the workflow and business rules.	
		Refer to business process write-up; SURS reports are automated.		
Are data and format standardized?	The process is supported by proprietary Electronic Data Interchange (EDI) and non-standardized data and format from multiple sources.	Internal data standards have been implemented, HIPAA standards for transactions are in use. Increased availability of data improves data usefulness for performance monitoring, management reporting and analysis over Level 1.	MITA data definitions and standard interfaces are used.	
		Refer to business process write-up		
How well does the process achieve State and Federal requirements?	The process conforms to State and federal regulations.	The process conforms to regulations and facilitates cost management and ongoing quality improvement.	The process is enhanced over Level 2 and also supports improved program management, meets MITA definitions, and supports the shift to shared business services.	
		Refer to business process write-up		
How are data used in this process verified?	The process is primarily a manual process and encompasses many different programs offered by the state, including Medicaid.	The process is a mixture of automation and manual intervention because of the need to interface between internal stakeholders.	The process is primarily automated with the use of MITA standards and steps are internally interoperable.	
		Refer to business process write-up		
Business Capability Quality: Timeliness of Process				



What Is the Timeliness of End to End Process?	The process meets State requirements for quarterly review of member and provider profiles. Manual nature of the process extends the length of time necessary to complete.	Improved automation of case identification and communications to obtain additional information and improves the turn-around time.	Use of MITA standard interface improves timeliness required for case identification. Automated parameters, pattern recognition, and other tools identify qualified cases and provide faster turnaround. Standard, large volume processes require 24 hours or less. Focused review processes are executed in real-time (60 seconds or less per request).	
		Refer to business process write-up		
Business Capability Quality: Data Access and Accuracy				
How accurate is the information available to the process?	Manual processes can adversely impact accuracy.	Internal standardization of data, use of HIPAA data exchange standards, and increased automation improves access and accuracy over Level 1.	Use of MITA data definitions and interfaces and automation of the steps further improves access and accuracy to 90% or better.	
		Refer to business process write-up		
How accessible is the information used in this process?	Information is stored in disparate systems.	Improvements in criteria used to identify cases streamlines access to data over Level 1.	Access to information ranges from 24 hours to 60 seconds.	
		Refer to business process write-up		
Business Capability Quality: Cost-Effectiveness				
What is the relationship of the cost of this process to the benefit of its results?	A primarily manual process meets compliance thresholds dictated by regulations.	Cost-effectiveness improves with a mix of manual and automated processes over Level 1.	Shared services, MITA standard interfaces, and inter-agency collaboration further improve cost-effectiveness over Level 2.	



		Refer to business process write-up		
Business Capability Quality: Effort to Perform; Efficiency				
How efficient is this End to End process?	Manual processing, lack of coordination with other processes, duplicative work, and lack of standards results in many opportunities to create or improve efficiency.	Increased automation, coordination with other processes, and introduction of standards improves efficiency over Level 1.	Use of MITA standards and reusable services further increases efficiency over Level 2.	
		Refer to business process write-up		
Business Capability Quality: Accuracy of Process Results				
How accurate are the results of the process?	Lack of data accuracy and completeness, lack of process integration, and manual processing negatively impacts the accuracy of the process.	Automation of business rules and process centralization, use of electronic interchange, standardization of data, and automated steps increases coordination, improves consistency, and simplifies data access over Level 1.	Use of MITA standards further improves accuracy over Level 2. Application of business rules is consistent at least 99% of the time.	
		Refer to business process write-up		
Business Capability Quality: Utility or Value to Stakeholders				
What is the level of satisfaction of stakeholders?	Lack of data accuracy and incomplete data plus manual processing negatively impacts satisfaction.	Electronic interchange and automated processes, increased coordination and improved timeliness, consistency, and access improves the satisfaction about the process. Stakeholder satisfaction is higher than found at level 1.	Increased automation and the use of MITA standard interfaces improves stakeholder satisfaction to 80% or higher.	



		Refer to business process write-up		
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PI Manage Case				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions				
This Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				
How integrated or centralized is the process?	The process is duplicated in multiple parts of the organization (siloed). There is little coordination among agency programs or between the Medicaid Enterprise and other stakeholders (e.g., other State agencies, CMS, intermediaries, other payers) in relation to this process.	The process is integrated within the Medicaid Enterprise. There is improved coordination between the Medicaid agency and other stakeholders in relation to this process.	MITA data standards enable data exchanges between the Medicaid Enterprise and other stakeholders in relation to this process.	
		Refer to business process write-up		
Is the process manual or automated?	The process consists primarily of manual, paper based steps. Manual compilation of data is required.	The process is a mix of manual and automated steps. Manual compilation of data remains a requirement in some cases.	The process automates most activities in the workflow.	
		Refer to business process write-up		
Are data and format standardized?	The process is supported by proprietary and non-standardized data and format from multiple sources.	Steps for managing the case, acquiring additional information, and reporting follow a State-specific protocol.	MITA data standards and standard interfaces are implemented.	
		Refer to business process write-up		



How well does the process meet State and Federal requirements?	The process conforms to State and Federal regulations.	The process conforms to regulations and facilitates cost management and ongoing quality improvement.	The process is enhanced over Level 2 and also supports outcome-oriented program management; meets MITA standards, and supports the shift to shared business services.	
		Refer to business process write-up		
Business Capability Quality: Timeliness of Process				
What Is the Timeliness of End to End Process?	Case management is primarily a manual process including a desk review of medical records and evidence, request for additional data, on-site audit of provider location, and final disposition and reporting. The process requires 3 months or more from the time the case is identified.	Some use of electronic interchange, automation of some steps, and internal data standards increase coordination and consistency, thus improving end-to-end time frames for communication and processing. The process requires 2 months or less from the time the case is identified.	Use of electronic interchange in all but exceptional situations minimizes time frames for the receipt/exchange of data. Processing is real-time and communications (i.e., request for and receipt of medical record) are immediate. Process requires 1 month or less to reach resolution.	
	Refer to business process write-up			
Business Capability Quality: Data Access and Accuracy				
How accurate is the information available to the process?	Manual processes can negatively impact accuracy.	Internal standardization of data, use of HIPAA data exchange standards, and increased automation improves access and accuracy over Level 1.	Use of MITA data standards and interfaces and automation of the steps further improves access and accuracy to 90% or better.	
		Refer to business process write-up		



How accessible is the information used in the process?	Access to data is limited by inconsistent and untimely receipt of and updates to information. Data acquisition to support the case may take 60 days or more.	Implementation of standardized processes simplifies data access improves over Level 1.	MITA data standards allow automation of routine access to information improves over Level 2. Exceptions can be researched through real-time access to data via MITA interfaces that provide users with a unified access point. Access to information takes 24 hours or less.	
		Refer to business process write-up		
How accessible are external interfaces (specifically Social Security Administration (SSA), Drug Enforcement Agency (DEA), Federal Drug Administration, Centers for Medicare and Medicaid Services, Provider Associations, etc.)?	The process relies on external interfaces to provide data on providers', members', contractors', and program qualifications. This data validation depends upon phone, fax, and limited email communication..	The process uses data and format standards that both parties (industry standards) can use. Data validation is a mixture of automated and manual activities.	MITA and Industry standards enable at least 90% automated data exchange with external stakeholders.	
		Refer to business process write-up		
Business Capability Quality: Cost-Effectiveness				
What is the relationship of the cost of this process to the benefit of its results?	This primarily manual process complies with thresholds dictated by regulations but cost effectiveness is negatively impacted by manual activities.	State defined data and content standards, centralization, as well as coordination among agency programs, improves cost-effectiveness and ongoing quality improvement, with a mix of manual and automation processes over Level 1.	Shared services, MITA standard interfaces, and inter-agency collaboration further improve cost-effectiveness over Level 2.	
		Refer to business process write-up		
Business Capability Quality: Effort to Perform; Efficiency				



How efficient is this End to End process?	Manual processing, lack of coordination with other processes, duplicative work, and lack of standards result in many opportunities to create or improve efficiency.	Increased automation, coordination with other processes, and introduction of standards reduce duplicative work and create more efficiency over Level 1.	Use of MITA standards and reusable services further increases efficiency over Level 2.	
		Refer to business process write-up		
Business Capability Quality: Accuracy of Process Results				
How accurate are the results of the process?	Manual processes can negatively impact accuracy.	Automation of business rules and process centralization, use of electronic interchange, standardization of data, and automated steps increases coordination, improves over Level 1.	Application of business rules is consistent at least 98% of the time. Use of MITA standards further improves quality and accuracy over Level 2.	
		Refer to business process write-up		
Business Capability Quality: Utility or Value to Stakeholders				
What is the level of stakeholder satisfaction?	Stakeholder satisfaction is negatively impacted by manual processes, with few resources dedicated to improvement and few measurements in place, e.g. reliance on complaints, legal mandates for action regarding improving stakeholder satisfaction.	Medicaid enterprise begins to identify gaps in levels of satisfaction and stakeholder expectations and priorities. Improvements are made strategically, increasing stakeholder satisfaction over Level 1.	Medicaid enterprise conducts internal and external audits/focus groups which take into consideration the results of its previous research along with other national standards to identify additional stakeholder expectations and priorities. Improvements are made based on national and MITA best practices, improving stakeholder satisfaction over Level 2.	
	Have not conducted a stakeholder satisfaction survey			



CM Manage Case				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions				
This Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				
Is this business process primarily manual or automated?	The process consists primarily of manual, paper based steps. Information is manually compiled; decisions based on interventions are subjectively determined.	This process is a mix of manual and automated reporting processes. Compiled data includes a mix of information gathered manually and automated reports.	Automation of most activities is in the workflow process. Notifications, requests for information, and other communications are transmitted using EDI standards.	
		Refer to business process write-up		
Does this business process use standards?	Manual actions are used to monitor compliance thresholds established by state and federal regulations, professional standards, or administrative rules governing the appropriate management of a case. Case data is indeterminate.	A mix of manual and automated processes is used to monitor compliance thresholds established by state and federal regulations, professional standards, or administrative rules. Some case data is based on HIPAA data standards.	MITA standard interfaces are used.	
	Refer to business process write-up			
How does the Medicaid agency collaborate with other agencies or entities in performing this process?	The business process consists primarily of manual processes (e.g., telephone contacts, facsimile, letters) to gather and share information between social services agencies, physician offices, and other provider types to coordinate care.	An automated process documents care plan and tracks cases. Authorized users are permitted to access other databases and retrieve pertinent information about the patient (i.e., eligibility, claims history).	Medicaid enterprise and other agencies collaborate through specific agreements to share responsibility in the identification, management, and funding of cases.	



	Refer to business process write-up			
Business Capability Quality: Timeliness of Process				
How timely is this end-to-end process?	The process meets State and Federal guidelines and national utilization review standards for timeliness of case reviews. Gathering of case data is dependent on manual processes and ability to locate information.	The process uses automated reports for tracking compliance with state and federal guidelines for case management and for the delivery of care, improving timeliness over	All information needed to manage the case is immediately available. Any manual interventions that occur outside of the Level 3 business service is an exception.	
	Timeliness is negatively impacted due to the manual processes.	Level 1.		
	Refer to business process write-up			
Business Capability Quality: Data Access and Accuracy				
How accurate is the information used in this process?	Manual processes result in subjective selection of data to be used. Some data may be incomplete, inaccurate, or irrelevant.	Automation and use of HIPAA standards increases accuracy and consistency of data over Level 1.	Use of MITA standard interfaces and data definitions improves accuracy of data over Level 2.	
			Data accuracy is measured at 90% of total data collected.	
	Refer to business process write-up			



How accessible is the information used in this process?	<p>The process manually gathers State-specific data elements.</p> <p>Access to data is controlled manually. Data access may take several business days.</p>	<p>The process is automated making information immediately available to authorized users. Data content and format uses its version of national data standards (e.g., HIPAA) for interfaces. It may use State specific standards for processing.</p> <p>The process uses on-line access to data. Data access is faster than at Level 1.</p>	<p>The process utilizes MITA standards for its interfaces and processing.</p> <p>The process has immediate access to standardized data. Data access takes no more than 3 seconds.</p>	
	Refer to business process write-up			
Business Capability Quality: Cost Effectiveness				
What is the ratio of the cost to perform this process compared to the benefits of the results?	<p>The process meets State budget guidelines or established dollar thresholds for case savings.</p>	<p>Improvements in automation increase cost effectiveness over Level 1.</p>	<p>The process demonstrates the Return on Investment projected by the Medicaid enterprise due to MITA standard interfaces. Cost effectiveness improves over Level 2.</p>	
	Have not conducted a cost-benefit analysis			
Business Capability Quality: Effort to Perform; Efficiency				
How efficient is this process?	<p>Manual processes identify services or actions to be performed and points for intervention. Opportunities for improvements exist at many points in the process.</p>	<p>Combination of manual and automated processes results in reduced time to identify services/actions to be performed and points for intervention. Efficiency improves over Level 1.</p>	<p>The process is fully automated to push and pull data from other systems and improve communications between case manager, member, and providers.</p>	
	Refer to business process write-up			
Business Capability Quality: Accuracy; Usefulness of Process Results				



How accurate are the results of this process?	<p>The process meets State and Federal expectations for member education, coordination of care between providers, and maintaining the plan of care.</p> <p>Decision making for the process is manually performed using established parameters and guidelines and may result in some subjective and inconsistent decisions.</p>	<p>Decision making for the process is based on Medicaid enterprise policy which has been automated resulting in uniform decisions in most situations. Outliers are reviewed on case-by-case basis using State and Federal guidelines.</p> <p>Process results are more consistent than at Level 1.</p>	<p>MITA standard interfaces and automation of the workflow further increase accuracy over Level 2.</p> <p>Process results are consistent at least 95% of the time.</p>	
	Refer to business process write-up			
Business Capability Quality: Utility or Value to Stakeholders				
How satisfied are the stakeholders?	<p>Stakeholder satisfaction is negatively impacted with few resources dedicated to improvement and few measurements in place, e.g. reliance on complaints, legal mandates for action regarding improving stakeholder satisfaction.</p>	<p>States begin to identify gaps in level of satisfaction and stakeholder expectations and priorities. Improvements are made strategically, increasing stakeholder satisfaction over Level 1.</p>	<p>Medicaid enterprise conducts internal and external audit/focus groups which take into consideration the results of its previous research along with other national standards to identify additional stakeholder expectations and priorities. Improvements are made based on national and MITA best practices, improving stakeholder satisfaction over Level 2.</p>	
	Have not conducted a satisfaction survey			



SC New Enter Claim				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions This Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				
How are claims submitted?	Claims are submitted hard copy and electronic formats (proprietary and state-specific)	Claims are submitted hard copy and electronic formats (following HIPAA standards).	The majority of claims are submitted electronically via interface and follow MITA-standards.	
		Refer to business process write-up. Receive electronic tapes from providers and interface.		
Is claim content validated for required fields?	Manually prescreened	Minimally electronically prescreened.	Full electronic validation.	
	Refer to business process write-up			
Business Capability Quality: Timeliness of Process				
How timely is the process from claims receipt to transmission to MMIS?	Several business days	Day of receipt	Immediate	
Business Capability Quality: Data Access and Accuracy				
How are hard copy claims stored?	Claims are imaged and not centrally stored (i.e. microfilm). Data storage span meets state and federal requirements.	Claims are imaged and centrally stored. Data storage span exceeds state and federal requirements.	Claims are archived and available for online viewing by authorized users. Data storage span is infinite.	
	Refer to business process write-up			
How are electronic claims stored?	Claims are not centrally stored. Data storage span meets state and federal requirements.	Claims are centrally stored. Data storage span exceeds state and federal requirements.	Claims are centrally stored and available for online viewing. Data storage span is infinite.	



How accurate is the data entered into MMIS?	Manual mark-up and manual data entry can lead to errors	Electronic claims entry reduces errors, but manual data entry errors remain.	Electronic claims entry and real-time entry validation nearly eliminates claims entry error.	
	Refer to business process write-up.			
Is there an audit trail?	There is no audit trail.	There is a minimal audit trail.	There is a full audit trail.	
	Refer to business process write-up.			
Business Capability Quality: Cost-Effectiveness				
How cost-effective is this model of claims entry?	Model is manual and is not cost-effective.	Model is a mix of manual and automated processes and improves cost-effectiveness.	Model is entirely automated and is cost-effective.	
		Refer to business process write-up		
Business Capability Quality: Effort to Perform; Efficiency				
How efficient is this process from claims receipt to entry in MMIS?	A high number of staff are required to open, sort, prescreen, image, key, and verify hard copy claims and to load electronic media claims.	Staff numbers are reduced by the introduction of automated processes.	Staff numbers are further reduced by a fully automated process.	
	Refer to business process write-up.			
Business Capability Quality: Accuracy of Process Results				
How accurate are the results of the process?	95% accuracy	98% accuracy	99% accuracy	
		Refer to business process write-up		
Business Capability Quality: Utility or Value to Stakeholders				



How satisfied are the stakeholders with the process? Note: Provider satisfaction is influenced not just by automation but also by maintaining variety of claims submission options.	Stakeholder satisfaction among all parties is relatively low.	Some stakeholder groups are satisfied.	All stakeholder groups are satisfied with this process.	
	We have not conducted a stakeholder satisfaction survey.			

SC New Perform Adjustment				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions This Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				
How are adjustments submitted?	Hard copy only. Entered into MMIS manually.	Mix of hard copy and electronic entry of adjustments. Electronic adjustments adhere to HIPAA standards.	All adjustments are submitted electronically.	
		Refer to business process write-up		
Are adjustments linked to claims?	Adjustments are gross-level and not linked to claims.	Adjustments are a mix of claim-level and gross-level.	All adjustments are linked to claims.	
		Gross-level adjustments are still required in certain cases - Refer to business process write-up.		
Business Capability Quality: Timeliness of Process				
How timely is the adjustment process from submission to reflection of adjustment on remittance advice?	Several weeks (i.e., potentially several claims cycles).	Several business days.	Immediate	



	Refer to business process write-up			
Business Capability Quality: Data Access and Accuracy				
How are completed and submitted adjustments accessed?	Hard copy adjustment forms are scanned and entered like claims.	Hard copy adjustment forms are scanned and entered like claims, with images archived. Electronic adjustments are accessed through MMIS.	All adjustments are centrally located and accessed via MMIS.	
		Refer to business process write-up.		
Business Capability Quality: Cost-Effectiveness				
How cost-effective is this model of adjustment?	Model is manual and is not cost-effective.	Model is a mix of manual and automated processes and improves cost-effectiveness.	Model is entirely automated and is cost-effective.	
		Refer to business process write-up		
Business Capability Quality: Effort to Perform; Efficiency				
How efficient is the adjustment process from submission to reflection of adjustment on remittance advice?	A high number of staff including contractor and program areas are required to generate and enter hard copy claim level adjustments, or to calculate and initiate gross level adjustments.	Staff numbers are reduced by the introduction of automated processes and fewer gross level adjustments.	Staff numbers are further reduced by a fully automated, claim-linked process.	
		Refer to business process write-up.		
Business Capability Quality: Accuracy of Process Results				
How accurate are the results of the process?	95% accuracy	98% accuracy	99% accuracy	
		Refer to business process write-up		
Business Capability Quality: Utility or Value to Stakeholders				
How satisfied are the stakeholders with the process?	Stakeholder satisfaction among all parties is relatively low.	Some stakeholder groups are satisfied.	All stakeholder groups are satisfied with this process.	



	We have not conducted a stakeholder satisfaction survey.			
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SC New Manage Edit Correction Forms				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions This Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				
How data is exchanged?	ECFs are hard copy only. Sent by courier and USPS. Corrected by hand. Entered into MMIS manually	ECFs are provided electronically online. ECFs are still submitted and entered manually.	All claim correction is automated and electronic.	
	Refer to business process write-up			
Are validation activities manual or automated?	Manual	Mix of manual and automated	Fully automated	
	All logic and processing rules are manual. No input logic exists in MMIS. ECF correction standards available in provider manual. Refer to business process write-up			
Business Capability Quality: Timeliness of Process				
How timely is the process from claims suspension/rejection to entry of corrected ECF?	Several weeks or months.	Several business days.	Immediate	
	Refer to business process write-up			
Business Capability Quality: Data Access and Accuracy				
How are completed and submitted ECFs accessed?	ECFs are processed and marked-up copies are not stored.	Hard copy ECFs are maintained and imaged.	ECFs are maintained electronically, or no ECFs are used.	



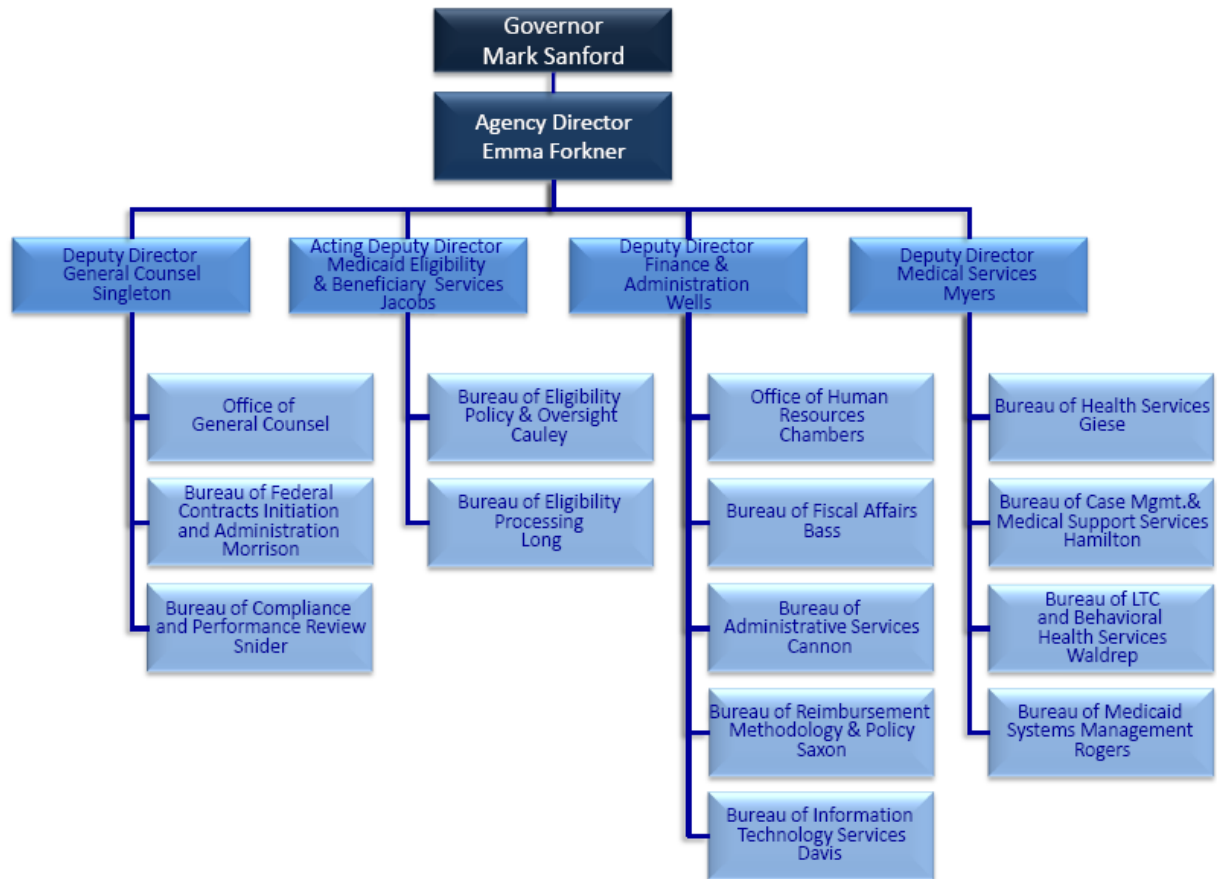
How accurate is the data entered into MMIS?	Manual mark-up and manual data entry can lead to errors	Data is entered manually. MMIS has edits to check entries.	Real-time claim correction. Automated	
	Refer to business process write-up.			
Business Capability Quality: Cost-Effectiveness				
How cost-effective is this model of claim correction?	Model is manual and is not cost-effective.	Model is a mix of manual and automated processes and improves cost-effectiveness.	Model is entirely automated and is cost-effective.	
	Refer to business process write-up. Executive staff interest in electronic remittance advices and ECFs.			
Business Capability Quality: Effort to Perform; Efficiency				
How efficient is this process from claims suspension/rejection to entry of corrected ECFs?	A high number of staff including contractor and program areas are required to produce, mail, correct, and enter hard copy ECFs.	Staff numbers are reduced by the introduction of automated processes.	Staff numbers are further reduced by a fully automated process.	
	Refer to business process write-up.			
Business Capability Quality: Accuracy of Process Results				
How accurate are the results of the process?	95% accuracy	98% accuracy	99% accuracy	
		Refer to business process write-up		
Business Capability Quality: Utility or Value to Stakeholders				
How satisfied are the stakeholders with the process?	Stakeholder satisfaction among all parties is relatively low.	Some stakeholder groups are satisfied.	All stakeholder groups are satisfied with this process.	



		<p>We have not conducted a stakeholder satisfaction survey. However, informal data suggests providers are satisfied with the ECF process. Many agency staff are dissatisfied with the process.</p>		
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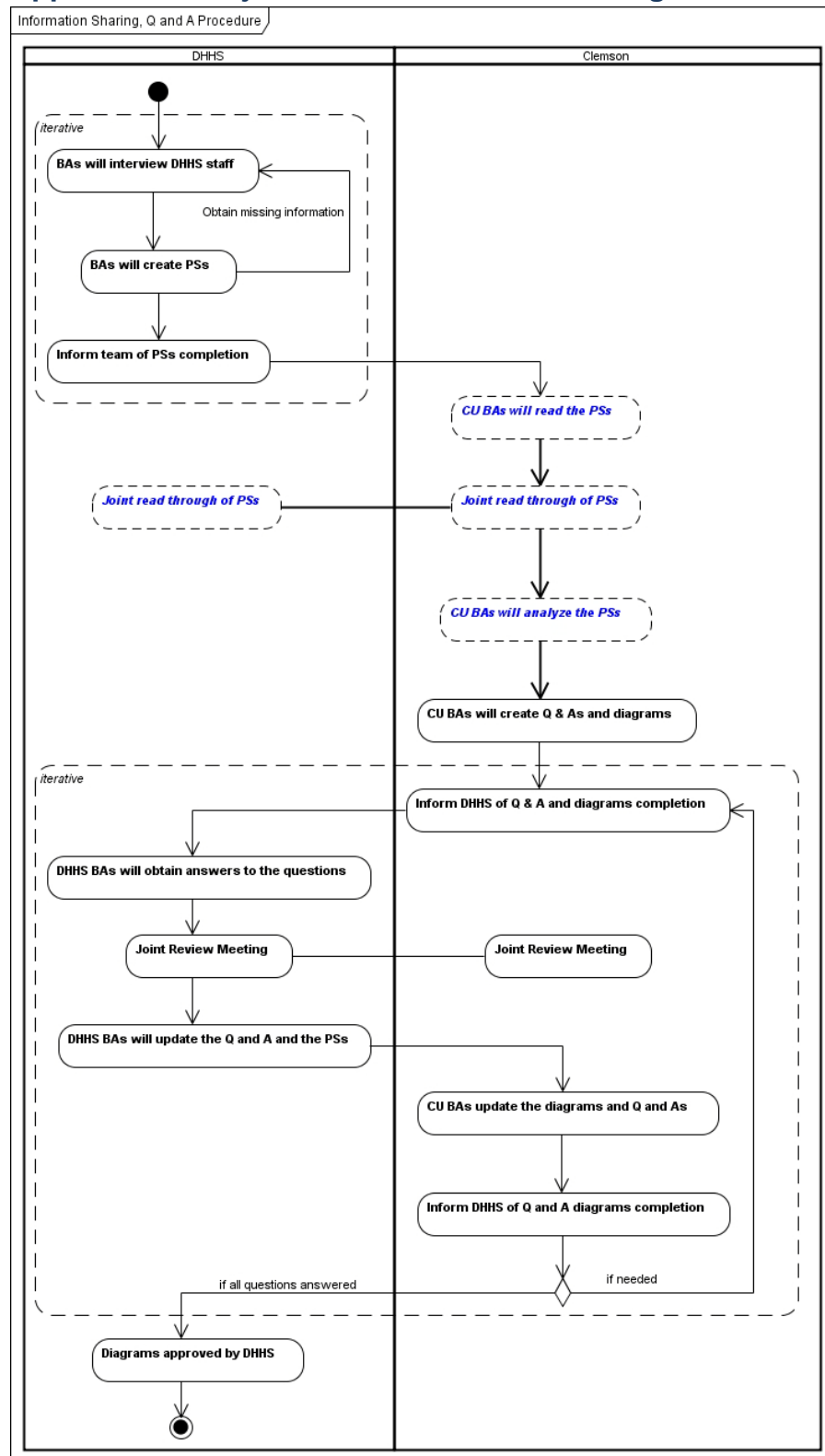


Appendix C: Agency Organization Chart





Appendix D: Project Communication Plan Diagram





Appendix E: List of Participants

Name		Area	Business Process(es), Interfaces, PC Application
Last	First		
Adams	Powanda	MMIS User Services	PM: Perform Provider Outreach
Ashford	Beverly	MGC Enrollment	PC Applications: BUS-Beneficiary Users System
Banks	Tammy	MMIS System Mgmt	MMIS Interfaces: Data Match
Barwick	Scarlett	Fiscal Services	PG: Manage FFP for MMIS, Draw and Report FFP, Manage FFP for Services, Manage F-MAP
Benecke	Mike	Bureau of Federal Contracts	PG: Develop and Manage Performance Measures and Reporting, Monitor Performance and Business Activity
Blakely	Mike	Pharmacy Department	OM: Authorize Referral, Authorize Service, Authorize Treatment Plan, Manage Drug Rebate PG: Designate Approved Services and Drug Formulary
BMSM	N/A	Bureau of Medicaid Systems Mgmt	MMIS Interfaces: Qualis, Milliman, DUR 1st IQ, IVRS, Care Call, USC, DDSN, MCO, COC, ACS, Gov Connect, TRICARE DEERS, SSA-8019, MCCS, ORS, DHEC, MHN
Boucher	Steve	Bureau of Federal Contracts	ME: Enroll Member, Disenroll Member OM: Prepare Capitation Premium Payment PG: Develop and Manage Performance Measures and Reporting, Monitor Performance and Business Activity
Brown	Bethanie	CLTC	OM: Authorize Referral, Authorize Service, Authorize Treatment Plan
Brown	Harvey	BITS	MMIS Interfaces: PFH PC Applications: Admin Days, Application-Xtender, BUS-Beneficiary Users System, CLTC-CMS, Hospital Services Tracking System, DME, Accounts Receivable Log (ARL), Cash Receipt Log System (CRL, Approach System, Check Cancellation System
Buchanan	Gail	Program Support	PG: Manage 1099s MMIS Interfaces: 1099s



Name		Area	Business Process(es), Interfaces, PC Application
Last	First		
Burkett	Felicia	MMIS User Services	CO: Perform Contractor Outreach PM: Enroll Provider, Disenroll Provider, Manage Provider Information, Inquire Provider Information, Manage Provider Communication, Manage Provider Grievance and Appeal PG: Manage Rate Setting
Busbee	Vanessa	CLTC	OM: Authorize Referral, Authorize Service, Authorize Treatment Plan
Cannon	Mike	Bureau Chief-Administrative Services	CO: Support Contractor Grievance and Appeal ME: Manage Member Grievance and Appeal PM: , Manage Provider Grievance and Appeal
Carlton	Jeanne	Behavioral Health Services	OM: Authorize Referral, Authorize Service, Authorize Treatment Plan
Carlyle	Lisa	Division of MEDS	ME: Disenroll Member, Enroll Member, Manage Member Information
Carrington	Shirley	Dental Department	OM: Authorize Referral, Authorize Service, Authorize Treatment Plan PC Applications: DPAS
Carter	Bruce	General Counsel	BR: Establish Business Relationship, Manage Business Relationship Communication, Manage Business Relationship, Terminate Business Relationship
Carter	Hope	Pharmacy Department	OM: Manage Drug Rebate
Clark	Melinda	Estate Recovery	OM: Manage Estate Recovery
Cooper	Pheobia	Behavioral Health Services	OM: Authorize Referral, Authorize Service, Authorize Treatment Plan
Cosby	Charley	Medicaid Systems Mgmt	ME: Inquire Member Eligibility OM: Inquire Payment Status
Covington	Julius	Beneficiary Eligibility	ME: Determine Eligibility, Enroll Member
Crouch	Vastine	Division of Appeals and Hearings	CO: Support Contractor Grievance and Appeal ME: Manage Member Grievance and Appeal PM: , Manage Provider Grievance and Appeal PC Applications: Appeals and Hearings System, Application-Xtender



Name		Area	Business Process(es), Interfaces, PC Application
Last	First		
Crout	Billy	DSIT	PC Applications: GAFRS
Davis	Patricia	Department of Interfaces	OM: Prepare Medicare Premium Payment MEDS Interfaces: SC State Retirement System (SCSRs), Employment Security Commission (ESC), State Data Exchange, Buy-in, Enumeration Verification System (EVS), Coordination of Benefits (COB), Medicare Modernization Act (MMA)
Davis	Rod	Bureau Chief-Information Technology Services	PC Applications: GAFRS
Derrick	Tara	TPL area	OM: Prepare COB, Manage TPL Recovery
Dimes	Erica	Division of Hospitals	OM: Authorize Referral, Authorize Service, Authorize Treatment Plan PM: Manage Provider Communication, Manage Provider Grievance and Appeal,
Douglas	Tamara	Central Eligibility Processing	PC Applications: Application-Xtender
Drayton	Ron	Bureau of Federal Contracts	PG: Manage 1099s
Eddins	Laurel	Office of Reporting and Special Projects	PG: Manage Program Information MMIS Interfaces: Thomson Reuters
Faulkenberry	Edith Moore	Division of Hospital Services	PG: Designate Approved Services and Drug Formulary PC Applications: Hospital Services Tracking System
Feagin	William	EPSDT	CM: Establish Case, Manage Case
Feaster	Rhonda	Community Long Term Care	OM: Authorize Referral, Authorize Service, Authorize Treatment Plan PC Applications: CLTC-CMS
Fernandez	Larry	Department of Managed Care	OM: Authorize Referral, Authorize Service, Authorize Treatment Plan
Fridy	Terri	Managed Care Enrollment	PC Applications: Application-Xtender, BUS-Beneficiary Users System
Fuller	Betsy	Division of	PC Applications: PFH



Name		Area	Business Process(es), Interfaces, PC Application
Last	First		
		Central Eligibility Processing	
Garick-Kelly	Kelley	Fiscal Affairs	PG: Perform Accounting Functions
Gaymon	Gwen	Division of TPL	OM: Prepare Premium EFT-check, Prepare Health Insurance Premium Payment
George	Bobby	Training-HR	PG: Develop Agency Goals and Objectives
German	Milton	Div of Financial Systems	PG: Perform Accounting Functions, Manage FFP for MMIS, Draw and Report FFP, Manage FFP for Services, Manage F-MAP PC Applications: Approach System
Giese	Melanie	BC-Bureau of Health Services	PM: Develop and Maintain Benefit Package, Develop Agency Goals and Objectives, Develop and Maintain Program Policy
Glover	Melanie	Managed Care Enrollment	PC Applications: BUS-Beneficiary Users System
Hall	Mark	MMIS Management	MMIS Interfaces: Continuum of Care (COC), Mental Health (DMH), DOE, SC SD&B
Hamilton	Beverly	Bureau Chief-Office of Medical Services	PM: Develop and Maintain Benefit Package, Develop Agency Goals and Objectives, Develop and Maintain Program Policy
Harbaugh	Bruce	Managed Care Enrollment	CO: Manage Contractor Information, Manage Contractor Communication, Perform Contractor Outreach PM: Manage Provider Communication ME: Perform Population and Member Outreach, Manage Applicant and Member Communication
Helliges	Jeff	Information Systems	MMIS Interfaces: MCOs
Hepfer	Rick	General Counsel	BR: Establish Business Relationship, Manage Business Relationship Communication, Manage Business Relationship, Terminate Business Relationship
Hickerson	Margie	CLTC	OM: Authorize Referral, Authorize Service, Authorize Treatment Plan
Hutto	Faye	Office of Finance	PG: Maintain State Plan



Name		Area	Business Process(es), Interfaces, PC Application
Last	First		
Hyleman	Brenda	Primary Care	OM: Authorize Referral, Authorize Service, Authorize Treatment Plan
Jackson	Molly	TPL, Fiscal Affairs	OM: Prepare COB, Prepare Premium EFT-check, Prepare Health Insurance Premium Payment, Manage TPL Recovery
Jacobs	Alicia	Deputy Dir	ME: Perform Population and Member Outreach, Disenroll Member, Enroll Member, Manage Member Information PG: Develop and Maintain Benefit Package
Jacobs	Benita	Dental	PC Applications: DPAS
Jefferson	Kia	Division of Community Options	OM: Authorize Referral, Authorize Service, Authorize Treatment Plan
Johnson	Renee	Department of Interfaces	OM: Prepare Medicare Premium Payment MEDS Interfaces: SC State Retirement System (SCSRS), Employment Security Commission (ESC), State Data Exchange, Buy-in, Enumeration Verification System (EVS), Coordination of Benefits (COB), Medicare Modernization Act (MMA)
Jones	Michael	Medicaid Systems Mgmt	ME: Disenroll Member, Enroll Member, Manage Member Information
Kelley	Rick	Database Administrator	PC Applications: Admin Days
Kerr	Amber	Estate Recovery	OM: Manage Estate Recovery
Larimore	Patty	Division of Procurement	CO: Close Out Contract, Manage Contract, Manage Contractor Information, Inquire Contractor Information, Manage Contractor Communication, Perform Contractor Outreach, Support Contractor Grievance and Appeal, Produce RFP
Lorick	Jennifer	Medical Finance	OM: Manage Drug Rebate
Martin	Mariann	MMIS User Services	OM; Edit Claim-Encounter, Price Claim- Value Encounter SC: Manage Edit Correction Forms, Enter Claim
McLeod	Diane	Diabetes Mgmt	CM: Establish Case, Manage Case



Name		Area	Business Process(es), Interfaces, PC Application
Last	First		
Milhouse	Paula	Policy/Planning, Eligibility/Policy Oversight	PC Applications: Application-Xtender
Mitchell-Threatt	Nicole	Mental Health and Rehabilitation	OM: Authorize Referral, Authorize Service, Authorize Treatment Plan
Mohamed	Zanipha	DME	ME: Manage Applicant and Member Communication OM: Authorize Referral, Authorize Service, Authorize Treatment Plan PC Applications: DME
Moore	Cynthia	Fiscal area	PG: Perform Accounting Functions
Moore	Eva	Bureau of Federal Contracts	PM: Perform Provider Outreach
Morrison	Rhonda	BC, Bureau of Federal Contracts	CO: Award Contract, Close Out Contract, Manage Contract, Manage Contractor Information, Inquire Contractor Information, Manage Contractor Communication, Perform Contractor Outreach, Support Contractor Grievance and Appeal, Produce RFP OM: Apply Mass Adjustment, Edit Claim-Encounter, Price Claim- Value Encounter, Prepare Provider EFT-check, Prepare Remittance Advice-Encounter Report, Prepare Capitation Premium Payment, Inquire Payment Status, Manage Payment Information PM: Perform Provider Outreach SC: , Manage Edit Correction Forms, Enter Claim, Perform Claim-Level Adjustment, Perform Gross-Level Adjustment PG: Develop and Maintain Benefit Package, Develop Agency Goals and Objectives, Develop and Maintain Program Policy ME: Disenroll Member, Enroll Member, Manage Member Information
Nowell	Steve	Division of Audits	PG: Develop and Manage Performance Measures and Reporting, Monitor Performance and Business Activity
Overbaugh	Larry	SURS	PC Applications: Program Integrity-Case Management System
Paeth	Brian	Fiscal	PG: Manage State Funds



Name		Area	Business Process(es), Interfaces, PC Application
Last	First		
Parker	Donna	Fiscal	PG: Formulate Budget, Manage State Funds
Patton	Maria	CLTC	OM: Authorize Referral, Authorize Service, Authorize Treatment Plan
Platanis	Maria	Medically Fragile Children's Program	OM: Authorize Referral, Authorize Service, Authorize Treatment Plan
Platts	Sheila	Disease Mgmt	CM: Establish Case, Manage Case
Riley	Margaret	Hospital Services	OM: Authorize Referral, Authorize Service, Authorize Treatment Plan
Risher	Anita	Payables	PG: Perform Accounting Functions PC Applications: Check Cancellation System
Rogers	Kevin	BC, BMSM	OM: Apply Mass Adjustment, Edit Claim-Encounter, Price Claim- Value Encounter, Prepare Provider EFT-check, Prepare Remittance Advice-Encounter Report PG: Manage Rate Setting, Manage Program Information SC: Manage Edit Correction Forms, Enter Claim ME: Disenroll Member, Enroll Member, Manage Member Information MMIS Interfaces: Companion HealthPort
Saxon	Jeff	BC-Reimbursement Methodology & Policy	OM: Manage Cost Settlement PG: Manage Rate Setting
Sessions	Neal	Division of PC Software	PC Applications: Appeals and Hearings System, CLTC-CMS, Hospital Services Tracking System
Sharpe	Nancy	MMIS User Services	CO: Perform Contractor Outreach OM: Edit Claim-Encounter, Price Claim- Value Encounter PM: Enroll Provider, Disenroll Provider, Manage Provider Information, Inquire Provider Information, Manage Provider Communication, Manage Provider Grievance and Appeal SC: Manage Edit Correction Forms, Enter Claim
Shealy	Virginia	Fiscal	PG: Manage F-MAP, Manage State Funds PC Applications: GAFRS



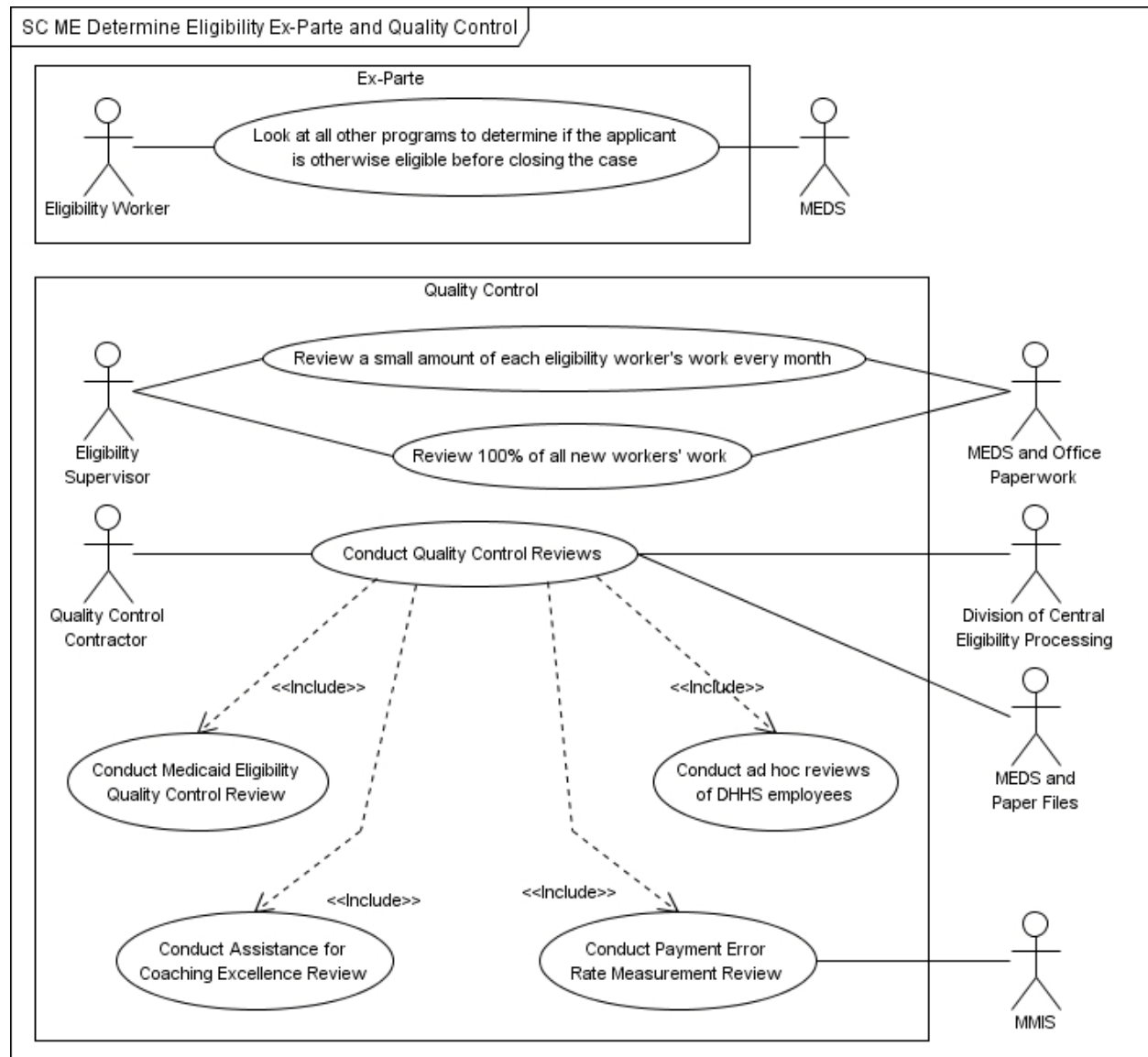
Name		Area	Business Process(es), Interfaces, PC Application
Last	First		
Smith	Roy	CLTC	OM: Authorize Referral, Authorize Service, Authorize Treatment Plan PC Applications: CLTC-CMS
Snider	Kathy	BC	OM: Prepare EOB PG: Develop and Manage Performance Measures and Reporting, Monitor Performance and Business Activity PI: Identify Candidate Case, Manage Case PC Applications: Program Integrity-Case Management System
Staley	Ernestine	Division of Contracts	CO: Award Contract, Close Out Contract, Manage Contract, Manage Contractor Information, Inquire Contractor Information, Manage Contractor Communication, Perform Contractor Outreach, Support Contractor Grievance and Appeal, Produce RFP Contract Log System (CLS)
Stewart	Gwendolyn	MMIS System Mgmt	MMIS Interfaces: USC, ORS, MHN
Thomas	Mary	Hospital Services	PC Applications: Admin Days
Tippins	Janice	MMIS User Services	CO: Perform Contractor Outreach PM: Enroll Provider, Disenroll Provider, Manage Provider Information, Inquire Provider Information, Manage Provider Communication, Manage Provider Grievance and Appeal PG: Manage Rate Setting
Twohey	Richard	User Interface	Admin Days, DME, DPAS
Vandegrift	Muriel	Estate Recovery	OM: Manage Estate Recovery
Vaughn	Zenovia	Division of Hospitals	PG: Designate Approved Services and Drug Formulary PC Applications: Hospital Services Tracking System
Waldrep	Sam	BC-Care Mgmt and Support Services	PM: Develop and Maintain Benefit Package, Develop Agency Goals and Objectives, Develop and Maintain Program Policy
Weimer	Donald	Division of MMIS System Mgmt	MMIS Interfaces: DDSN
West-Barnett	Angela	TPL, Fiscal Affairs	PC Applications: Application-Xtender



Name		Area	Business Process(es), Interfaces, PC Application
Last	First		
Wilson	Jametta	Div of Financial Systems	PG: Perform Accounting Functions PC Applications: Approach System
Wilson	Lynette	Fiscal Affairs, Accounts Receivable	PG: Perform Accounting Functions PC Applications: Application-Xtender, Accounts Receivable Log (ARL), Cash Receipt Log System (CRL)
Wood	Jim	Information Systems	MMIS Interfaces: PDP Part D
Yarrell	Ervin	Hospital Services	PM: Manage Provider Communication, Manage Provider Grievance and Appeal

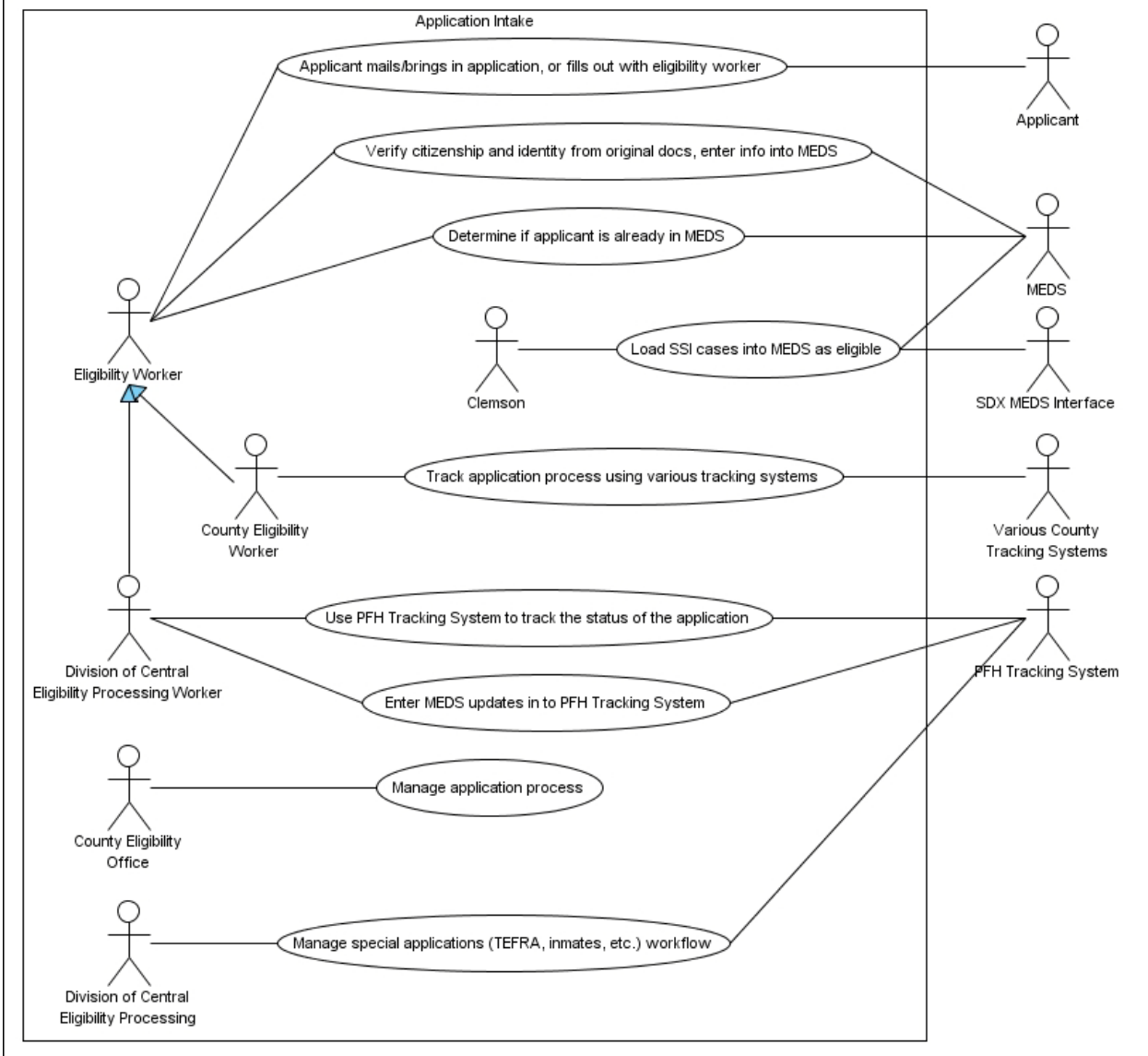


Appendix F: Use Case and Activity Diagrams



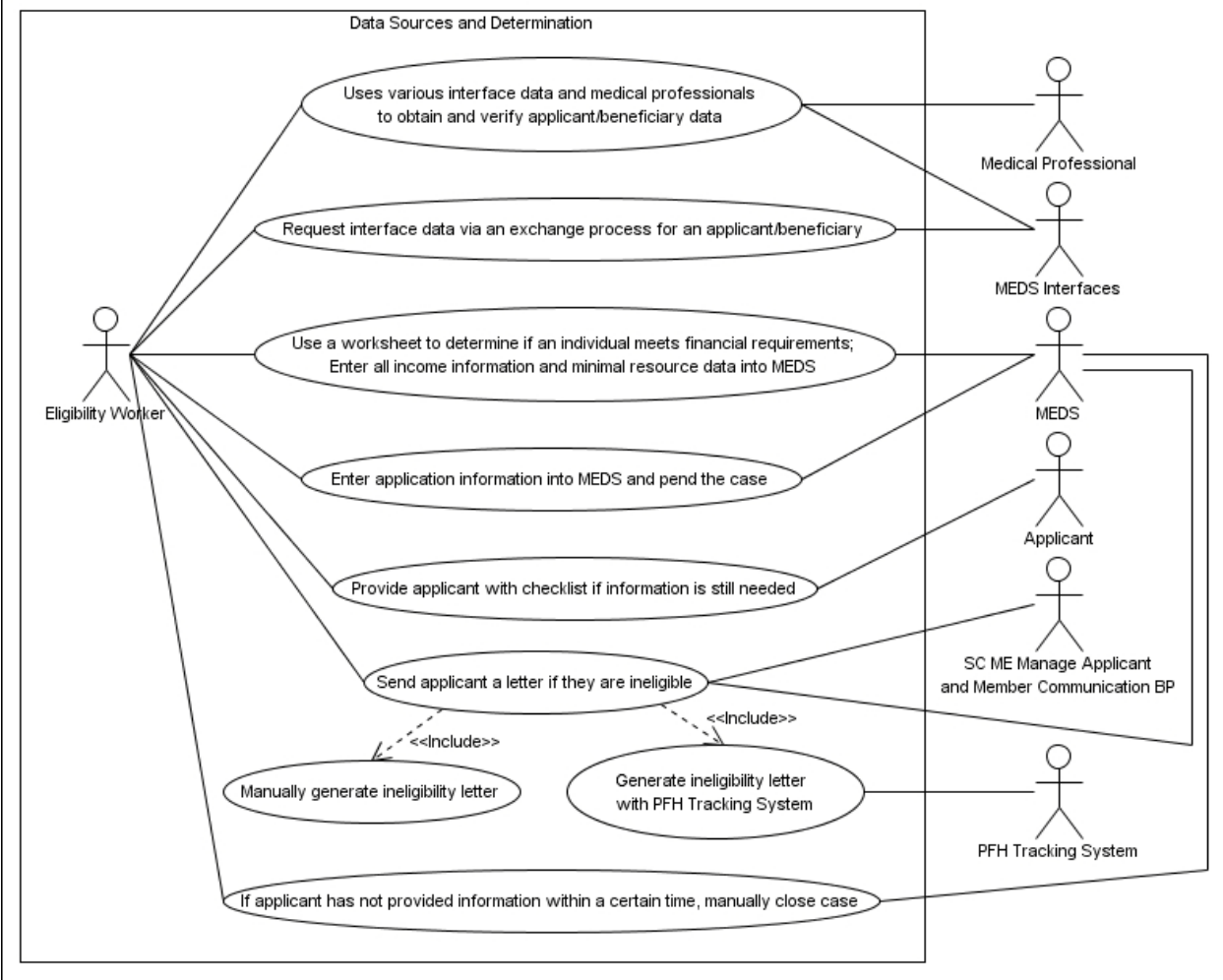


SC ME Determine Eligibility Application Intake



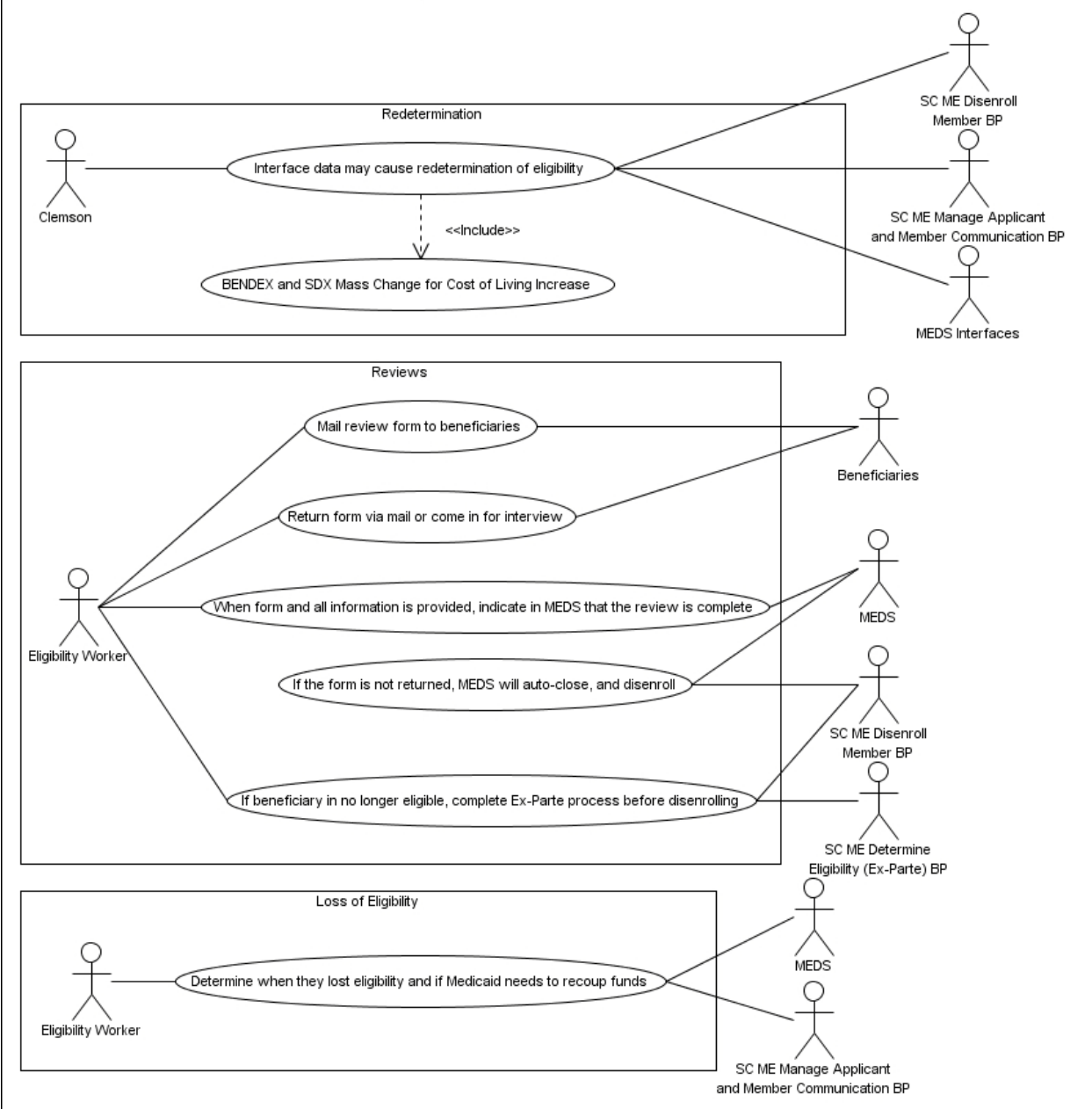


SC ME Determine Eligibility Data Sources and Determination



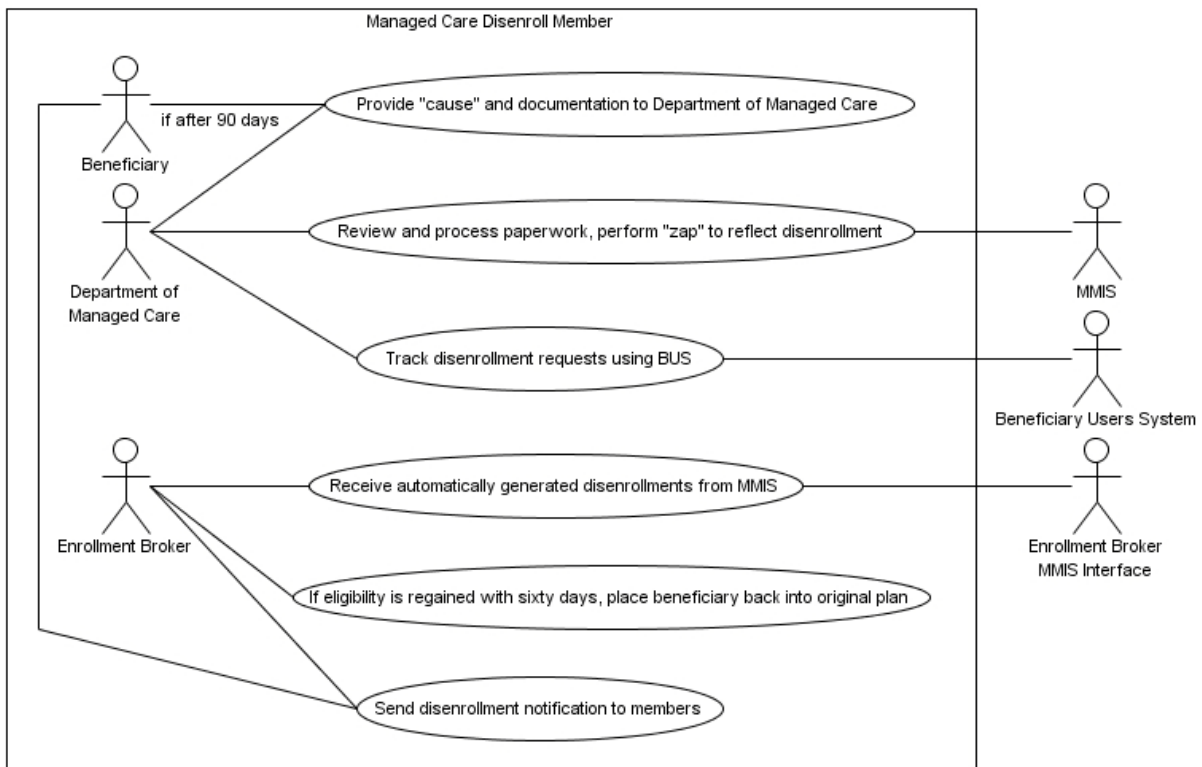


SC ME Determine Eligibility Redetermination and Reviews

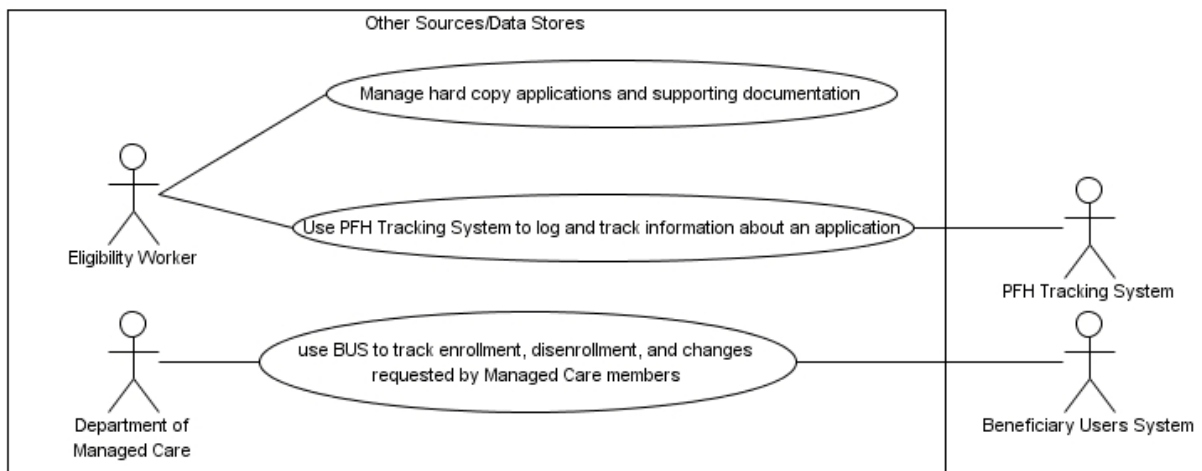


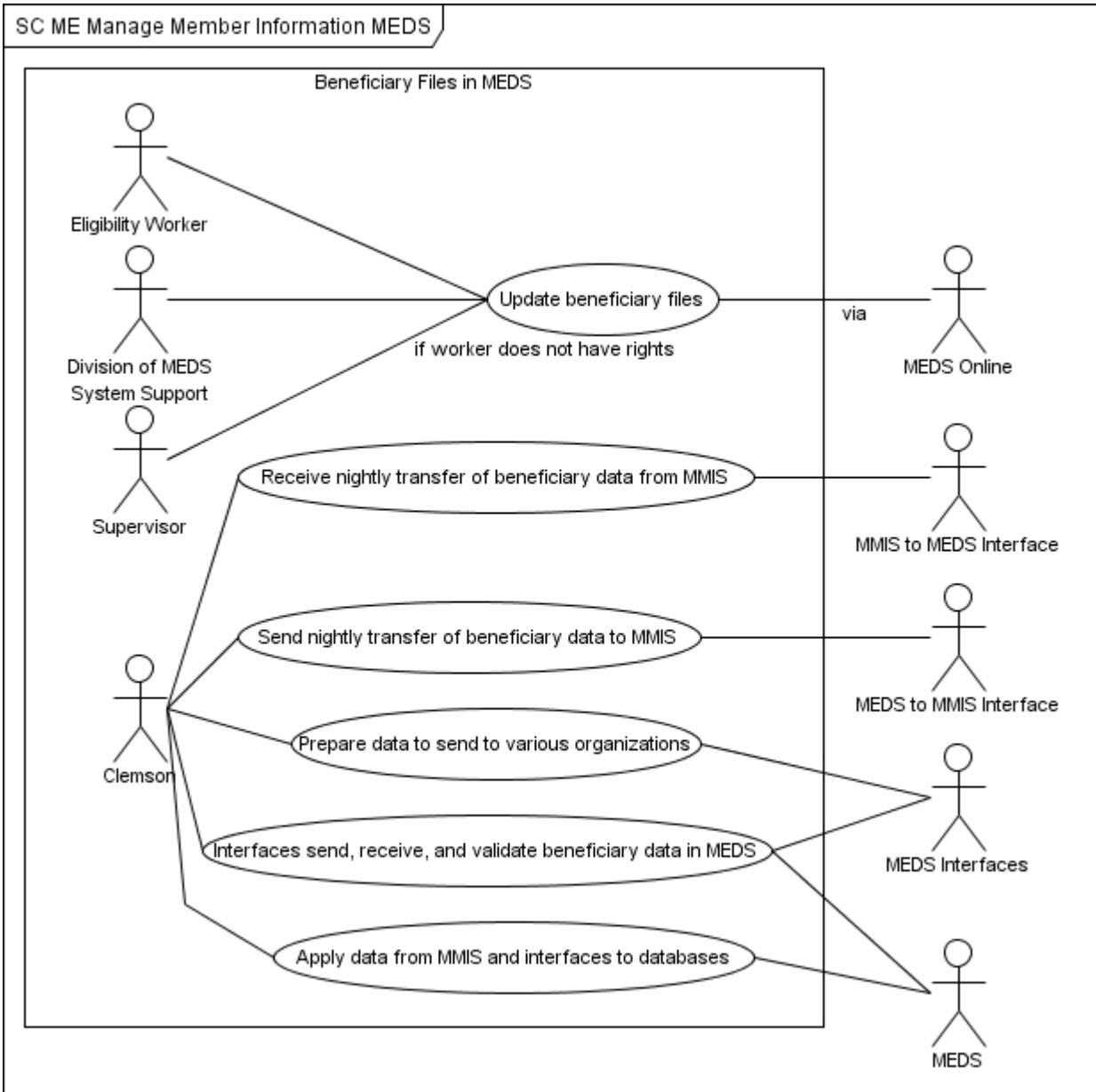


SC ME Disenroll Member Managed Care



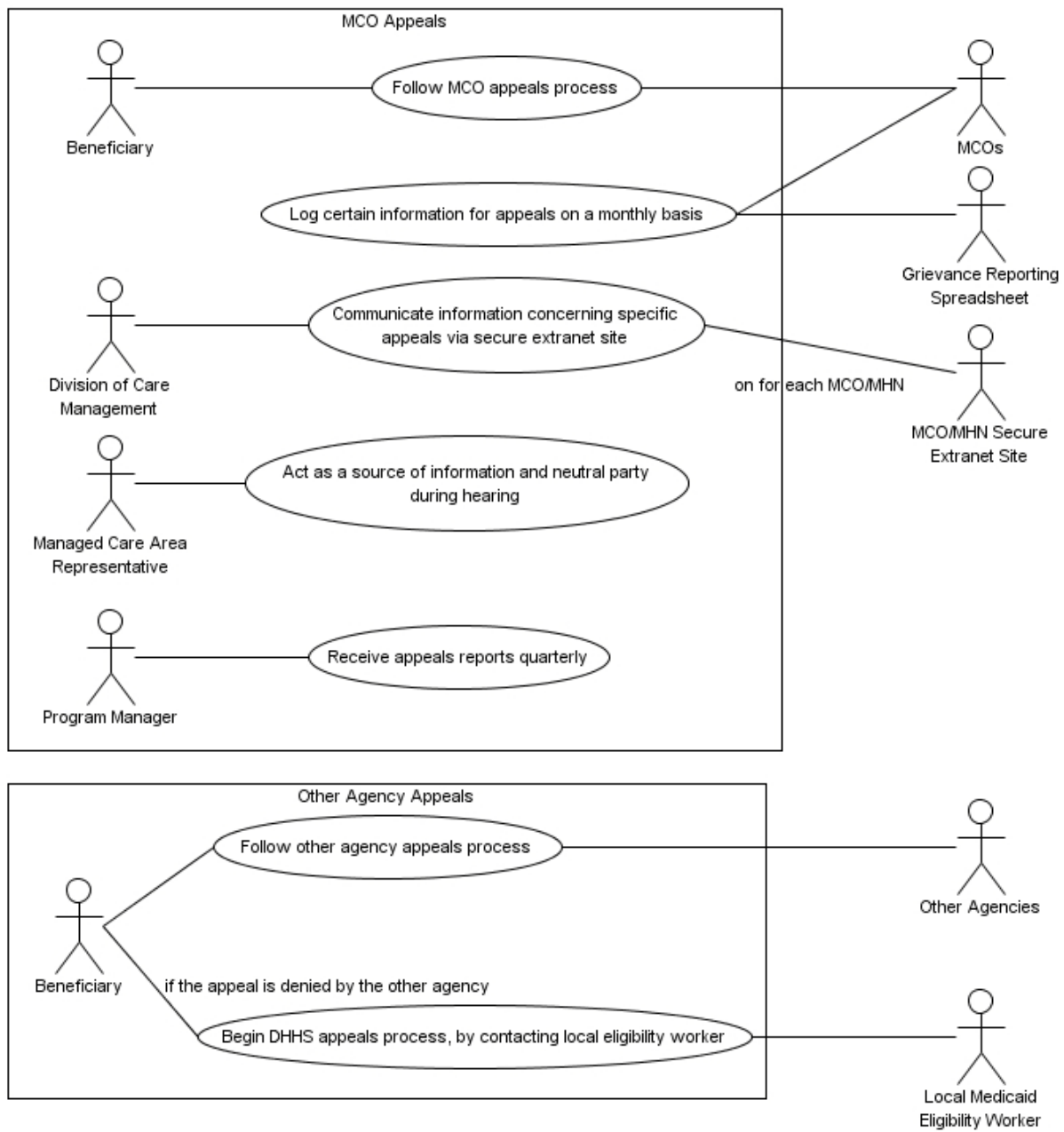
SC ME Manage Member Information Other Sources





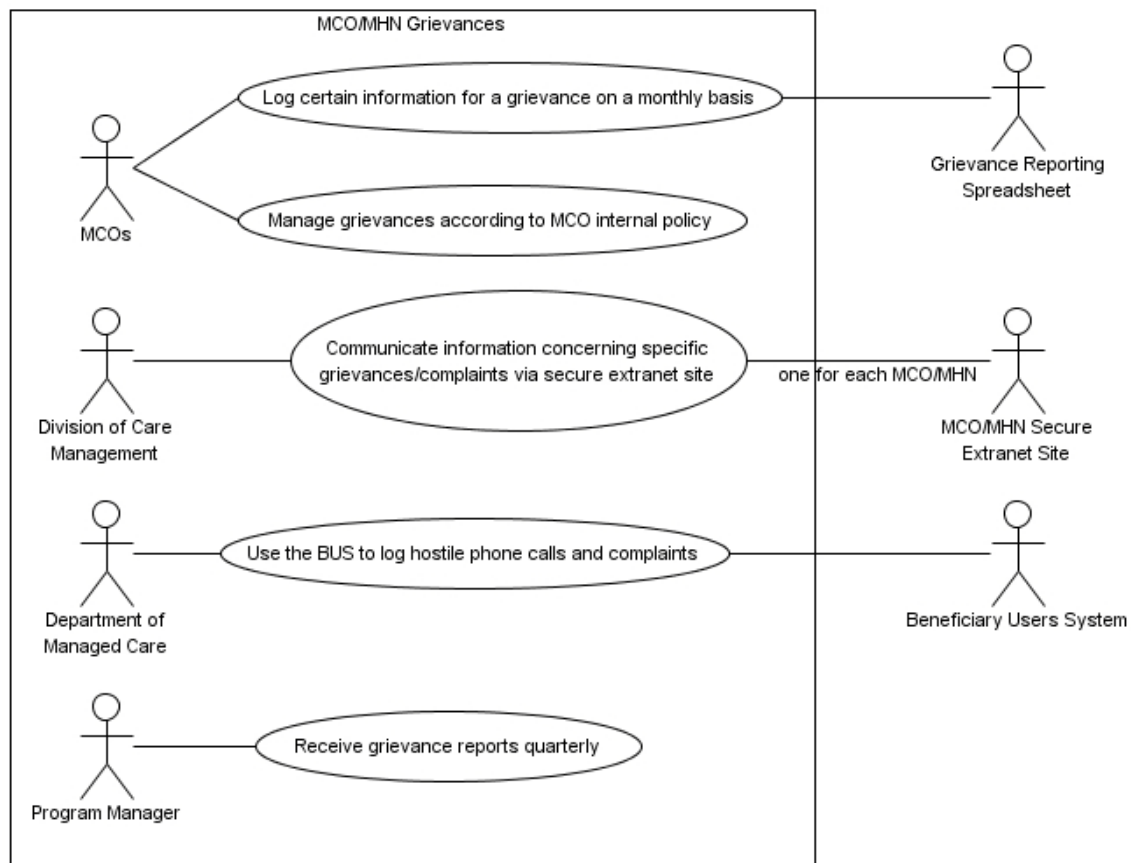
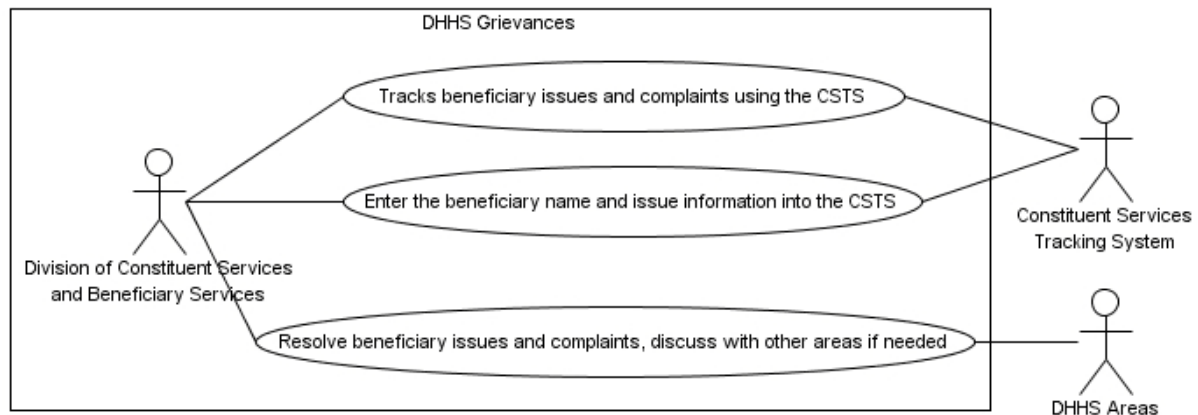


SC ME Manage MCO and Other Agency Appeals



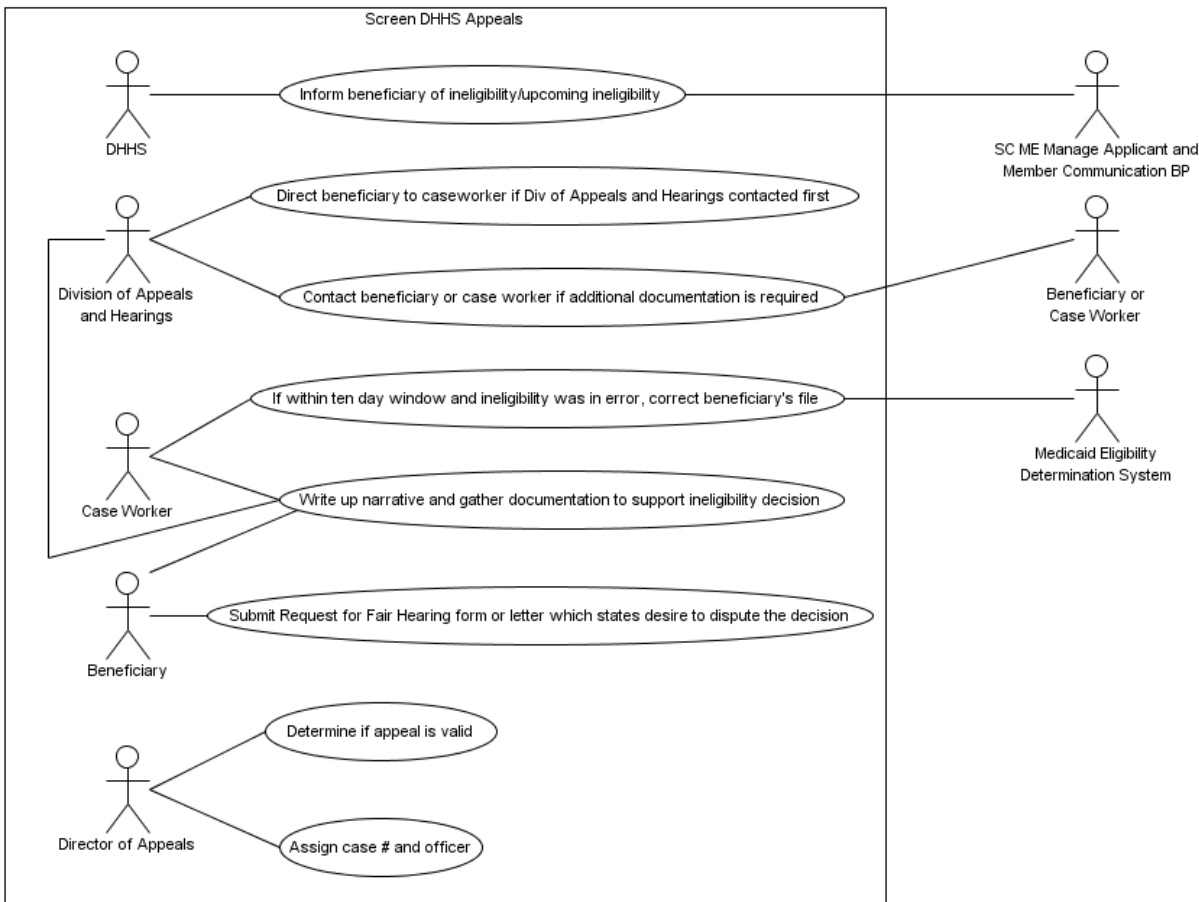


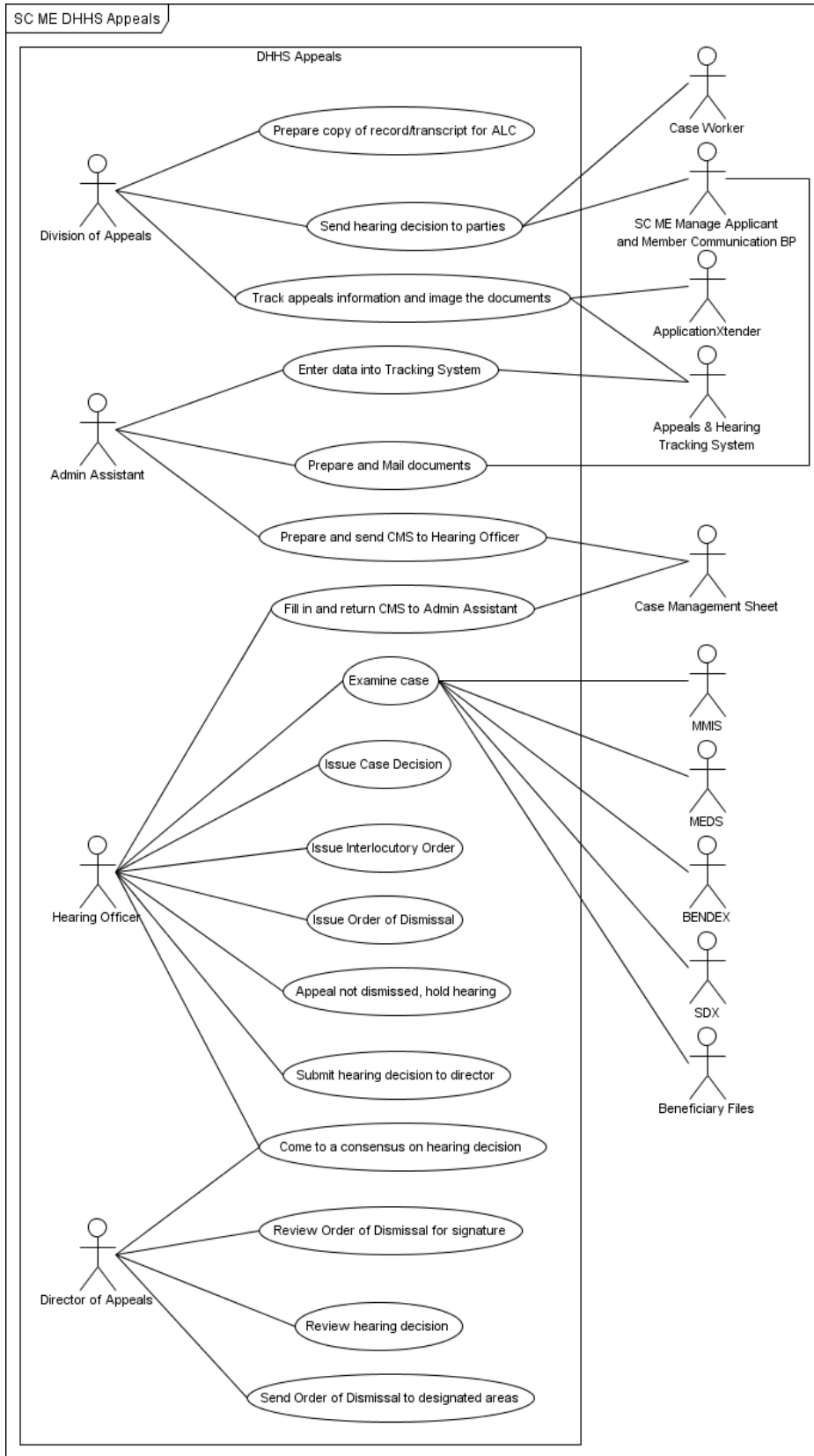
SC ME Manage Grievances





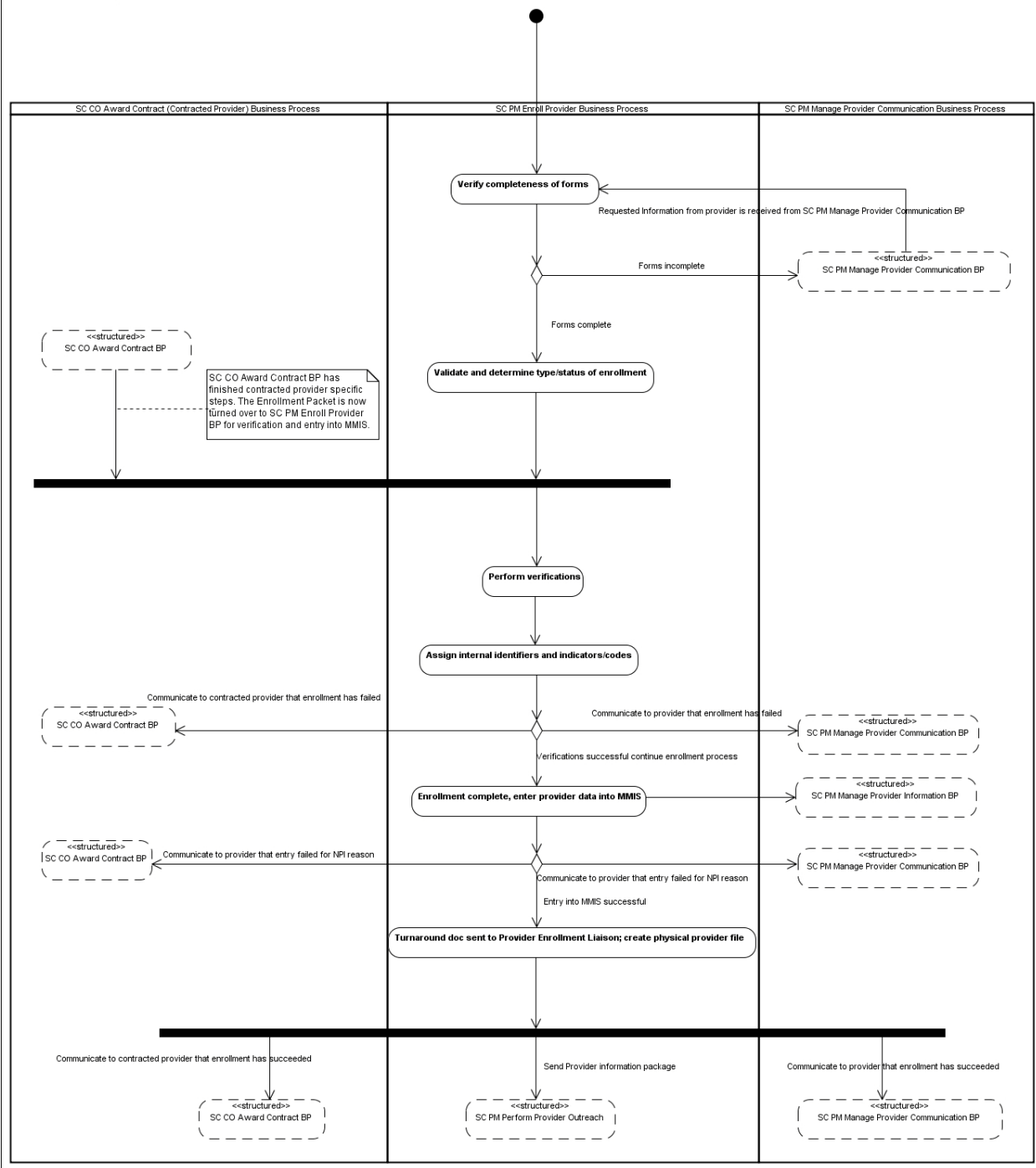
SC ME Screen DHHS Appeals

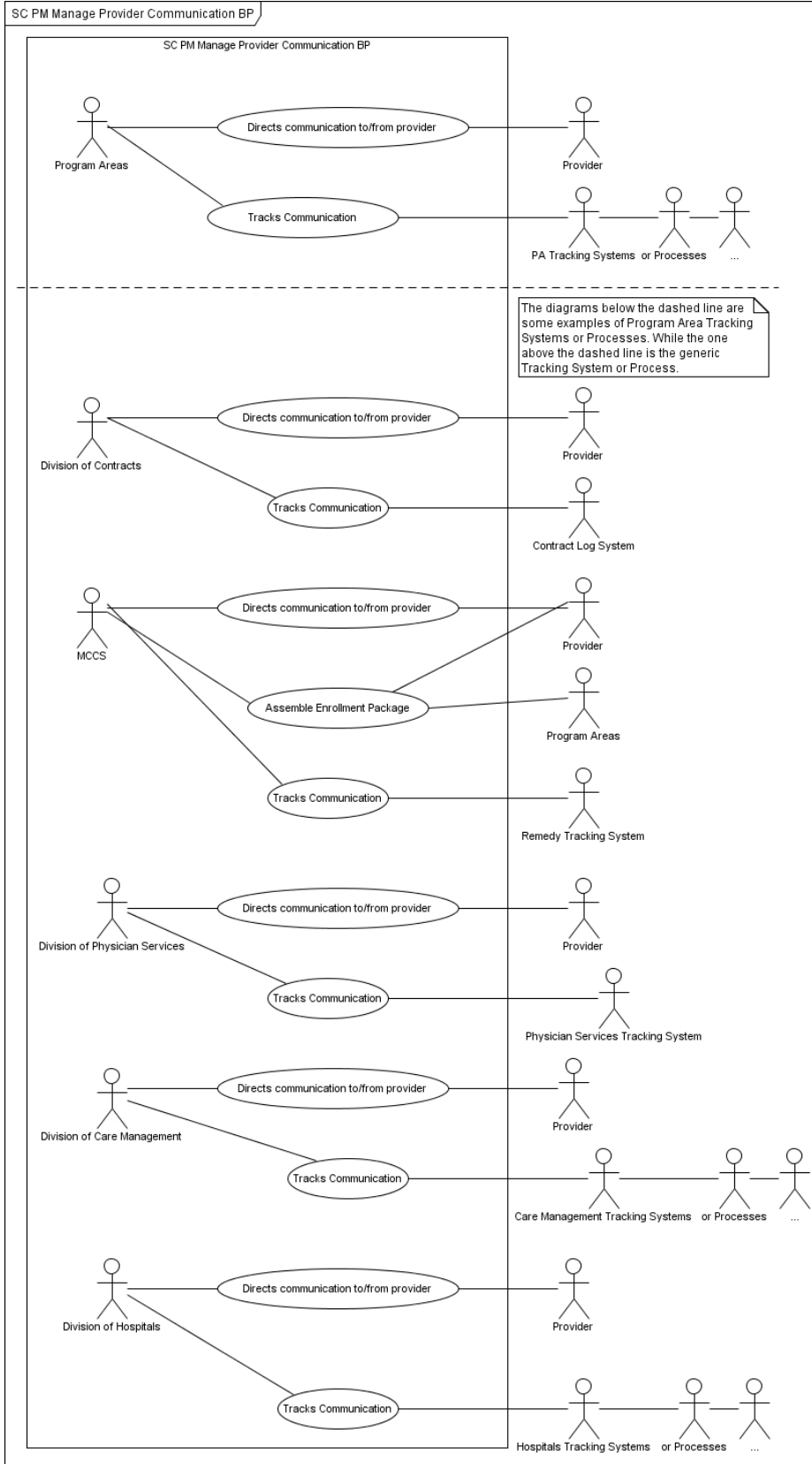






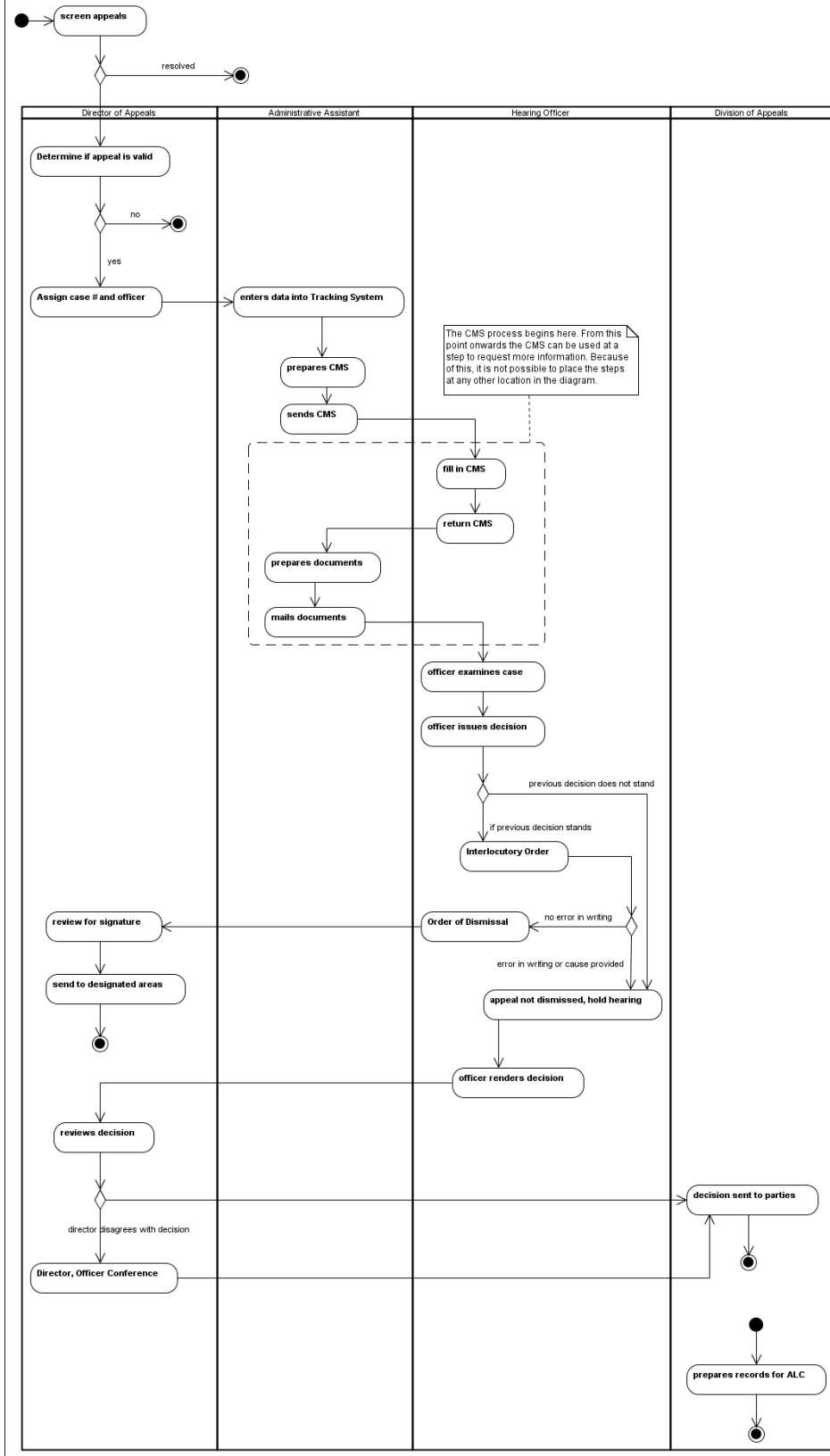
SC PM Enroll Provider BP





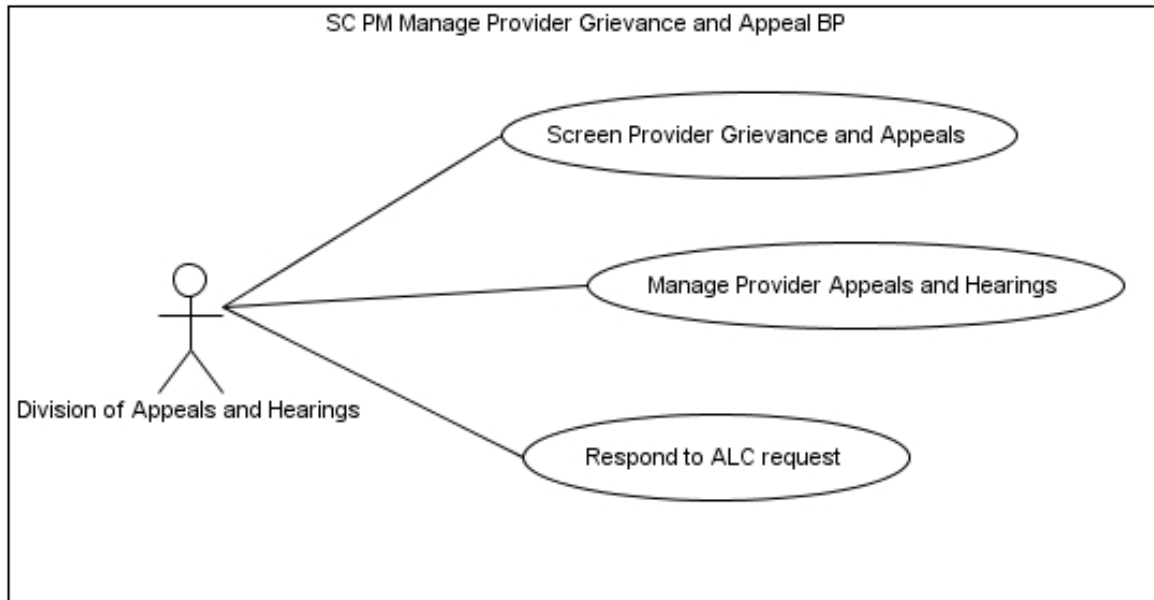


SC PM Manage Provider Grievance and Appeals BP





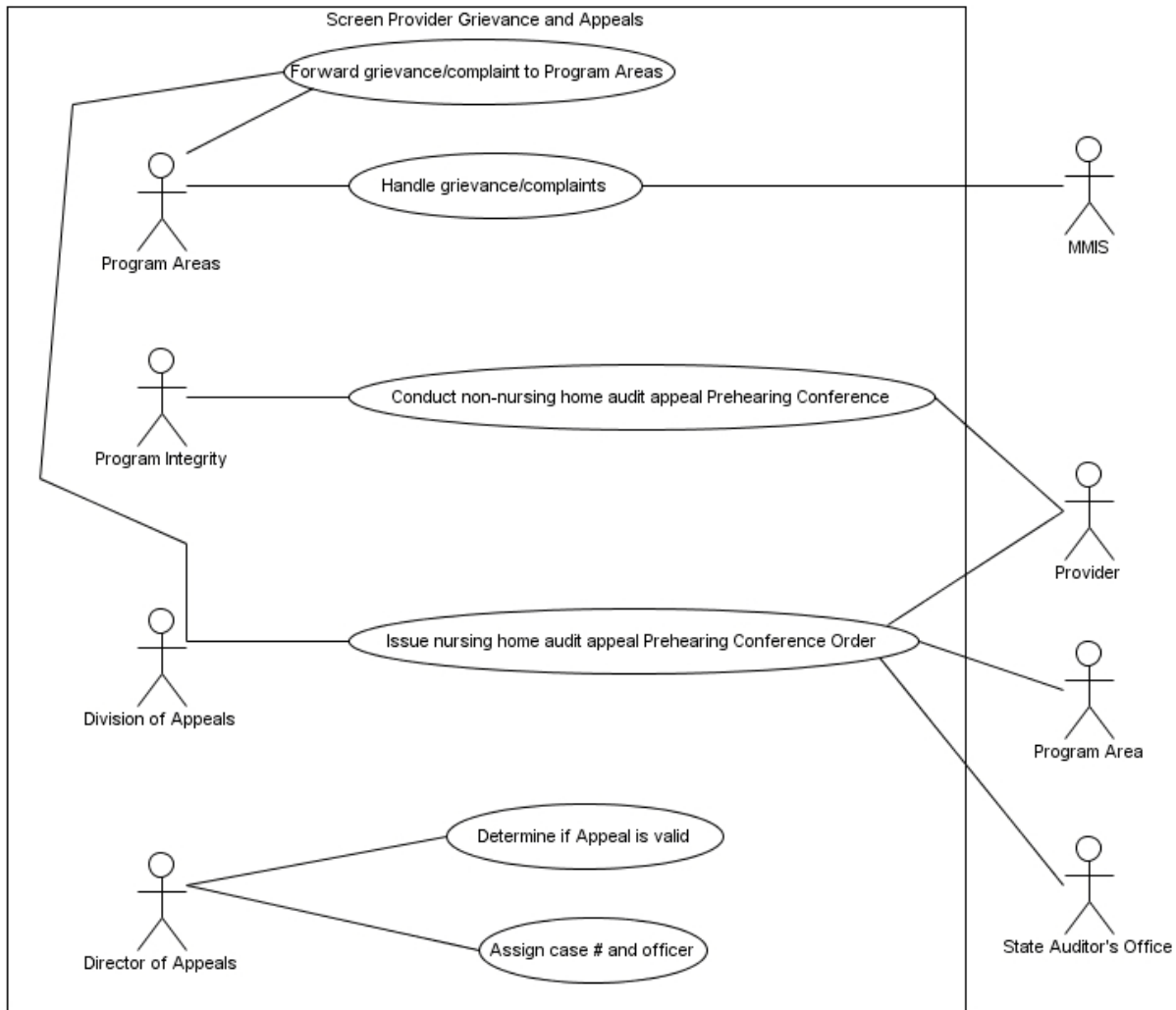
SC PM Manage Provider Grievance and Appeal BP





Screen Provider Grievance and Appeals

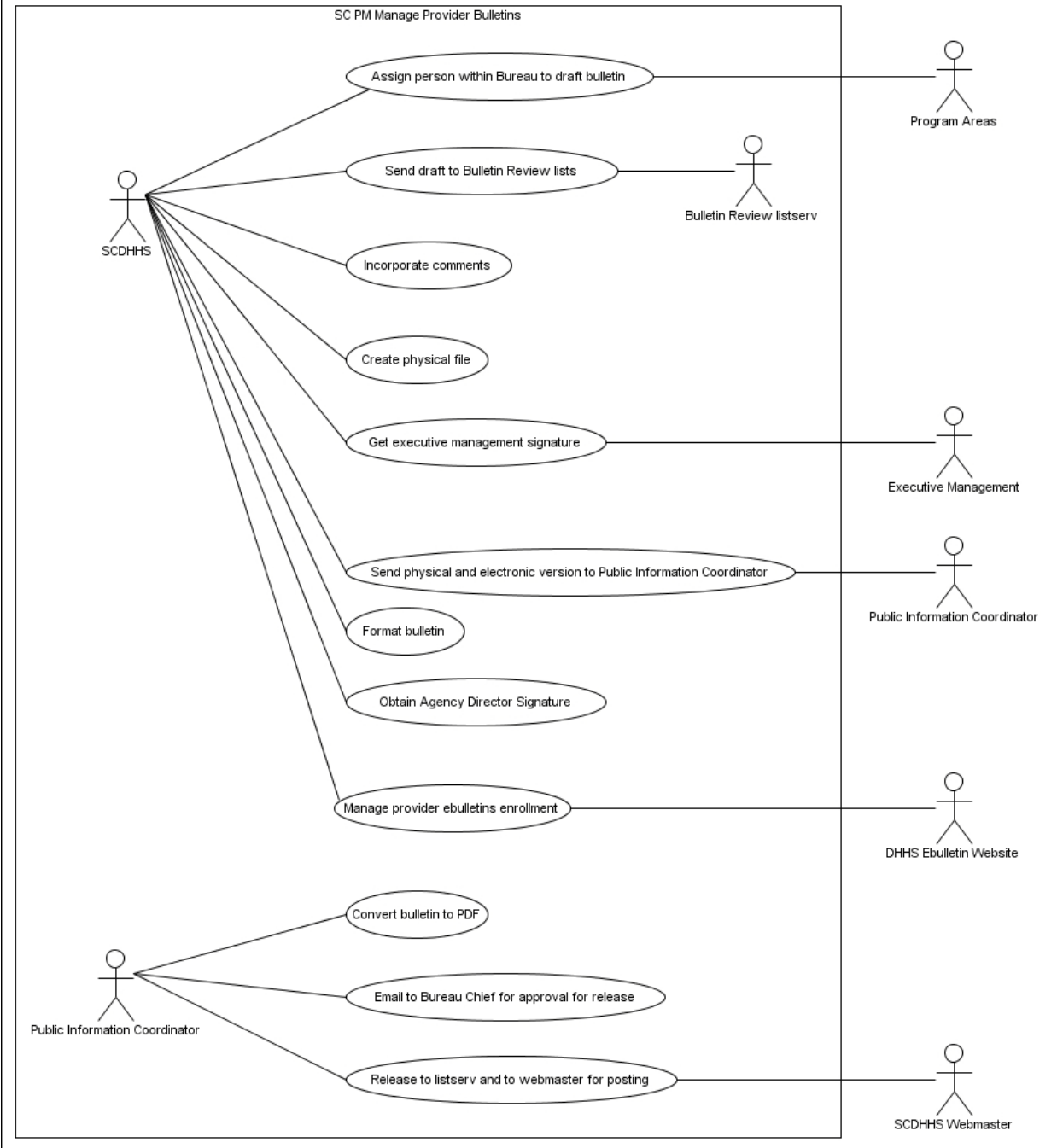
Diagram based on SC PM Manage Provider
Grievance and Appeal BP Problem Statement.





SC PM Manage Provider Bulletins

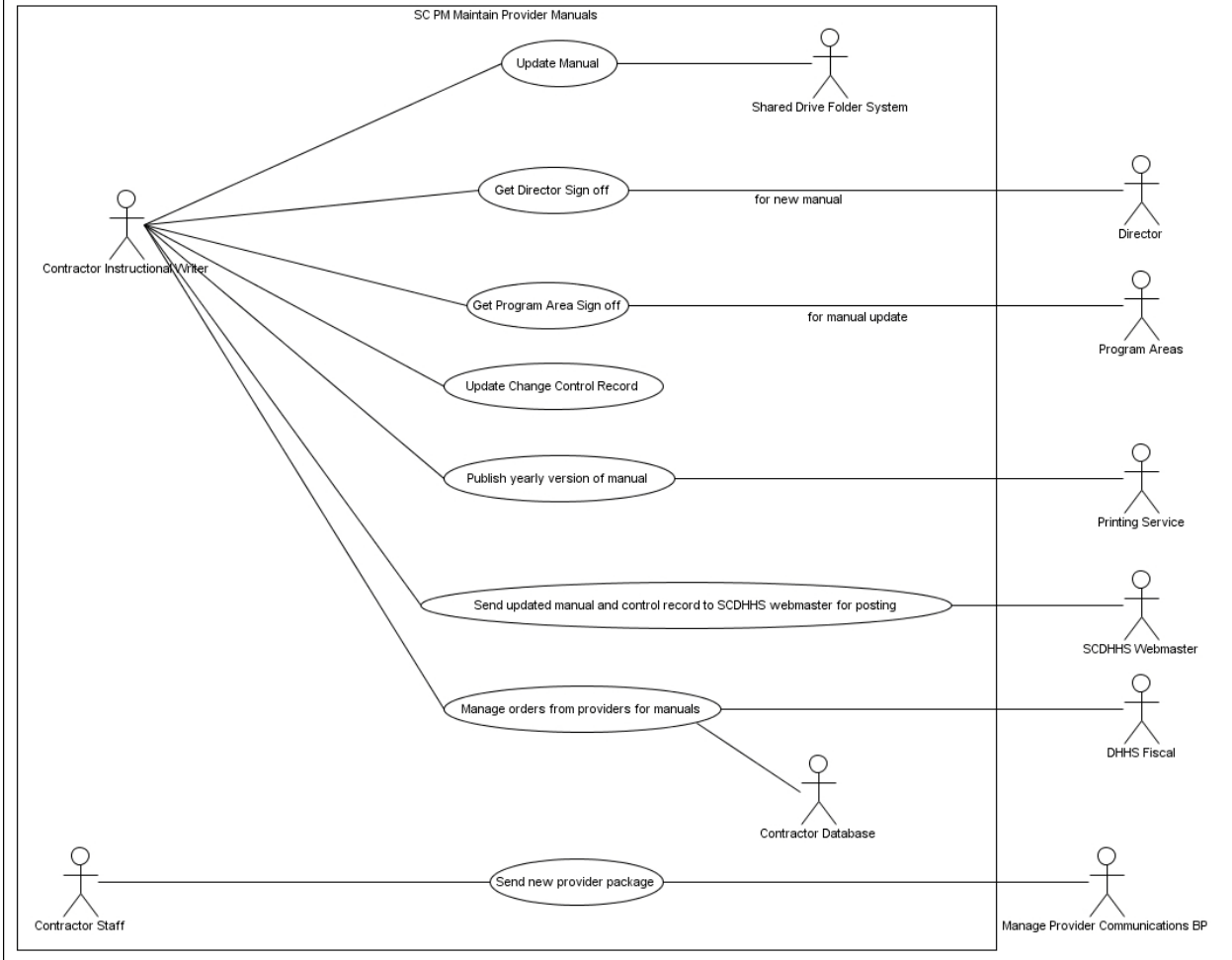
Diagram based on SC PM Perform
Provider Outreach Problem Statement





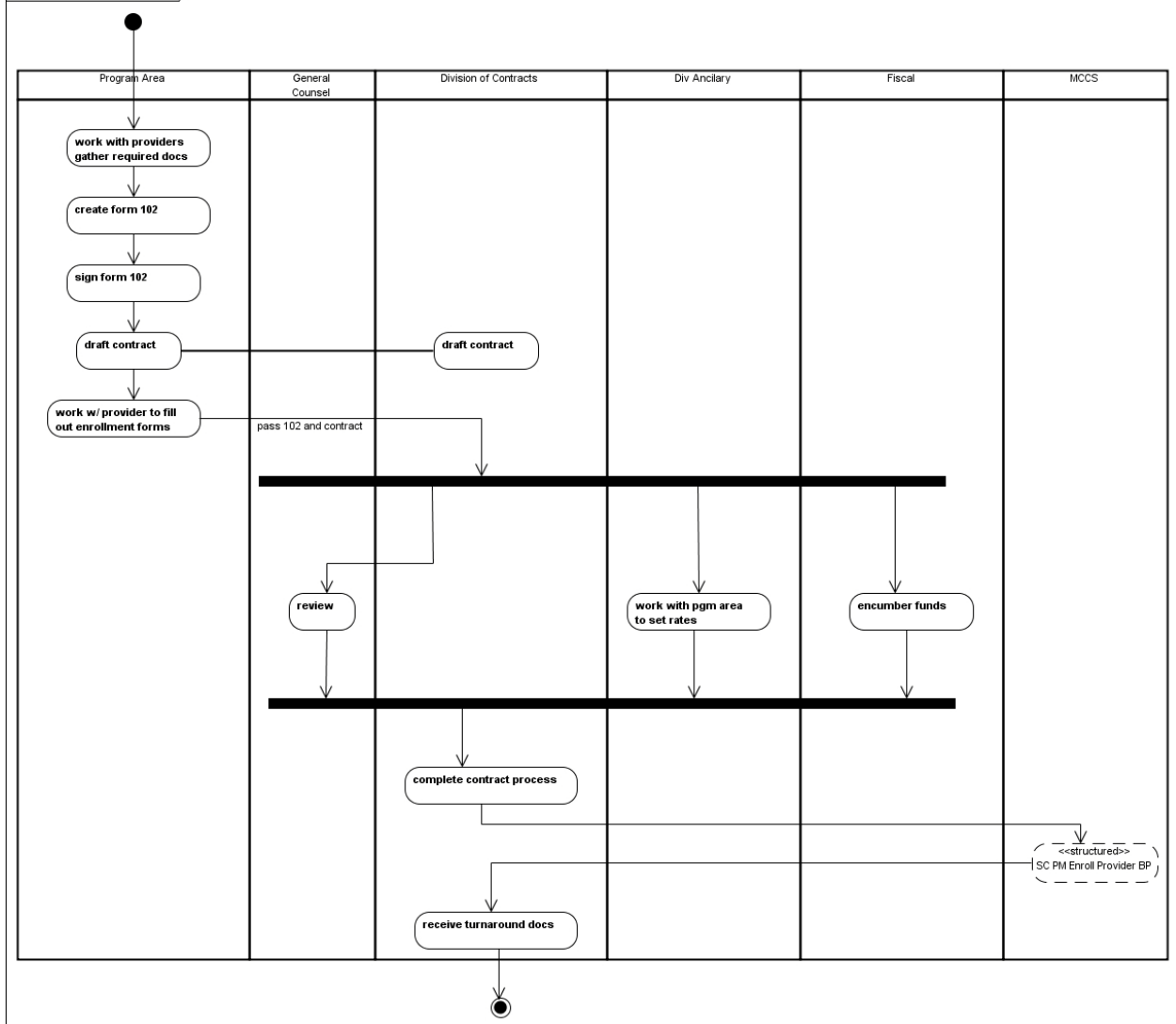
SC PM Maintain Provider Manuals

Diagram based on SC PM
Perform Provider Outreach
Problem Statement



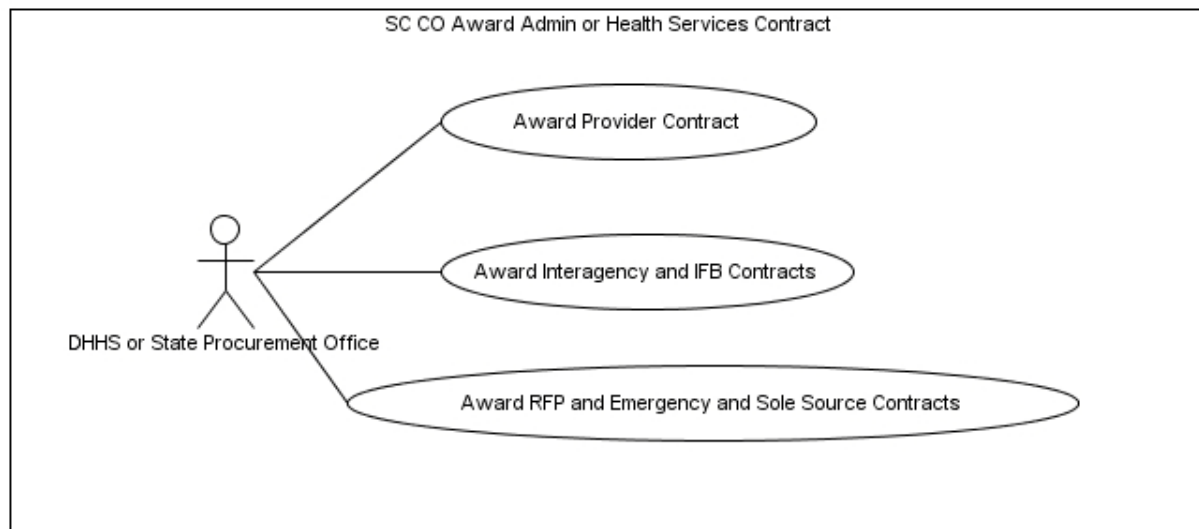


SC CO Award Provider Contract

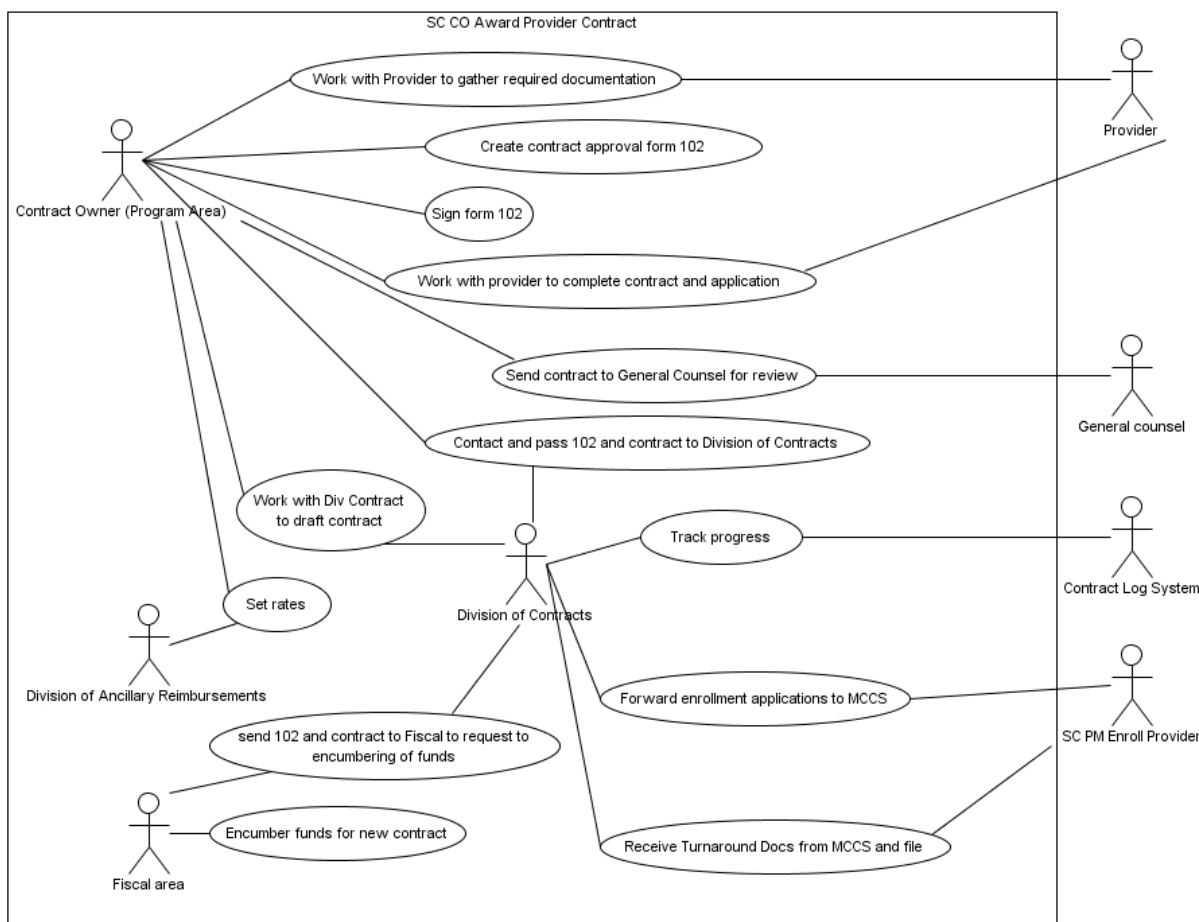




SC CO Award Admin or Health Services Contract

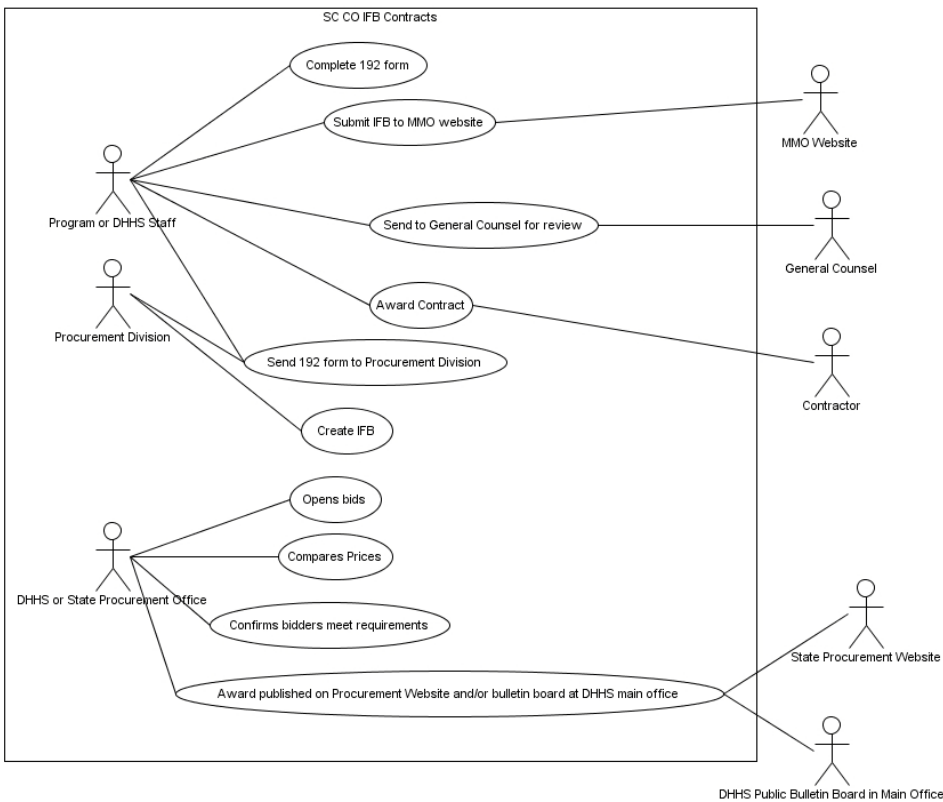
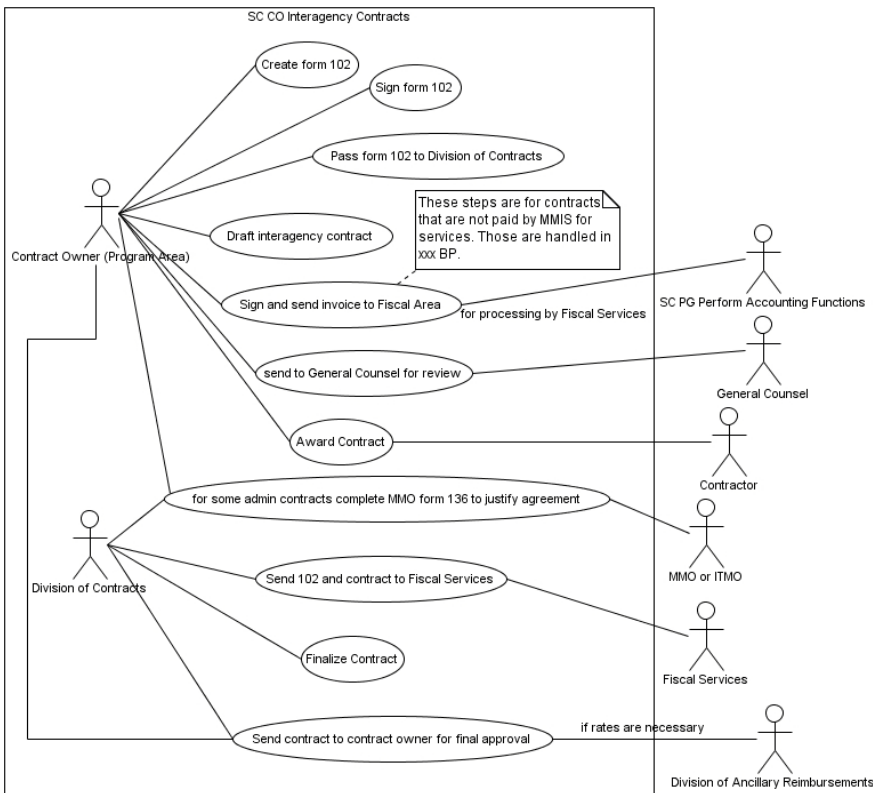


SC CO Award Provider Contract



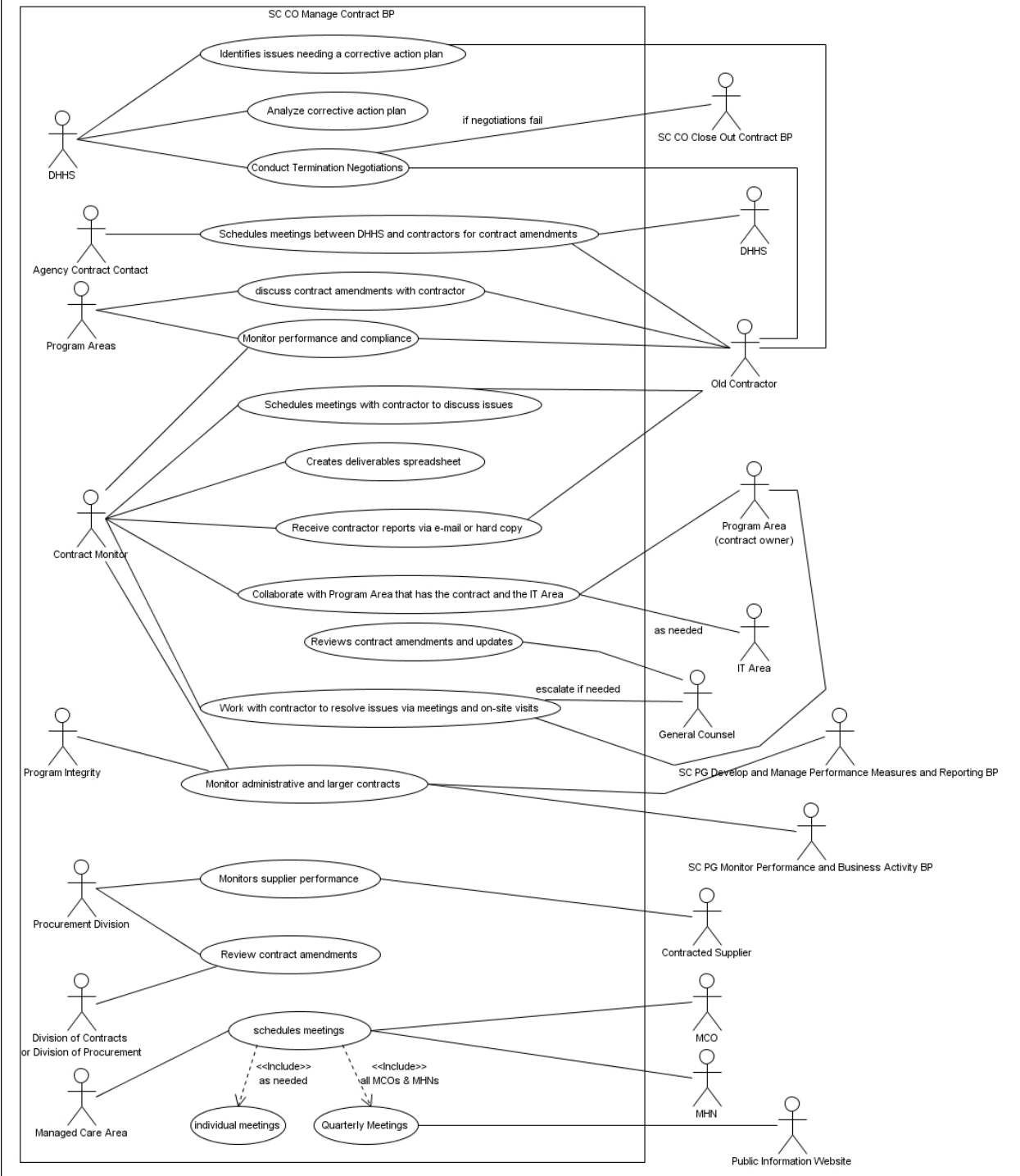


SC CO Award Interagency and IFB Contracts



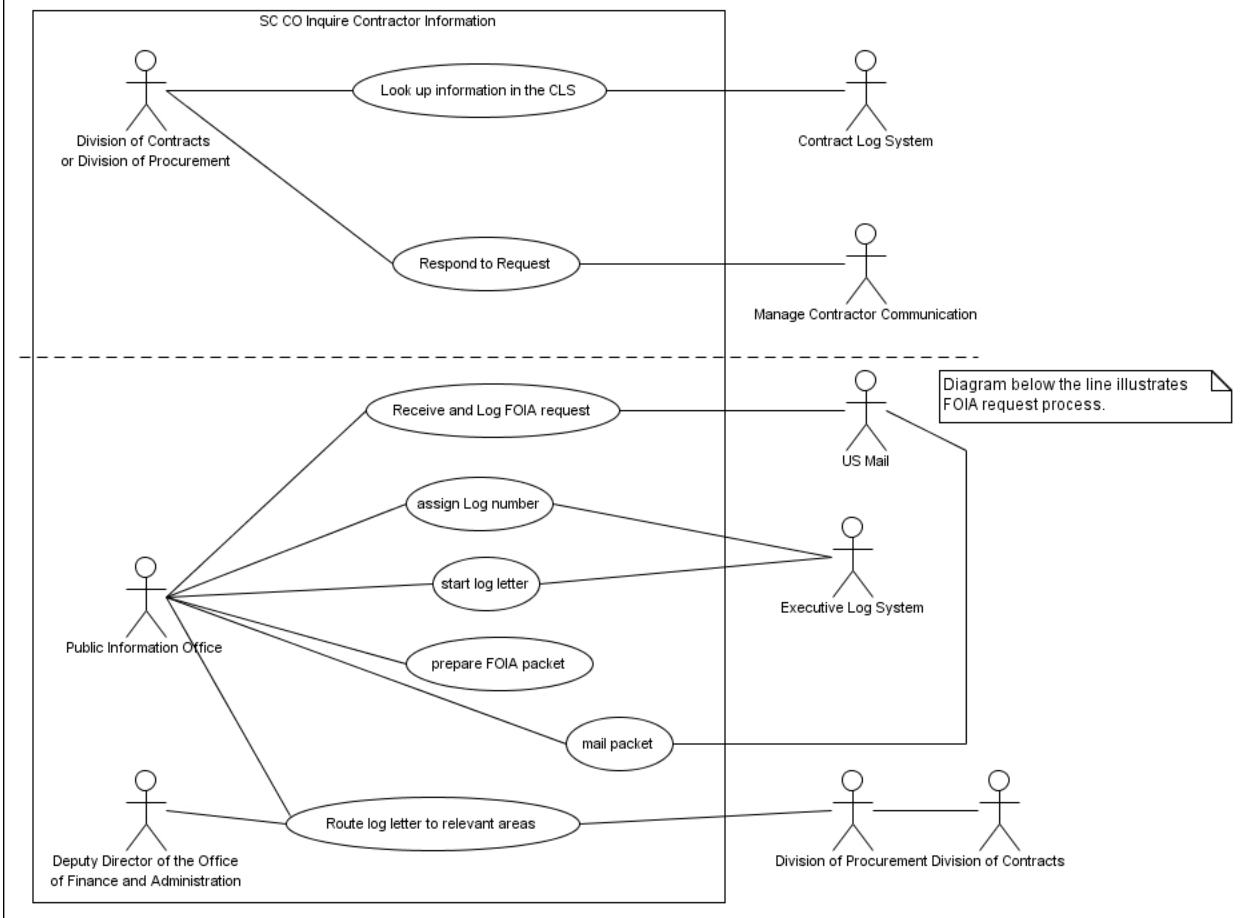


SC CO Manage Contract BP



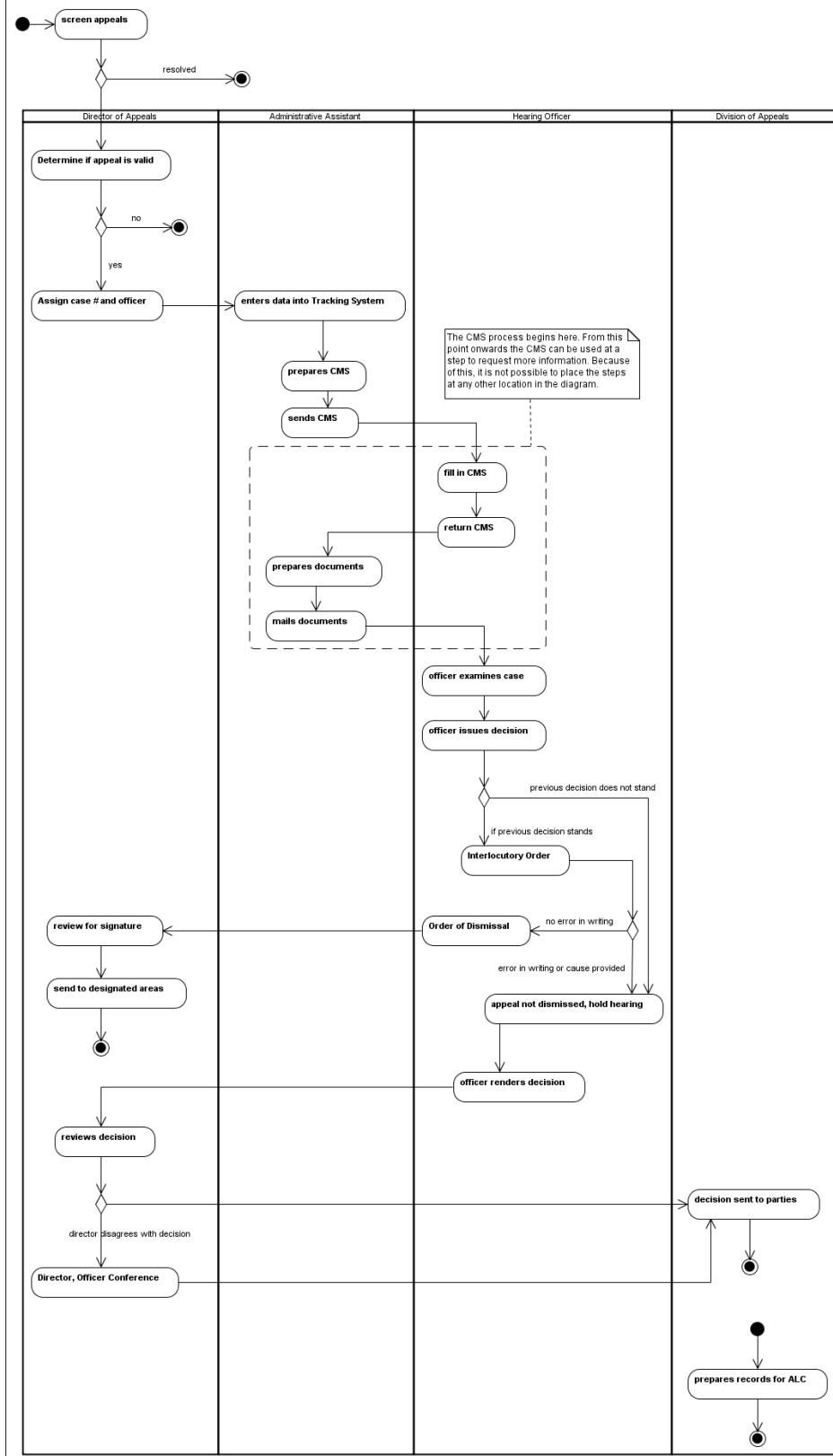


SC CO Inquire Contractor Information



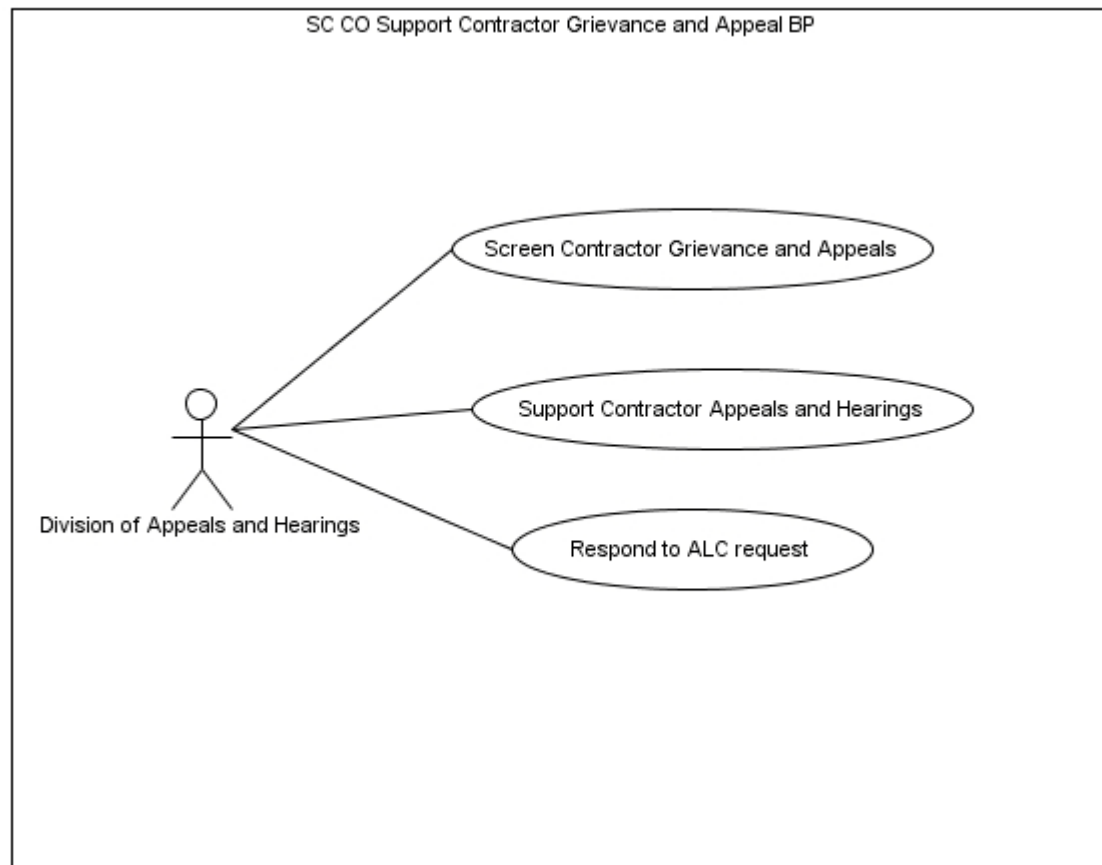


SC CO Support Contractor Grievance and Appeals BP



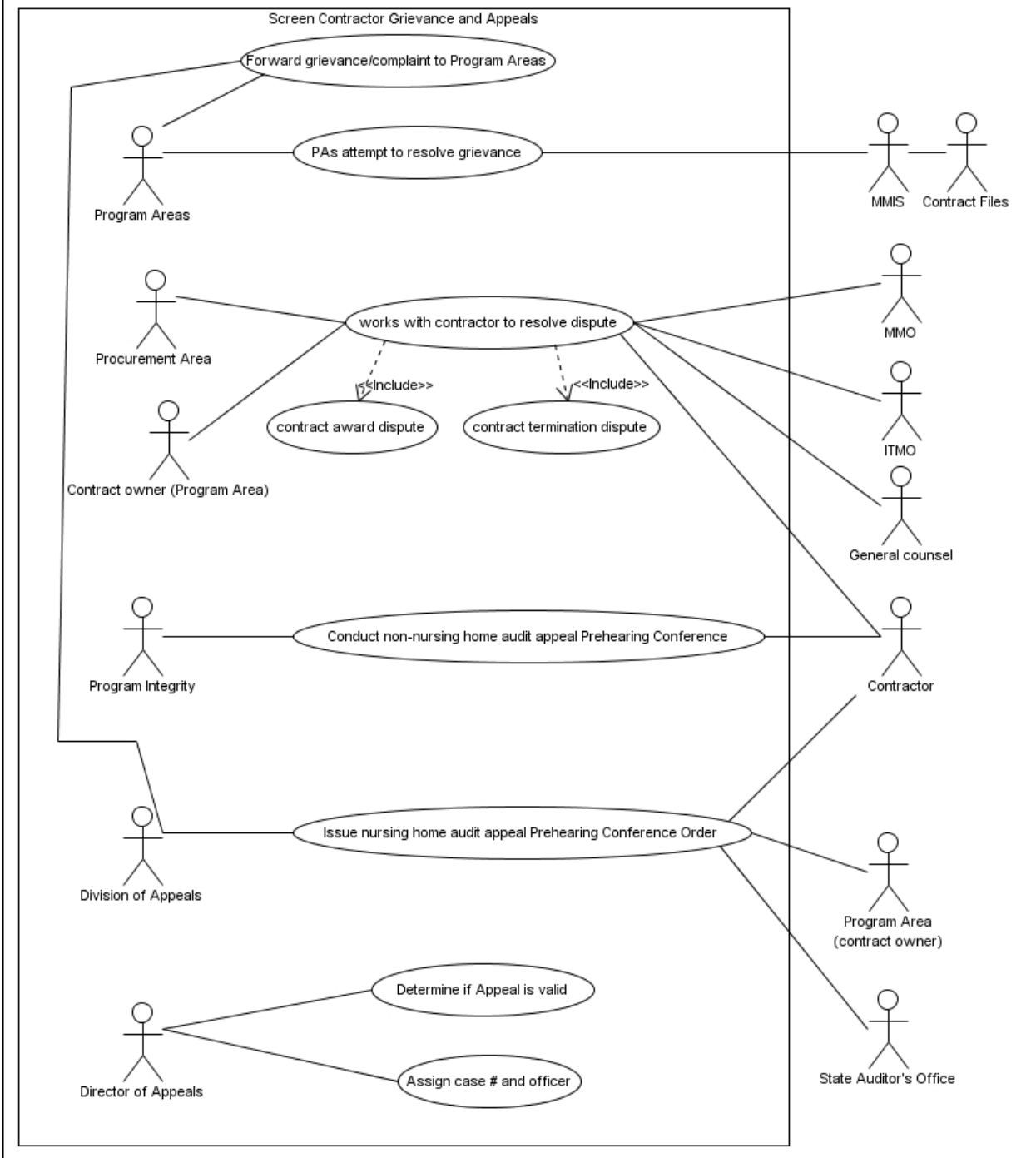


SC CO Support Contractor Grievance and Appeal BP



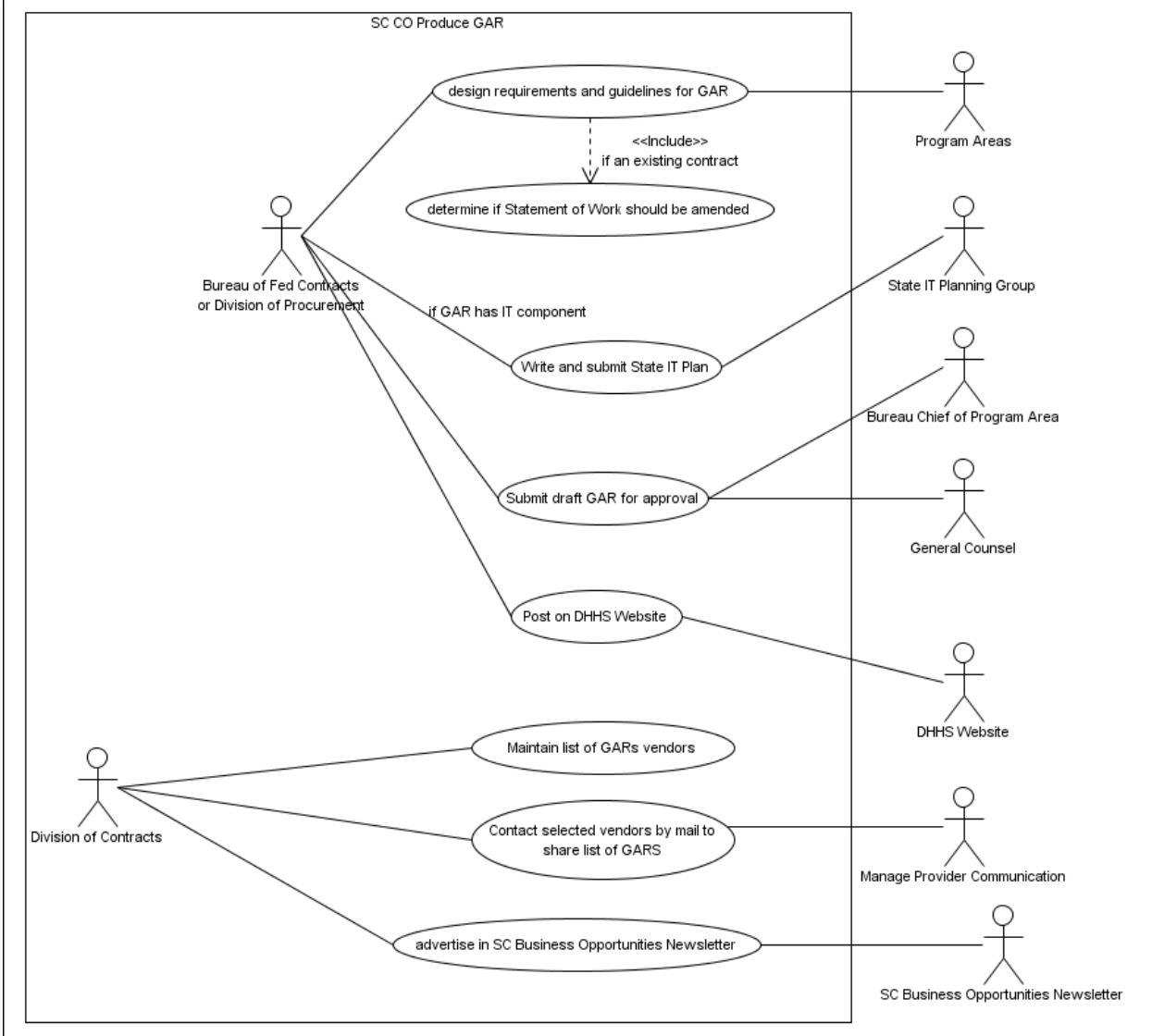


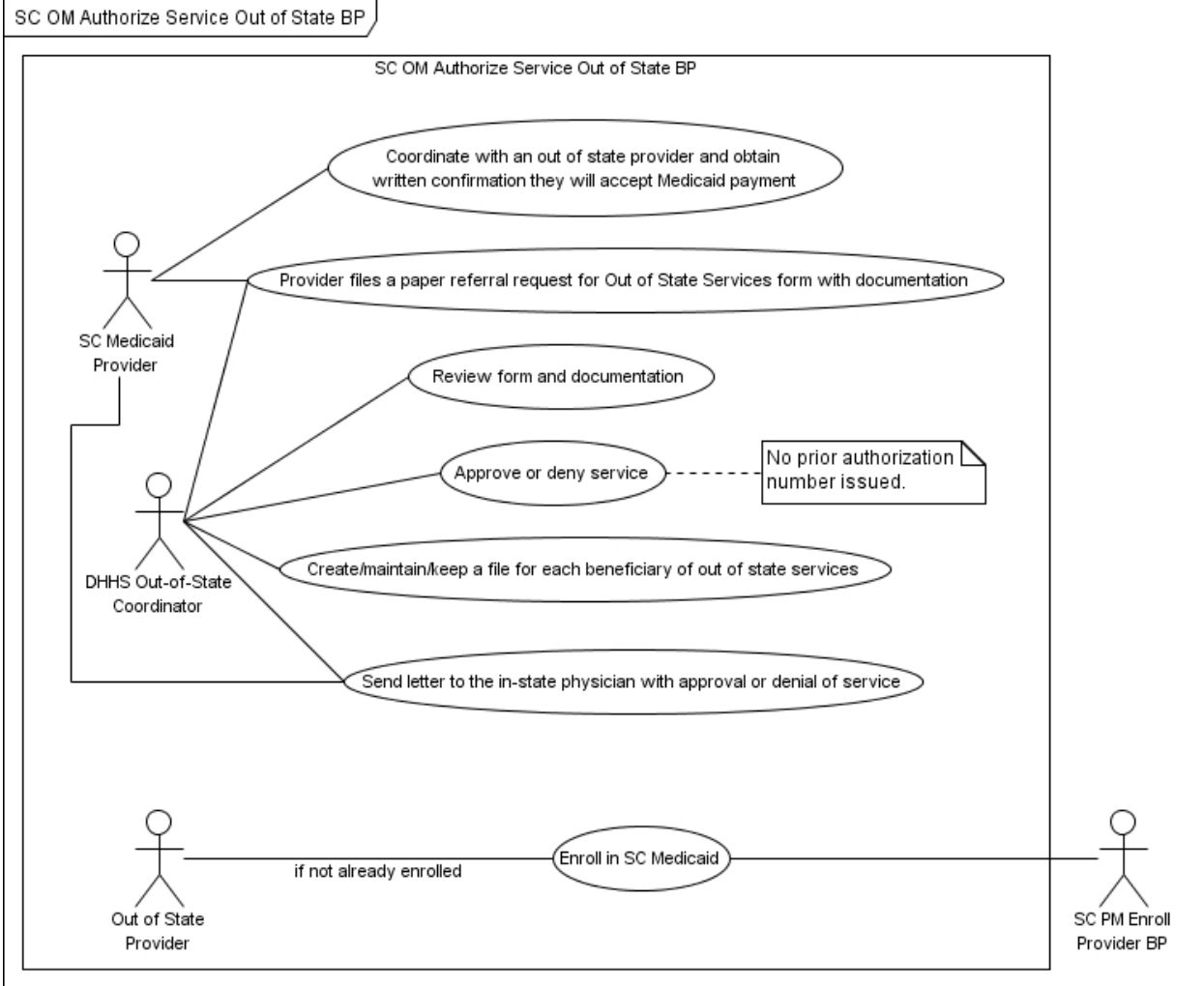
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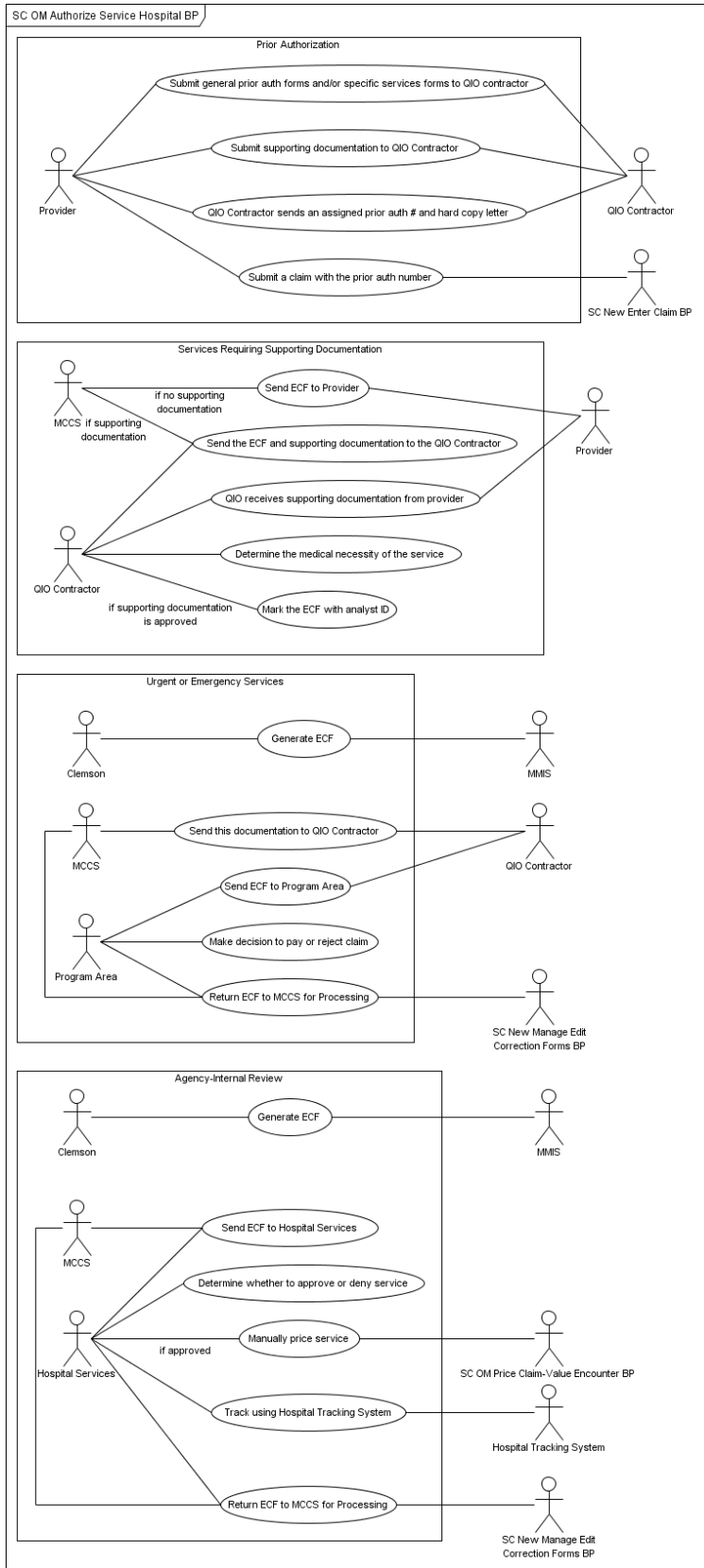




SC CO Produce GAR

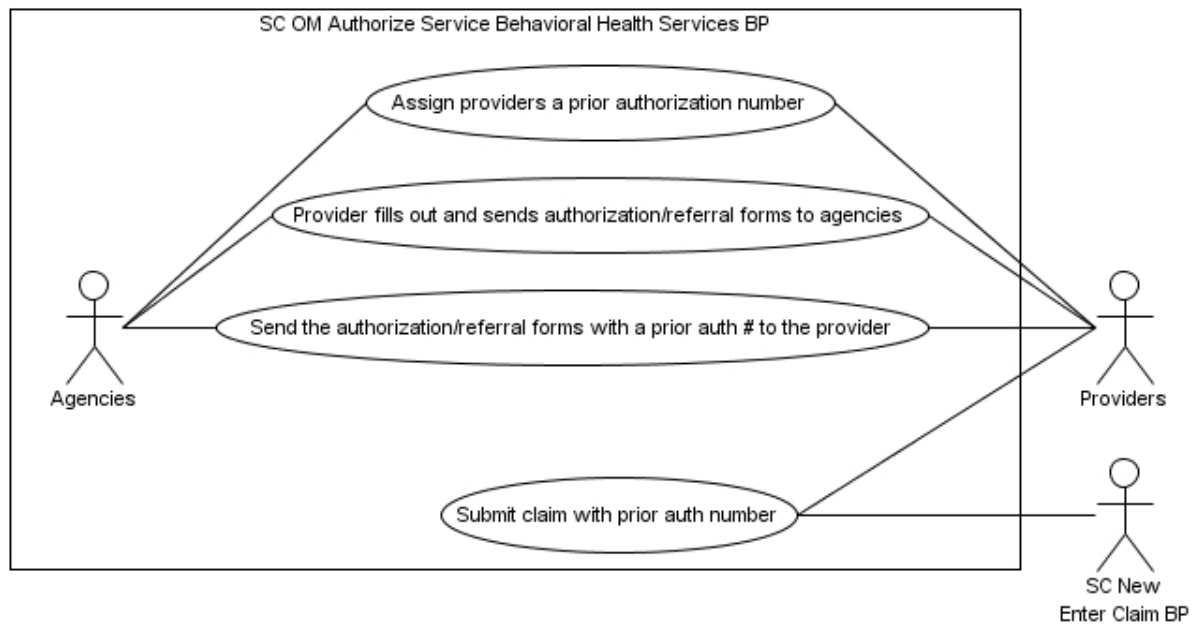






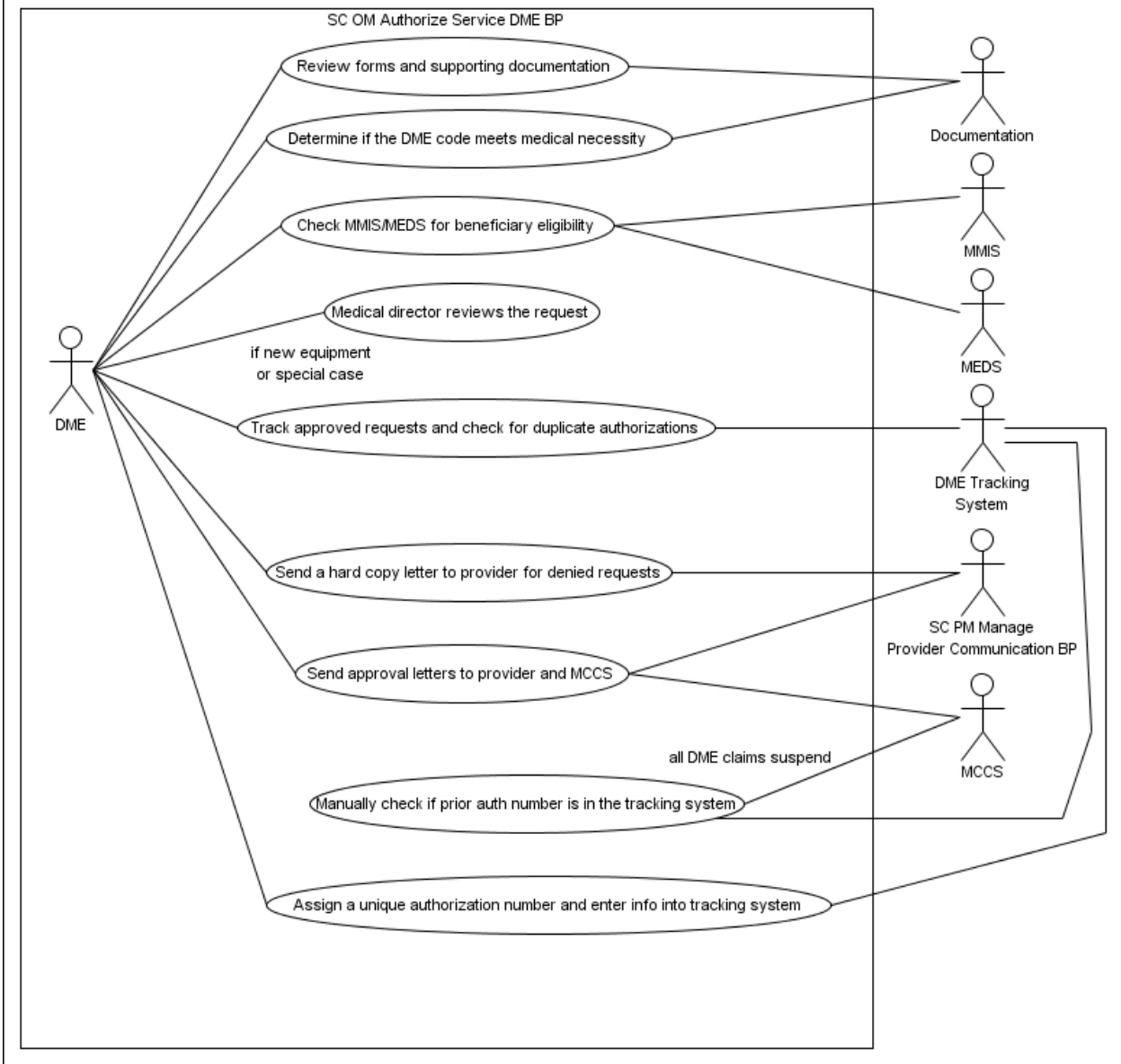


SC OM Authorize Service Behavioral Health Services BP



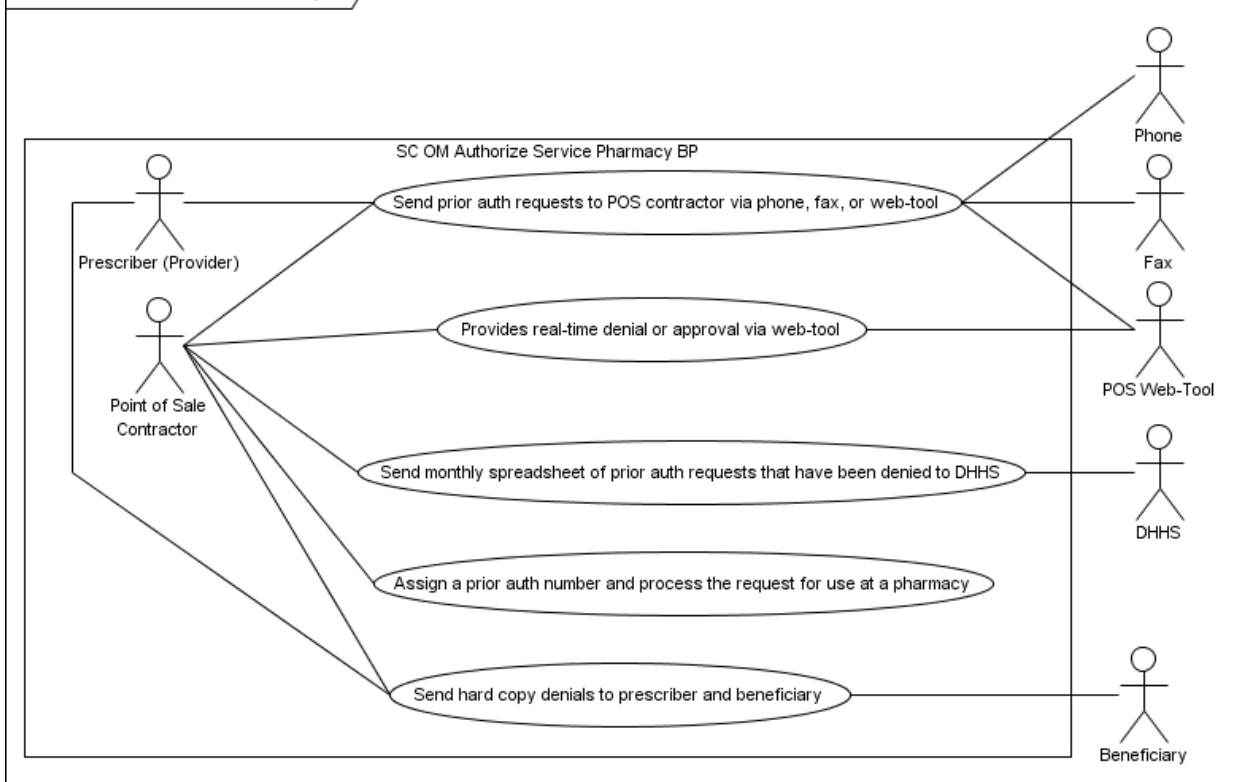


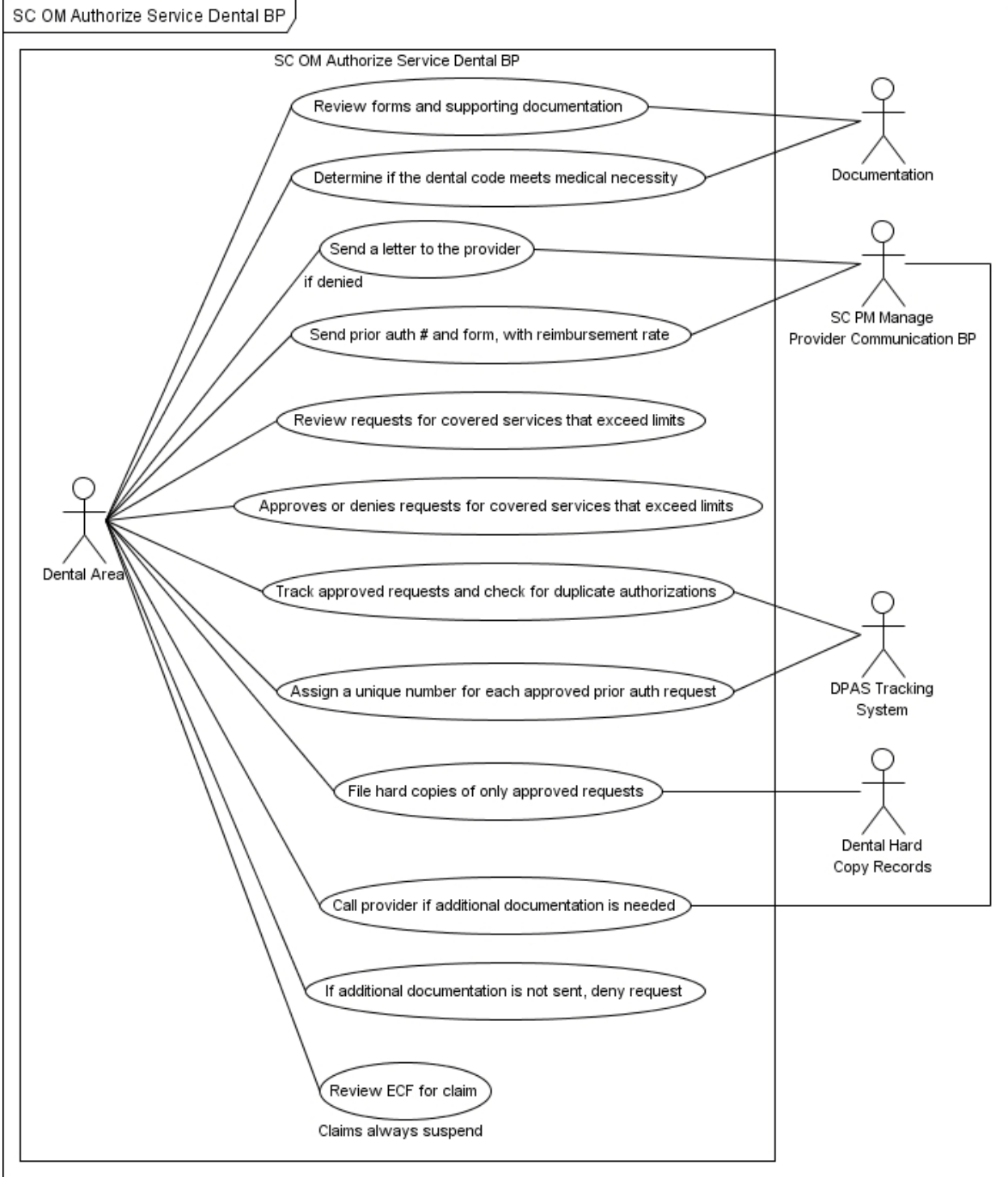
SC OM Authorize Service DME BP

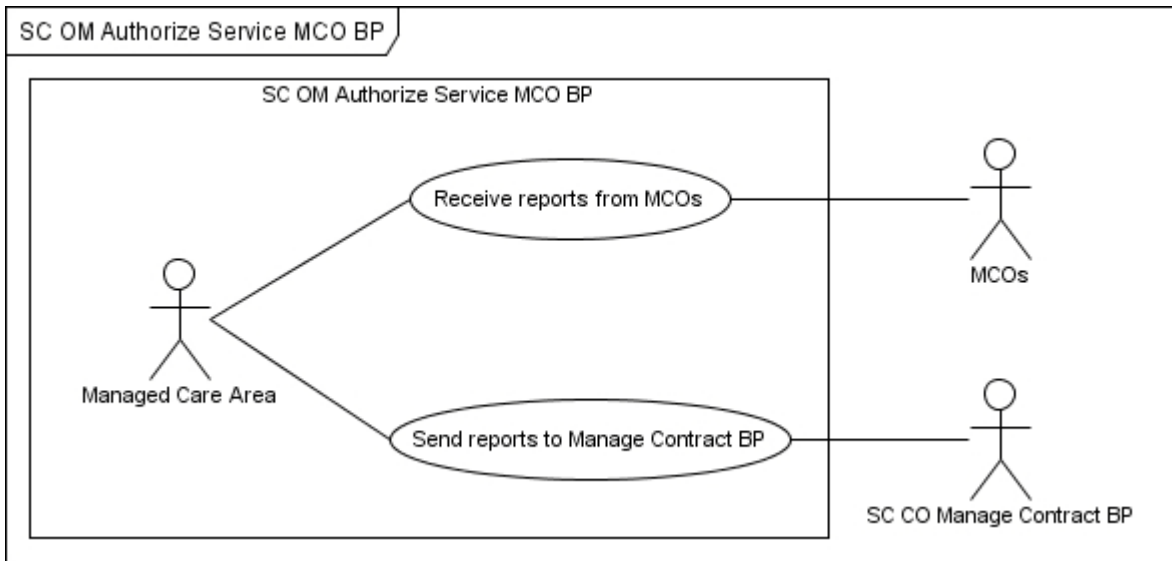




SC OM Authorize Service Pharmacy BP

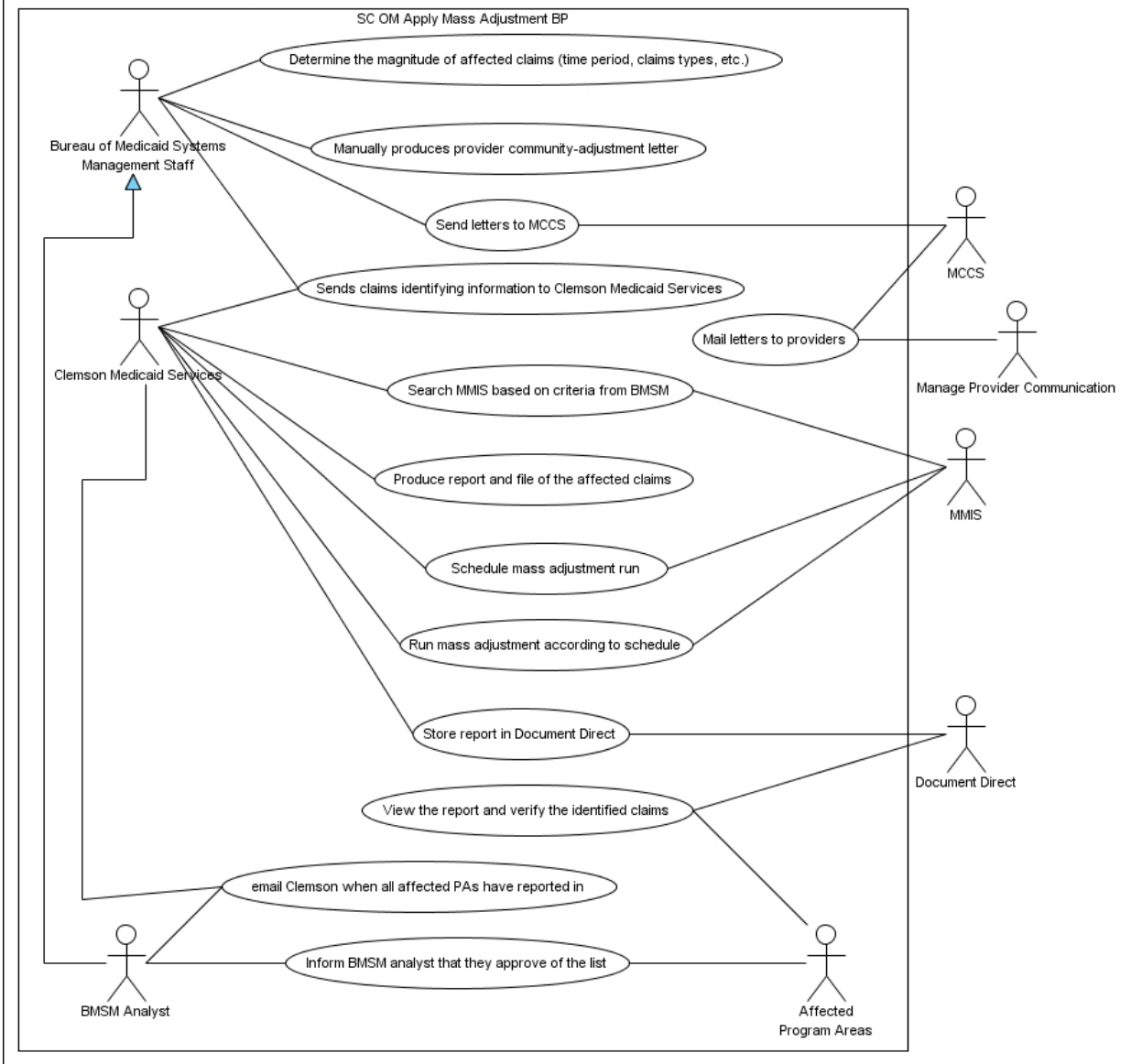






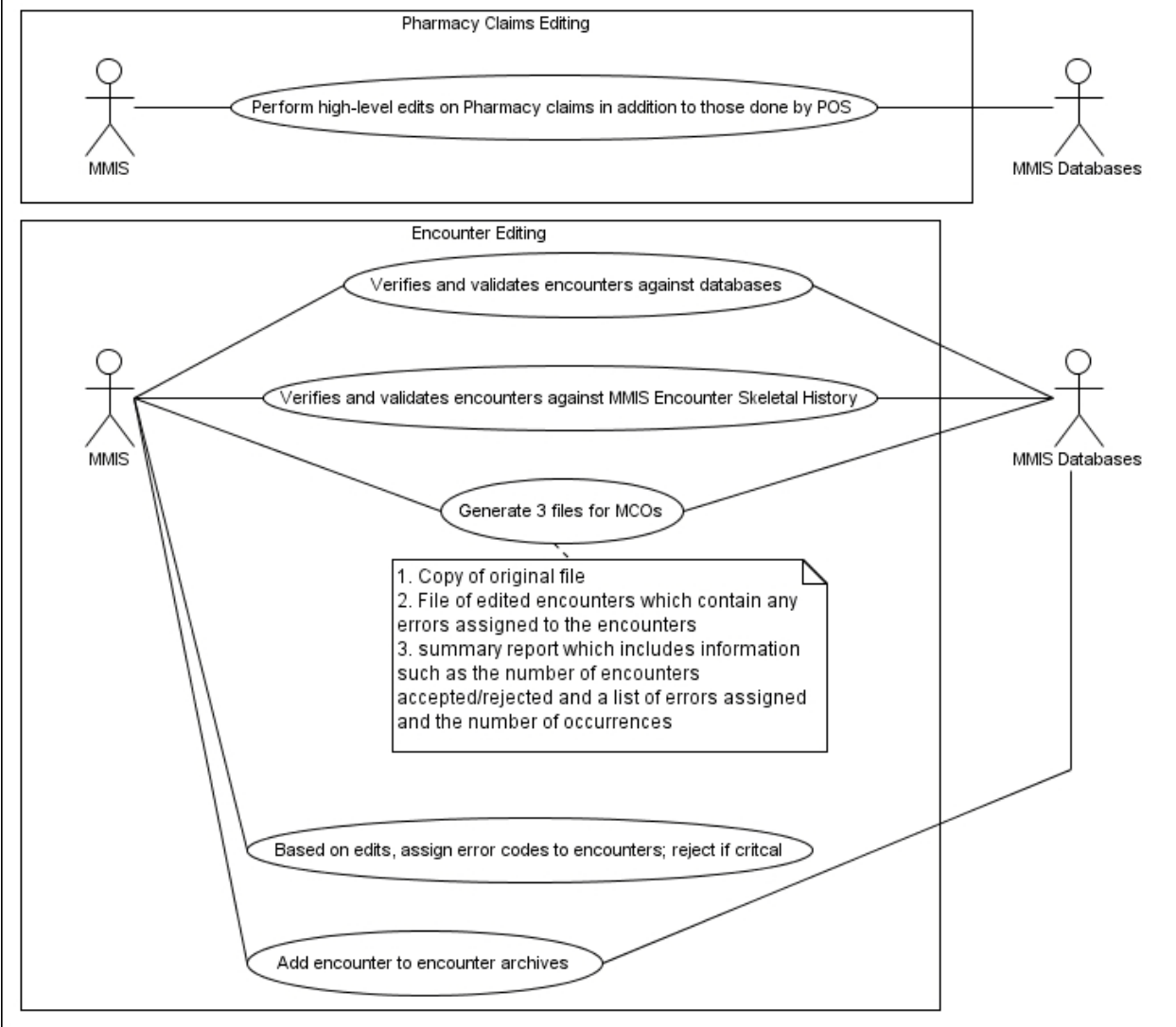


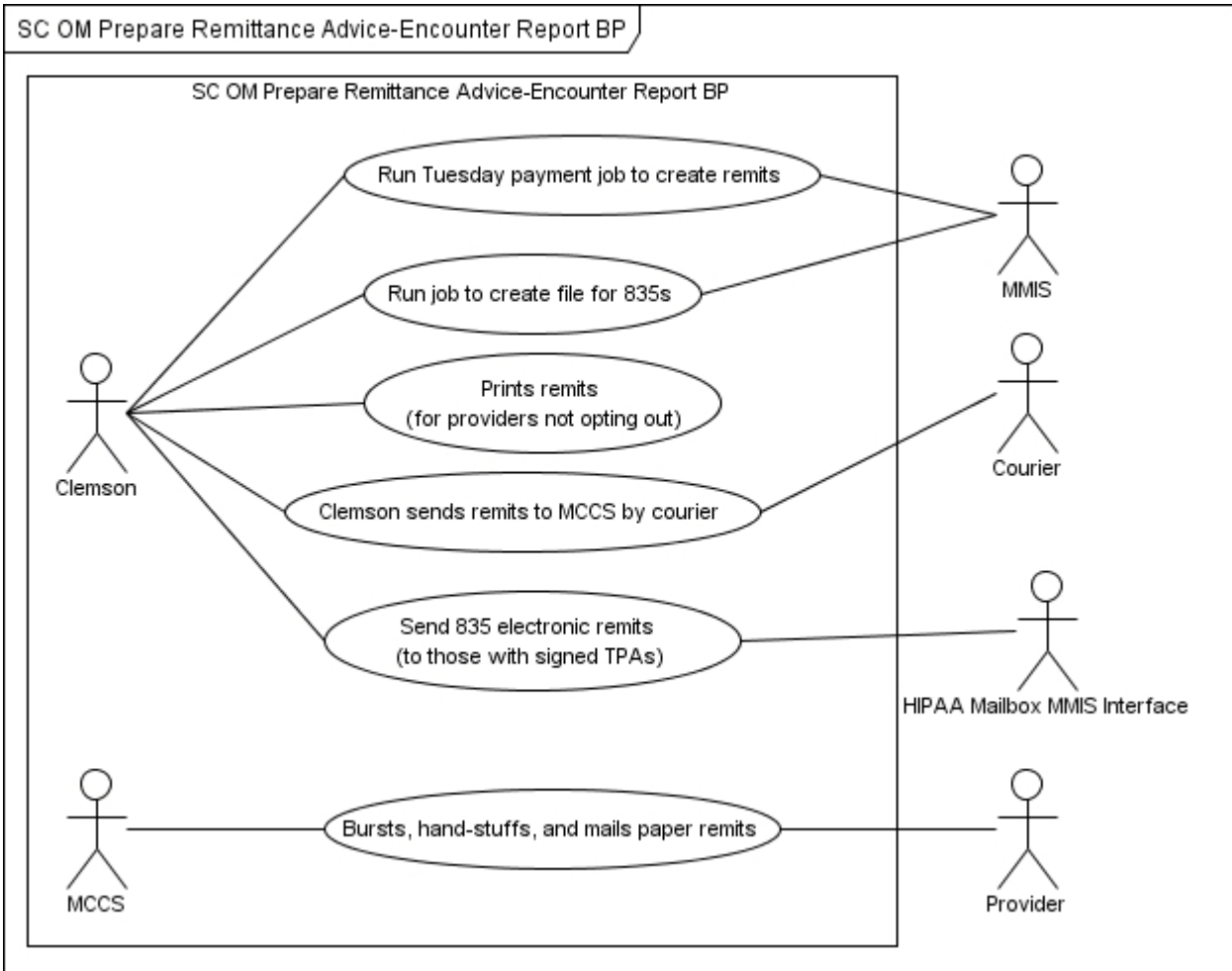
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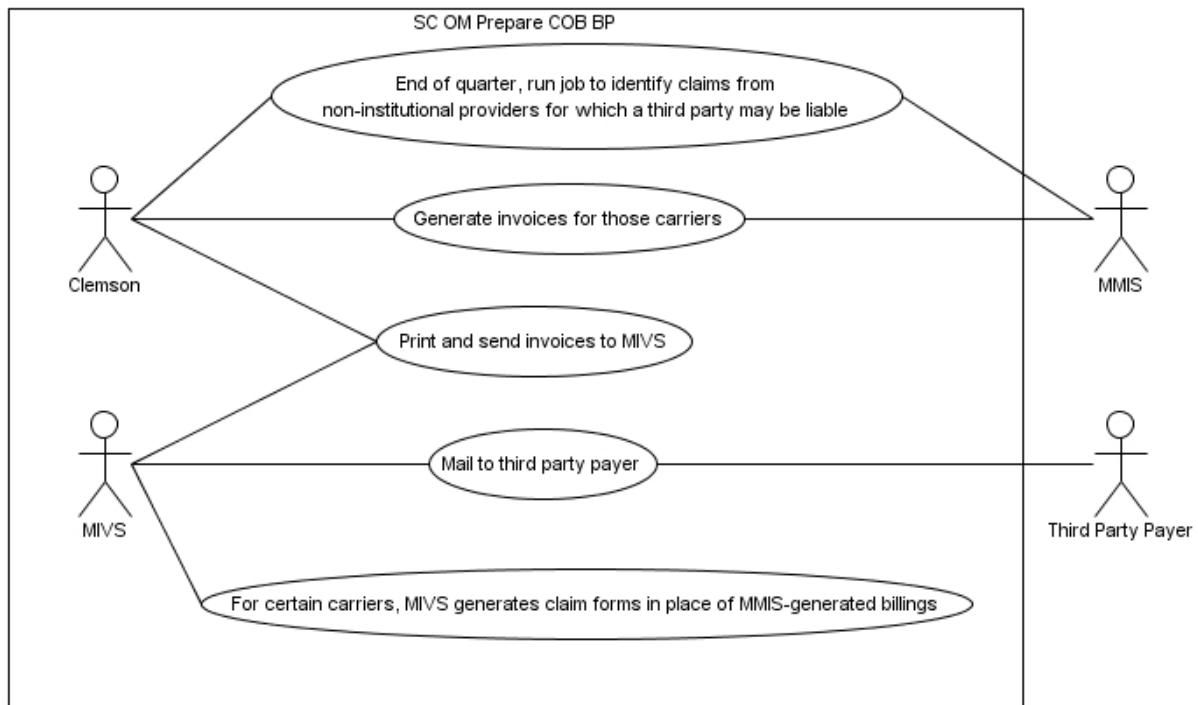
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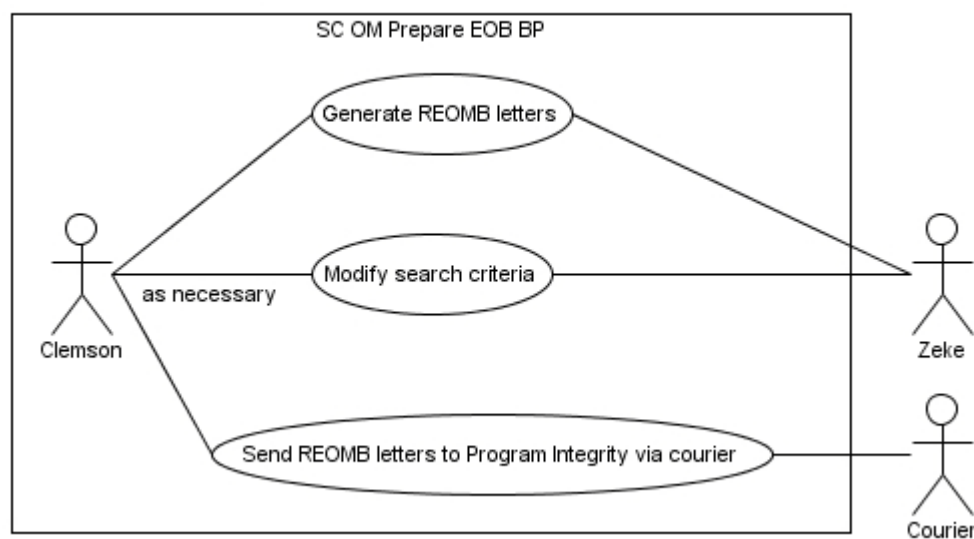




SC OM Prepare COB BP

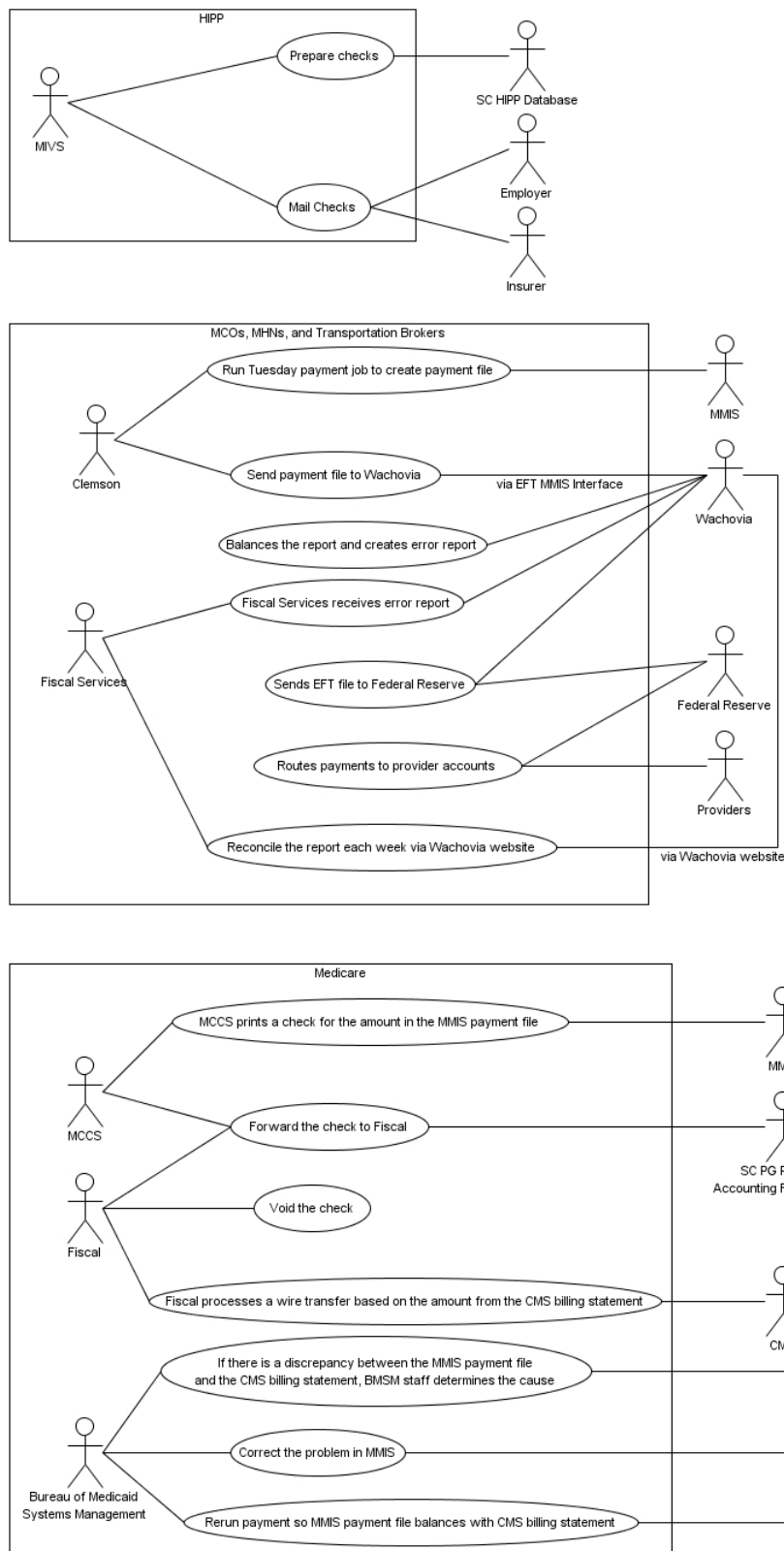


SC OM Prepare EOB BP



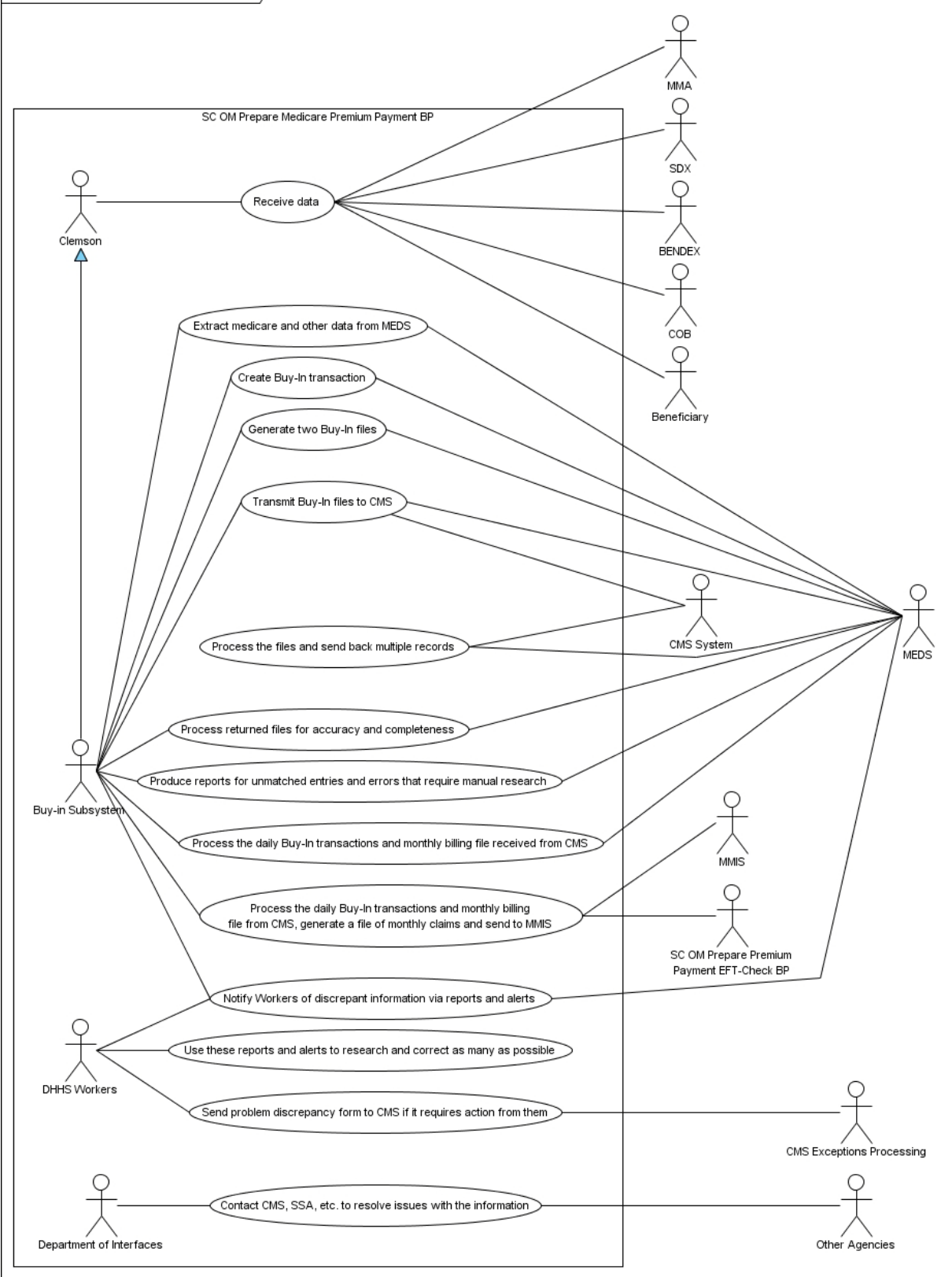


SC OM Prepare Premium EFT-Check BP



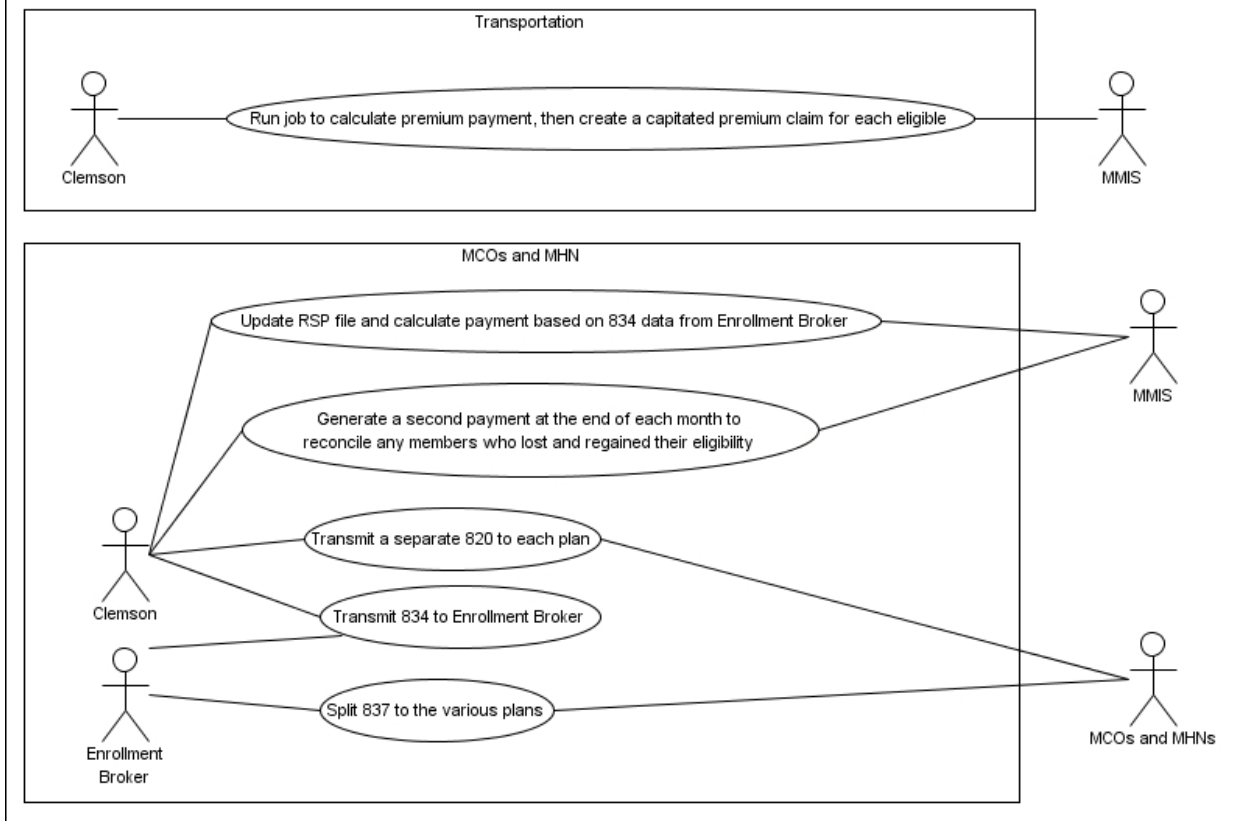


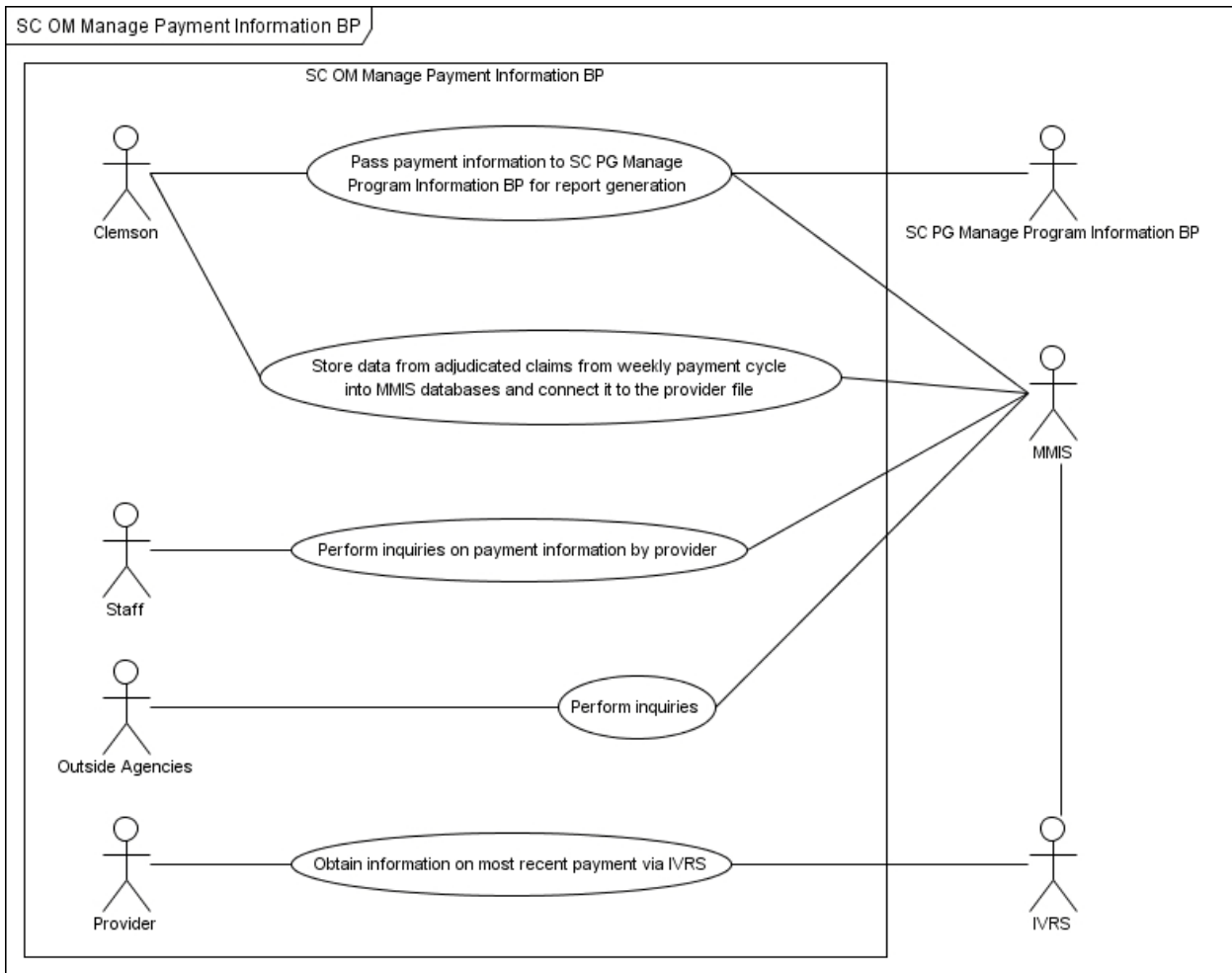
SC OM Prepare Medicare Premium Payment





SC OM Prepare Capitation Premium Payment BP

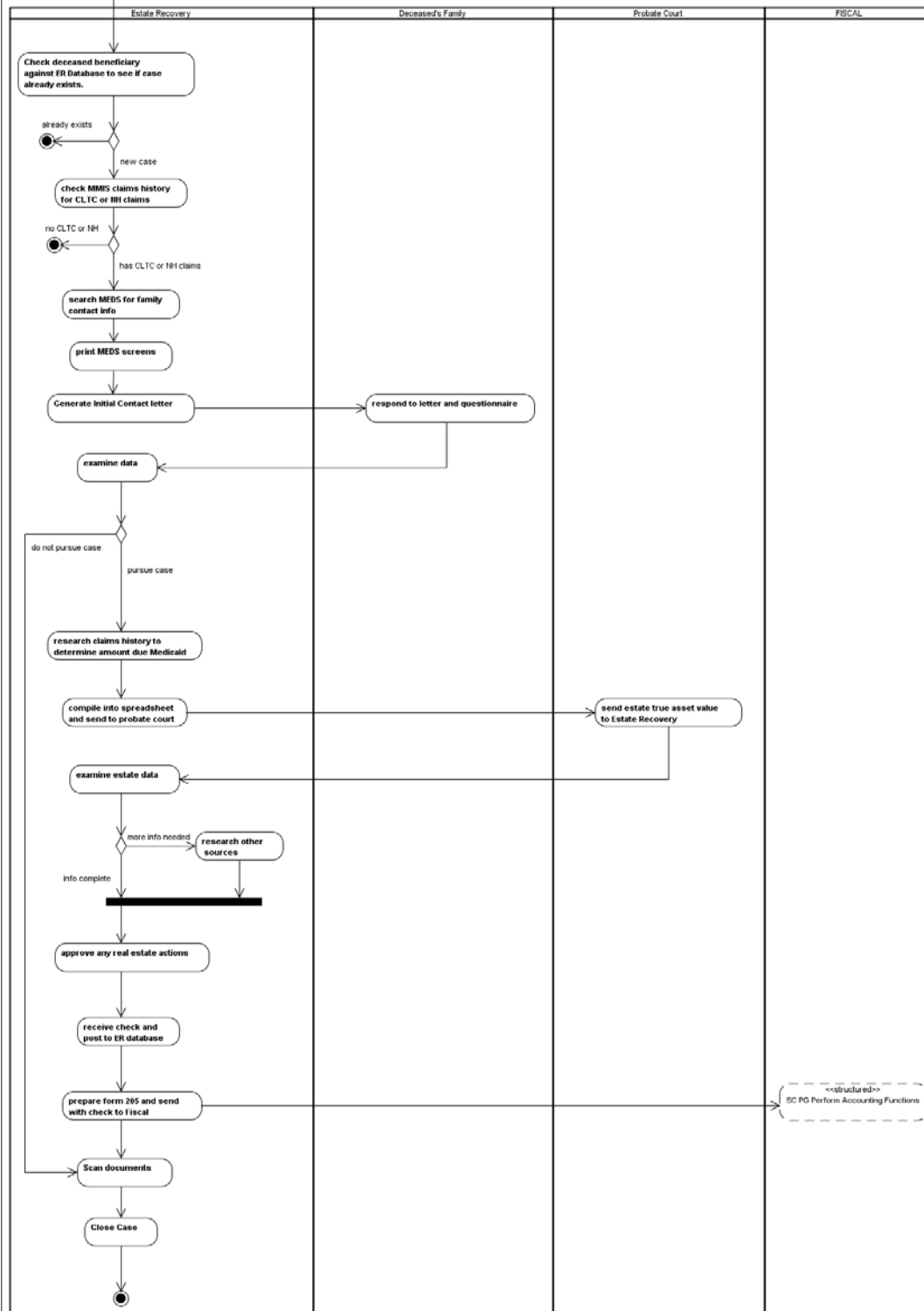


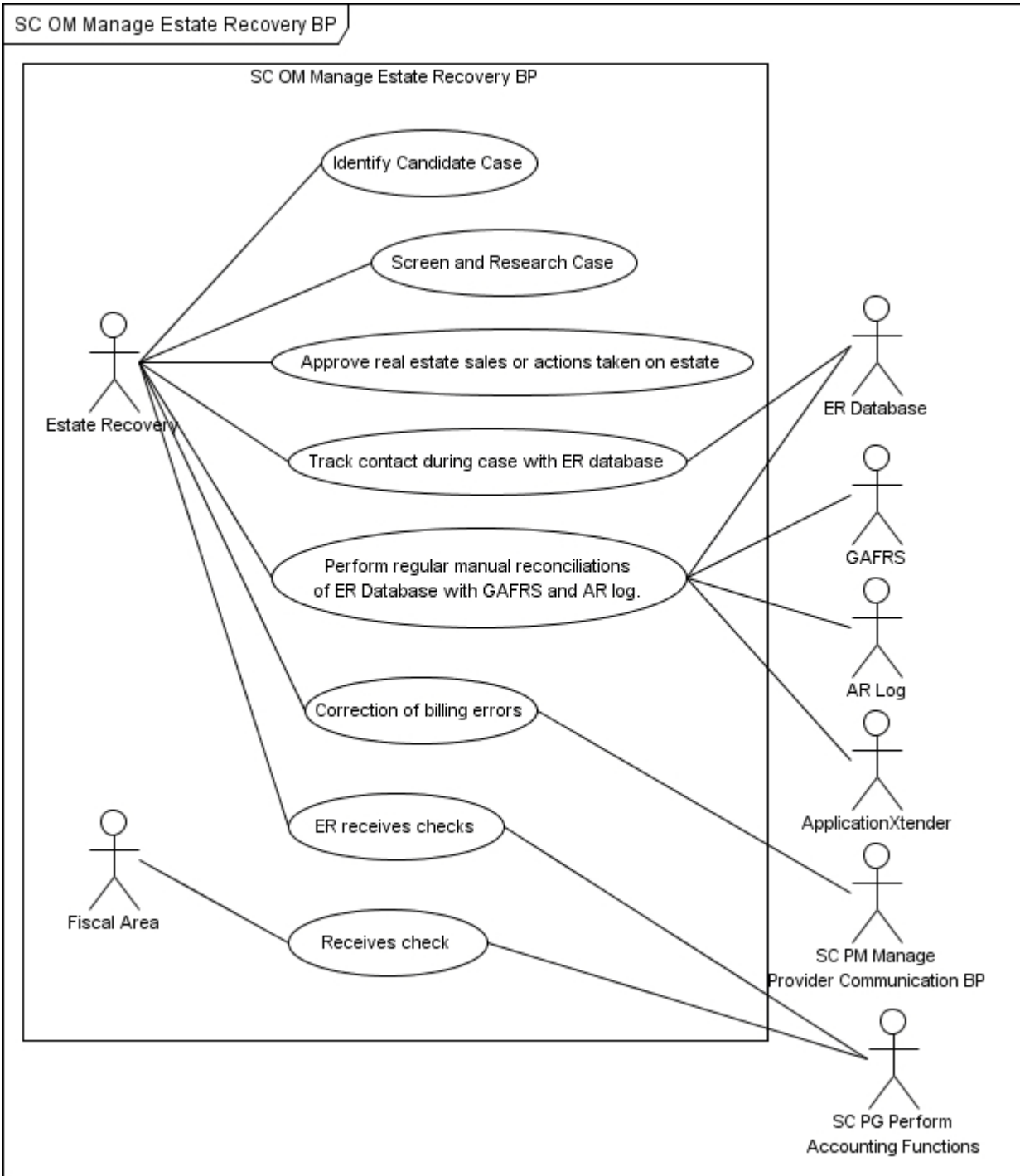




SC OM Manage Estate Recovery

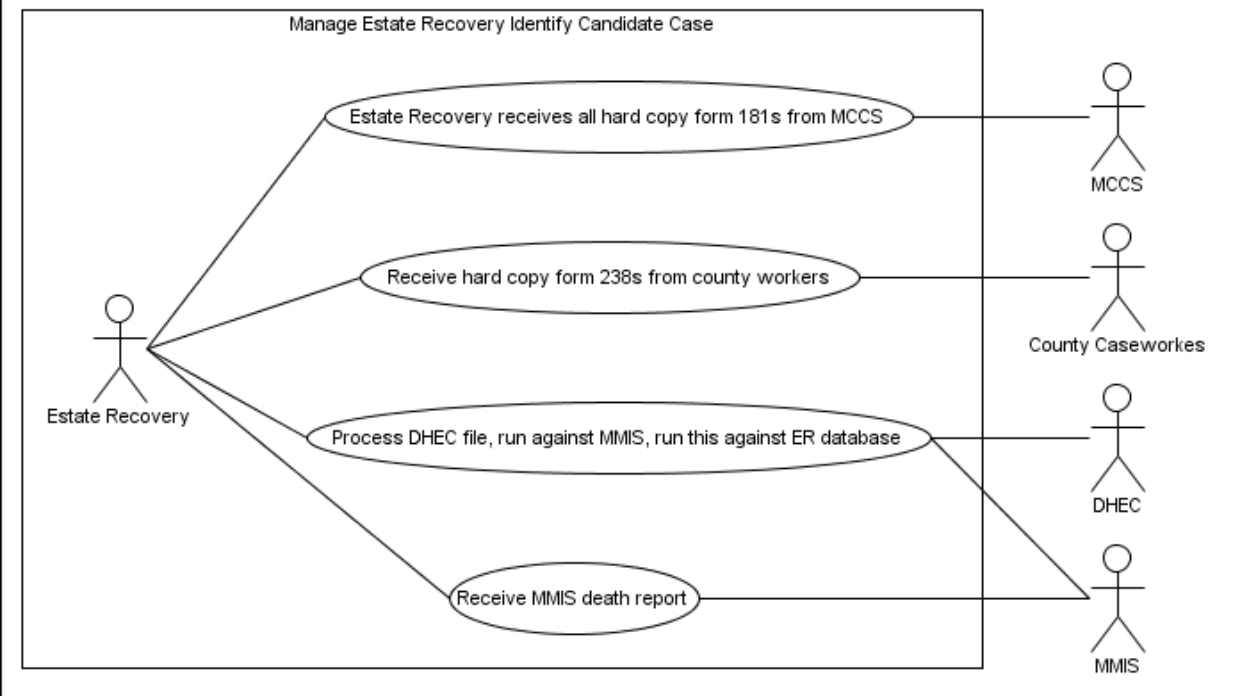
Estate Recovery receives notice of death from various sources including form 181 from MCCC, form 238 from county caseworker, a death file from DHEC which is first processed against MMIS to identify which are Medicaid, and a death report from MMIS.





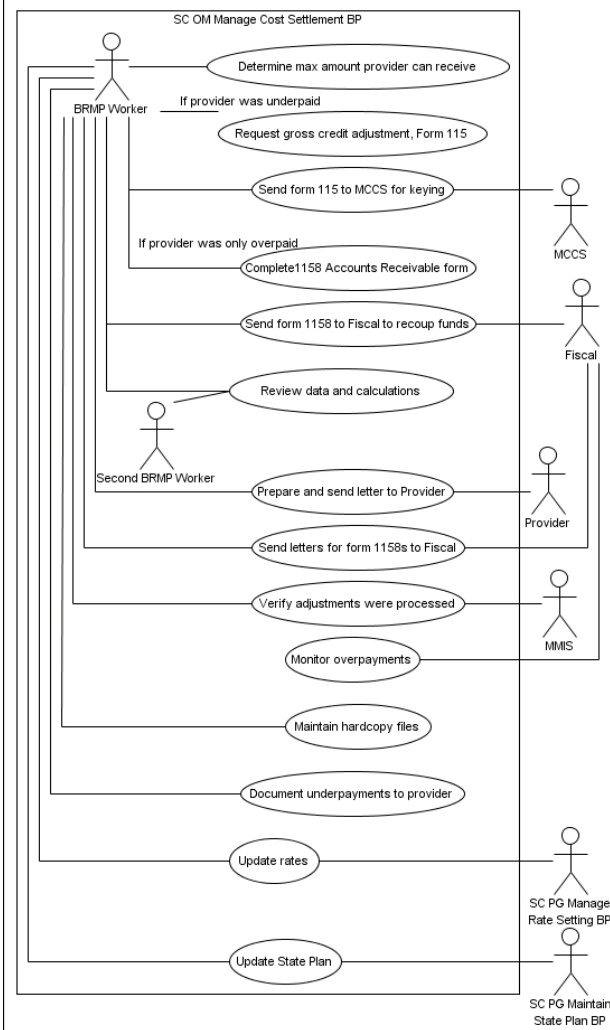


SC OM Manage Estate Recovery Identify Candidate Case



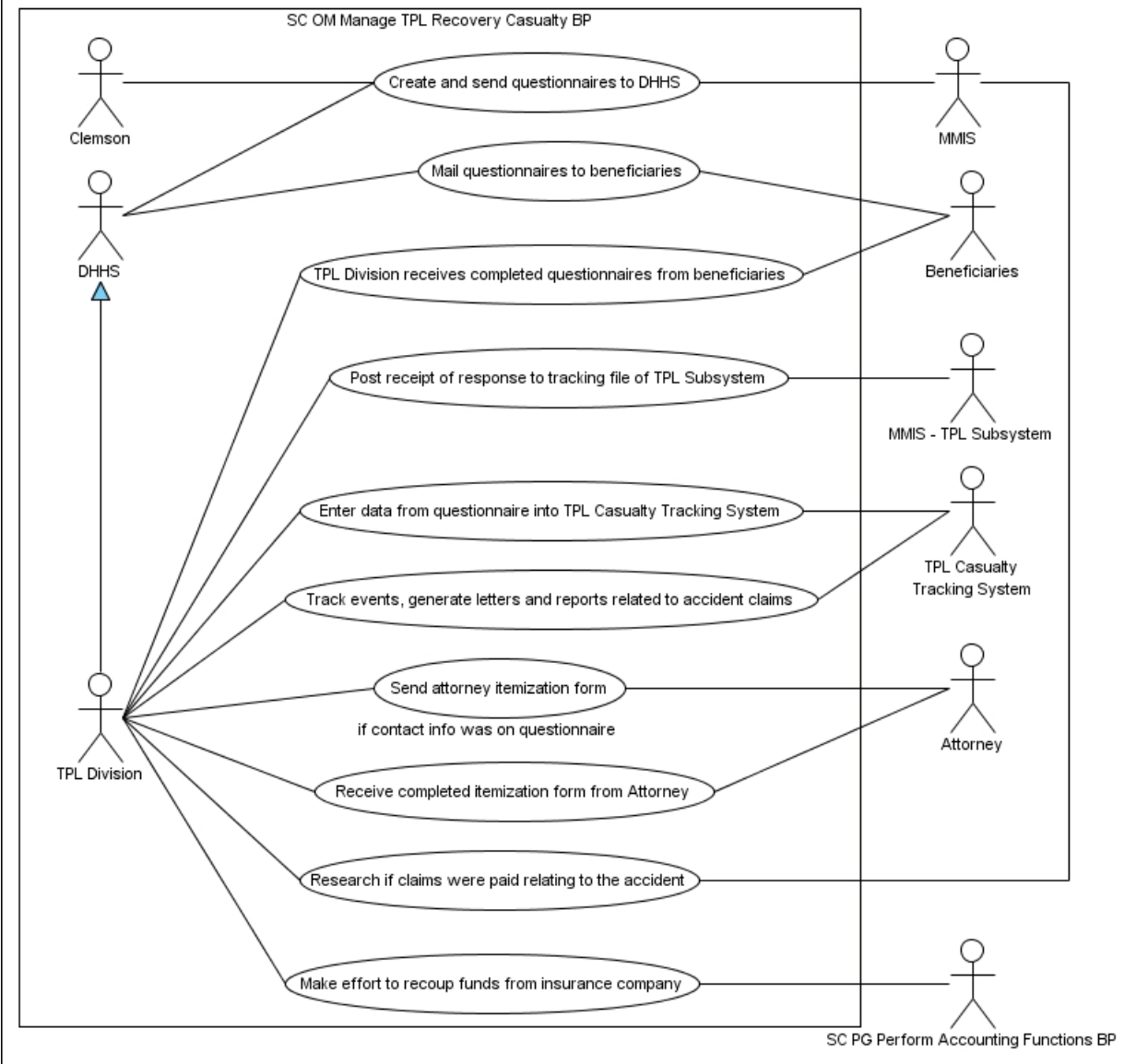


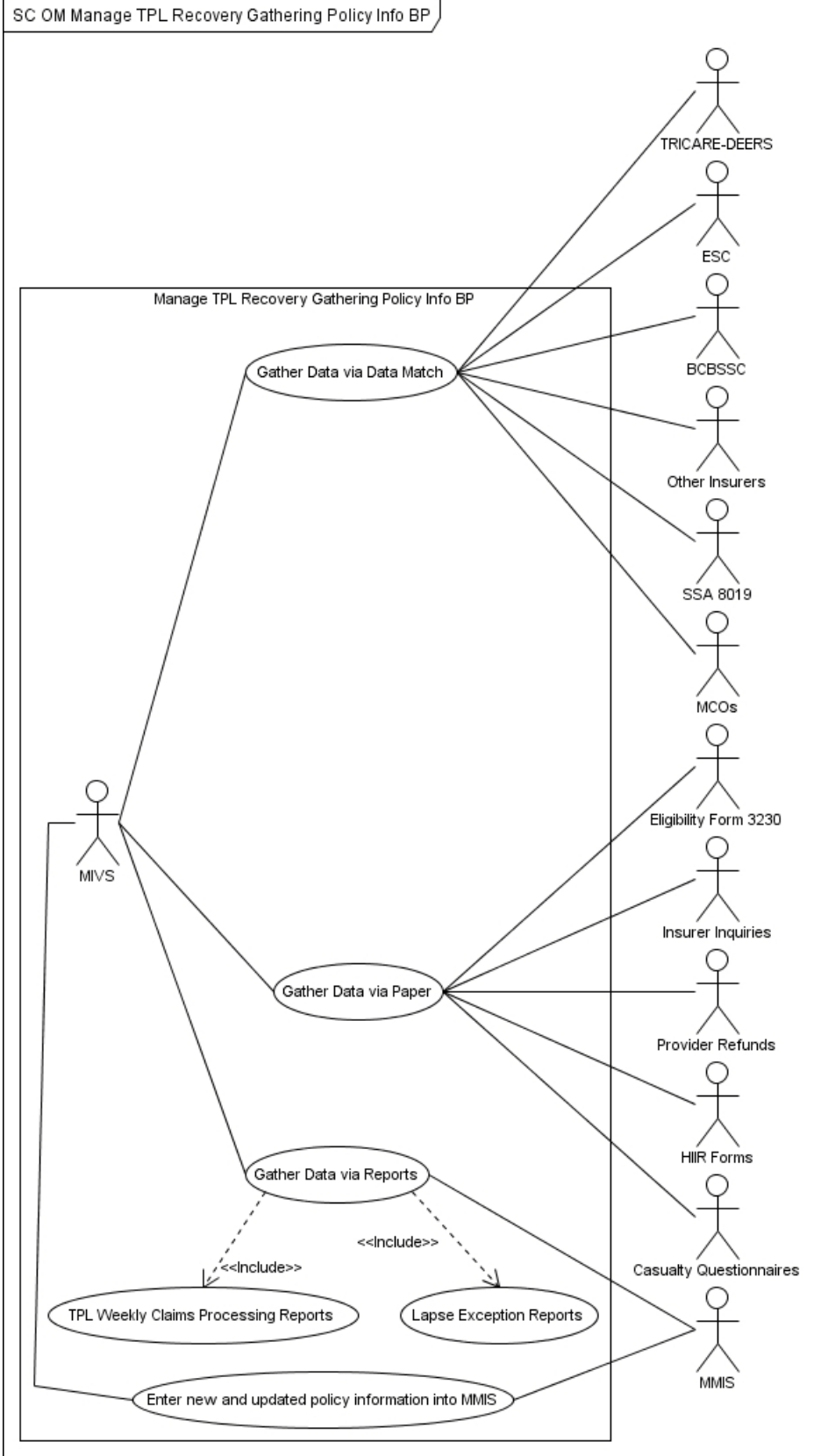
SC OM Manage Cost Settlement BP Page 2





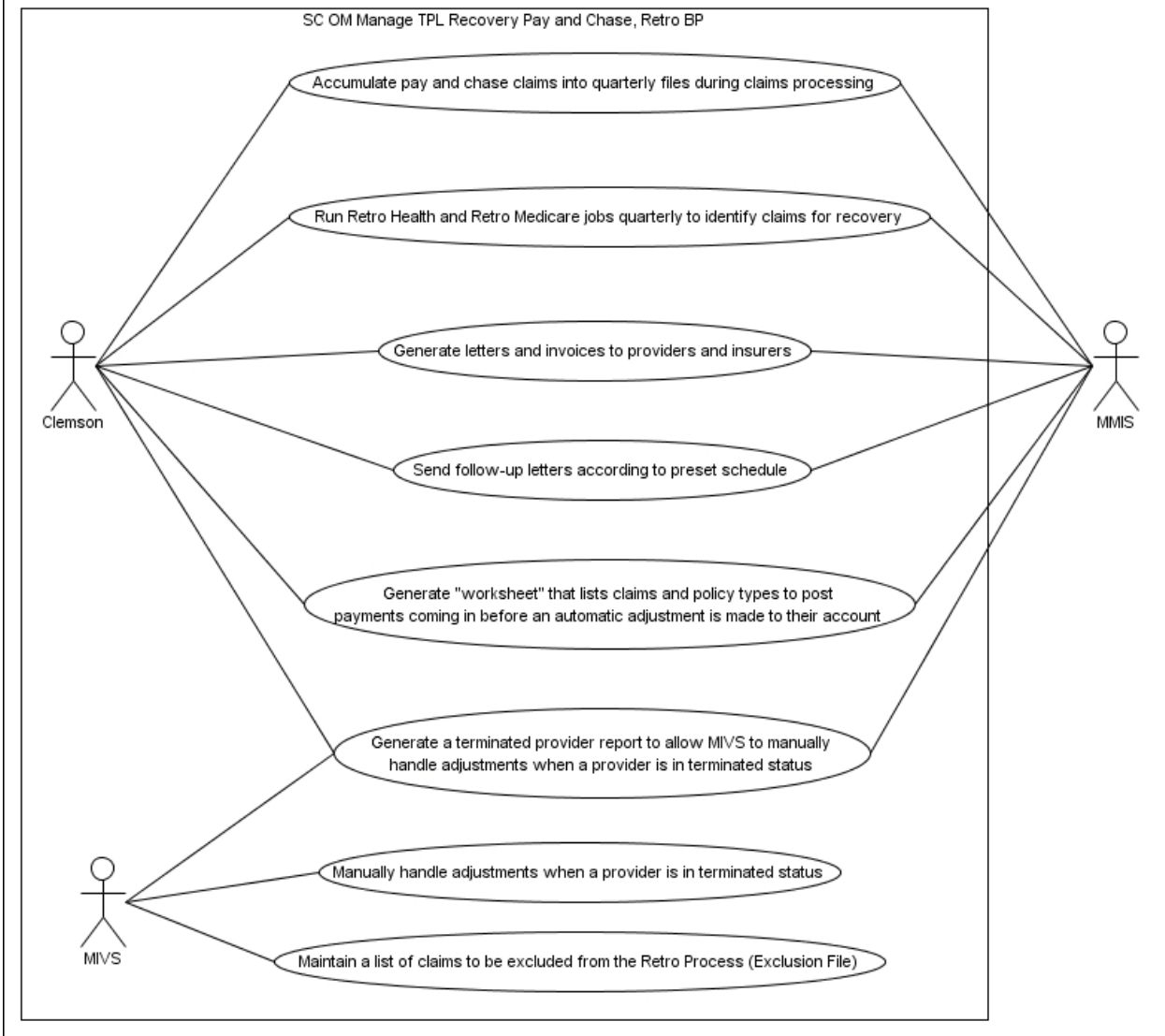
SC OM Manage TPL Recovery Casualty BP





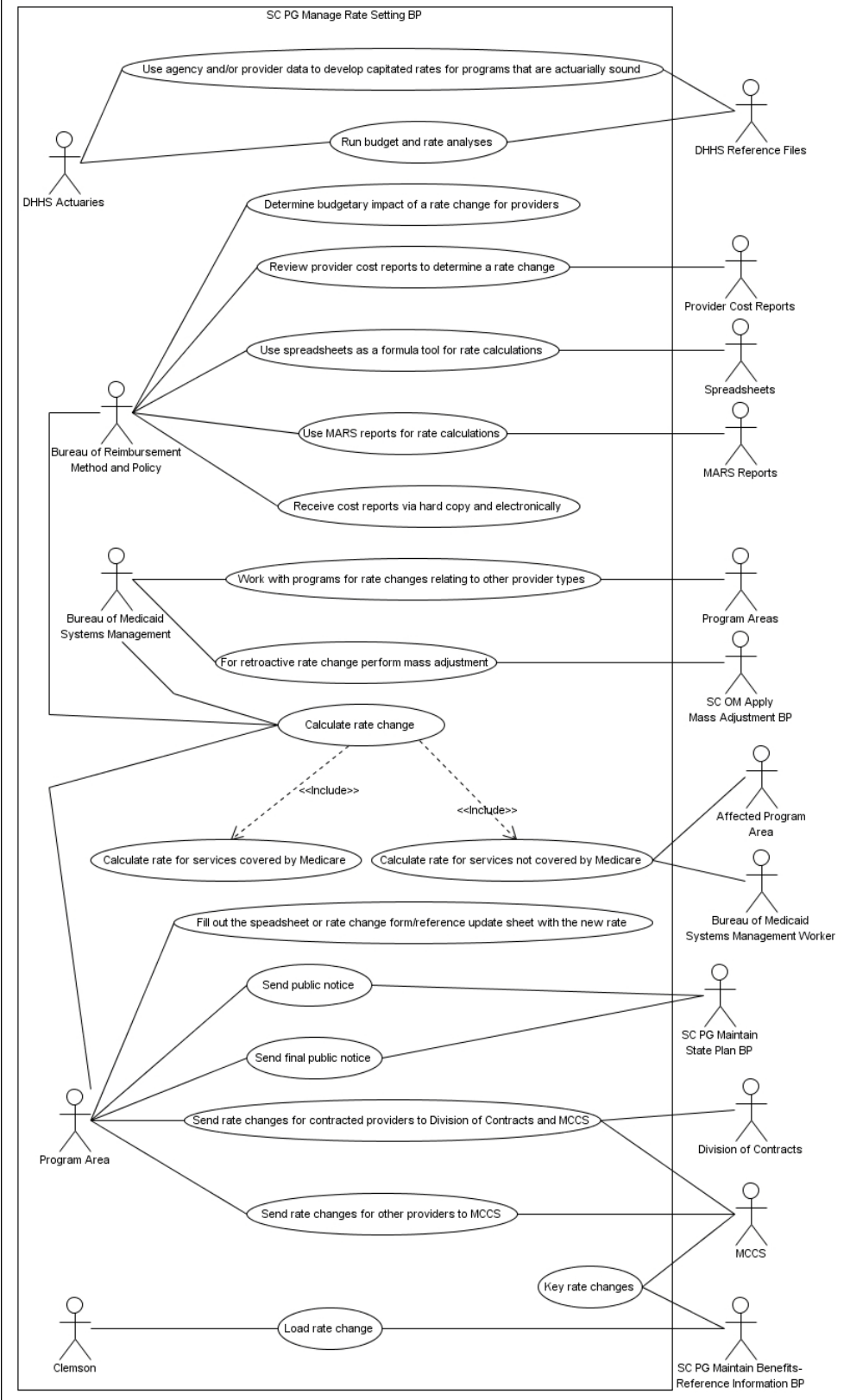


SC OM Manage TPL Recovery Pay and Chase, Retro BP



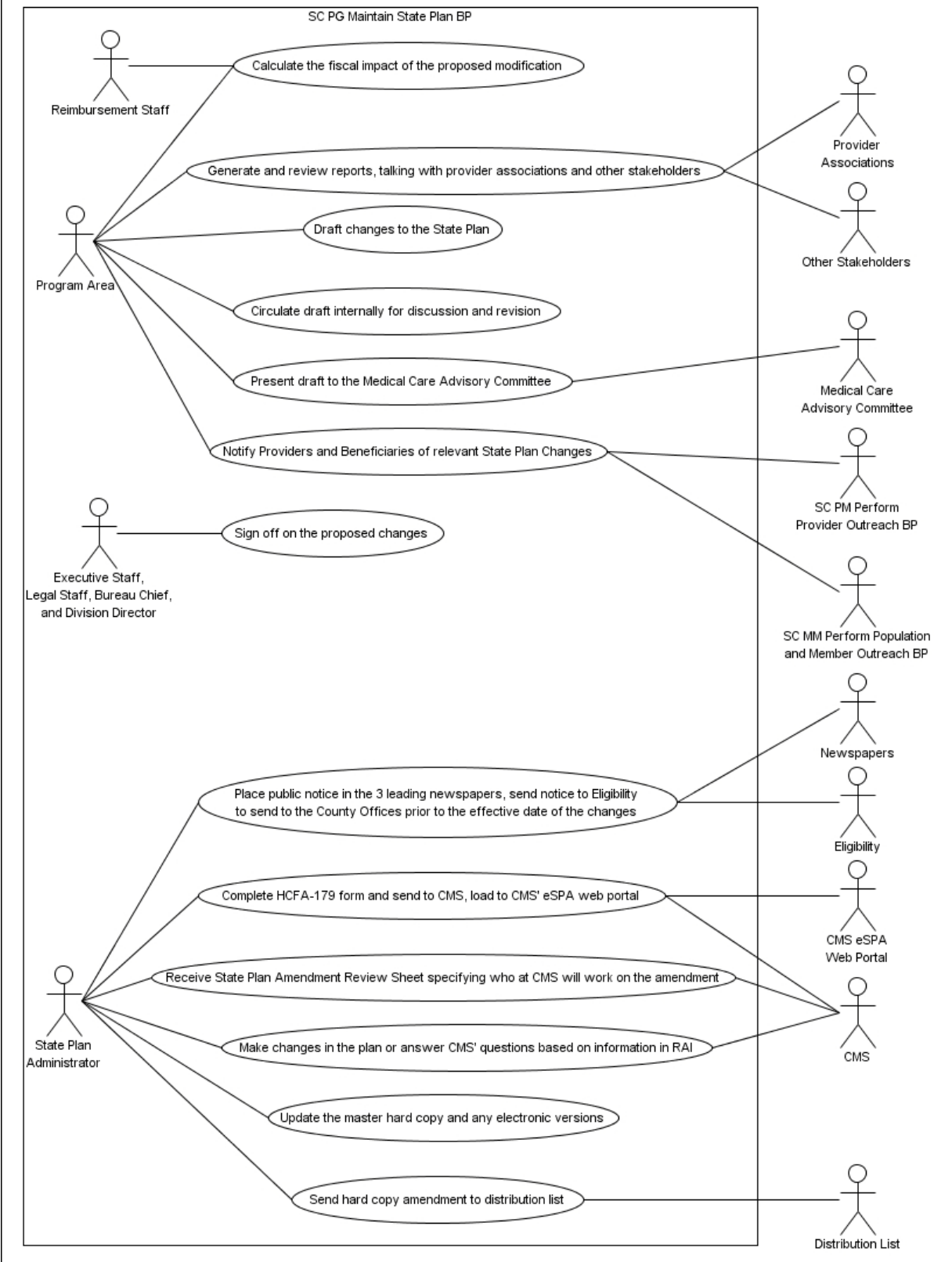


SC PG Manage Rate Setting BP



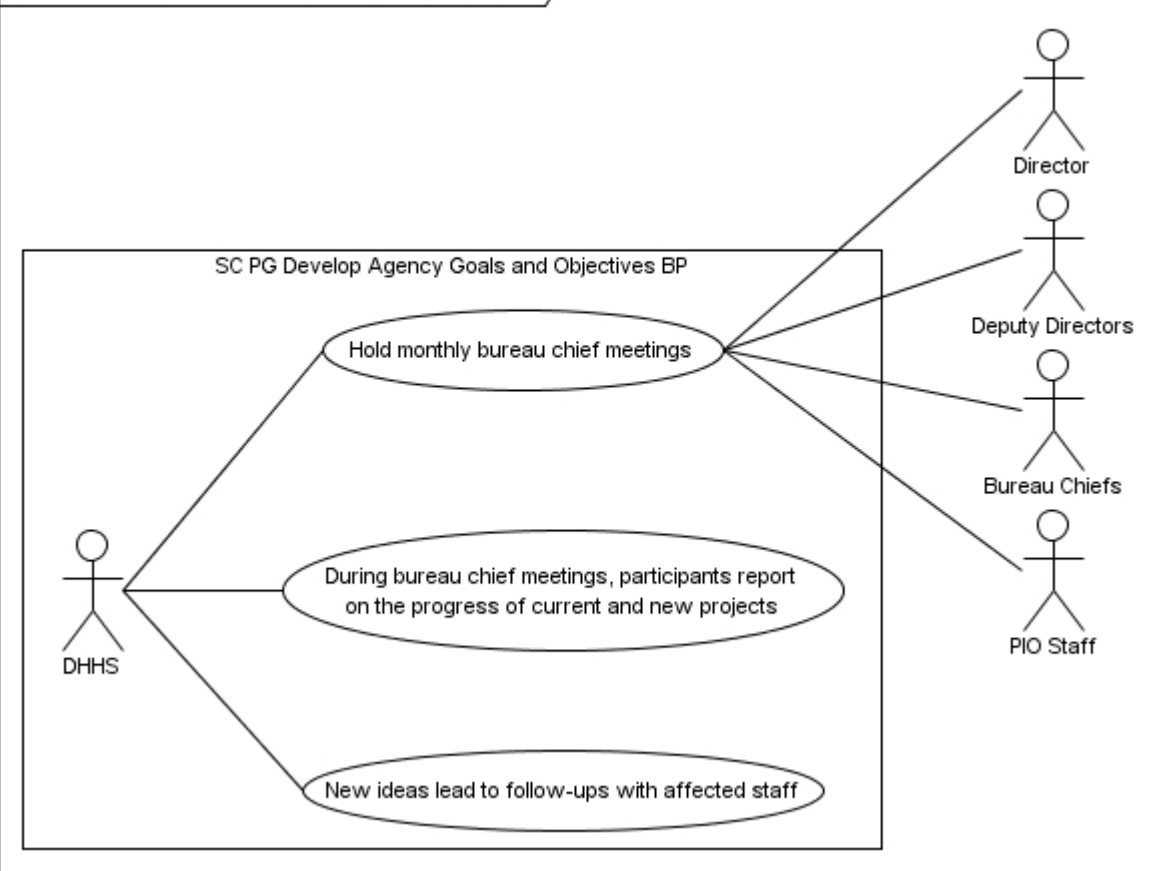


SC PG Maintain State Plan BP



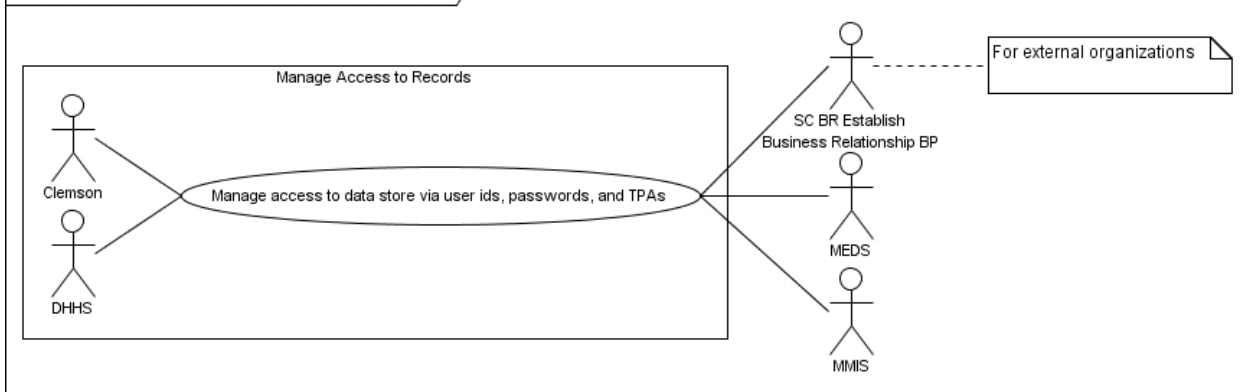


SC PG Develop Agency Goals and Objectives BP



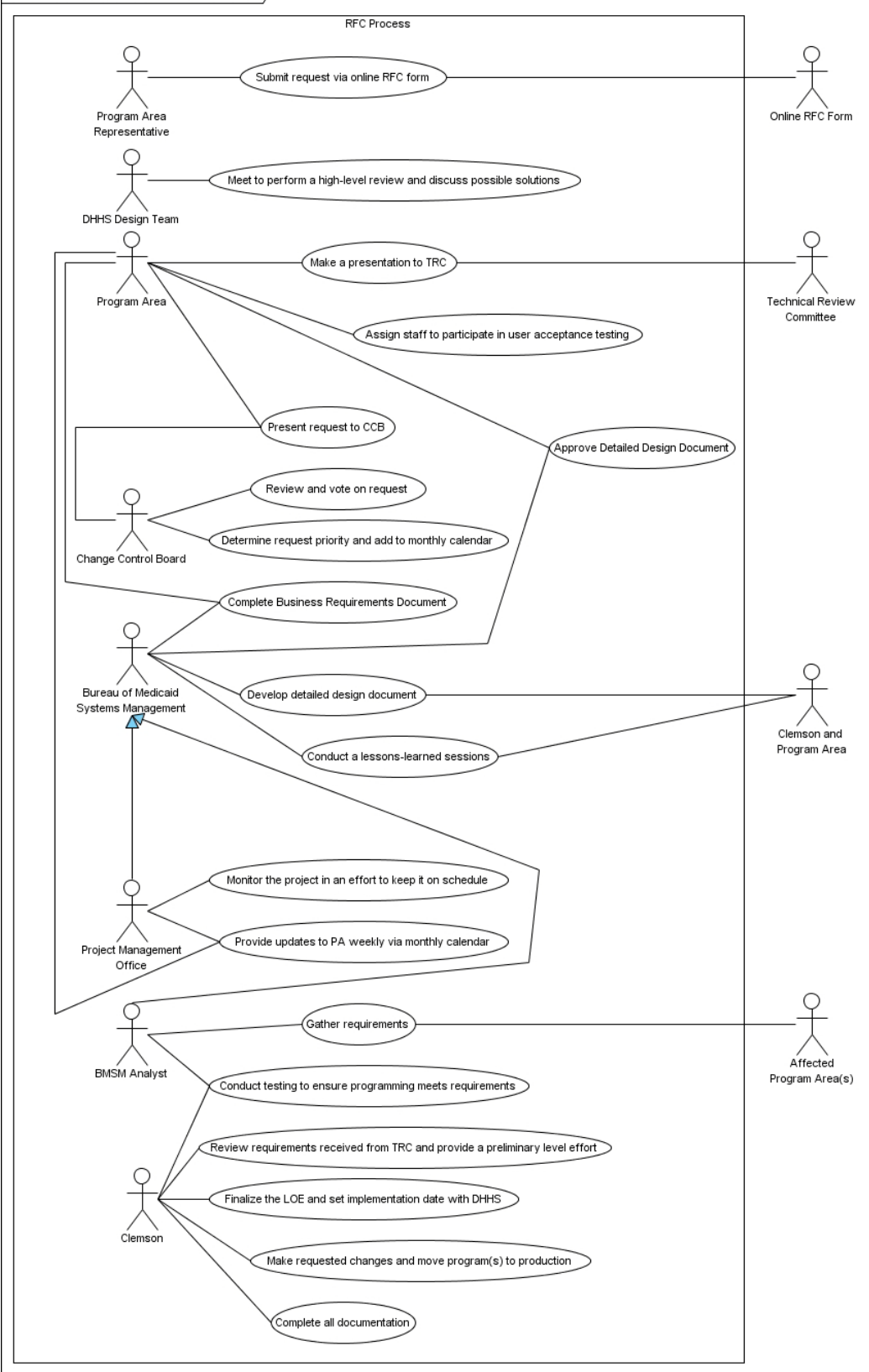


SC PG Manage Program Information Access to Records



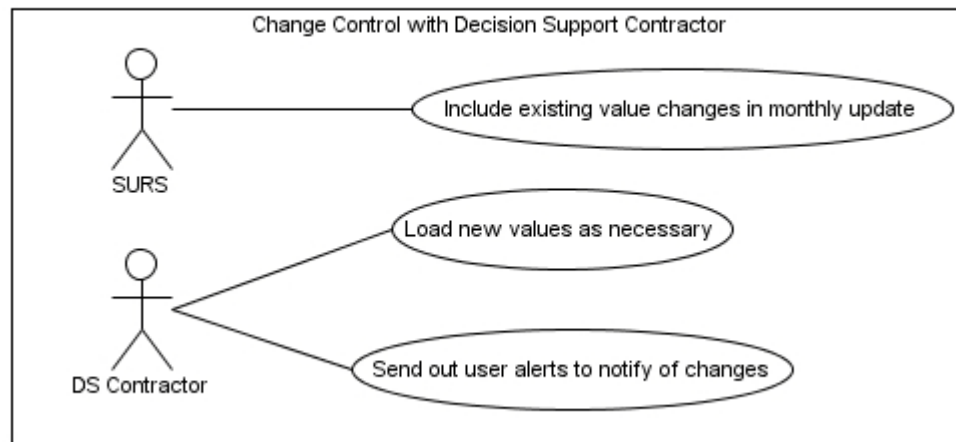


SC PG Manage Program Information RFC BP



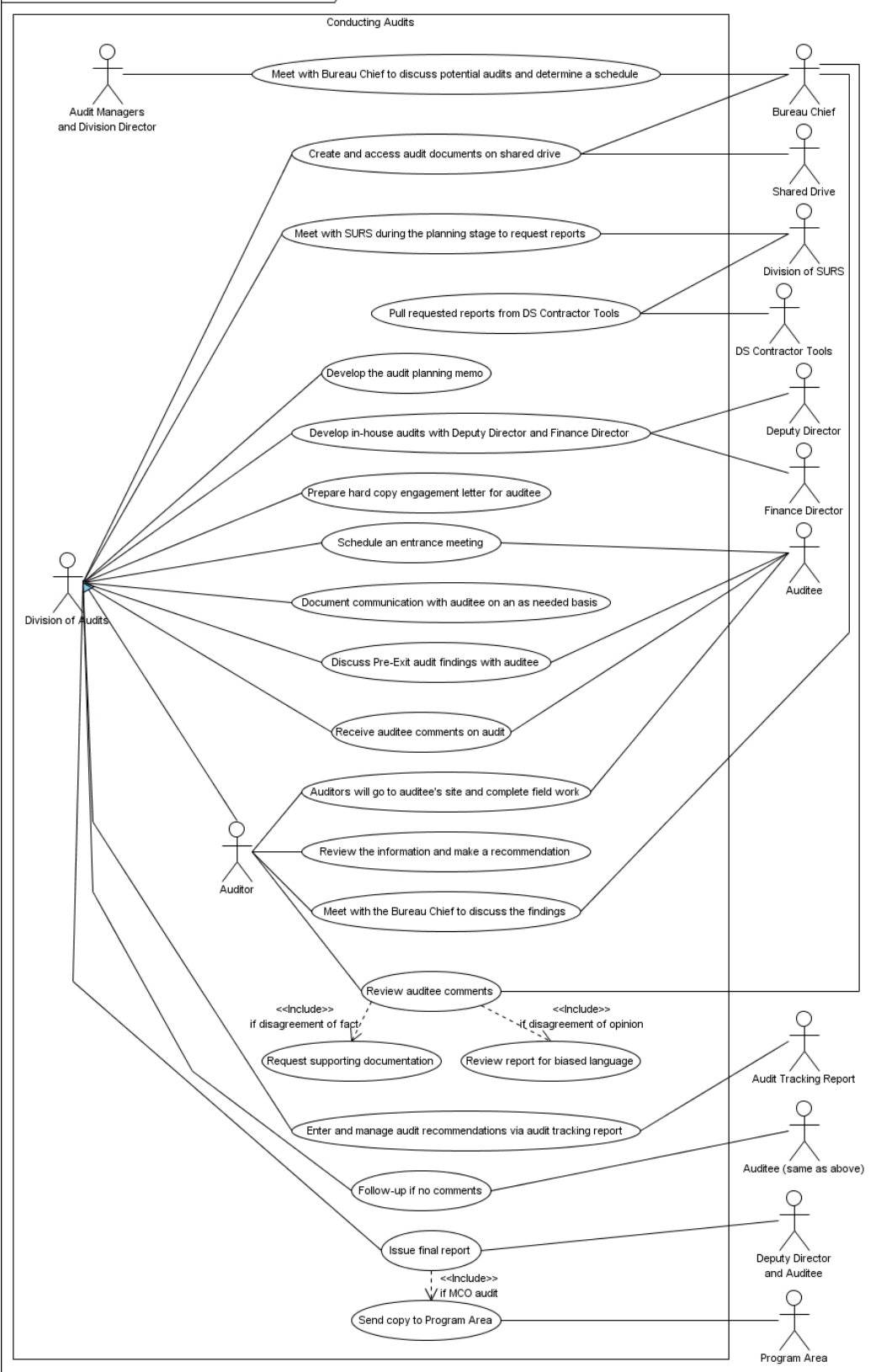


SC PG Manage Program Information Change Control DSC BP



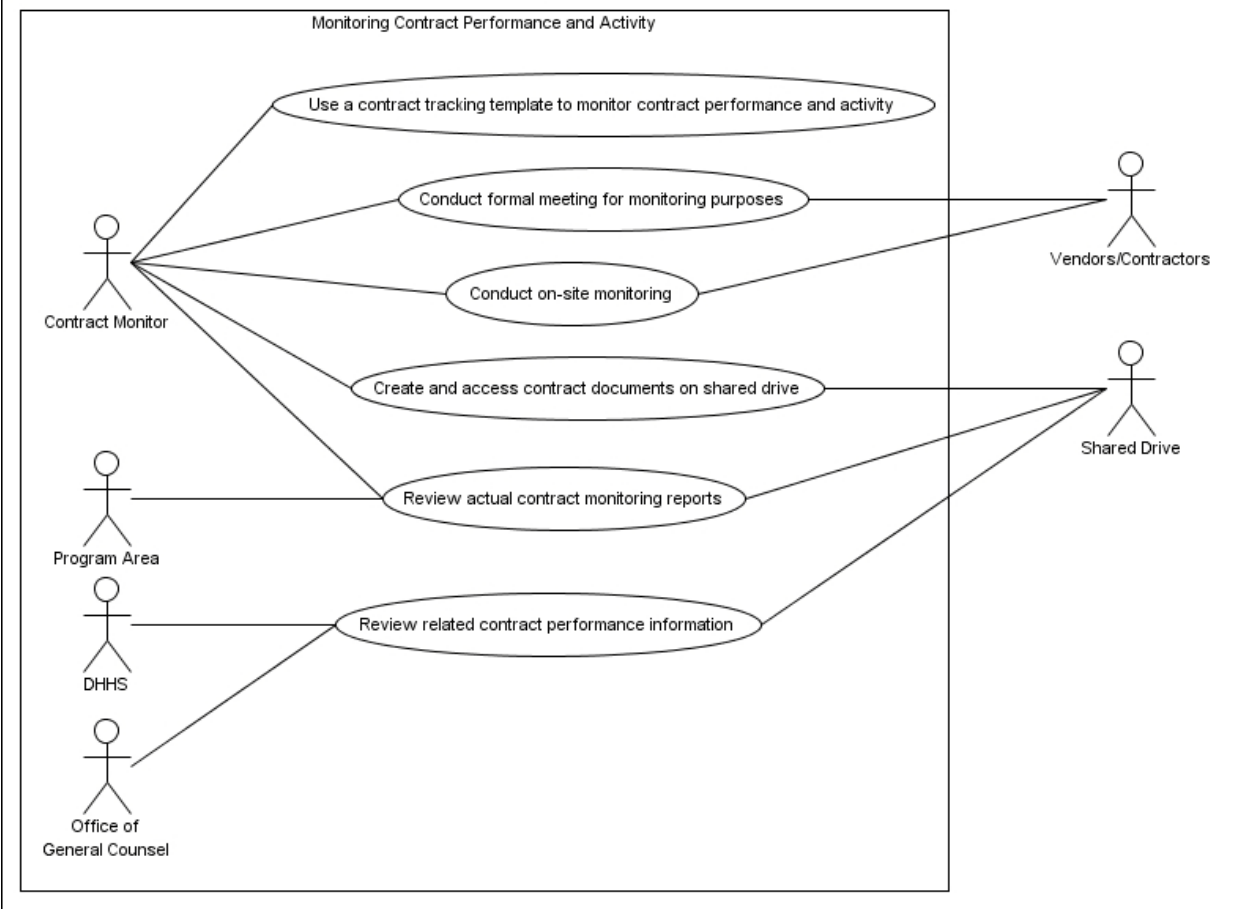


SC PG Monitor Performance and Business Activity Audits BP



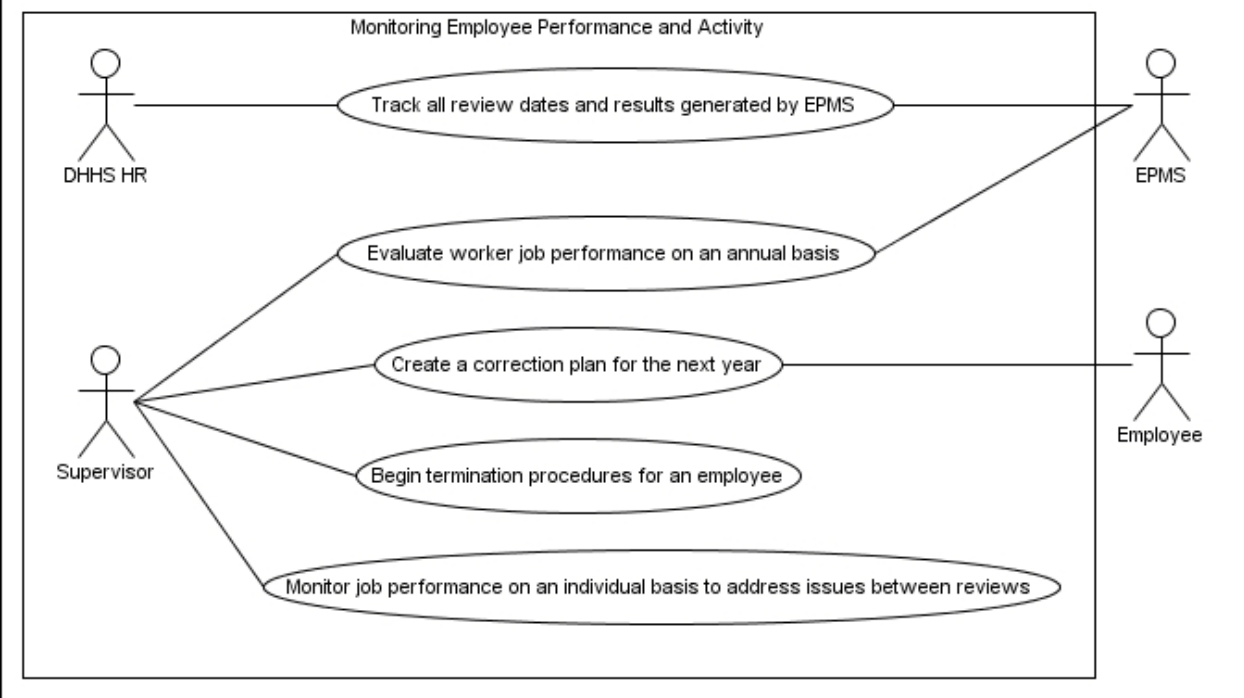


SC PG Monitor Performance and Business Activity Contract BP



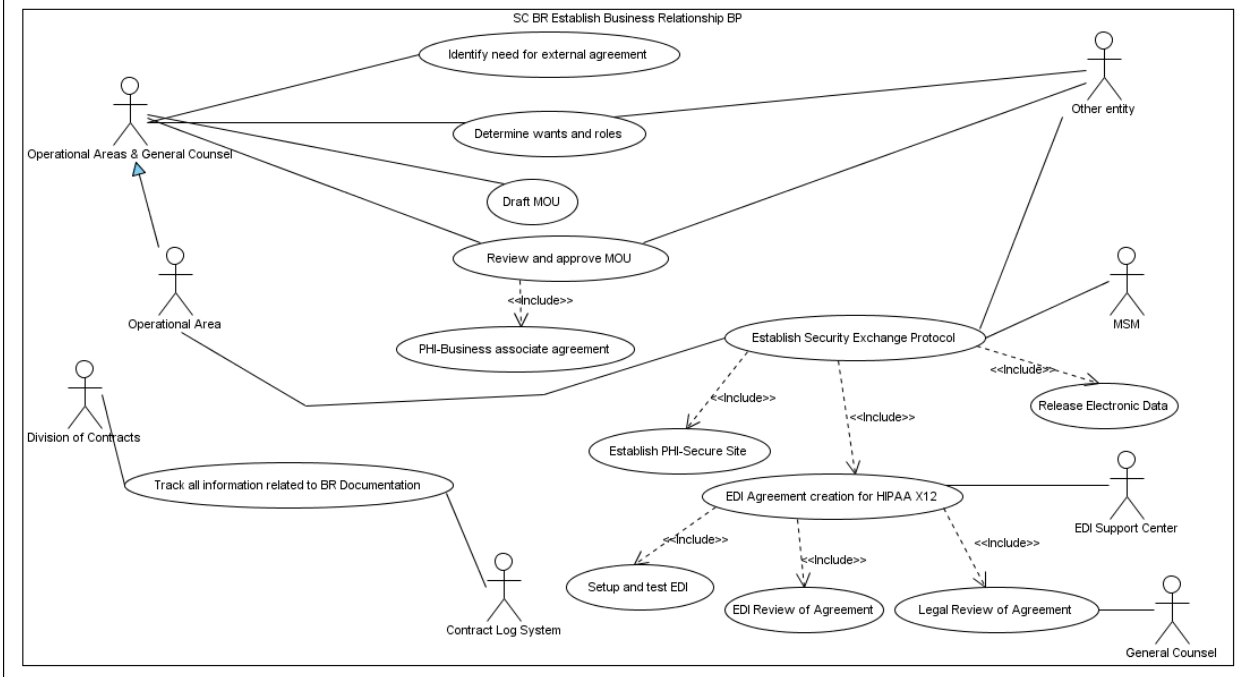


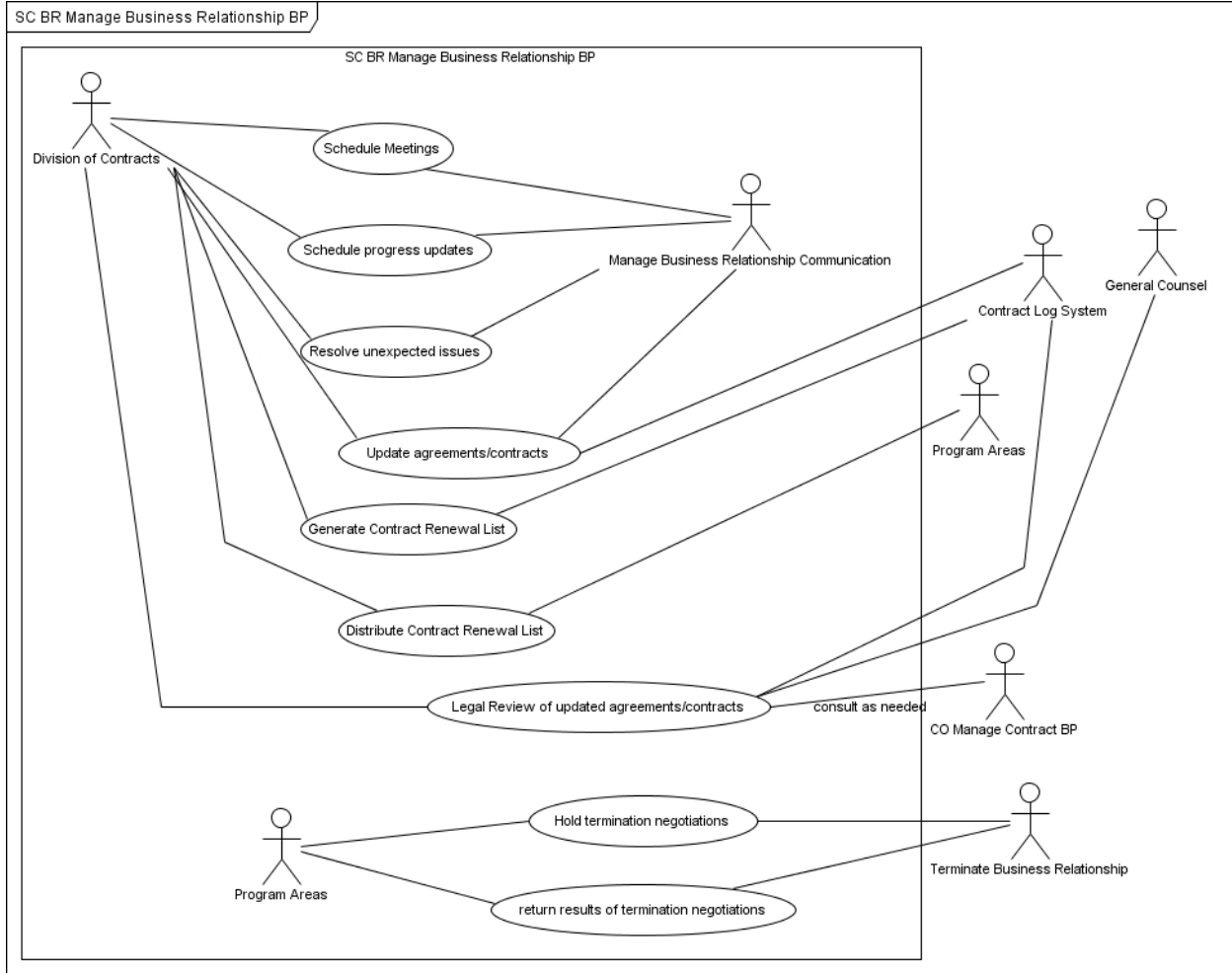
SC PG Monitor Performance and Business Activity Employee BP





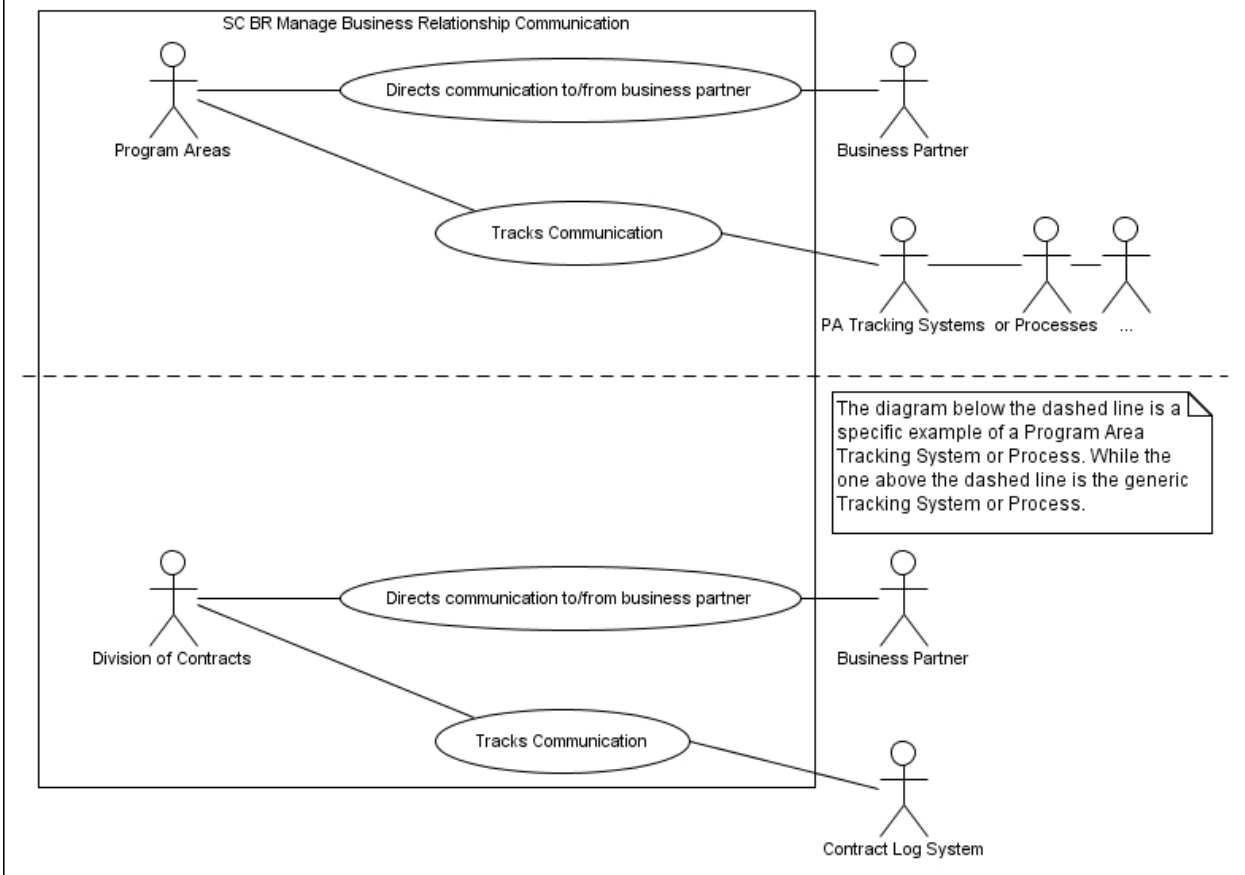
SC BR Establish Business Relationship BP





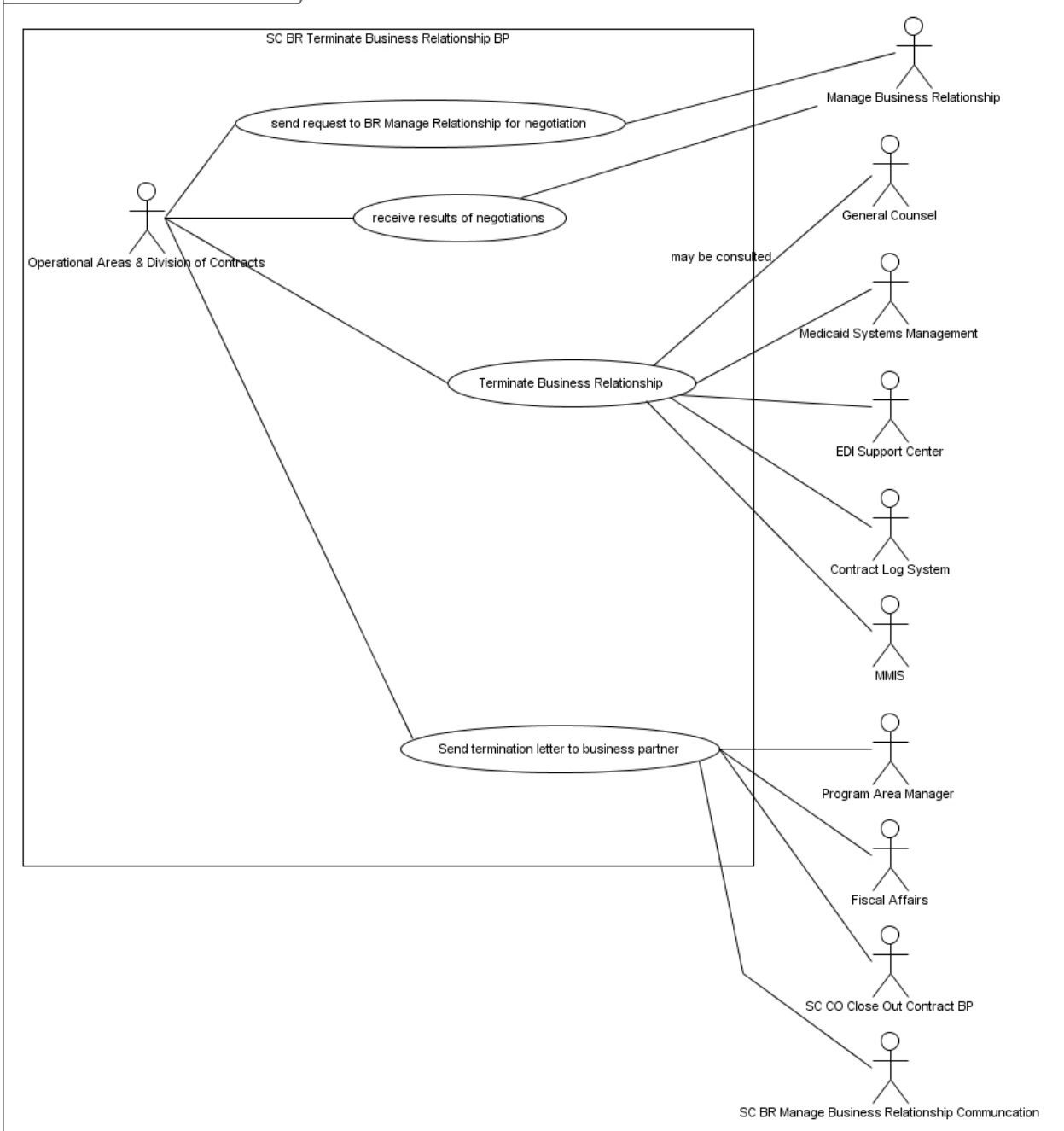


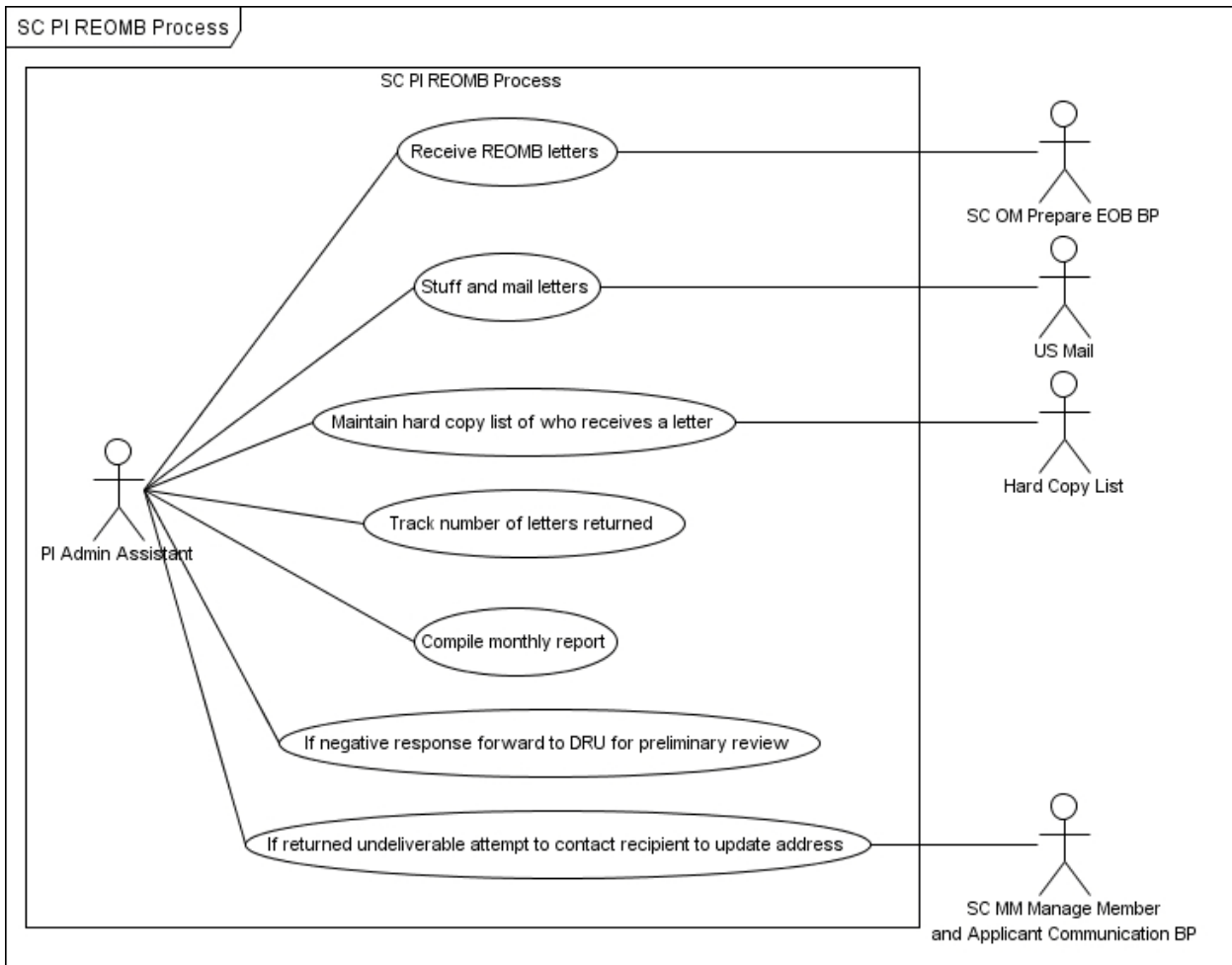
SC BR Manage Business Relationship Communication





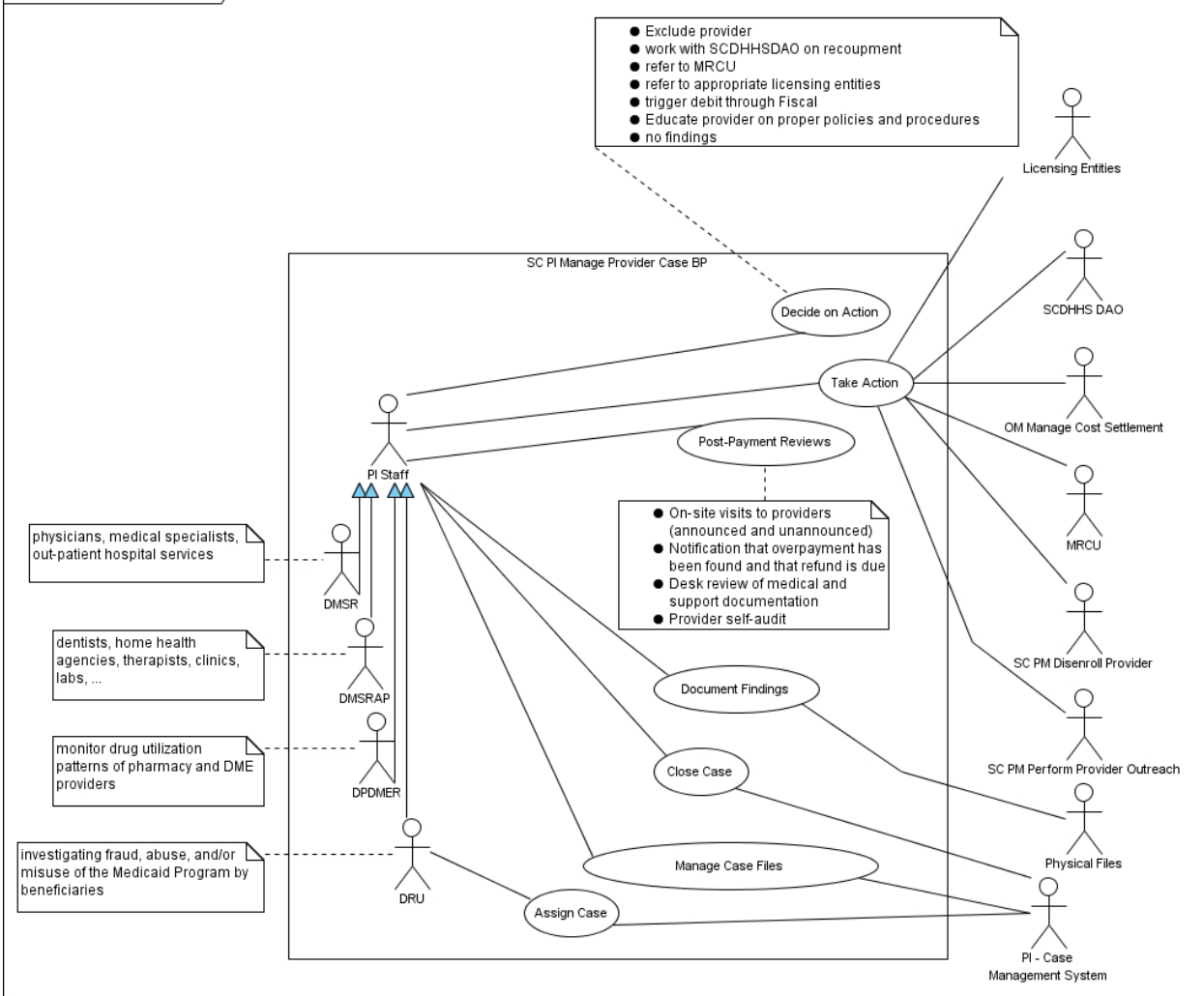
SC BR Terminate Business Relationship BP





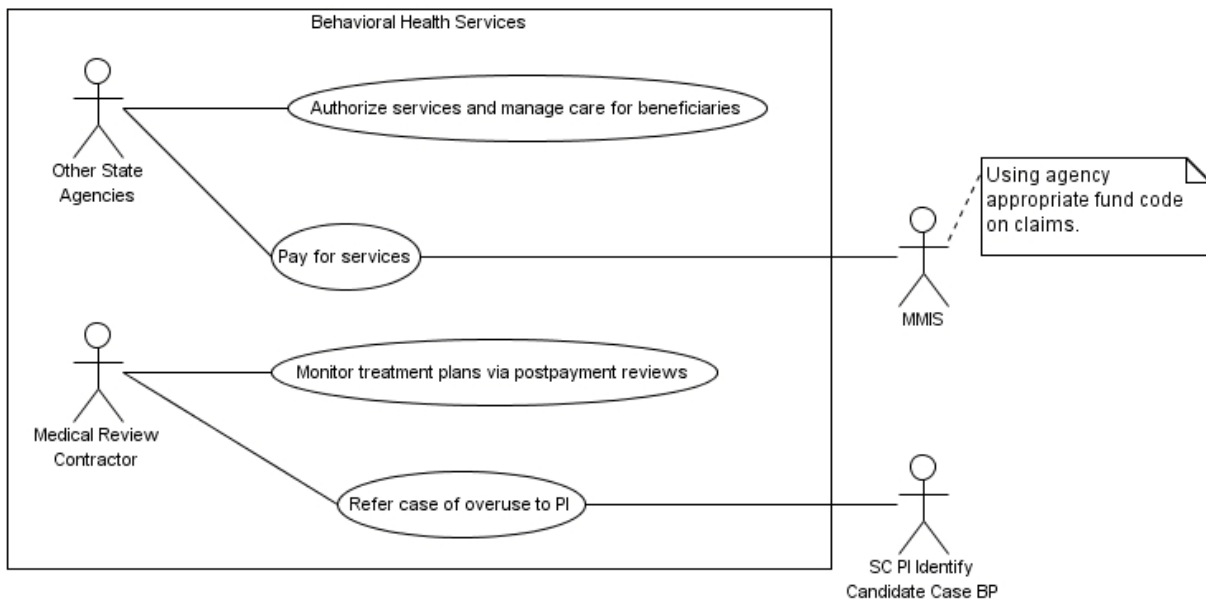
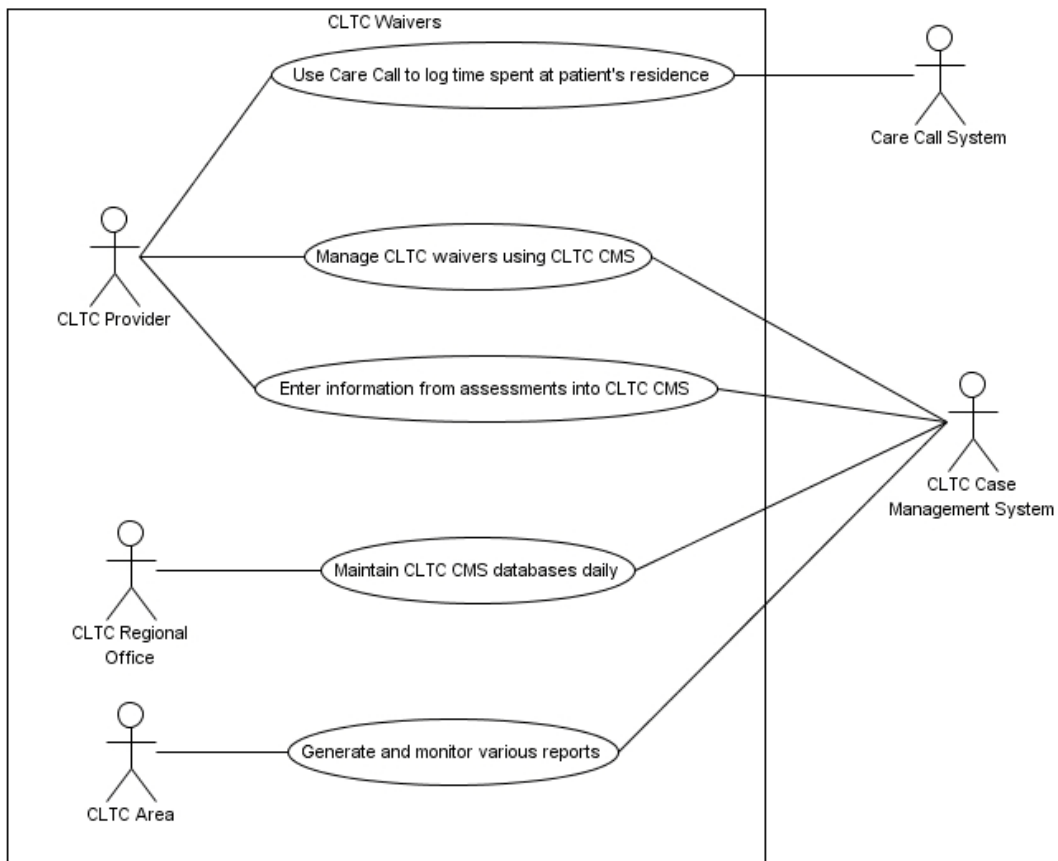


SC PI Manage Case Provider BP



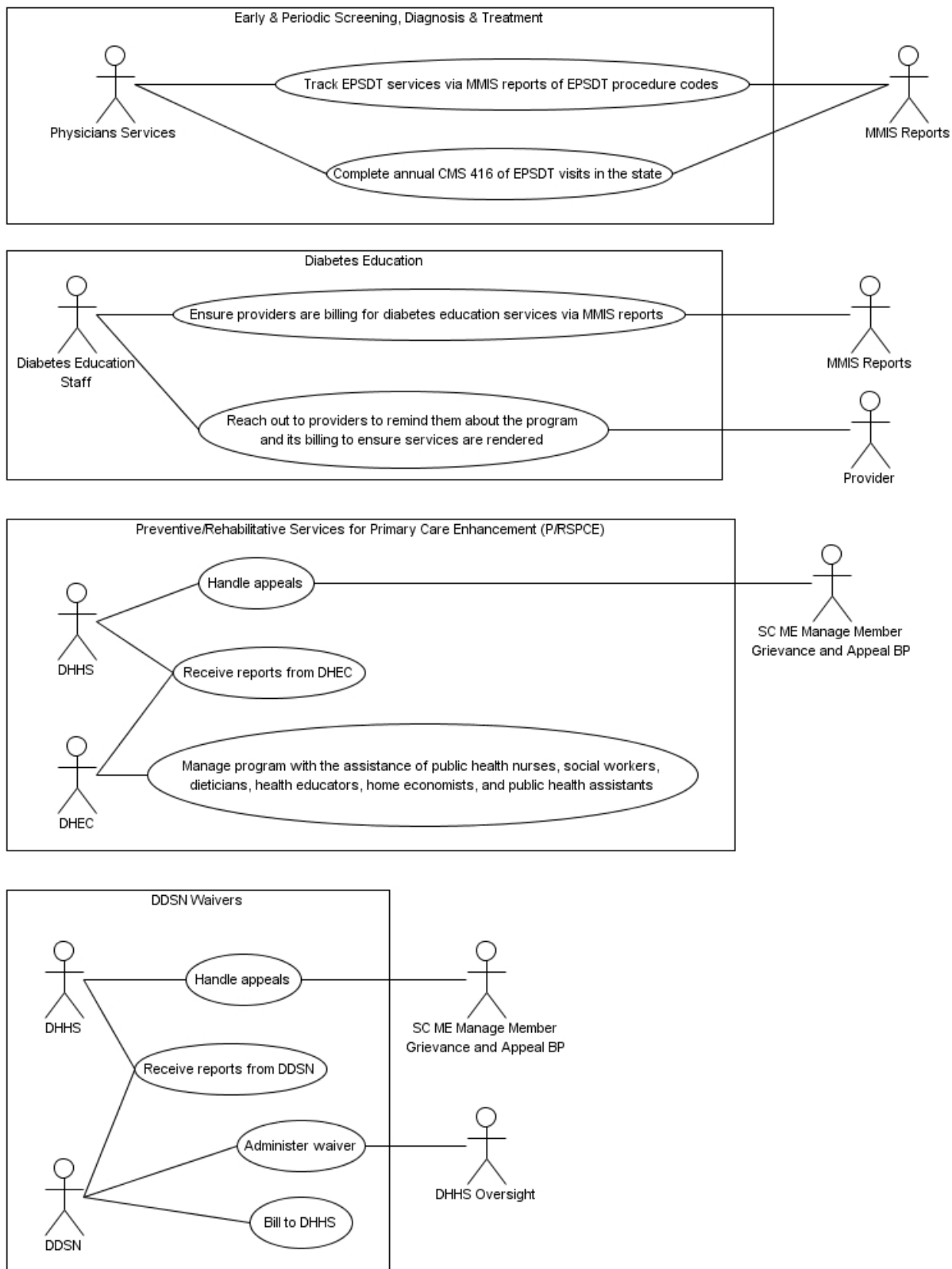


SC CM Manage Case CLTC, Behavioral



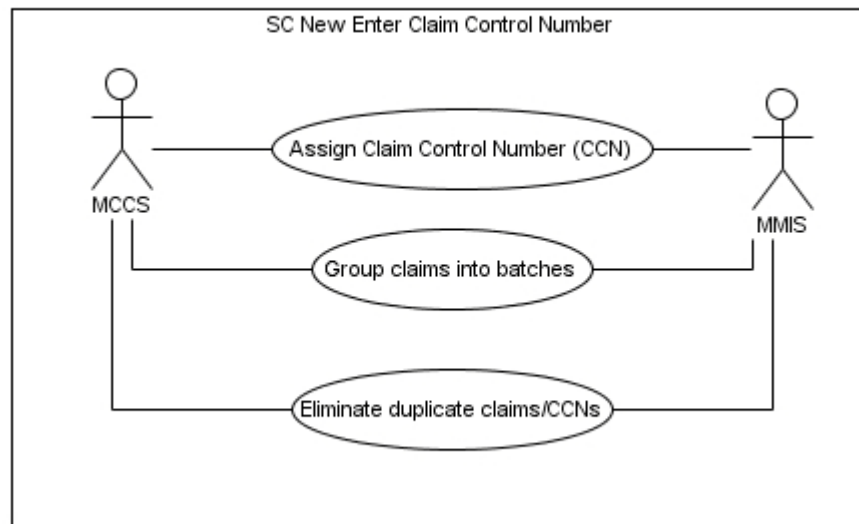


SC CM Manage Case EPSDT, Diabetes, P/RSPCE, DDSN



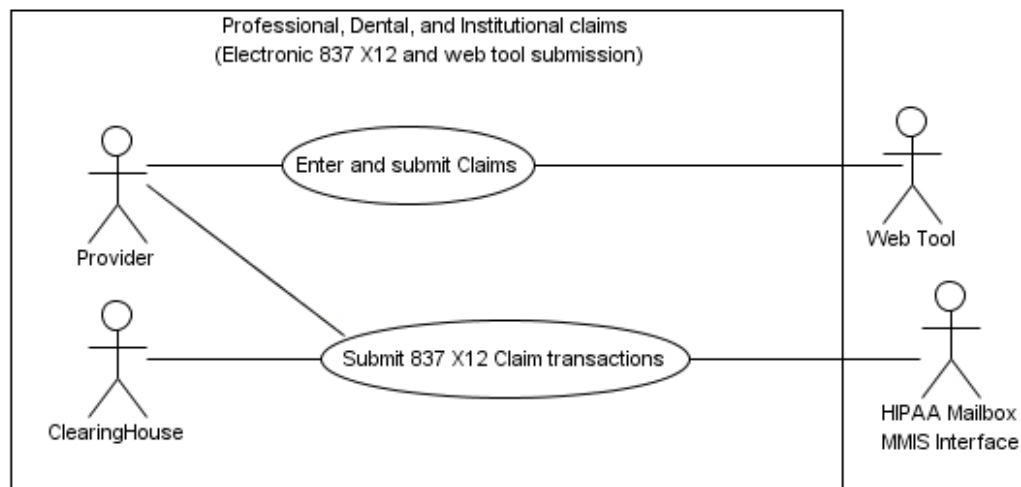
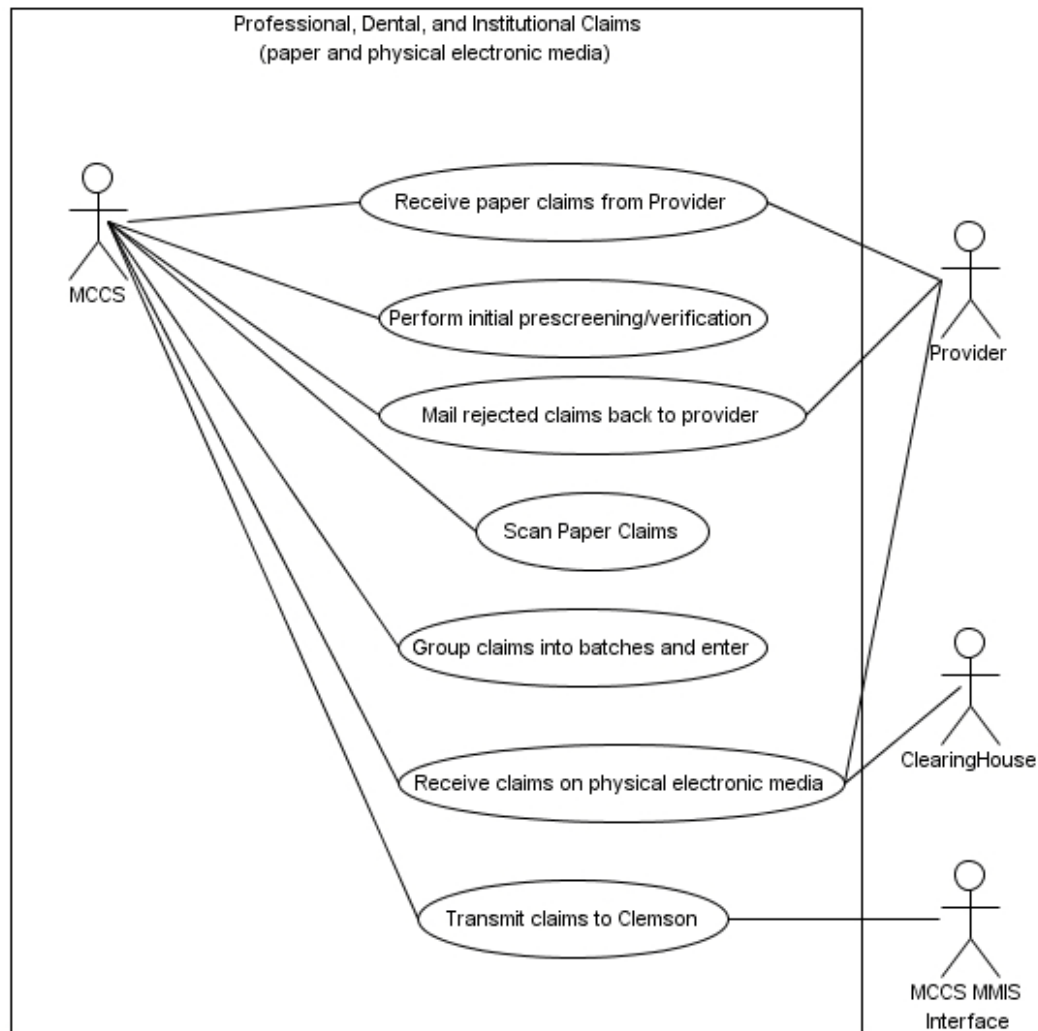


SC New Enter Claim Control Number BP



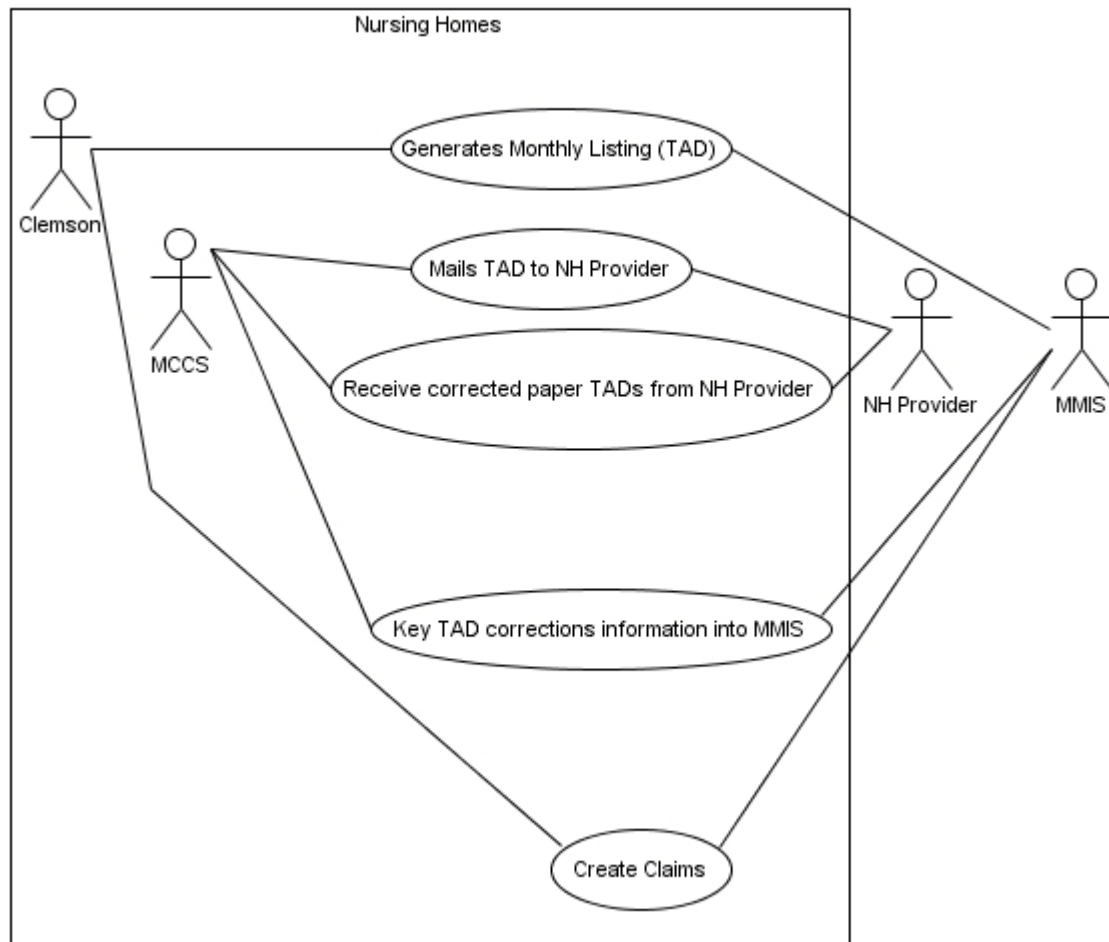


SC New Enter Claim Professional, Dental, and Institutional BP



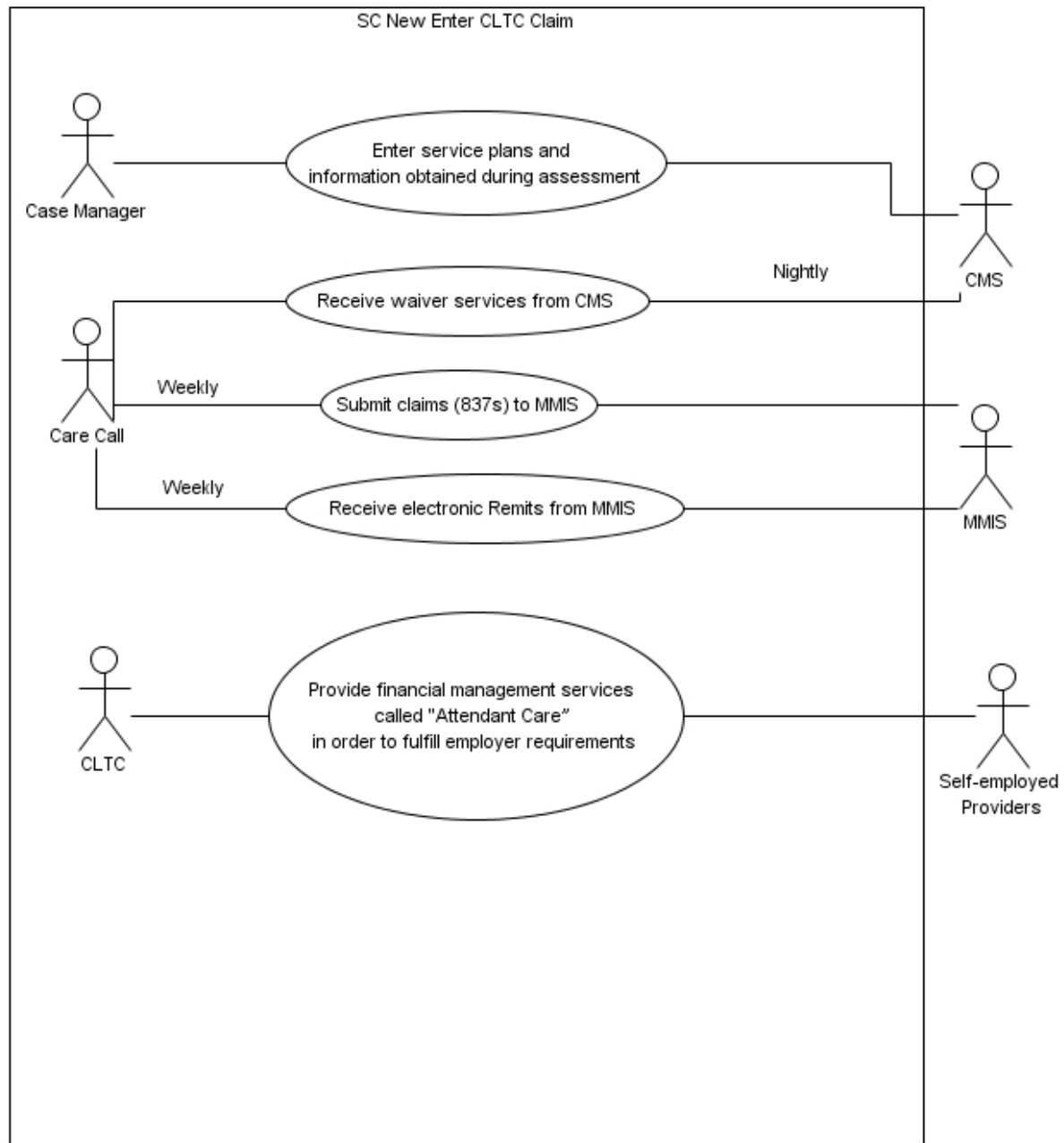


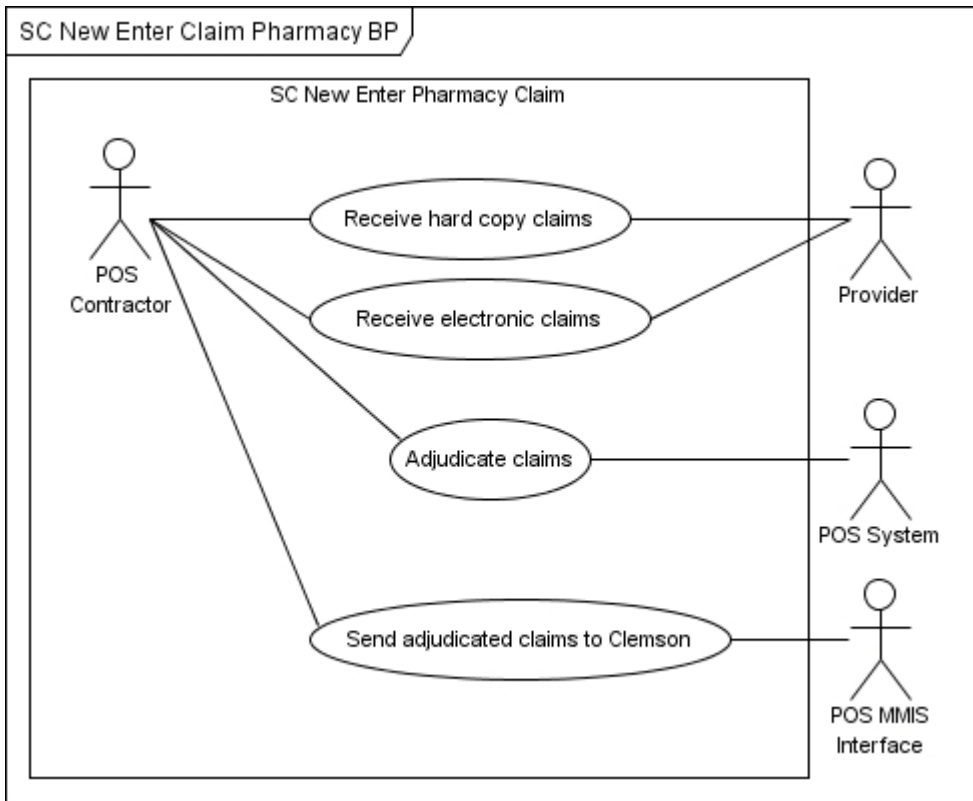
SC New Enter Claim Nursing Home BP





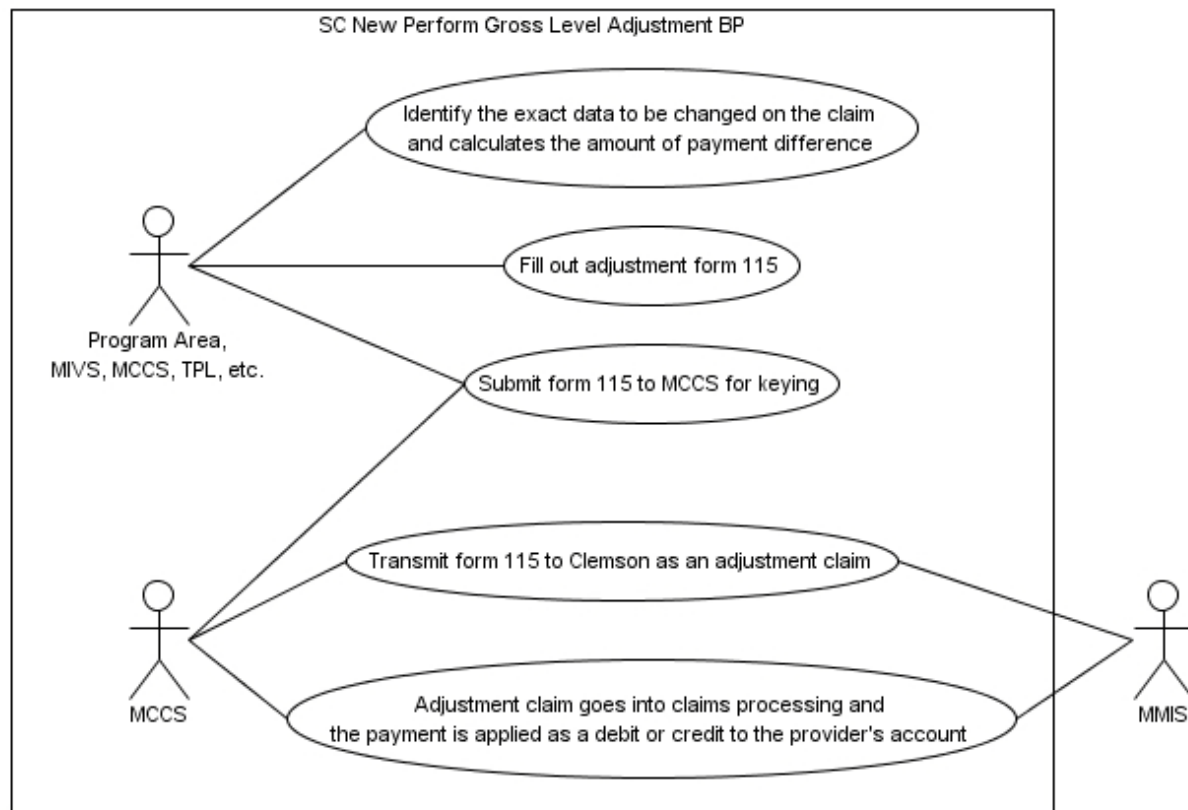
SC New Enter Claim CLTC BP

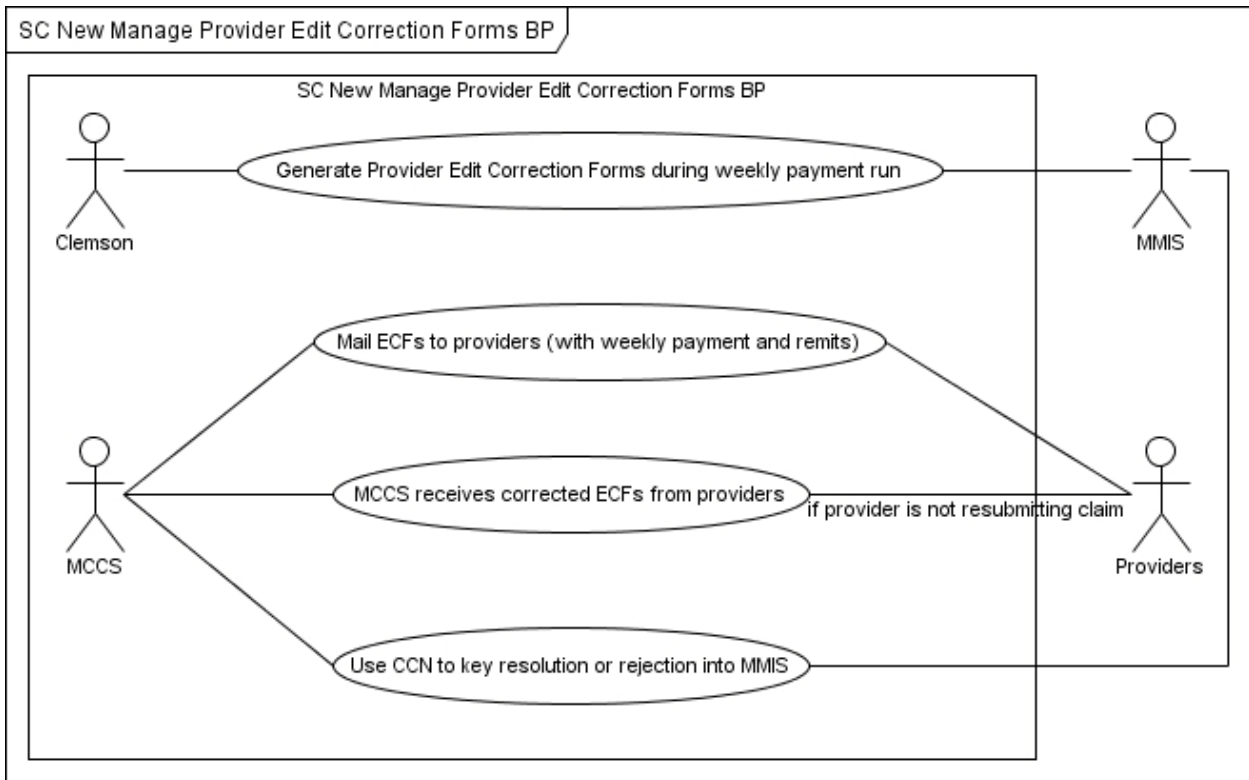


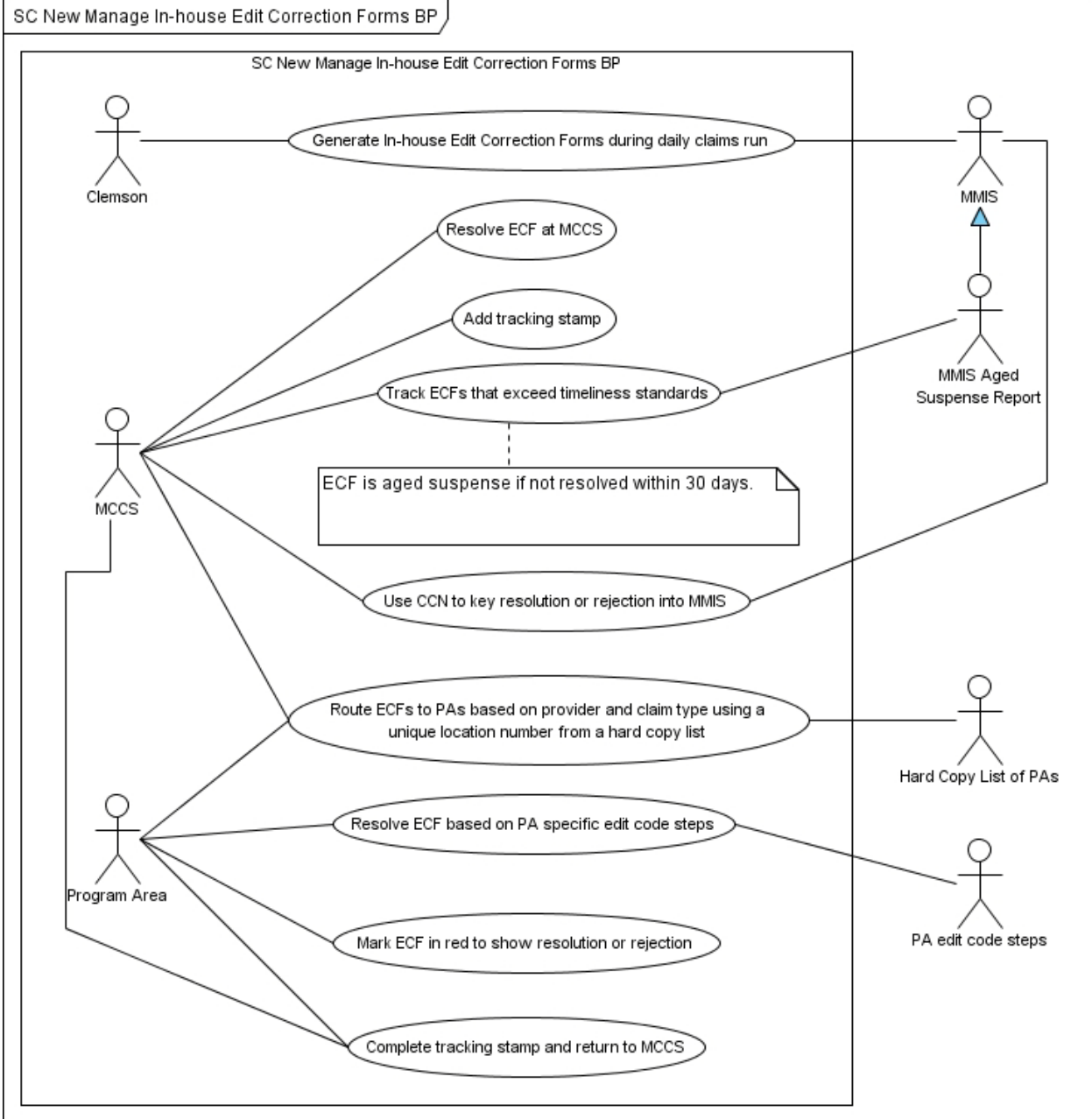




SC New Perform Gross Level Adjustment BP









Appendix G: Process Profiles

Process Name	SC ME Determine Eligibility BP
Parent Process	
Subprocess(es)	
Description	This business process receives eligibility application data from the applicant and/or from SSI interfaces (See SDX).
Owner Group	DHHS eligibility area
Purpose (<i>Intent</i>)	To take applicant data, edit/verify data, determine eligibility in a program. If moving to another program, determine eligibility in the new program. Determine eligibility at review time. Review eligibility workers' work.
Input (<i>What is required for the process to execute?</i>)	<ul style="list-style-type: none"> • Applicant data • Eligibility review form to re-determine eligibility • Information from other data sources
Output (<i>What is the result of the process?</i>)	<ul style="list-style-type: none"> • Eligible or not
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	<ul style="list-style-type: none"> • MEDS Interfaces • MMIS online • Paper applications • MEDS online • SDX Interface as input • Partners for Health (PFH) Tracking System/Central Eligibility Tracking System • Excel workbook to determine if an individual meets the financial requirements for Medicaid eligibility • Quality control mechanisms at USC • Redetermination/review form
Trigger (<i>Any processes that precede this process?</i>)	<ul style="list-style-type: none"> • Beneficiary losing eligibility in one program • Beneficiary change in status to go to a different program • Change in beneficiary data
Dependency (<i>Any processes dependent on the completion of this process?</i>)	<ul style="list-style-type: none"> • ME Enroll Member • ME Disenroll Member • ME Manage Applicant and Member Communication
Key Stakeholders	<ul style="list-style-type: none"> • Sponsored positions for eligibility workers to work onsite • Eligibility workers • Applicants • Beneficiaries • Division of Central Eligibility Processing
Frequency/Timing/Events/Cycles	
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	<ul style="list-style-type: none"> • The worker enters application information into MEDS and pends the case within three business days of receipt.
Known Issues	
Procedures/Tasks	<p>Application Intake</p> <ul style="list-style-type: none"> • Applicant mails/brings in application, and/or • Applicant fills out app with worker • Worker verifies citizenship and identity from original docs, enters info into MEDS



	<ul style="list-style-type: none"> • County eligibility office manages application process. • Some applications are processed by the Division of Central Eligibility Processing (TEFRA, inmates, etc) and some are processed at the county office. • Eligibility is pre-determined by SSA for SSI beneficiaries. These SSI cases are loaded into MEDS automatically as eligible. (SDX Interface) • Worker determines if applicant is already in MEDS. • Worker uses the Partners for Health (PFH) Tracking System/Central Eligibility Tracking System to track the status of the application. • If the applicant is determined to be ineligible, the worker uses the PFH tracking system to send the applicant a letter. See ME Manage Applicant and Member Communication. <p>Ex-Parte</p> <ul style="list-style-type: none"> • If it appears that an individual is not eligible for the program he applied for, the eligibility worker will look at all programs before closing the case. • MEDS will assist in this determination by providing the payment category, but otherwise, the worker must manually make this decision. <p>Quality Control</p> <ul style="list-style-type: none"> • Supervisors in each county review a small amount of eligibility workers' work each month. For new workers, a supervisor will review 100% of their work. • SCDHHS also contracts with the contractor for other quality control reviews for eligibility determination: <ul style="list-style-type: none"> • Medicaid Eligibility Quality Control (MEQC) This review consists of two options: 1. A random sample is pulled, and USC assigns an error rate. 2. SCDHHS can identify a specific area that is known to have problems and then must make a corrective action plan. • Payment Error Rate Measurement Review (PERM) This review is conducted for Medicaid and SCHIP and separate error rates and payment review processes are reported. If it is found that a case should have been ineligible, an error in claims payment is reported. • Assistance for Coaching Excellence (ACE Review) This review has a sample of cases from each supervisory unit. This review is different from the two above in that it is a desk review and information is not verified again. • The contractor also conducts other reviews on an ad hoc basis including a review of SCDHHS employees that receive Medicaid or a supervisor request to investigate an individual worker's cases. A supervisor will report their suspicions of the worker to the agency prior to USC conducting a review. <p>Redetermination</p> <ul style="list-style-type: none"> • The annual BENDEX and SDX Mass Change for Cost-of-Living Increases may result in loss of eligibility due to income increases (see Disenroll Member BP and Manage Applicant and Member Communication BP).
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- Other interface data may cause redetermination
- When a beneficiary loses his eligibility, eligibility workers research at what point his eligibility was lost. SCDHHS has a threshold for recouping money from beneficiaries when payments were made on their behalf during a period of ineligibility. SCDHHS will not pursue recoupment if the amount is below this threshold. The eligibility worker sends a letter and requests payment from the beneficiary (see **Manage Applicant and Member Communication**).

Reviews

- Eligibility workers mail a review form to beneficiaries.
- Some beneficiaries come in for an interview, but most choose to return the review form via mail.
- When a form is returned and all information is provided, the eligibility worker will indicate in MEDS that the review was completed.
- If a beneficiary does not return the form by the requested date, MEDS will auto-close the case, terminating eligibility. See **Disenroll Member BP**.
- When a beneficiary loses his eligibility, eligibility workers research at what point his eligibility was lost. SCDHHS has a threshold for recouping money from beneficiaries when payments were made on their behalf during a period of ineligibility. SCDHHS will not pursue recoupment if the amount is below this threshold. The eligibility worker sends a letter and requests payment from the beneficiary (see **Manage Applicant and Member Communication**).

Ex Parte

- If it is found that a beneficiary is no longer eligible, the worker must complete the manual ex parte process to ensure that the beneficiary is also not eligible for any other Medicaid program.

Eligibility Data Sources and Determination

- Workers uses various Interface data (and a medical professional (e.g. doctor, midwife, registered nurse, prenatal) clinic in the case of pregnancy) to obtain and verify applicant/beneficiary data
- Workers can request interface data via an exchange process for a specific applicant/beneficiary in determining eligibility.
- Workers use a worksheet to determine if an individual meets the financial requirements for Medicaid eligibility. Worker enters all income information and minimal resource data into MEDS.
- The worker enters application information into MEDS and pends the case within three business days of receipt. If additional information is still needed the eligibility worker provides the potential beneficiary with a checklist to show what information is still needed.
- If the applicant is determined to be ineligible, MEDS will, depending on reason code, generate a notice for the beneficiary. If MEDS does not generate a notice, the worker may use the PFH tracking system to send the applicant a letter.
- If an applicant fails to supply the required information to complete



	the application, a worker will manually close the case after certain period of time.
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	<ul style="list-style-type: none"> • SCDHHS would like to also offer an on-line application with web-based submission. • SCDHHS would like to have context-driven interviews to gather applicant information more effectively. • SCDHHS would like for MEDS to reflect how the application came in to the system (e.g. paper-based via an interview, mail, drop-off at office, etc.). • SCDHHS would like to incorporate tracking and reporting features into MEDS for eligibility determination including timeliness, verification, and redetermination reports available down to the location and user level. • Certain circumstances still require that a worker complete the calculations manually. SCDHHS would like MEDS to have automated budget calculations (income and resources) for all programs to assist in the eligibility determination process. • SCDHHS would like to improve MEDS efficiency for eligibility workers' use (e.g. only entering data once, system prompt for mandatory fields, ability to make changes). • SCDHHS would like for individual eligibility workers to have the ability to tailor MEDS to their format and workload management. Currently, many workers have too much work to complete for an individual workload. Workload management would allow for the workers to have and create alerts, reviews, case transfers, and case notations in order to effectively manage their time in opening new cases and allow for even distribution of the workload. • PLANS: In the near future, SCDHHS plans for all application paperwork to be scanned, set up in folders, and provide a full case record in MEDS. This would allow for all documentation to be passed electronically, and managers would then have the ability to distribute work to different areas. • SCDHHS would like to have an automated workflow, so that once an application is scanned, the work would be distributed throughout the state to allow for more timely and efficient work. SCDHHS would also like for all related application documentation to be linked to the case file (e.g. insurance policy, etc.). • PLANS: Beginning in January 2010, the SSA will send an electronic referral to the agency for those individuals that currently receive Medicare Part B benefits and apply to the SSA for LIS, a subsidy to help pay Part D premiums. SCDHHS will treat these referrals as applications and process them to determine if the individual is eligible for Medicaid (which in turn determines their eligibility for the LIS). • SCDHHS would like MEDS to have logic that would determine automatically all categories and programs for which an individual is



	<p>eligible. Currently, an individual may be denied for Medicaid when in actuality he/she is eligible under a different eligibility category or program.</p> <ul style="list-style-type: none"> • SCDHHS would like to generate a review form for redetermination that shows incomes, who lives in the household, etc to end to recipients. This way, beneficiaries could confirm if nothing has changed or mark changes on the populated review form. Currently, the review form mirrors the application and requires the beneficiary to fill out a lot of paperwork. • PLANS: Also, the agency's plans for online record access would allow for more reviews to be conducted. Currently, SCDHHS sends USC the records to be scanned. USC has MEDS terminal access. • SCDHHS would like for MEDS to close a case automatically once a death certificate is produced. • SCDHHS would like for cases for individuals who turn nineteen to automatically close. For this population, it will be necessary to include information about applying for other Medicaid programs if the beneficiary has a disability or is pregnant.
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Process Name	SC ME Enroll Member BP
Parent Process	ME Determine Eligibility BP
Subprocess(es)	
Description	Enroll Medicaid eligibles into Medicaid as Fee For Service or in an MCO.
Owner Group	DHHS Office of Medicaid Eligibility & Beneficiary Services
Purpose (<i>Intent</i>)	Enroll Medicaid eligibles into Medicaid as Fee For Service or in an MCO.
Input (<i>What is required for the process to execute?</i>)	The results of ME Determine Eligibility .
Output (<i>What is the result of the process?</i>)	<ul style="list-style-type: none"> • A daily file of candidates for MCO's is created in the form of an 834 X12 transaction and sent to the Enrollment Broker • Members who are candidates for MCO's are sent an enrollment package by the Enrollment Broker.
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	<ul style="list-style-type: none"> • MEDS and MMIS systems. • Beneficiary User System (BUS) • X12 834 transactions • Applications • Enrollment Package sent by the Enrollment Broker • Various notification/confirmation letters
Trigger (<i>Any processes that precede this process?</i>)	The eligibility worker "acts" on the decision via MEDS online.
Dependency (<i>Any processes dependent on the completion of this process?</i>)	
Key Stakeholders	SCDHHS Eligibility Office, Beneficiary, Local Eligibility worker, program areas, Enrollment Broker, MCO, MHN, SCDHHS Dept of Managed Care
Frequency/Timing/Events/Cycles	<ul style="list-style-type: none"> • Once a year anniversary letter from Enrollment Broker to beneficiary concerning option to remain in plan or choose another. • 90 day choice period



	<ul style="list-style-type: none"> • X12 834 sent daily to Enrollment Broker • Monthly file from MMIS to Enrollment Broker that enrollment decisions have been accepted.
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	<ul style="list-style-type: none"> • Member must notify Enrollment Broker by deadline specified or the beneficiary will be auto-enrolled.
Known Issues	
Procedures/Tasks	<ul style="list-style-type: none"> • A local eligibility office worker creates a file in MEDS to reflect enrollment into the Medicaid program. For new applications, all information is verified. Once the application is approved, the eligibility worker enters this information into MEDS. • The different program areas that oversee Recipient Special Programs (RSPs)/waiver programs enroll beneficiaries into appropriate programs via MMIS online which interfaces with MEDS to update the RSP indicator in its files (see MMIS to MEDS interface for technical details; see Manage Member Information). Waiver programs have certain criteria that qualify individuals for programs. <p>Managed Care</p> <ul style="list-style-type: none"> • MMIS sends an 834 daily to the Enrollment Broker that includes individuals that are eligible for Managed Care based on payment category and Recipient Special Program (RSP). No information is sent to the Enrollment Broker concerning individuals that are not eligible for managed care. • Monthly, the MMIS confirms back to the Enrollment Broker that enrollment decisions have been accepted. MMIS approves everything unless a member is no longer eligible. • Within two day of receipt of the 834, the Enrollment Broker sends enrollment packets to managed care eligibles, which includes selection options and deadlines. • Regular managed care members can choose a plan or be auto-assigned. • Once a regular member chooses a plan, a confirmation letter is sent. • If a regular member does not choose a plan, the Enrollment Broker will auto-assign the member to a plan and sends the member a notification letter. Some members cannot be auto assigned (ex. Foster care children) and will remain in fee for service until a plan is chosen. • Newborns may be enrolled retroactively into an MCO if their mother is in an MCO. • Members can make one change within ninety days from entry into a health plan (known as the 90-day choice period). After ninety days, the member is locked into the health plan for the remainder of the year (known as the lock-in period). • The Enrollment Broker sends a letter to the member sixty days prior to the anniversary date. • Every anniversary date, the member has the option to remain in his current plan or choose another. If a member chooses another plan this is known as a transfer. • If a member wants to move to another health plan and the ninety day has passed, he must provide "cause" (as defined by CMS regulations) and submit documentation to the Department of Managed Care. • The Department reviews and processes all paperwork, and a worker



	<ul style="list-style-type: none"> updates the MMIS to reflect new enrollment information. The Department of Managed Care tracks member enrollment requests using the Beneficiary Users System (BUS; see BUS for technical details).
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	None listed.

Process Name	SC ME Disenroll Member BP
Parent Process	
Subprocess(es)	
Description	Disenroll member from Medicaid or from a specific health care plan a member was enrolled in through Medicaid.
Owner Group	DHHS Office of Medicaid Eligibility & Beneficiary Services
Purpose (<i>Intent</i>)	Disenroll member from Medicaid or from a specific health care plan a member was enrolled in through Medicaid.
Input (<i>What is required for the process to execute?</i>)	<ul style="list-style-type: none"> Hard copy disenrollment request from beneficiary Data coming in as a result of the triggers
Output (<i>What is the result of the process?</i>)	<ul style="list-style-type: none"> Disenrollment letter MMIS updated (via online) to reflect disenrollment from MCO health plan after 90 day choice period Disenrollment notice from Enrollment Broker
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	<ul style="list-style-type: none"> Disenrollment request form MEDS and MMIS MMIS to MEDS interface Beneficiary User System (BUS) Disenrollment letters Disenrollment notices form Enrollment broker CMS Regulations (regarding "cause" for disenrolling from health plan)
Trigger (<i>Any processes that precede this process?</i>)	<ul style="list-style-type: none"> Loss of eligibility, which is triggered by: <ul style="list-style-type: none"> Redetermination calculations (see Determine Eligibility) Loss of SSI eligibility (see State Data Exchange (SDX) interface for technical details) Change in medical condition (waiver programs have specific beneficiary health requirements) Findings from a Program Integrity investigation: <ul style="list-style-type: none"> Abuse and/or Fraud Receipt of Medicaid benefits from more than one state (see Public Assistance Reporting, Office of Children and Family Services [PARIS] interface for technical details) Hard copy disenrollment request sent from beneficiary
Dependency (<i>Any processes dependent on the completion of this process?</i>)	<p>In some cases SC ME Manage Member Grievance and Appeal</p> <p>In some cases SC ME Enroll Member to enroll in a new plan</p>
Key Stakeholders	<ul style="list-style-type: none"> SCDHHS Eligibility Office Beneficiary



	<ul style="list-style-type: none"> Local Eligibility worker program area Enrollment Broker MCO MHN SCDHHS Dept of Managed Care
Frequency/Timing/Events/Cycles	As needed based on triggers
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	<ul style="list-style-type: none"> Beneficiaries can only disenroll from a health plan one time in the 90-day choice period. If a member is auto-closed and regains eligibility within 60 days, the member is placed back into the plan from which he left and will keep the same anniversary date Members enrolled with Health Connections Kids (HCK) may not disenroll and opt for fee-for-service Medicaid. SCHIP is the only insurer for these members.
Known Issues	
Procedures/Tasks	<ul style="list-style-type: none"> Eligibility workers send disenrollment letters to the beneficiary when a beneficiary loses his eligibility for one of the reasons listed above. (SC ME Manage Member Communications BP) The same worker or area that enrolled a beneficiary is responsible for disenrollment and updating the recipient file in MEDS or MMIS. (SC ME Manage Member Information BP) Some disenrollments are automatically initiated based on information from an interface. (SC ME Manage Member Information BP) Waiver program disenrollments are sent to MEDS nightly (see MMIS to MEDS interface for technical details). <p>Managed Care</p> <ul style="list-style-type: none"> Members may request to disenroll from a plan. If a member wants to disenroll from a health plan and the 90-day period has passed, he must provide “cause” (as defined by CMS regulations) and submit documentation to the Department of Managed Care. The Department reviews and processes all paperwork, and a Managed Care worker performs a “zap” in the MMIS to reflect disenrollment. The Department of Managed Care tracks member disenrollment requests using the Beneficiary Users System (BUS; see BUS for technical details). Some disenrollments are due to a loss of Medicaid eligibility and are automatically generated from the MMIS and sent to the Enrollment Broker (ex: a member is automatically disenrolled from Healthy Connections Kids [HCK] when he turns 19). These are known as auto-closures. If a member is auto-closed and then regains eligibility within sixty days, he will be placed back into the plan from which he left and will keep the same anniversary date. The Enrollment Broker sends a disenrollment notification to members for all disenrollments.



Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	None listed in p.s.

Process Name	SC ME Manage Member Information BP
Parent Process	
Subprocess(es)	
Description	This business process is responsible for managing all operational aspects of the Member data store, which is the source of comprehensive information about applicants and members, and their interactions with the state Medicaid.
Owner Group	DHHS
Purpose (<i>Intent</i>)	To manage the member data store information
Input (<i>What is required for the process to execute?</i>)	<ul style="list-style-type: none"> Data inputted by Eligibility office workers, program areas that administer Recipient Special Programs (RSPs), and workers in the Division of MED System Support to update beneficiary files. Files from MEDS to MMIS, and vice versa Files from other sources
Output (<i>What is the result of the process?</i>)	<ul style="list-style-type: none"> Updated data stores Data files to interfaces
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	<ul style="list-style-type: none"> MEDS and MEDS online MMIS and MMIS online TPA MEDS to MMIS Interface MMIS to MEDS Interface PARIS Interface Partners for Health (PFH) Tracking System/Central Eligibility Tracking System Beneficiary Users System (BUS)
Trigger (<i>Any processes that precede this process?</i>)	Enroll Member BP, Disenroll member BP, Determine Eligibility BP , changes to data.
Dependency (<i>Any processes dependent on the completion of this process?</i>)	Manage Applicant and Member Communication, Identify Candidate Case
Key Stakeholders	DHHS (Eligibility office workers, program areas that administer Recipient Special Programs (RSPs), and workers in the Division of MED System Support), Clemson (MMIS, MEDS)
Frequency/Timing/Events/Cycles	As they occur and also regularly scheduled changes
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	None
Known Issues	
Procedures/Tasks	Beneficiary Files in MEDS <ul style="list-style-type: none"> Eligibility office workers and workers in the Division of MED System Support update beneficiary files via the MEDS online.



	<ul style="list-style-type: none"> Note: If an individual wants to make changes to a record but does not have update access, he must go to his supervisor to make changes or the Division of MEDS System Support. MEDS interfaces with the MMIS in a nightly transfer of data See MEDS to MMIS Interface. <p>Beneficiary Files in MMIS</p> <ul style="list-style-type: none"> MMIS interfaces with MEDS in a nightly transfer of data MMIS applies Managed Care-specific edits, the Managed Care file is sent to the Enrollment Broker, All data is secured and accessible by anyone that is using the system or receiving data through a TPA with a user ID and password. MMIS receives RSP and TPL data through various interfaces. <p>Other Sources - Eligibility Offices</p> <ul style="list-style-type: none"> Hard copy applications and supporting documentation are kept <p>Other Sources - Interfaces and Systems</p> <ul style="list-style-type: none"> Interfaces send and receive data in MEDS and MMIS. Eligibility workers use the Partners for Health (PFH) Tracking System/Central Eligibility Tracking System to log and track information related to a Medicaid application. See interface. SCDHHS uses the Beneficiary Users System (BUS) to track enrollment, disenrollment, and changes requested by Managed Care members See Interface. The Enrollment Counselor and MCOS/MHNs all have their own proprietary systems that house beneficiary information. Not in diagram, for informational purposes only.
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	<ul style="list-style-type: none"> SCDHHS would for MEDS to be web-based and easily scalable based on the number and location of users with no system impact. SCDHHS would like to validate addresses based on US postal standards and have data matches with credit bureaus. SCDHHS would like for all MEDS interfaces to automatically populate beneficiary records. This would reduce time spent manually checking information receiving through an interface. SCDHHS would like a central screen to show all the services that are available to a beneficiary. SCDHHS would like to have all beneficiary information centralized including all information relating to communication, grievances, appeals, and Program Integrity cases. Currently, eligibility workers have to consult several sources to gather information on one individual SCDHHS would like for the MEDS system to have more flexibility and adaptability to support small and large-scale changes. Currently, any desired changes may take several months, and some changes are never implemented due to other pressing agency issues. Also, SCDHHS would like for the MEDS system to be adaptable to support functional organization changes (e.g. intake, processing, maintenance, privatized intake).



	<ul style="list-style-type: none"> SCDHHS would like for beneficiaries to have access to an eligibility file in order to update information like addresses and access to other program information.
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Process Name	SC OM Inquire Member Eligibility BP
Parent Process	
Subprocess(es)	
Description	This business process receives requests for eligibility verification from authorized providers, programs or business associates, applicants; performs the inquiry; and prepares the response data
Owner Group	
Purpose (<i>Intent</i>)	To receive and process requests for determining member eligibility
Input (<i>What is required for the process to execute?</i>)	Requests from: <ul style="list-style-type: none"> Applicants Providers and authorized consultants Providers using the toll-free IVRS number HIPAA Submitters (either clearinghouses or individual providers)
Output (<i>What is the result of the process?</i>)	Applicant's eligibility <ul style="list-style-type: none"> via phone diskette and, if requested, in hard copy IVRS 271 Transaction
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	<ul style="list-style-type: none"> Partners for Health Tracking System/Central Eligibility Tracking System IVRS Data Match Interface HIPAA mailbox on CD's, disks, or cassettes MEVS
Trigger (<i>Any processes that precede this process?</i>)	Eligibility requests
Dependency (<i>Any processes dependent on the completion of this process?</i>)	None
Key Stakeholders	DHHS, providers, authorized consultants, clearinghouses
Frequency/Timing/Events/Cycles	As requested
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	Providers and authorized consultants use this process to request recipient data that is older than thirteen months
Known Issues	Data match is a manual task and few providers use this process.
Procedures/Tasks	<p>Applicants</p> <ul style="list-style-type: none"> Call the Central Eligibility office Central Eligibility Staff use the Partners for Health Tracking System/Central Eligibility Tracking System to look up the status of an application and respond to the caller's inquiry <p>Data Match</p> <ul style="list-style-type: none"> Providers and authorized consultants submit requests for eligibility data on



	<p>CD's, disks, or cassettes</p> <ul style="list-style-type: none"> Bureau of Medicaid Systems Managements returns the requested data on diskette and, if requested, in hard copy <p>IVRS</p> <ul style="list-style-type: none"> Providers call the toll-free IVRS number IVRS sends a 270 transaction to the Medicaid Eligibility Verification Server (MEVS) MEVS returns a 271 Transaction <p>270/271 HIPAA Transactions</p> <ul style="list-style-type: none"> Submitters can use a VPN connection to MEVS or the Web Tool to transmit 270 transactions to MEVS. NOTE: these methods do not use the HIPAA mailboxes Submitters (either clearinghouses or individual providers) transmit 270 files to their HIPAA mailbox Transaction is passed to MEVS MEVS replies with a 997 acknowledgment transaction 271 Transaction is placed in the submitter's mailbox.
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	

Process Name	SC ME Perform Population and Member Outreach BP
Parent Process	
Subprocess(es)	
Description	<p>This business process originates internally within the Agency for purposes such as:</p> <ul style="list-style-type: none"> Notifying prospective applicants and current members about new benefit packages and population health initiatives New initiatives from Program Administration Receiving indicators on underserved populations from the Monitor Performance and Business Activity process (Program Management)
Owner Group	DHHS
Purpose (<i>Intent</i>)	To notify prospective applicants and current members
Input (<i>What is required for the process to execute?</i>)	Materials intended for beneficiaries
Output (<i>What is the result of the process?</i>)	Materials going to beneficiaries
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	<p>Common Sense Checklist</p> <p>Letters and postcards, Beneficiary newsletters</p> <p>Handbook sent to all new Medicaid beneficiaries</p> <p>The main SCDHHS website</p> <p>The Enrollment Broker website</p> <p>Advocacy groups, the Medical Care Advisory Committee, and legislators</p>
Trigger (<i>Any processes that</i>	New information for beneficiaries



<i>precede this process?)</i>	
Dependency (Any processes dependent on the completion of this process?)	None
Key Stakeholders	DHHS, (potential) beneficiaries, Medicaid Eligibility and Beneficiary Services program area, the Budget & Control Board, Bureau of Medicaid Systems Management (BMSM), Enrollment Broker
Frequency/Timing/Events/Cycles	
Constraints (Location/Interfaces Required for inputs/outputs)	
Known Issues	
Procedures/Tasks	<p>Potential Members</p> <ul style="list-style-type: none"> • The Medicaid Eligibility and Beneficiary Services program area consults with advocacy groups, the Medical Care Advisory Committee, legislators and with internal stakeholders to identify outreach priorities. • The Medicaid Eligibility and Beneficiary Services program area works with the Budget & Control Board to determine potential groups for outreach. • The program area responds to public requests for outreach. Speakers from the area make presentations at conferences and seminars, and staff may set up informational tables at health fairs and other events. • The managed care plans (MCOs) perform outreach of their own via billboards, flyers, etc., which have the effect of promoting the Medicaid program to potential beneficiaries. <p>Existing Members</p> <ul style="list-style-type: none"> • The program area reviews every policy or coverage change to decide whether beneficiaries need to be directly informed of it, or whether providers and/or eligibility workers can pass the information along, using the Common Sense Checklist. • These newsletters are coordinated by the Public Information Office with the help of the Medicaid Eligibility and Beneficiary Services program area. • The handbook sent to all new Medicaid beneficiaries with their ID card is another important outreach method. The handbook is revised whenever supplies are low or a major change requires it. • The main SCDHHS website contains information for potential and existing beneficiaries, such as enrollment forms, contact information and eligibility criteria. • A worker from the Bureau of Medicaid Systems Management (BMSM) utilizes a file from the MMIS_Provider database record created from a job on the mainframe (the job is in library HHS.PROD.JCL(PROVWEB)) to populate the SCDHHS website with the Medicaid provider information. • The Enrollment Broker provides a website available to prospective and current members concerning information regarding the Healthy Connection Choices and Kids programs. <p>HIPP Outreach</p> <ul style="list-style-type: none"> • SCDHHS staff send a letter about the program to every family of a TEFRA beneficiary, and some caseworker training has been held (see OM Prepare Health Insurance Premium Payment BP).
Performance Measures (efficient)	



<i>and/or effective)</i>	
<i>Roles (performing)</i>	
<i>Related Business Goals</i>	
<i>Wish List/Needs</i>	SCDHHS would like to expand and enhance HIPP outreach.

Process Name	SC ME Manage Applicant and Member Communication BP
Parent Process	
Subprocess(es)	
Description	This Business Process maintains communication between the beneficiary, SCDHHS, and MCOs.
Owner Group	DHHS
Purpose (<i>Intent</i>)	This Business Process maintains communication between the beneficiary, SCDHHS, and MCOs.
Input (<i>What is required for the process to execute?</i>)	<ul style="list-style-type: none"> Inquiry from beneficiary or other interested outside parties. Communications from other SCDHHS BP's to beneficiary.
Output (<i>What is the result of the process?</i>)	Information to be communicated to/from the beneficiary
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	Beneficiary Users System PFH Tracking System/Central Eligibility Tracking System Letters Phone Card carrier Medicaid Card Handbook
Trigger (<i>Any processes that precede this process?</i>)	Receipt of information to be communicated to/from beneficiary
Dependency (<i>Any processes dependent on the completion of this process?</i>)	
Key Stakeholders	Managed Care Area DHHS DME Area Division of Central Eligibility Processing MCCS Beneficiary
Frequency/Timing/Events/Cycles	As necessary
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	
Known Issues	
Procedures/Tasks	<ul style="list-style-type: none"> Direct Communication to appropriate location Track communication (examples: Contract Log System, and Division of Care Management Tracking Systems) Managed Care Area <ul style="list-style-type: none"> The Managed Care area receives calls from members concerning eligibility, program information, etc If the worker does not have access to the information needed, the



	<p>caller is referred to the appropriate Managed Care Organization (MCO) for further information</p> <ul style="list-style-type: none"> • There is no standard call log for tracking this communication. Each staff member maintains his own log either via hard copy or electronically • Staff may use the Beneficiary Users System (BUS) to log information related to hostile phone calls <p>DME Area</p> <ul style="list-style-type: none"> • The DME area receives calls from beneficiaries concerning the status of prior authorizations for DME • The DME will give a status of the prior authorization (denied, approved, under review), but cannot send any information back to the beneficiary since the provider is the one who sent the prior authorization request. The beneficiary is encouraged to contact the provider who requested the prior authorization for additional information <p>Division of Central Eligibility Processing</p> <ul style="list-style-type: none"> • The PFH Tracking System/Central Eligibility Tracking System generates letters based on application-related events (e.g. acceptance or denial into Medicaid program) and to request additional information from a prospective beneficiary • The Division of Central Eligibility Processing receives hundreds of pieces of mail each day that must be forwarded to the appropriate caseworker. The mail is opened, time stamped, and entered into the tracking system. • The original mail is filed, and a copy is forwarded to the appropriate caseworker. • The tracking system is also used when a prospective beneficiary calls to inquire about their application status. The worker receiving the call enters the tracking system to see what the status of the application is and responds to the inquiry • SCDHHS sends letters to those beneficiaries who will lose their eligibility based on a redetermination (see Determine Eligibility). <p>Medicaid Program Information</p> <ul style="list-style-type: none"> • The card carrier, Medicaid ID card, and handbook sent out to newly enrolled beneficiaries • SCDHHS contracts with MCCA for the printing of new Medicaid ID cards and re-printing for beneficiaries who have lost their cards see MCCA Interface
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	



Process Name	SC ME Manage Member Grievance and Appeal BP
Parent Process	
Subprocess(es)	
Description	<p>The Manage Member Grievance and Appeal business process performs the necessary actions to resolve beneficiary grievances and appeal cases through case reviews and hearings. Grievances are managed and resolved by the Division of Constituent Services and Beneficiary Services or the MCO or MHN a beneficiary is enrolled with. Depending on the nature of the appeal, appeals are managed and resolved by different routes. Members enrolled in programs internally managed by SCDHHS appeal to the Division of Appeals and Hearings. Members enrolled in an MCO or MHN must first appeal to that organization prior to requesting an appeal through SCDHHS. Members enrolled in programs managed by another agency must first appeal to that agency prior to requesting an appeal through SCDHHS.</p> <p>Note: The DHHS appeals process is the same for the contractor, member and provider, other than preliminary steps getting to the Division of Appeals and Hearings.</p>
Owner Group	DHHS
Purpose (<i>Intent</i>)	The Manage Member Grievance and Appeal business process performs the necessary actions to resolve beneficiary grievances and appeal cases through case reviews and hearings.
Input (<i>What is required for the process to execute?</i>)	<ul style="list-style-type: none"> • Grievances/complaints/Protests. • Appeal Request
Output (<i>What is the result of the process?</i>)	Ruling
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	<ul style="list-style-type: none"> • MMIS • MEDS • Hearing • BENDEX • SDX • Appeals and Hearings Tracking System - Logs/tracking of complaints and grievances • ApplicationXtender Imaging System • Case files. • Interlocutory Order (Intermediate Decision) • Order of Dismissal • Final Decision • Provider Manuals • Appeal Request • Case Management Sheet (CMS) • Order for Prehearing Conference • Record/transcript of the hearing • Kinko's • State Auditor's Office • Boiler plate documents • Constituent Services Tracking System • Secure extranet site • Beneficiary Users System
Trigger (<i>Any processes that</i>	Beneficiary appeals may be triggered by the following:



<i>precede this process?)</i>	<ul style="list-style-type: none"> • Loss of Medicaid eligibility • Denial of Medicaid eligibility • Recoupment for services for retroactive loss of eligibility • Denial of Prior Approval for prescribed medication • Denial of Prior Approval for medical procedure • Discharge from a nursing home against the beneficiary's will • Receipt of beneficiary appeal request from Manage Applicant and Member Communication • Receipt of beneficiary grievance/complaint from Manage Applicant and Member Communication
Dependency (<i>Any processes dependent on the completion of this process?</i>)	
Key Stakeholders	<ul style="list-style-type: none"> • Applicant/Beneficiary • Program Areas • Division of Appeals and Hearings • Director of Appeals • Hearing Officer • Office of General Counsel • Division of Constituent Services and Beneficiary Services • MCO • MHN • Division of Care Management • Department of Managed Care • Eligibility/Case Worker
Frequency/Timing/Events/Cycles	As needed or when they come in.
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	
Known Issues	
Procedures/Tasks	<p>Grievances</p> <ul style="list-style-type: none"> • The Division of Constituent Services and Beneficiary Services uses the Constituent Services Tracking System to track beneficiary issues and complaints • Users enter the name of the beneficiary into the system and information associated with the issue. • beneficiary issues and complaints, discuss with other areas if needed <p>MCO Grievances</p> <ul style="list-style-type: none"> • MCOs have an internal process for managing grievances, and those are not appealable to the Division of Appeals. • Each MCO must log certain information for a grievance on a monthly basis • In the Division of Care Management, information concerning specific grievances/complaints is communicated via a secure extranet site. Each MCO and Medical Home Network (MHN) has its own secure site for this communication with SCDHHS. • Program managers receive grievance reports quarterly. • The Department of Managed Care uses the Beneficiary Users System (BUS) to log hostile phone calls and complaints and information related to these calls.



	<p>Appeals</p> <ul style="list-style-type: none"> • Federal regulations require that a prospective or current Medicaid beneficiary be informed of the cause for ineligibility or eligibility termination (see Manage Applicant and Member Communication). • SCDHHS sends a letter to the beneficiary informing him of his ineligibility/upcoming ineligibility, and he has ten days to contact his case worker if he wants to dispute the decision before the Medicaid Eligibility Determination System (MEDS) reflects the upcoming closing of the case. • Sometimes, the beneficiary will contact the Appeals and Hearings area instead of his case worker, but the beneficiary will be referred to his case worker to begin the appeals process. • Within the thirty day window, there is a ten day window for the member to contact the eligibility/case worker (located in a county eligibility office) before the MEDS system reflects the upcoming loss of eligibility. This window allows the eligibility worker to correct an error if it is discovered that that the beneficiary should remain eligible for Medicaid before the beneficiary's file reflects a change. • The beneficiary must complete and sign a hard copy "Request for Fair Hearing" form or submit a letter which acknowledges his desire to keep the case open and dispute the decision • The worker then writes up a narrative detailing the decision and provides supporting documents from the case file, such as copies of check stubs, bank statements, deeds of property transfer, trust documents, life insurance policies, etc. that were used in making the determination of ineligibility. • This narrative and supporting information is then sent via hard copy to the Division of Appeals and Hearings with a copy to the applicant/beneficiary. • If additional information is needed from the eligibility worker, the Division of Appeals and Hearings contacts the worker via telephone or email. Any additional information is returned via email, fax, or regular mail. The Division of Appeals and Hearings may also contact the beneficiary directly for additional information, which the beneficiary returns via fax or regular mail. • Track appeal case information and image information documents • Image documents using ApplicationXtender • Director of Appeals determines if the appeal is valid. If it is not valid it is not entered into the Tracking System and the provider notified. • If valid the Director assigns a case number and hearing officer • Admin assistant enters appeal data into Appeals and Hearings Tracking System • Admin assistant prepares the Case Management Sheet • Admin sends it to the hearing officer • Hearing officer selects appropriate documents on the Case Management Sheet • Hearing officer returns it to admin assistant • Admin assistant prepares documents • Admin assistant mails documents • Hearing Officer examines case <ul style="list-style-type: none"> ○ Reviews case information using mechanisms ○ He contact the case worker for information
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	<ul style="list-style-type: none"> • Hearing Officer issues decision <ul style="list-style-type: none"> ○ If previous decision stands an Interlocutory Order (Intermediate Decision) is sent ○ If beneficiary doesn't respond to the Interlocutory Order in 10 days an Order of Dismissal is prepared <ul style="list-style-type: none"> ▪ The Director reviews the Order of Dismissal for signature. ▪ The Order of Dismissal is then sent to designated areas. • If appeal is not dismissed the Hearing Officer holds a hearing • Hearing Officer renders a decision • The Director of Appeals reviews the decision • If the Director approves, the decision is sent to the beneficiary. • If the Director disapproves, the Hearing Officer and the Director reach a consensus and then the decision is sent. • Division of Appeals and Hearings prepares a copy of the complete record/transcript of the hearing at the request of the ALC. (A party can appeal the Hearing Officer's decision to the South Carolina Administrative Law Court, if they feel it was in error) <p>MCO Appeals</p> <ul style="list-style-type: none"> • Through the Managed Care area, the Managed Care Organizations (MCOs) have an internal appeal process that beneficiaries must request prior to filing an appeal with the SCDHHS Division of Appeals. • Each MCO must log certain information for a grievance on a monthly basis. • Each MCO has its own appeals procedures. • In the Division of Care Management, information concerning specific grievances/complaints is communicated via a secure extranet site. Each MCO and Medical Home Network (MHN) has its own secure site for this communication with SCDHHS. • Program managers receive grievance reports quarterly. • In the case of a denial of Medicaid service to a beneficiary by a Managed Care plan (MCO), the beneficiary is told on the MCO denial notice that they can appeal to the SCDHHS Division of Appeals. A Managed Care area representative attends the hearing as a source of information and acts as neutral party. <p>Other Agency Appeals</p> <ul style="list-style-type: none"> • If a beneficiary is appealing to another agency, the beneficiary is first instructed to request an appeal through that original agency. • If the beneficiary is denied again, he/she is sent a summary of the decision, and informed of their appeal rights (through SCDHHS Division of Appeals). If the beneficiary decides to appeal, he/she contacts their assigned local eligibility worker, who then will begin preparing documents on their behalf. (see Appeals section above)
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	The Division of Appeals and Hearings desires a more user-friendly tracking system, which would encourage division-wide use.



Process Name	SC PM Enroll Provider BP
Parent Process	
Subprocess(es)	SC PM Manage Provider Communication BP
Description	Perform functions required to accept provider request for enrollment, validate and verify according to policy and enter accepted provider into Medicaid.
Owner Group	Various Program Areas
Purpose (<i>Intent</i>)	Enroll provider into SC Medicaid
Input (<i>What is required for the process to execute?</i>)	<ul style="list-style-type: none"> Enrollment forms, which vary according to provider services, are received from Manage Provider Communication BP Enrollment forms received from SC PM Award Contract BP
Output (<i>What is the result of the process?</i>)	<ul style="list-style-type: none"> Enrollment package for Provider sent to SC PM Manage Provider Communication BP or to SC PM Award Contract BP for contracting providers. Provider information is entered into MMIS Turnaround doc is generated and sent to Program Area Physical provider file is created
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	<ul style="list-style-type: none"> Procedure Manuals (paper and online) Paper Enrollment Forms Tracking system Licensing entities (not automated) Sanction lists/Exclusion lists (not automated)
Trigger (<i>Any processes that precede this process?</i>)	Receipt of enrollment packet from Manage Provider Communication . Receipt of enrollment packet from SC PM Award Contract BP
Dependency (<i>Any processes dependent on the completion of this process?</i>)	
Key Stakeholders	<ul style="list-style-type: none"> Providers BCBS Provider Enrollment Staff (MCCS) Program Areas Division of Contracts
Frequency/Timing/Events/Cycles	
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	
Known Issues	
Procedures/Tasks	<ol style="list-style-type: none"> Provider Enrollment contractor verifies the completeness of enrollment forms If the forms are incomplete communicate to SC PM Manage Provider Communication BP to query the provider for the needed information The Provider Enrollment contractor uses MMIS to determine type of enrollment (new, update, reactivate, or duplicate) <ul style="list-style-type: none"> For contracting providers, the enrollment packet is received from SC CO Award Contract BP where packet has already been checked for completeness. <ol style="list-style-type: none"> The Provider Enrollment contractor performs verifications on the



	<p>forms based on procedure manuals. Verifications may include licensing entities, sanction lists, and exclusion lists. There are no automated verifications.</p> <ol style="list-style-type: none"> 5. Provider Enrollment contractor assigns internal (legacy) identifiers and indicators/codes based on procedure manuals. Note: there is not always a 1:1 mapping from the legacy identifier to the NPI. A provider may have multiple legacy ID's for one NPI. 6. If enrollment is denied communicate to SC PM Manage Provider Communication BP to send a denial notification letter to provider 7. The Provider Enrollment contractor enters the enrollment data into MMIS for an approved provider. It is possible for an NPI related edit to stop this entry into MMIS from being completed or require research and additional steps in order to complete. 8. Turnaround doc is generated and sent to the provider enrollment liaison within the department of MMIS User Services or Division of Contracts for contracting providers; physical provider file is created 9. Provider Enrollment contractor sends enrollment package and notification letter to SC Manage Provider Communication BP for mailing to Provider for non-contracting provider. 10. Provider Enrollment contractor sends successfully enrolled provider a packet of information including his provider number, provider manual and other program information using Perform Provider Outreach BP (SC Maintain Provider Manuals BP).
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	<ul style="list-style-type: none"> • Incorporate tracking system into MMIS • Automate some of the verification interfaces (as many as possible) • Automate ID assignment process for providers who don't have NPI's • Use NPI Number as default ID number when possible

Process Name	SC PM Disenroll Provider BP
Parent Process	
Subprocess(es)	PM Manage Provider Communication
Description	This business process performs the voluntary or involuntary disenrollment/termination of providers who no longer meet eligibility requirements or no longer wish to participate in the Medicaid program.
Owner Group	Dept of MMIS User Services, MCCS, Program Areas
Purpose (<i>Intent</i>)	Terminate provider from Medicaid.
Input (<i>What is required for the process to execute?</i>)	<ul style="list-style-type: none"> • Request to disenroll provider from Manage Provider Communication BP. (request from provider) • Request to disenroll from Program Integrity BP (involuntary disenroll) (update form) • Program Areas and Division of Contracts request to disenroll provider via update forms (includes voluntary since provider may call program areas to request to be disenrolled.)



Output (<i>What is the result of the process?</i>)	Turn around docs (TADS)
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	<ul style="list-style-type: none"> • MMIS (Inactivity Report) • Manual tracking of inactivity report process • Authorization list for modifying provider information • Turn around docs (TADS)
Trigger (<i>Any processes that precede this process?</i>)	<ul style="list-style-type: none"> • PI Manage Case BP • PM Manage Provider Communication • PM Manage Provider Information (produces the Inactivity report)
Dependency (<i>Any processes dependent on the completion of this process?</i>)	
Key Stakeholders	<ul style="list-style-type: none"> • Providers • Provider Enrollment Contractor (MCCS) • Program Areas • Division of Contracts • Department of MMIS User Services
Frequency/Timing/Events/Cycles	Regular file maintenance through annual inactivity report from MMIS identifying inactive providers.
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	<ul style="list-style-type: none"> • No set schedule for checking with outside entities for conditions resulting in disenrollment of providers.
Known Issues	
Procedures/Tasks	<ul style="list-style-type: none"> • Review Provider Inactivity report. • Initiate request to inactive providers through Manage Provider Communication BP. • Monitor/track response from inactive provider letters to track when 30 days have elapsed. • Program areas can choose to receive a copy of the inactivity report after 30 days because they don't want the providers to be automatically terminated. In this case they make annotations on the report as to what action should be taken and then send report back to MCCS. • Verify update form has authorized signature • Disenroll Provider • Send Turn around docs to program area
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	Interfaces with DHEC, licensing boards and other entities in order to check for conditions that would cause disenrollment.

Process Name	SC PM Manage Provider Information BP
Parent Process	
Subprocess(es)	
Description	Manage provider data stores.
Owner Group	Various Program Areas



Purpose (<i>Intent</i>)	Control the updates to provider information in MMIS and manage other provider data stores as well.
Input (<i>What is required for the process to execute?</i>)	New updated provider information (could be letter from provider or from program areas) Update Forms New authorized signature cards from SCDHHS management Hard copy notification from OIG of newly excluded providers PI realization that a provider needs to be added to an exclusion list
Output (<i>What is the result of the process?</i>)	Updated data in MMIS. Turnaround doc. Inactivity report Updated exclusion list sent to designated individuals/entities
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	MMIS Signature cards file. File of paper provider contracts maintained by Division of Contracts. Physical Provider File kept by Provider Enrollment Contractor Program Areas maintain their own files of additional information as needed. PE Contractor's proprietary tracking system. Update Forms Turnaround Documents Exclusion Lists Letters from providers informing DHHS of new information
Trigger (<i>Any processes that precede this process?</i>)	Receipt of new information from Manage Provider Communication (MCCS can fill out an update form when a provider contacts them directly.) Receipt of new excluded provider letter from OIG Receipt of update form from other Program Areas Receipt of new authorized signature card from SCDHHS
Dependency (<i>Any processes dependent on the completion of this process?</i>)	
Key Stakeholders	Provider Enrollment Contractor (MCCS) Provider Program Areas Division of Contracts Division of Program Integrity
Frequency/Timing/Events/Cycles	SURS sends new list of excluded providers every month OIG sends new list of excluded providers every month
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	Only certain contractor staff have update access to MMIS.
Known Issues	
Procedures/Tasks	<ul style="list-style-type: none"> • Program Areas fill out update form and send to PE Contractor • PE Contractor (MCCS) fills out an update form when contacted directly. • PE Contractor staff verify signature is valid/authorized • PE Contractor staff key updates into MMIS • PE Contractor sends turnaround docs to the area who requested the update. • PE Contractor validates license information where applicable • PE Contractor staff update Authorized Signature Card file • SURS updates exclusion lists



	<ul style="list-style-type: none"> • SURS sends updated exclusion lists to designated individuals/entities • PE Contractor staff generate annual provider inactivity report from MMIS
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	<p>Dramatically expand the amount and types of information the MMIS provider file can hold.</p> <p>Field size expanded. (name, license number etc. see problem statement)</p> <p>Multiple CLIA Certification categories.</p> <p>Web-based access so that providers have the ability to verify updates for correctness and eventually allow providers to make changes themselves.</p> <p>Interfaces to allow for the verification of provider information in a more accurate and automated fashion.</p>

Process Name	SC PM Inquire Provider Information BP
Parent Process	
Subprocess(es)	
Description	Manage inquiries of provider enrollment verification.
Owner Group	MCCS/DHHS
Purpose (<i>Intent</i>)	Respond to inquiries regarding provider enrollment status.
Input (<i>What is required for the process to execute?</i>)	Request for enrollment verification in the form of hard copy or phone call.
Output (<i>What is the result of the process?</i>)	Enrollment verification response. Hard copy or fax.
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	<ul style="list-style-type: none"> • MMIS • Remedy Tracking System (PE Contractor's proprietary application)
Trigger (<i>Any processes that precede this process?</i>)	<p>Receipt of request for provider enrollment status from Manage Provider Communication BP</p> <p>Receipt of request for provider information from DHHS agency staff</p>
Dependency (<i>Any processes dependent on the completion of this process?</i>)	PM Manage Provider Communications BP
Key Stakeholders	<ul style="list-style-type: none"> • Providers • PE Contractor Staff (MCCS) • Program Areas
Frequency/Timing/Events/Cycles	
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	
Known Issues	
Procedures/Tasks	<ul style="list-style-type: none"> • Track request via proprietary tracking system • Look up information in MMIS or Remedy • If inquiry is by phone, information is given and not tracked • Send response via PM Manage Provider Communications or directly to DHHS agency staff for internal inquiries.



Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	None were listed in problem statement.

Process Name	SC PM Manage Provider Communication BP
Parent Process	
Subprocess(es)	
Description	Manages communications to/from prospective and current providers regarding program and personal enrollment information.
Owner Group	Any program area that has communications to/from providers.
Purpose (<i>Intent</i>)	Conduit and tracking of information between provider and SC DHHS
Input (<i>What is required for the process to execute?</i>)	Inquiry from provider or other interested. Communications from other SCDHHS BP's to provider.
Output (<i>What is the result of the process?</i>)	Information to be communicated to provider - including enrollment application packages, provider manuals, notification letters. etc. Information communicated from provider to SCDHHS including completed application and etc.
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	MMIS Program Area Specific methods of logging communications. (examples: Contract Log System, Remedy Tracking System, Division of Physician Services Tracking System, Division of Care Management Tracking Systems, Division of Hospitals Tracking Systems)
Trigger (<i>Any processes that precede this process?</i>)	Request for inbound/outbound communication
Dependency (<i>Any processes dependent on the completion of this process?</i>)	Various BPs that require communication with providers. Example Enroll Provider.
Key Stakeholders	Provider DHHS Program Areas PE Contractor (MCCS) Division of Contracts
Frequency/Timing/Events/Cycles	
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	
Known Issues	
Procedures/Tasks	<ul style="list-style-type: none"> • Direct Communication to appropriate location • Determine which enrollment package to send to prospective provider (per Enroll Provider BP) • Track communication (examples: Contract Log System, Remedy Tracking System, Division of Physician Services Tracking System, Division of Care Management Tracking Systems, Division of Hospitals Tracking Systems)
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	



Related Business Goals	
Wish List/Needs	Central call center Central agency policy and information online resource and repository. Central communications tracking system to standardize the way the agency tracks any communication with providers.

Process Name	SC PM Manage Provider Grievance and Appeal BP
Parent Process	
Subprocess(es)	
Description	The Manage Provider Grievance and Appeal business process handles grievances and appeals concerning enrolled providers and works to meet a resolution through claims reviews, hearings, and appeals.
Owner Group	Division of Appeals and Hearings
Purpose (<i>Intent</i>)	Handle grievances, hearings, and appeals concerning provider claims.
Input (<i>What is required for the process to execute?</i>)	Grievances/complaints. Appeal Request
Output (<i>What is the result of the process?</i>)	Ruling.
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	MMIS MEDS Hearing Appeals and Hearings Tracking System - Logs/tracking of complaints and grievances ApplicationXtender Imaging System Case files. Interlocutory Order (Intermediate Decision) Order of Dismissal Final Decision Provider Manuals Appeal Request Case Management Sheet (CMS) Order for Prehearing Conference Record/transcript of the hearing Kinko's State Auditor's Office Boiler plate documents
Trigger (<i>Any processes that precede this process?</i>)	Receipt of provider appeal request from Manage Provider Communication Receipt of provider grievance/complaint from Manage Provider Communication
Dependency (<i>Any processes dependent on the completion of this process?</i>)	
Key Stakeholders	Providers Program Areas Division of Appeals and Hearings Director of Appeals Hearing Officer



	Office of General Counsel
Frequency/Timing/Events/Cycles	Deadlines for appeal of decision
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	
Known Issues	
Procedures/Tasks	<ul style="list-style-type: none"> • Forward complaint/grievance to program area. • PA attempts to correct claim (this maybe done through Edit Claim – Encounter) • Track appeal case information and image information documents • Image documents using ApplicationXtender • Hold optional Prehearing Conference for non-nursing home audit appeals with Division of Program Integrity • Division of Appeals and Hearings issues an Order of Prehearing Conference for nursing home audit appeals. • Hold optional Prehearing Conference for nursing home audit appeals. • Director of Appeals determines if the appeal is valid. If it is not valid it is not entered into the Tracking System and the provider notified. • If valid the Director assigns a case number and hearing officer • Admin assistant enters appeal data into Appeals and Hearings Tracking System • Admin assistant prepares the Case Management Sheet • Admin sends it to the hearing officer • Hearing officer selects appropriate documents on the Case Management Sheet • Hearing officer returns it to admin assistant • Admin assistant prepares documents • Admin assistant mails documents • Hearing Officer examines case <ul style="list-style-type: none"> ○ Reviews case information using mechanisms ○ He contact the provider for information • Hearing Officer issues decision <ul style="list-style-type: none"> ○ If previous decision stands an Interlocutory Order (Intermediate Decision) is sent ○ If provider doesn't respond to the Interlocutory Order in 10 days an Order of Dismissal is prepared <ul style="list-style-type: none"> ▪ The Director reviews the Order of Dismissal for signature. ▪ The Order of Dismissal is then sent to designated areas. • If appeal is not dismissed the Hearing Officer holds a hearing • Hearing Officer renders a decision • The Director of Appeals reviews the decision • If the Director approves, the decision is sent to the provider. • If the Director disapproves, the Hearing Officer and the Director reach a consensus and then the decision is sent. • Division of Appeals and Hearings prepares a copy of the complete record/transcript of the hearing at the request of the ALC. (A party can appeal the Hearing Officer's decision to the South Carolina Administrative Law Court, if they feel it was in error)



Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	More user-friendly tracking system

Process Name	SC PM Maintain Provider Manuals BP
Parent Process	
Subprocess(es)	
Description	Update provider manuals based on various changes including policy changes, codes, etc. and manage publishing of the manuals in various media.
Owner Group	MCCS and DHHS
Purpose (<i>Intent</i>)	Keep provider informed of Medicaid Policies and changes
Input (<i>What is required for the process to execute?</i>)	Change in policies (often comes to this BP in the form of a provider bulletin)
Output (<i>What is the result of the process?</i>)	Updated or new Provider Manuals
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	Folder system on shared drive (WORD and PDF versions of documents) Change Control record (track amendments to each manual) Website. Database for logging orders for provider manuals.
Trigger (<i>Any processes that precede this process?</i>)	Provider Bulletins, Request from Program areas.
Dependency (<i>Any processes dependent on the completion of this process?</i>)	
Key Stakeholders	BCBS (Instructional Writer, provider outreach contract manager, Providers, Program Areas)
Frequency/Timing/Events/Cycles	Varies. Some processes are monthly (e.g. routine changes to provider manual) Some are yearly. Others are based on triggers.
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	Manuals have specific formatting standards from DHHS or Program Area specific.
Known Issues	
Procedures/Tasks	Update Manual Get Program Area sign off for revisions to existing manuals. Get Director sign off for brand new manuals. Update change control record to track amendments to manuals. Send updated manual and control record to SCDHHS webmaster for posting. Publish yearly version of provider manuals. (in some cases requires external print shop) Manage orders from providers for manuals. (includes receiving and forwarding of payment to DHHS Fiscal) Send new provider packages
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	



Wish List/Needs	Document Management System. More interactive website with full look-up capability or a revised manual format.
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Process Name	SC PM Manage Provider Training BP
Parent Process	
Subprocess(es)	
Description	Develops provider training materials and conducts provider training classes.
Owner Group	MCCS with input and oversight by DHHS
Purpose (<i>Intent</i>)	Train providers concerning SC Medicaid program.
Input (<i>What is required for the process to execute?</i>)	Information about new/changed policies/programs. Details of request for new class or changes to existing class.
Output (<i>What is the result of the process?</i>)	Updated and/or new training Classes and materials.
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	Change Control record (track amendments to each manual) Provider Outreach Website.
Trigger (<i>Any processes that precede this process?</i>)	Request from DHHS for new or updated training, updates in policies/programs.
Dependency (<i>Any processes dependent on the completion of this process?</i>)	
Key Stakeholders	Provider outreach contractor, Providers, Program Areas, DHHS, EDI Support Call Center
Frequency/Timing/Events/Cycles	Varies.
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	
Known Issues	
Procedures/Tasks	<p>Provider Outreach contractor performs the following:</p> <ul style="list-style-type: none"> Update training class. Get SCDHHS approval for presentations and handouts. Advertise training. Enroll providers into training classes (currently done by EDI Support call center) Maintain class list and class schedule Maintain Provider Outreach website for providers to view class schedules and enroll in training Schedule facilities/location for classes. Conduct Training. (physical and virtual) Collect evaluations to monitor performance. <p>SCDHHS</p> <ul style="list-style-type: none"> • Conduct individual ad hoc training on as-needed basis which includes going onsite to provider's offices. • Program Areas develop materials for this ad hoc individual training.
Performance Measures (<i>efficient and/or effective</i>)	Contractor uses evaluation form to monitor performance via provider feedback.
Roles (<i>performing</i>)	



Related Business Goals	
Wish List/Needs	A more automated process such as printing training announcements directly on remits. Expand training to include more online training that is self-paced for providers.

Process Name	SC PM Manage Provider Bulletins BP
Parent Process	
Subprocess(es)	
Description	Manages creation of provider electronic bulletins.
Owner Group	DHHS
Purpose (<i>Intent</i>)	Keep provider informed of Medicaid Policies and changes
Input (<i>What is required for the process to execute?</i>)	Change in policies
Output (<i>What is the result of the process?</i>)	Provider Bulletins
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	Bulletin Review Listserv. Physical File. Transmittal for Director's Signature form on blue paper?? (see problem statement) Provider Distribution List Website
Trigger (<i>Any processes that precede this process?</i>)	Need for clarification. Change in policy. New policy.
Dependency (<i>Any processes dependent on the completion of this process?</i>)	
Key Stakeholders	Providers, Program Areas, Executive Management, Public Information Coordinator within the Office of Public Information
Frequency/Timing/Events/Cycles	Varies. Some processes are monthly (e.g. routine changes to provider manual) Some are yearly. Others are based on triggers.
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	
Known Issues	
Procedures/Tasks	Assign someone within Bureau to draft bulletin. Send draft to Bulletin Review listserv. Incorporate comments. Create physical file. Get executive management signature (transmittal form?) Send physical file to Public information coordinator. Send electronic version of bulletin and deadline to Public Information Coordinator. Format bulletin. Obtain Agency Director's signature. Convert to PDF. Email to Bureau Chief requesting approval for release.



	Release to listserv and to webmaster for posting. Manage provider ebuletins enrollment
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	

Process Name	SC CO Award Admin or Health Services Contract BP
Parent Process	
Subprocess(es)	SC PM Enroll Provider BP, SC BR Establish Business Relationship
Description	Awards contracts in different ways depending on the type of commodity, service, or contracted entity.
Owner Group	
Purpose (<i>Intent</i>)	Award contracts for administrative or health services.
Input (<i>What is required for the process to execute?</i>)	RFP Request from Provider to enroll as contracted provider. (note: while not used in recent history and therefore not documented in the process, the agency occasionally finds prospective providers using a bid or grant process) Required documents from prospective provider (enrollment form/application, budgets, staffing plans, seclusion and restraint policies, etc.) MMO form 136 Information needed for interagency contract. Information on form 192 (for Invitation for Bids (IFBs) Turn around documents (input to the end of the process for contracting with provider - verification of enrollment)
Output (<i>What is the result of the process?</i>)	Interagency Contract Provider Contract (includes setting rates) Invitation for Bid Award of the contract as result of IFB. Intent to Award Evaluation/scores for RFP Award of RFP Emergency/Sole Source Award
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	Form 102 Contract Log System Form 192 IFB boilerplates/form MMO Website (part of SAP(Systems, Applications and Products in Data Processing) State Procurement Website Public Bulletin board at SCDHHS main office. DHHS Website Intent to Award
Trigger (<i>Any processes that precede</i>)	Need for service from another agency when that exchange requires a



<i>this process?</i>	contract. Need identified by program or other SCDHHS for IFB Receipt of RFP from SC CO Produce Admin or Health Services BP . Emergency need for procurement.
Dependency (Any processes dependent on the completion of this process?)	
Key Stakeholders	Provider (contracted) Program Area MCCS (Provider enrollment contractor) Division of Contracts MMIS User Services ? Division of Ancillary Reimbursements Office of General Counsel Fiscal Services Other agency (for interagency contracts) MMO SCDHHS Contract Owner Contractor/vendor SCDHHS evaluators Procurement Officer State Procurement Office/authority
Frequency/Timing/Events/Cycles	
Constraints (Location/Interfaces Required for inputs/outputs)	Protest Period
Known Issues	
Procedures/Tasks	<p>Provider Contracts</p> <ul style="list-style-type: none"> • Program area works with provider to gather required documentation • Program area creates form 102 (contract approval form). • The contract owner signs the form 102. • Program area contacts the Division of Contracts to begin the draft contract. • The Program Area works with the provider to complete the enrollment application. • Pass the 102 and contract to the Division of Contracts. • The CLS is used to log all new contracts as they move through the agency • Division of Ancillary Reimbursements area works with program area to set rates • Send the 102 and contract to the Fiscal area to encumber funds for new contracts • Once the contracting process is complete, the division of contracts forwards enrollment information to the provider enrollment contractor • Receive turn around documents and file from MCCS(from MMIS) <p>Interagency Contracts</p> <ul style="list-style-type: none"> • Program Area (contract owner) creates form 102. • Contract owner signs form 102 and passes to Division of



	<p>Contracts and Bureau of Fiscal Services</p> <ul style="list-style-type: none"> • Draft interagency contract • Division of contract completes MMO form 136 to justify interagency agreement • SCDHHS contract owner signs invoice • Contract owner signs and sends invoice to Fiscal Area (SC PG Perform Accounting Functions) • SC PG Perform Accounting Functions processes invoice • Send contract to General Counsel for review • Division of Contracts sends the 102 and contract to Fiscal Services • Div Contracts finalizes the contract • Div Contracts sends the contract to the contract owner for final approval and the Division of Ancillary Reimbursements if necessary • The contract owner awards the contract <p>Invitation for Bids (IFBs)</p> <ul style="list-style-type: none"> • Program or other SCDHHS staff complete a 192 form • Send form 192 to procurement division • Procurement creates the IFB • Owner sends the contract to General Counsel for review • Owner awards the contract • Submit to MMO website • SCDHHS or state procurement office opens bids and compares prices, and confirms bidder meets requirements. • Award published on state Procurement website and/or public bulletin board at SCDHHS main office. <p>RFP</p> <ul style="list-style-type: none"> • SCDHHS evaluators review bids and score technical proposals based on criteria in RFP • State procurement officer reviews bids for compliance with criteria • State procurement officer calculates scores • State procurement officer announces the intent to award on DHHS public bulletin board and Procurement website • After 10 day protest period is up, award contract. <p>Internal RFPs</p> <ul style="list-style-type: none"> • SCDHHS evaluators review bids and score technical proposals based on criteria in GAR • Division of Contracts reviews bids for compliance with criteria • Division of Contracts officer calculates scores • Division of Contracts officer announces the intent to award on DHHS public bulletin board and DHHS website. • After 10 day protest period is up, award contract. <p>Emergency and Sole Source contracts</p> <ul style="list-style-type: none"> • Justify the need for sole source with the State Procurement
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	<p>authority</p> <ul style="list-style-type: none"> • Program Area drafts contract • Contract owner creates form 102 • Contract owner signs form 102 • PA sends contract and form 102 to Division of Contracts and General Counsel • Division of Contracts reviews contract • General Counsel reviews contract • Contract owner awards contract
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	

Process Name	SC CO Close Out Administrative or Health Services BP
Parent Process	
Subprocess(es)	SC BR Terminate Business Relationship BP SC CO Manage Contract BP SC PM Disenroll Provider BP
Description	To complete all the processes necessary to close out a contract between DHHS and a contractor.
Owner Group	Division of Contracts and Program Areas
Purpose (<i>Intent</i>)	To complete all the processes necessary to close out a contract.
Input (<i>What is required for the process to execute?</i>)	Termination Request
Output (<i>What is the result of the process?</i>)	Termination notice Contract is terminated
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	<ul style="list-style-type: none"> • MMIS • Contract Log System • Certified Mail • Change Order Form (fiscal to unencumber funds) • Hard copy update form (notify MCCS to perform disenroll) • Email (to fiscal to unencumber funds) • Turnover Plan
Trigger (<i>Any processes that precede this process?</i>)	<p>Receipt of a termination request from:</p> <ul style="list-style-type: none"> • Operations or program area • Program Integrity • Another area of DHHS based on Program Integrity findings • The contractor • Failed negotiations result in trigger from SC CO Manage Contract BP
Dependency (<i>Any processes dependent on the completion of this process?</i>)	
Key Stakeholders	<ul style="list-style-type: none"> • Program and other SCDHHS areas.



	<ul style="list-style-type: none"> Contractors (including contracted providers) Procurement General Counsel Division of Contracts MCCS Bureau of Medicaid Systems Management (MSM) EDI Support Center DHHS Fiscal
Frequency/Timing/Events/Cycles	
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	
Known Issues	
Procedures/Tasks	<ul style="list-style-type: none"> Div of Contracts or Procurement sends a letter or change order to provider or vendor, via Certified Mail, announcing end of contract Div of Contracts or Procurement contacts Fiscal (send copy of termination letter) to unencumber funds. If Health Services contract, Div of Contracts submits hard copy update forms to SC PM Disenroll Provider BP for termination out of MMIS Bureau of Medicaid Services Management and/or EDI support center removes any data access for the contractor Request turnover plan from contractor. Work with current and new contractor to complete a smooth transition and turnover of deliverables.
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	Add information concerning the appeals process to the termination letter.

Process Name	SC CO Manage Contract BP
Parent Process	
Subprocess(es)	
Description	The Manage Contract process monitors the performance and compliance of DHHS contractors, schedules meetings, monitors Managed Care Organizations and Medical Home Network contractors, amend contracts, and conduct negotiations.
Owner Group	Division of Contracts
Purpose (<i>Intent</i>)	To keep the contracts between DHHS and its contractor up to date, to monitor performance and compliance of contractors, schedule meetings, monitor MCOs and MHNs, and conduct negotiations.
Input (<i>What is required for the process to execute?</i>)	<ul style="list-style-type: none"> Information regarding updates Monitoring information about a contract Monitoring reports from contractor Corrective Action Plan (not an initial input to the process)



Output (<i>What is the result of the process?</i>)	<ul style="list-style-type: none"> Monitoring deliverable spreadsheets Amended contracts Resolved issues Failed negotiations result in termination of contract
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	<ul style="list-style-type: none"> Contract Log System Boilerplates for deliverable spreadsheets Public Notice Website Meetings (individual and quarterly) On-site visits
Trigger (<i>Any processes that precede this process?</i>)	<ul style="list-style-type: none"> The awarding of a contract from SC CO Award Contract BP Receipt of: <ul style="list-style-type: none"> Information for contract amendment Information for contract monitoring contractor reports for performance and compliance purposes a need for negotiations (non-compliance or termination)
Dependency (<i>Any processes dependent on the completion of this process?</i>)	<ul style="list-style-type: none"> SC CO Close Out Contract BP SC BR Terminate Business Relationship
Key Stakeholders	<ul style="list-style-type: none"> Division of Contracts General Counsel Contractor Division of Care Management Bureau of Federal Contracts Procurement Division General Counsel Program Areas
Frequency/Timing/Events/Cycles	<ul style="list-style-type: none"> Quarterly meetings
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	
Known Issues	
Procedures/Tasks	<ul style="list-style-type: none"> Program Areas and Contract Monitors monitor performance and compliance of contractors Program Area person schedules meetings between DHHS and contractors for contract amendments Contract monitor schedules meetings to discuss issues with contractor Contract monitor (Bureau of Federal Contracts using Develop and Manage Performance Measures and Reporting and Monitor Performance and Business Activity) and Program Integrity monitor administrative and larger contracts Contract monitor creates deliverables spreadsheet Contract monitor collaborates with program area that holds the contract and the IT area as needed Procurement Division monitors supplier performance DHHS identifies issues needing a corrective action plan Analyzes corrective action plan Monitor and program area work with contractor to resolve issues via meetings and on-site visits. Escalated to General Counsel if needed



	<ul style="list-style-type: none"> Managed Care Area schedules individual meetings as needed Managed Care Area schedules quarterly meetings with all MCOs and MHNs (advertised via public notice website) Contract Monitor receives contractor reports via e-mail or hard copy Program Area discusses contract amendments with contractor Division of Contracts and/or Procurement division review contract changes General Counsel reviews contract amendments and updates DHHS conducts termination negotiations <ul style="list-style-type: none"> If negotiations fail, send to Close Out Contract BP
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	<ul style="list-style-type: none"> Managed Care wants data history (reports in Document Direct) to be kept for more than 18 months previous. Increase in access to reports from other entities and interfaces.

Process Name	SC CO Produce Admin or Health Services RFP BP
Parent Process	
Subprocess(es)	
Description	Create and initiate posting of Request for Proposals (RFP) for administrative or health services to be provided by an outside entity. Not to be used when the decision will be based on price alone. For those see other methods under Award Contract .
Owner Group	Bureau of Federal Contracts, Division of Procurement and Support Services (Bureau of Admin Services – under Finance and Admin)
Purpose (<i>Intent</i>)	Solicit proposals from vendors to fill need for admin or health services according to federal and state guidelines.
Input (<i>What is required for the process to execute?</i>)	Information about need to be fulfilled.
Output (<i>What is the result of the process?</i>)	RFP
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	RFP Boilerplate (not mentioned in this problem statement, but is referred to in Award Contract BP) State Procurement System (SCEIS) and website SC Business Opportunities newsletter Agency Procedures
Trigger (<i>Any processes that precede this process?</i>)	A need for an RFP arises and price is not the only deciding factor: For example when an existing contract is coming to an end and must be re-procured. A new need for services is identified that meets the criteria for needing an RFP.
Dependency (<i>Any processes dependent on the completion of this process?</i>)	RFP portion of the SC CO Award Admin or Health Services Contract BP
Key Stakeholders	SCDHHS Bureau of Federal Contracts



	<p>CMS MMO (Materials Management Office) ITMO State IT Planning Office Procurement Office Program Area SC State Procurement office</p>
Frequency/Timing/Events/Cycles	In case of contract coming to an end, BP must be initiated based on length of time for going through the entire RFP process.
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	<p>Requirements from the Program Area Federal and State guidelines MMO and ITMO administers RFP process when amount is \$150,000 for goods and services and \$125,000 for IT procurements.</p>
Known Issues	
Procedures/Tasks	<p>Produce RFP with State Procurement Office:</p> <ul style="list-style-type: none"> • Bureau of Federal Contracts or Division of Procurement work with Program Area to design requirements and guidelines for RFP. <ul style="list-style-type: none"> ◦ If it is an existing contract determine whether or and how the Statement of Work portion of the RFP should be amended. • If request involves automated data processing and the cost of the contract is estimated to total more than \$5 million over the contract period <ul style="list-style-type: none"> ◦ Produce an Advance Planning Document (APD) and submit to CMS. ◦ If APD approved, submit draft RFP to CMS for review and approval. • If RFP includes procurement of IT component, Division of Procurement will write and submit the State IT Plan to State IT Planning group • Submit draft RFP for approval to Bureau chief of Program Area, Deputy Director of Bureau, and General Counsel • Work with state procurement office MMO or ITMO to develop, issue and manage the RFP process. • Advertise RFP in SC Business Opportunities newsletter • Division of Procurement posts the RFP on the DHHS website • In some cases Bureau of Federal Contracts and State Procurement Officer contact individual vendors to let them know about the RFP <p>Produce Grant Application Request (Internal RFP):</p> <ul style="list-style-type: none"> • Bureau of Federal Contracts or Division of Procurement work with Program Area to design requirements and guidelines for RFP. <ul style="list-style-type: none"> ◦ If it is an existing contract determine whether or and how the Statement of Work portion of the RFP should be amended. • If RFP includes procurement of IT component, Division of Procurement will write and submit the State IT Plan to State IT Planning group • Submit draft RFP for approval to Bureau chief of Program Area and General Counsel • If value exceeds \$10,000, advertise RFP in SC Business Opportunities



	<ul style="list-style-type: none"> newsletter Division of Procurement posts the RFP on the DHHS website Maintain list of GARs vendors In some cases Bureau of Federal Contracts and Division of Contracts contact individual vendors to let them know about the RFP
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	None identified

Process Name	SC CO Manage Contractor Information BP
Parent Process	
Subprocess(es)	
Description	Manage any information associated with the contractor.
Owner Group	
Purpose (<i>Intent</i>)	Manage any information associated with the contractor.
Input (<i>What is required for the process to execute?</i>)	Contract New information concerning a contract or contractor
Output (<i>What is the result of the process?</i>)	
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	Contract Log System Procurement office maintains a spreadsheet with contact information for the contractors. ApplicationXtender
Trigger (<i>Any processes that precede this process?</i>)	Change in status of contract (can come from Manage Contract or Close Out Contract or Manage Contractor Communication)
Dependency (<i>Any processes dependent on the completion of this process?</i>)	
Key Stakeholders	Division of Contract Contractors Procurement Office ITMO/MMO Fiscal Area Director Program Areas
Frequency/Timing/Events/Cycles	
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	Contracts are not kept electronically.
Known Issues	Currently don't track when enrollment sheet for contracted provider is sent to MMIS
Procedures/Tasks	<ul style="list-style-type: none"> Enter information into the CLS Update information in the CLS Procurement staff manually maintain a hard copy spreadsheet of contractor contact information Fiscal Area scans contract paperwork that comes to them via



	ApplicationXtender. This would only be fiscal related paperwork kept for their purposes.
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	None listed

Process Name	SC CO Inquire Contractor Information BP
Parent Process	
Subprocess(es)	
Description	Respond to inquiries from contractors or other entities concerning contracts.
Owner Group	
Purpose (<i>Intent</i>)	Respond to inquiries from contractors or other entities concerning contracts.
Input (<i>What is required for the process to execute?</i>)	Inquiry from contractors. Inquiry from outside entity under Freedom of Information Act (FOIA)
Output (<i>What is the result of the process?</i>)	Response to inquiry. FOIA response is a packet of information that could include a copy of the contract.
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	Contract Log System Phone/fax/email Letter Invoice for copy fee (FOIA) Log number (FOIA) assigned by Director's office Executive Log System Blue Sheet
Trigger (<i>Any processes that precede this process?</i>)	Receipt of inquiry
Dependency (<i>Any processes dependent on the completion of this process?</i>)	
Key Stakeholders	Contractor Outside entity making an inquiry under FOIA Division of Contracts Director Public Information Office Deputy Director/Bureau Chief of the Office of Finance and Administration/Bureau of Administrative Services Procurement Division
Frequency/Timing/Events/Cycles	FOIA requests must be completed within 14 days
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	Division's response may be limited by what information is kept in the contract log system.
Known Issues	
Procedures/Tasks	<ul style="list-style-type: none"> Look up information in the CLS. Respond to inquiry FOIA Request <ul style="list-style-type: none"> Received by Public Information Office via US Mail



	<ul style="list-style-type: none"> Public Information office assigns log number manually in sequential order using the Executive Log System Public Information starts a log letter using the Executive Log System Routed via Deputy dir/bureau chief of the Office of Finance and Administration/Bureau of Administrative Services to Procurement Office or Division of contracts Div Contracts or Procurement completes log letter and blue sheet Then sends it to the Bureau Chief Bureau chief sends it to Public Information office Public information office prepares packet including letter, copy of contract, invoice for copy fee. If MMO Contract only a letter giving MMO contact information is sent out PIO mails the packet via US Mail
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	None provided

Process Name	SC CO Manage Contractor Communication BP
Parent Process	
Subprocess(es)	
Description	This Business Process maintains communication between the contractor and SCDHHS. Also, maintains electronic list of Procurement Office prospective vendors.
Owner Group	Division of Contracts and DHHS Program Areas
Purpose (<i>Intent</i>)	Maintain communication between DHHS and contractors. Maintain prospective vendor list for Procurement Office.
Input (<i>What is required for the process to execute?</i>)	<ul style="list-style-type: none"> Inquiry from contractor or other interested outside parties. Communications from other SCDHHS BP's to contractor.
Output (<i>What is the result of the process?</i>)	Information to be communicated to/from the contractor
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	<ul style="list-style-type: none"> Phone Email Fax Mail Contract Log System PAs Tracking Systems and Processes Procurement Office Prospective vender electronic list Managed Care area Q and A sheet for each MCO Division of Contracts Paper Files W-9 Form
Trigger (<i>Any processes that precede this process?</i>)	Request for inbound/outbound communication



Dependency (<i>Any processes dependent on the completion of this process?</i>)	Various BPs that require communication with contractor. Example Award Administrative or Health Services Contract .
Key Stakeholders	Division of Contracts DHHS Program Areas Contractor Procurement Office
Frequency/Timing/Events/Cycles	
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	
Known Issues	
Procedures/Tasks	<ul style="list-style-type: none"> • Direct Communication to appropriate location • Track communication (examples: Contract Log System, and Division of Care Management Tracking Systems) • The Procurement Office keeps an electronic log of vendors who have contacted them to be considered as contractors. • Receive vendor W-9 • The Division of Care Management (Managed Care area) sends and receives MCO Q and A sheets. • The Division of Care Management compiles answers to the MCO Q and A sheets.
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	None Identified.

Process Name	SC CO Perform Contractor Outreach BP
Parent Process	
Subprocess(es)	<ul style="list-style-type: none"> • Perform Provider Outreach handles Contracted Provider bulletins and manuals (not really a subprocess but fits here better than in Dependency) • Possible overlap with Perform Population and Member Outreach (not really a subprocess but fits here better than in Dependency). We think there is overlap because the same website is designed for use by recipients.
Description	This business process allows for communication of information (bulletins, changes to a specific program, and creation of a new program or contract) from DHHS to relevant contractors.
Owner Group	Department of Managed Care, MCCC, and DHHS
Purpose (<i>Intent</i>)	To keep contractors informed of changes in SC Medicaid
Input (<i>What is required for the process to execute?</i>)	<ul style="list-style-type: none"> • Information concerning change in SC Medicaid policy (for bulletins, manuals, and MCO website) • Information and services needed for RFI • Invitation for business fairs
Output (<i>What is the result of the process?</i>)	<ul style="list-style-type: none"> • New bulletins and manuals • Updated MCO website



	<ul style="list-style-type: none"> Information collected from RFI's Information collected from business fairs
Mechanism (Systems/Application/Tool/manual or automated)	<ul style="list-style-type: none"> Request for Information (RFI) South Carolina Business Opportunity Letter (hard copy or soft copy) E-bulletins Program manuals MCO Information website Interested vendor/business contact list
Trigger (Any processes that precede this process?)	<ul style="list-style-type: none"> Receipt of: <ul style="list-style-type: none"> New information concerning changes in SC Medicaid Need for RFI Invitation for business fair New information to be posted on MCO website
Dependency (Any processes dependent on the completion of this process?)	
Key Stakeholders	<ul style="list-style-type: none"> Division of Procurement DHHS MCCS Program Areas Contractors Department of Managed Care
Frequency/Timing/Events/Cycles	Timing of business fairs
Constraints (Location/Interfaces Required for inputs/outputs)	
Known Issues	
Procedures/Tasks	<ul style="list-style-type: none"> DHHS issues Request for Information (RFI) in the South Carolina Business Opportunity Letter Receive solution from vendor to RFI posted in South Carolina Business Opportunity Letter Division of Procurement attends Business Fairs In rare cases, Program Area contacts a provider or hospital if they perform a specialized service. Contracted Provider bulletins and manuals handled by SC PM Perform Provider Outreach BP Department of Managed Care updates MCO Information Website
Performance Measures (efficient and/or effective)	
Roles (performing)	
Related Business Goals	
Wish List/Needs	None identified.

Process Name	SC CO Support Contractor Grievance and Appeal BP
Parent Process	
Subprocess(es)	
Description	



Owner Group	Division of Appeals and Hearings
Purpose (<i>Intent</i>)	
Input (<i>What is required for the process to execute?</i>)	Grievances/complaints/Protests. Appeal Request
Output (<i>What is the result of the process?</i>)	Ruling
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	MMIS MEDS Hearing Appeals and Hearings Tracking System - Logs/tracking of complaints and grievances ApplicationXtender Imaging System Case files. Interlocutory Order (Intermediate Decision) Order of Dismissal Final Decision Provider Manuals Appeal Request Case Management Sheet (CMS) Order for Prehearing Conference Record/transcript of the hearing Kinko's State Auditor's Office Boiler plate documents
Trigger (<i>Any processes that precede this process?</i>)	Receipt of provider appeal request from Manage Contractor Communication Receipt of provider grievance/complaint from Manage Contractor Communication
Dependency (<i>Any processes dependent on the completion of this process?</i>)	
Key Stakeholders	Providers Program Areas Division of Appeals and Hearings Director of Appeals Hearing Officer Office of General Counsel
Frequency/Timing/Events/Cycles	Deadlines for appeal of decision
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	
Known Issues	
Procedures/Tasks	<p><i>Grievances Tasks</i></p> <ul style="list-style-type: none"> Forward complaint/grievance to program area. PA attempts to resolve grievance <p><i>Contract Award Protest Tasks</i></p> <ul style="list-style-type: none"> Work with ITMO or MMO, or Program Area to resolve dispute <p><i>Contract Termination Protest Tasks</i></p> <ul style="list-style-type: none"> Work with ITMO or MMO, or Program Area to resolve dispute



	<p><i>Hearings and Conferences</i></p> <ul style="list-style-type: none"> • Track appeal case information and image information documents • Image documents using ApplicationXtender • Hold optional Prehearing Conference for non-nursing home audit appeals with Division of Program Integrity • Division of Appeals and Hearings issues an Order of Prehearing Conference for nursing home audit appeals. • Hold optional Prehearing Conference for nursing home audit appeals. • Director of Appeals determines if the appeal is valid. If it is not valid it is not entered into the Tracking System and the provider notified. • If valid the Director assigns a case number and hearing officer • Admin assistant enters appeal data into Appeals and Hearings Tracking System • Admin assistant prepares the Case Management Sheet • Admin sends it to the hearing officer • Hearing officer selects appropriate documents on the Case Management Sheet • Hearing officer returns it to admin assistant • Admin assistant prepares documents • Admin assistant mails documents • Hearing Officer examines case <ul style="list-style-type: none"> ○ Reviews case information using mechanisms ○ He contact the provider for information • Hearing Officer issues decision <ul style="list-style-type: none"> ○ If previous decision stands an Interlocutory Order (Intermediate Decision) is sent ○ If provider doesn't respond to the Interlocutory Order in 10 days an Order of Dismissal is prepared <ul style="list-style-type: none"> ▪ The Director reviews the Order of Dismissal for signature. ▪ The Order of Dismissal is then sent to designated areas. • If appeal is not dismissed the Hearing Officer holds a hearing • Hearing Officer renders a decision • The Director of Appeals reviews the decision • If the Director approves, the decision is sent to the provider. • If the Director disapproves, the Hearing Officer and the Director reach a consensus and then the decision is sent. <p>Division of Appeals and Hearings prepares a copy of the complete record/transcript of the hearing at the request of the ALC. (A party can appeal the Hearing Officer's decision to the South Carolina Administrative Law Court, if they feel it was in error)</p>
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	More user-friendly tracking system



Process Name	SC OM Authorize Referral BP
Parent Process	
Subprocess(es)	
Description	This business process receives reports from MCOs concerning the referral authorizations they have completed.
Owner Group	Department of Managed Care, Program Area
Purpose (<i>Intent</i>)	To oversee the authorize referral process at Medicaid MCOs.
Input (<i>What is required for the process to execute?</i>)	<ul style="list-style-type: none"> MCO organization reports
Output (<i>What is the result of the process?</i>)	MCO reports
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	MCO organization reports
Trigger (<i>Any processes that precede this process?</i>)	Receipt of a report from an MCO.
Dependency (<i>Any processes dependent on the completion of this process?</i>)	SC CO Manage Contract BP
Key Stakeholders	MCOs, DHHS Managed Care Area
Frequency/Timing/Events/Cycles	
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	
Known Issues	
Procedures/Tasks	<ul style="list-style-type: none"> Receive reports Forward to SC CO Manage Contract BP
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	

Process Name	SC OM Authorize Service (DME) BP
Parent Process	
Subprocess(es)	
Description	DME requires authorization for certain codes. The auth can have supporting documentation. DME uses a system to track approved (authorized) requests. Duplicate authorizations are discovered through this tracking.
Owner Group	DHHS Durable Medical Equipment area
Purpose (<i>Intent</i>)	Receive requests for DME authorization. Approve or deny requests. Correspond with providers, administrative contractor (MCCS).
Input (<i>What is required for the</i>	Prior Auth form (DHHS 214) and any supporting documentation



<i>process to execute?)</i>	
Output (<i>What is the result of the process?</i>)	Denied requests - letters to provider Approved requests – prior auth number, letter to provider and MCCC
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	<ul style="list-style-type: none"> • DME provider manual • Documentation – physician’s notes, lab reports, mfg’s information, a completed Medicaid Certificate of Medical Necessity for that equipment or service type. • Tracking system of approved requests • Hard copy files at MCCC for prior auth docs from DME • MMIS/MEDS
Trigger (<i>Any processes that precede this process?</i>)	Receiving the form 214 and any documentation
Dependency (<i>Any processes dependent on the completion of this process?</i>)	none
Key Stakeholders	Providers, MCCC, DHHS (DME area)
Frequency/Timing/Events/Cycles	No frequency, as necessary from provider
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	There is no place in the tracking system to log denied prior authorization requests.
Known Issues	
Procedures/Tasks	<ul style="list-style-type: none"> • DME reviews form and supporting documentation • DME determines if the DME code meets medical necessity • DME checks MMIS/MEDS for beneficiary eligibility • If new equipment or special case the medical director may review the request • DME uses a system to track approved (authorized) requests and check for duplicate authorizations. • DME sends a hard copy letter to provider for denied requests • For approved requests the DME assigns a unique authorization number and enters info into the tracking system • DME sends approval letters to the provider and MCCC. • All DME claims suspend. MCCC does manual checks if the prior auth number on the claim is in the tracking system. If number is not on the claim or no match is found in the tracking system, MCCC rejects the claim.
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	<ul style="list-style-type: none"> • The DME area recommends imaging or electronic submission of this information, which would greatly reduce the volume of hard copy materials received. • Increased functionality in the MMIS and MEDS system including the ability to view multiple screens and do criteria-specific searches would greatly improve this process.



Process Name	SC OM Authorize Service (Dental) BP
Parent Process	
Subprocess(es)	
Description	Dental prior auth is required for medically necessary, non-covered services for EPSDT beneficiaries and for services deemed medically necessary that extend beyond DHHS listed service limits. Requests and documentation come into the DHHS Dental area.
Owner Group	DHHS Dental area
Purpose (<i>Intent</i>)	Receive requests for Dental authorization. Approve or deny requests. Correspond with providers.
Input (<i>What is required for the process to execute?</i>)	<ul style="list-style-type: none"> • Prior Auth form (DHHS 214) and any supporting documentation • Requests for covered services that exceed normal limits.
Output (<i>What is the result of the process?</i>)	<p>Denied requests - letters to provider</p> <p>Approved requests – prior auth number, letter to provider</p>
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	<ul style="list-style-type: none"> • Form DHHS 214 in the provider manual • Dental Prior Authorization System (DPAS) tracking system for prior authorization requests that have been approved. • Hard copy letter for approval or denial • Rate sheet
Trigger (<i>Any processes that precede this process?</i>)	Receipt of the prior auth form and supporting documentation
Dependency (<i>Any processes dependent on the completion of this process?</i>)	none
Key Stakeholders	DHHS (Dental area), providers
Frequency/Timing/Events/Cycles	No frequency, as necessary from provider
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	There is no place in the tracking system to log denied prior authorization requests.
Known Issues	
Procedures/Tasks	<ul style="list-style-type: none"> • Dental area reviews form and supporting documentation • Dental consultant determines if the dental code meets medical necessity and approves or denies the request. • If denied, a letter is sent to the provider • If approved, the prior authorization number and prior authorization form, with reimbursement rate, is sent back to the provider. • Dental area reviews requests for covered services that exceed normal limits. • Dental area approves or denies these requests. (Not the Dental Consultant). • Dental area uses a system to track approved (authorized) requests and check for duplicate authorizations. • The DPAS system then assigns a unique number for each approved prior authorization request. • The Dental area files hard copies of the only the approved requests. • If additional documentation is needed, the Dental area will call the provider and request it. • If the additional documentation is sent by the provider, the Dental



	<p>area or Dental consultant reviews the request again. If a provider does not send additional documentation, the request will be denied.</p> <ul style="list-style-type: none"> Claims always suspend, ECF is sent to Dental area.
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	<ul style="list-style-type: none"> SCDHHS has released an RFP and is currently seeking a Dental Administrative Service Organization (ASO) to manage the prior authorization request process for the Dental area in the future. The entire prior authorization process in the Dental area is manual and completed using hard copies. This process would benefit from automation in any way possible.

Process Name	SC OM Authorize Service (CLTC Waiver Management) BP
Parent Process	
Subprocess(es)	
Description	Case managers (providers who work at other agencies) authorize services for beneficiaries via a waiver program. CLTC CMS has forms for different services. Case managers fill out forms electronically in CMS and these are available to DHHS staff.
Owner Group	DHHS CLTC
Purpose (<i>Intent</i>)	Receive requests for CLTC services authorization. Approve or deny requests. Correspond with providers.
Input (<i>What is required for the process to execute?</i>)	Request forms from case managers.
Output (<i>What is the result of the process?</i>)	<ul style="list-style-type: none"> All authorization decisions Copy of the authorization of service to the provider
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	<ul style="list-style-type: none"> Community Long Term Care Case Management System (CLTC CMS).
Trigger (<i>Any processes that precede this process?</i>)	<ul style="list-style-type: none"> Receipt of prior form that goes over the predetermined threshold Receipt of request forms from case managers
Dependency (<i>Any processes dependent on the completion of this process?</i>)	none
Key Stakeholders	DHHS CLTC, case managers, beneficiaries
Frequency/Timing/Events/Cycles	No frequency, as necessary from case manager
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	None
Known Issues	None
Procedures/Tasks	<ul style="list-style-type: none"> The case manager authorizes a certain number of hours for a service up to a pre-determined limit SCDHHS (local area office staff) must prior authorize the determination by the case manager that exceeds the pre-determined limit. Otherwise no prior auth is required.



	<ul style="list-style-type: none"> The CLTC CMS sends Care Call the authorization. Case manager enters the authorization information into CMS.
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	none

Process Name	SC OM Authorize Service (Out of State Services) BP
Parent Process	
Subprocess(es)	
Description	<p>When needed services are not available in South Carolina or within 25 miles of its borders (the South Carolina Medical Service Area), South Carolina Medicaid providers can refer members to providers outside the SCMSA.</p> <p>The DHHS Out-of-State Coordinator reviews the authorization request form and documentation and decides whether or not to approve the service. The coordinator sends a letter to the in-state physician saying whether the service is approved. There is no authorization number.</p>
Owner Group	DHHS Out-of-State Coordinator
Purpose (<i>Intent</i>)	Receive requests for out-of-state service authorization. Approve or deny requests. Correspond with in-state providers.
Input (<i>What is required for the process to execute?</i>)	Requests for out-of-state service authorization.
Output (<i>What is the result of the process?</i>)	Approved or denied requests for authorization of service.
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	<ul style="list-style-type: none"> Written confirmation that the outside provider will accept Medicaid payment. Referral Request for Out of State Services (paper form) Supporting documentation (with above form) Approval/denial letter to provider File on a shared network drive for each recipient of out of state services. The folder houses all documentation associated with the referral request.
Trigger (<i>Any processes that precede this process?</i>)	Receipt of Referral Request for Out of State Services
Dependency (<i>Any processes dependent on the completion of this process?</i>)	Enroll Provider
Key Stakeholders	
Frequency/Timing/Events/Cycles	No frequency, as necessary from in-state providers
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	None
Known Issues	None
Procedures/Tasks	<ul style="list-style-type: none"> The SC Medicaid providers coordinate with an out of state provider and obtain written confirmation that the outside provider will accept Medicaid payment.



	<ul style="list-style-type: none"> The SC Medicaid provider then files a paper Referral Request for Out of State Services form to the DHHS Out-of-State Coordinator along with specified supporting documentation. The Out-of-State Coordinator at SCDHHS reviews the form and documentation. The Out-of-State Coordinator decides whether or not to approve the service. The Out-of-State Coordinator sends a letter to the in-state physician saying whether the service is approved or denied. There is no authorization number. The Out-of-State Coordinator creates/maintains/keeps a file for each beneficiary of out of state services. If not already enrolled, the out of state provider must enroll with South Carolina Medicaid through MCCA Provider Enrollment before Medicaid will process claims. See Enroll Provider.
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	None

Process Name	SC OM Authorize Service (Hospital Services) BP
Parent Process	
Subprocess(es)	
Description	<p>SCDHHS contracts with a Quality Improvement Organization (QIO) contractor for reviews of prior/pre-authorizations and support documentation for services rendered by physicians.</p> <p>It is the physician's responsibility to obtain prior authorization for a service or submit support documentation (i.e., for hospital-based services requiring authorization, the physician, not the hospital, obtains the authorization).</p>
Owner Group	DHHS, Quality Improvement Organization (QIO) contractor
Purpose (<i>Intent</i>)	For a physician to obtain prior authorization for a service or submit support documentation (i.e., for hospital-based services requiring authorization, the physician, not the hospital, obtains the authorization).
Input (<i>What is required for the process to execute?</i>)	<ul style="list-style-type: none"> General Prior Authorization form and supporting documentation Certain service specific forms
Output (<i>What is the result of the process?</i>)	Authorization number and a hard copy letter of authorization to the provider.
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	<ul style="list-style-type: none"> Fax or hard copy form Web-based program called i-exchange SCDHHS provider manuals MMIS
Trigger (<i>Any processes that precede this process?</i>)	<ul style="list-style-type: none"> Services needing prior authorization as listed in the SC Provider Manual Suspended Claims needing supporting docs
Dependency (<i>Any processes</i>)	Manage Edit Correction Forms



<i>dependent on the completion of this process?)</i>	
Key Stakeholders	<ul style="list-style-type: none"> • DHHS • QIO contractor • Providers • MCCC
Frequency/Timing/Events/Cycles	As needed
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	none
Known Issues	
Procedures/Tasks	<p>Prior Authorization</p> <ul style="list-style-type: none"> • Provider submits general Prior Authorization forms and/or specific service forms to QIO contractor • Provider submits supporting documentation to QIO contractor • CIO contractor grants prior authorization via an assigned number and hard copy letter • Provider submits a claim with the prior auth number <p>Services Requiring Support Documentation</p> <ul style="list-style-type: none"> • MCCC sends the ECF and supporting documentation to the QIO contractor • The QIO contractor determines the medical necessity of the service. • If the support documentation is approved by the contractor, a reviewer will mark the ECF with his or her analyst ID • If the claim is submitted without supporting documentation, MCCC sends the ECF to the provider • The provider sends supporting documentation to contractor • The QIO contractor determines the medical necessity of the service. • If the support documentation is approved by the contractor, a reviewer will mark the ECF with his or her analyst ID <p>Urgent or emergency services</p> <ul style="list-style-type: none"> • MMIS generates an ECF • MCCC sends this documentation to the QIO contractor. • The contractor then sends the ECF to the program area • The program area makes the decision to pay or reject the claim and returns the ECF to MCCC for processing (see Manage Edit Correction Forms). <p>Agency-Internal Review Hospital Services</p> <ul style="list-style-type: none"> • MMIS generates an ECF • MCCC sends these to Hospital Services for review hospital services RN and medical directors • Hospital Services makes the decision to approve or deny • Hospital Services manually prices – see Price Claim-Value Encounter BP • Track using Hospital Tracking System • Return to MCCC for processing
Performance Measures (<i>efficient</i>)	



<i>and/or effective)</i>	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	Hospital and Physicians management recommend an interface between the agency and its contractor to automate the prior authorization and support documentation process and reduce hard copy communication. The contractor should not have to worry about marking up ECFs; their expertise is in medical review. This interface could also allow for prior authorization information to be included in member files. Having the contractor send prior authorization and support documentation approval directly to MCCS for payment processing would improve this process and greatly reduce fraud.

Process Name	SC OM Authorize Service (Behavioral Health Services) BP
Parent Process	
Subprocess(es)	
Description	For behavioral health services, other state agencies such as DSS are responsible for the Authorize Service business function.
Owner Group	
Purpose (<i>Intent</i>)	To submit requests for Behavioral Health Service Authorizations
Input (<i>What is required for the process to execute?</i>)	<ul style="list-style-type: none"> authorization/referral forms
Output (<i>What is the result of the process?</i>)	<ul style="list-style-type: none"> authorization including the prior auth number
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	<ul style="list-style-type: none"> forms prior auth rules set by SCDHHS
Trigger (<i>Any processes that precede this process?</i>)	<ul style="list-style-type: none"> Submission of form to state agencies
Dependency (<i>Any processes dependent on the completion of this process?</i>)	
Key Stakeholders	<ul style="list-style-type: none"> DHHS, other state agencies, providers
Frequency/Timing/Events/Cycles	As needed
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	none
Known Issues	
Procedures/Tasks	<ul style="list-style-type: none"> The provider fills out authorization/referral forms and sends to other state agencies (not DHHS) The agencies assign providers a prior authorization number The agencies send the authorization/referral forms with a prior authorization number to the provider prior to rendering services. Providers submit claims to SCDHHS. See Enter Claim
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	



Wish List/Needs	The Behavioral Health area would like to allow these other agencies access to the Medicaid Enterprise system or provide some other program allowing them to enter prior authorization data. They would also like to validate the entire referral/PA number to ensure proper referrals.
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Process Name	SC OM Authorize Service (Pharmacy Services) BP
Parent Process	
Subprocess(es)	
Description	The prescriber (provider) sends prior authorization requests via phone, fax, or web-tool to the Point of Sale (POS) contractor. The contractor provides real-time denial or approval of the prior authorization.
Owner Group	
Purpose (<i>Intent</i>)	For prior auths of pharmacy claims
Input (<i>What is required for the process to execute?</i>)	<ul style="list-style-type: none"> sends prior authorization requests
Output (<i>What is the result of the process?</i>)	<ul style="list-style-type: none"> Time denial or approval of the prior authorization Monthly spreadsheets of the prior authorization requests that have been denied. To DHHS
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	<ul style="list-style-type: none"> Phone, fax, or POS web-tool Preferred Drug List (PDL) SCDHHS Pharmacy manual listing other reasons for requiring prior authorizations and exceptions.
Trigger (<i>Any processes that precede this process?</i>)	<ul style="list-style-type: none"> Receipt of prior auth request
Dependency (<i>Any processes dependent on the completion of this process?</i>)	
Key Stakeholders	<ul style="list-style-type: none"> DHHS, provider, Point of Sale (POS) contractor
Frequency/Timing/Events/Cycles	Monthly spreadsheet
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	
Known Issues	
Procedures/Tasks	<ul style="list-style-type: none"> The prescriber (provider) sends prior authorization requests via phone, fax, or web-tool to the Point of Sale (POS) contractor. The contractor provides real-time denial or approval of the prior authorization via the web tool. Denials are sent via hard copy letter to the prescriber and the beneficiary The contractor sends SCDHHS monthly spreadsheets of the prior authorization requests that have been denied. If a request is approved, the contractor assigns a prior authorization number and processes the request for use at a pharmacy.
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	none



Process Name	SC OM Authorize Service (Department of Managed Care) BP
Parent Process	
Subprocess(es)	
Description	This business process receives reports from MCOs concerning the referral authorizations they have completed.
Owner Group	Department of Managed Care, Program Area
Purpose (<i>Intent</i>)	To oversee the authorize service process at Medicaid MCOs.
Input (<i>What is required for the process to execute?</i>)	<ul style="list-style-type: none"> MCO organization reports
Output (<i>What is the result of the process?</i>)	MCO reports
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	MCO organization reports
Trigger (<i>Any processes that precede this process?</i>)	Receipt of a report from an MCO.
Dependency (<i>Any processes dependent on the completion of this process?</i>)	SC CO Manage Contract BP
Key Stakeholders	MCOs, DHHS Managed Care Area
Frequency/Timing/Events/Cycles	
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	
Known Issues	
Procedures/Tasks	<ul style="list-style-type: none"> Receive reports Forward to SC CO Manage Contract BP
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	none

Process Name	SC OM Apply Attachment BP
Parent Process	
Subprocess(es)	
Description	This process handles the receipt, scanning, and association of hard copy attachments with claims by CCN.
Owner Group	DHHS, MCCS
Purpose (<i>Intent</i>)	To handle the receipt, scanning, and association of hard copy attachments with claims by CCN.
Input (<i>What is required for the process to execute?</i>)	Hard copy attachment with either a hard copy claim or ECF



Output (<i>What is the result of the process?</i>)	Attachment is scanned to microfilm and associated with claim via CCN
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	Microfilm ECF Attachments
Trigger (<i>Any processes that precede this process?</i>)	Receipt of attachment with either hard copy claim or ECF from SC PM Manage Provider Communication BP
Dependency (<i>Any processes dependent on the completion of this process?</i>)	Manage ECFs
Key Stakeholders	DHHS, MCCS, Providers
Frequency/Timing/Events/Cycles	As necessary
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	No attachments accepted electronically Attachments must come in with either hard copy claims or ECFs
Known Issues	
Procedures/Tasks	<ul style="list-style-type: none"> The attachments are scanned to microfilm The attachments are associated with the claim based on CCN For in-house ECFs, the claims area at MCCS routes the attachment, hard copy claim, and ECF to the appropriate program staff.
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	DHHS desires to automate the submission of attachments.

Process Name	SC OM Apply Mass Adjustment BP
Parent Process	
Subprocess(es)	
Description	This business process is used to identify large numbers of claims that need adjustments for various reasons. The criteria for the adjustments are determined in this BP. The business process then the payment amount is adjusted.
Owner Group	<ul style="list-style-type: none"> Bureau of Medicaid Systems Management Clemson Medicaid Services MCCS
Purpose (<i>Intent</i>)	To identify and process void and replace mass adjustments to claims
Input (<i>What is required for the process to execute?</i>)	Criteria for a mass claims adjustment
Output (<i>What is the result of the process?</i>)	<ul style="list-style-type: none"> Voided Claims New claims (replacement claims) Provider community adjustment letter
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	<ul style="list-style-type: none"> MMIS Report that lists all affected claims Document Direct
Trigger (<i>Any processes that precede this process?</i>)	Need for mass adjustment of claims



Dependency (<i>Any processes dependent on the completion of this process?</i>)	
Key Stakeholders	<ul style="list-style-type: none"> • Providers • Bureau of Medicaid Systems Management • Clemson Medicaid Services • MCCS • Program Areas • BMSM analyst
Frequency/Timing/Events/Cycles	<ul style="list-style-type: none"> • Time to modify MMIS search program • Wait for DHHS on criteria of MMIS search • Wait period for letters to be sent to affected providers • Time for MMIS to run through all claims takes a significant amount of time
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	
Known Issues	
Procedures/Tasks	<ul style="list-style-type: none"> • BMSM staff determines the magnitude of affected claims (time period, claims types, etc.) • BMSM sends claims identifying information to Clemson Medicaid Services • Clemson searches MMIS based on criteria from BMSM • Clemson produces a report and file of the affected claims • Clemson stores the report in Document Direct • Affected Program Areas view the report • Affected Program Areas verifies the identified claims • Program Areas alerts Bureau of Medicaid System Management analyst once the list of claims is verified • BMSM analyst emails Clemson when all affected Program Areas have reported • Clemson schedules the mass adjustment • BMSM manually produces provider community-adjustment letter (photocopy and produce mailing labels) • BMSM sends the letters to MCCS • MCCS mails the letters to the Provider via Manage Provider Communication • Clemson runs the mass adjustment according to schedule
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	<ul style="list-style-type: none"> • Automate and accelerate the process of identifying affected claims • Add functionality to “void and replace” a claim that has already been replaced



Process Name	SC OM Audit Claim-Encounter BP
Parent Process	
Subprocess(es)	
Description	Auditing claims against history (18 months worth) and verifying authorization of services
Owner Group	<ul style="list-style-type: none"> • Program Areas • MCCS • Bureau of Medicaid Systems Management
Purpose (<i>Intent</i>)	Auditing claims against history (18 months worth) and verifying authorization of services
Input (<i>What is required for the process to execute?</i>)	<ul style="list-style-type: none"> • Edited Claim • "Edited" Encounter
Output (<i>What is the result of the process?</i>)	<ul style="list-style-type: none"> • Audited Claim • "Audited" Encounter
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	<ul style="list-style-type: none"> • MMIS • MMIS skeletal claims history • MMIS MCO skeletal history
Trigger (<i>Any processes that precede this process?</i>)	Receipt if an edited claim or encounter
Dependency (<i>Any processes dependent on the completion of this process?</i>)	Price Claim/Value Encounter BP
Key Stakeholders	<ul style="list-style-type: none"> • MCCS • Program Areas • MMIS
Frequency/Timing/Events/Cycles	
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	MMIS skeletal claims history is only handle for 18 months
Known Issues	
Procedures/Tasks	<ul style="list-style-type: none"> • Audit edited claim against MMIS skeletal claims history • Audit edited encounter against MMIS MCO skeletal history • Audit prior authorization against MMIS data • For some service types, claim suspends and the program area or MCCS must manually check
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	<ul style="list-style-type: none"> • Perform more extensive auditing of claims and encounters, most likely through a third-party vendor that would audit claims in real time and determine whether they were edited correctly by the MMIS

Process Name	SC OM Edit Claim-Encounter BP
Parent Process	
Subprocess(es)	(parallel) Price Claim-Encounter BP



Description	Validates and verifies the claims, assigning error codes used to determine approval, denial, or suspense
Owner Group	DHHS
Purpose (<i>Intent</i>)	Validates and verifies the claims, assigning error codes used to determine approval, denial, or suspense
Input (<i>What is required for the process to execute?</i>)	Claim Encounter Pharmacy Claims
Output (<i>What is the result of the process?</i>)	Edited claim with error codes added Edited encounter with error codes added Claim information is stored in various formats, if claim approved (ex. approved claims are stored in order to be picked up for duplicate editing later)
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	<ul style="list-style-type: none"> • Zeke • MMIS database areas including: <ul style="list-style-type: none"> ○ Skeletal database ○ Provider database ○ Recipient database ○ TPL database ○ Procedure Code File ○ Diagnosis file ○ Revenue code ○ DRG Grouper information ○ Error Code Reference File ○ Encounter archives ○ Encounter skeletal database
Trigger (<i>Any processes that precede this process?</i>)	Execution of daily claims run JCL job Execution of daily encounters JCL job Execution of weekly pharmacy JCL job
Dependency (<i>Any processes dependent on the completion of this process?</i>)	Prepare Remittance Advice/Encounter Report BP Prepare Provider EFT-Check BP Manage ECF Forms
Key Stakeholders	Provider DHHS MCCS FirstHealth
Frequency/Timing/Events/Cycles	Multiple claims runs per day except on Tuesday
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	50,000 claims at a time Only 18 months of data in skeletal history
Known Issues	
Procedures/Tasks	<ul style="list-style-type: none"> • MMIS verifies and validates claims against Provider, Recipient, and TPL databases; Procedure Code, Diagnosis, Revenue Code, and Error Code Reference Files; and DRG Grouper information • MMIS verifies and validates claims against skeletal history database <ul style="list-style-type: none"> ○ Duplicate edits ○ Frequency edits ○ Conflicting edits • MMIS performs high-level edits on Pharmacy claims in addition to those done by POS • MMIS performs prior authorization editing



	<ul style="list-style-type: none"> Some service types suspends the claim, the program area or MCCS manually checks the number against the Prior Authorization form As result of various edits, error codes are assigned to the claim. These error codes can be assigned at the claim or line level. Error codes can cause claim to suspend or reject Approved or denied claims move on to Remits and EFT BPs Rejected claims generate ECFs see Manage Error Correction Forms BP <p>Encounter</p> <ul style="list-style-type: none"> Verifies and validates against databases Verifies and validates against MMIS Skeletal history. Based on edits, assign error codes to encounters. Reject if critical If approved, add encounter to encounter archives Create three files: <ul style="list-style-type: none"> Copy of original file File of edited encounters with contain any errors assigned to the encounters Summary report which includes information such as the number of encounters accepted/rejected and a list of errors assigned and the number of occurrences.
Performance Measures (<i>efficient and/or effective</i>)	Meets Fed standard of processing a claim within 30 days from date of receipt. Hard copy claims must be keyed and sent to Clemson within 5 days. Claims Resolution must resolve 98% of the suspended claims within 30 calendar days of receipt.
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	None identified

Process Name	SC OM Price Claim-Value Encounter BP
Parent Process	
Subprocess(es)	
Description	The MMIS automatically prices claims. This BP will describe the manual pricing of a claim without a specific rate or one having a miscellaneous code. Encounters are not priced.
Owner Group	DHHS
Purpose (<i>Intent</i>)	Manual pricing of certain claims
Input (<i>What is required for the process to execute?</i>)	Suspended claim as an ECF
Output (<i>What is the result of the process?</i>)	Corrected ECF
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	MMIS, blank ECF, Procedure Code Pricing Record reference file, contracted provider reference files, pricing form to determine amount of claim.
Trigger (<i>Any processes that precede this process?</i>)	Receipt of an ECF from the Manage ECF Business Process
Dependency (<i>Any processes</i>)	Manage ECF Business Process



<i>dependent on the completion of this process?)</i>	
Key Stakeholders	DHHS, MCCS
Frequency/Timing/Events/Cycles	Normal claims processing schedule
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	
Known Issues	
Procedures/Tasks	<ul style="list-style-type: none"> • MMIS automatically prices claims • Specific Program areas receive ECF that requires manual pricing • Program area rep will use a pricing form to determine amount of claim • A program area representative corrects the ECF manually in red and lists his/her analyst number • The program area returns the ECF to MCCS for processing and payment.
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	The Bureau of Medicaid System Management would like to retain a complete history of all pricing for all services. Currently, the MMIS holds the current price and one prior price. A system request has been made for this new functionality.

Process Name	SC OM Prepare COB BP (related to Manage TPL Recovery)
Parent Process	
Subprocess(es)	
Description	MMIS generates invoices to insurers for pay & chase and retro recoveries. South Carolina Medicaid does not invoice third parties for cost avoided claims; in those cases, providers must bill the third parties themselves.
Owner Group	
Purpose (<i>Intent</i>)	MMIS generates invoices to insurers for pay & chase and retro recoveries.
Input (<i>What is required for the process to execute?</i>)	<ul style="list-style-type: none"> • Pay and chase claims • Regular Retro claims • Retro Medicare claims
Output (<i>What is the result of the process?</i>)	Invoices to third part insurers
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	<ul style="list-style-type: none"> • Insurance policy • Paper Invoices to third party payers • Pay and chase recoveries • Retro recoveries • US Mail system • MMIS
Trigger (<i>Any processes that precede this process?</i>)	Price Claim/Value Encounter, (claims retro jobs- process unknown at this time)
Dependency (<i>Any processes dependent on the completion of this process?</i>)	Send Outbound Transaction



Key Stakeholders	DHHS, third party payers, MIVS
Frequency/Timing/Events/Cycles	<ul style="list-style-type: none"> Based on claims having the potential of having a third party policy documented in MMIS. Insurers who do not respond are billed a second time four months later. Generally, the state takes no further action. At the end of each quarter, Clemson runs a job that identifies claims from non-institutional providers for which a third party may be liable.
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	
Known Issues	
Procedures/Tasks	<ul style="list-style-type: none"> At the end of each quarter, Clemson runs jobs that identify claims from non-institutional providers for which a third party may be liable. The MMIS generates invoices to send to those carriers. Clemson prints and sends these invoices to MIVS MIVS mails them to the third party payer. <hr/> <p>MIVS</p> <ul style="list-style-type: none"> For certain carriers, MIVS generates claim forms to send to the third party payer in place of the MMIS-generated billings.
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	

Process Name	SC OM Prepare EOB BP
Parent Process	
Subprocess(es)	
Description	This business process manages the generation, sending, receiving, and distribution of REOMB letters.
Owner Group	Division of Program Integrity
Purpose (<i>Intent</i>)	To manage the generation, sending, receiving, and distribution of REOMB letters.
Input (<i>What is required for the process to execute?</i>)	<ul style="list-style-type: none"> Selection criteria for sample (not always present) Order to generate letters Recipient-completed REOMB letters
Output (<i>What is the result of the process?</i>)	REOMB letter Preliminary PI review (not always done)
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	<ul style="list-style-type: none"> REOMB letter MMIS Hard copy list of recipients Clemson University Data Center Courier
Trigger (<i>Any processes that precede this process?</i>)	<ul style="list-style-type: none"> Regularly scheduled generation of REOMB letters



	<ul style="list-style-type: none"> Recipient-completed REOMB letter
Dependency (<i>Any processes dependent on the completion of this process?</i>)	<ul style="list-style-type: none"> In some instances SC PI Identify Candidate Case
Key Stakeholders	Division of Program Integrity
Frequency/Timing/Events/Cycles	REOMB letters generated every month
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	
Known Issues	
Procedures/Tasks	<ul style="list-style-type: none"> CU generates REOMB letters CU modify criteria based on input from PI Division CU send generated REOMB letters to PI via courier
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	<ul style="list-style-type: none"> PI Division would like to directly generate the sample selection and modify the criteria as necessary PI Division would like to improve the appearance of the letter

Process Name	SC OM Prepare Premium EFT/Check BP Process Profile BP
Parent Process	
Subprocess(es)	
Description	<p>HIPP HIPP premiums are paid by ACS, and billed to SCDHHS as pass-through costs. The contractor collects the data and logs them to the HIPP Access database, and then prepares and mails a check to the beneficiary or other payee.</p> <p>MCOs, MHN, and Transportation Brokers Payments are pulled into a file and sent via EFT to Wachovia each Wednesday. EFT payments are pulled into a file and sent to Wachovia each Wednesday.</p> <p>Medicare A check is printed by MCCS, as part of the standard check pull process, and forwarded to Fiscal. Fiscal then voids the check and processes a wire transfer to CMS.</p>
Owner Group	<ul style="list-style-type: none"> DHHS Fiscal
Purpose (<i>Intent</i>)	To prepare and pay premiums via EFT and or check
Input (<i>What is required for the process to execute?</i>)	<ul style="list-style-type: none"> MEDICARE - billing statement (paper document) received from CMS MCOs, MHN, and Transportation Brokers – input is the file from MMIS HIPP - collected beneficiary data in the HIPP Access database
Output (<i>What is the result of the process?</i>)	<ul style="list-style-type: none"> HIPP – premium payments to the beneficiary or payee MEDICARE – check to CMS MCO's etc. – EFT sent to Wachovia, who sends to Fed Reserve who EFT's to various payees.
Mechanism (<i>Systems/Application/Tool/manual</i>)	<ul style="list-style-type: none"> HIPP access database



<i>or automated)</i>	<ul style="list-style-type: none"> EFT method Reconciliation of EFTs Billing statement
Trigger (<i>Any processes that precede this process?</i>)	
Dependency (<i>Any processes dependent on the completion of this process?</i>)	Perform Accounting Function and/or State Financial Management
Key Stakeholders	<ul style="list-style-type: none"> SCDHHS – FISCAL ACS CMS Wachovia
Frequency/Timing/Events/Cycles	<ul style="list-style-type: none"> Medicare – when billing statement comes in monthly EFT payments are pulled into a file and sent to Wachovia each Wednesday Wachovia balances the report and creates an error report that must be worked each week by Fiscal staff
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	None
Known Issues	None
Procedures/Tasks	<p>HIPP</p> <ul style="list-style-type: none"> Prepare check Mail check <p>MCO's, etc</p> <ul style="list-style-type: none"> EFT payments are pulled into a file and sent to Wachovia each Wednesday Wachovia balances the report and creates an error report Fiscal reconciles the report each week via access to the Wachovia website. Wachovia sends the EFT file to the Federal Reserve. Fed Reserve routes the payments to the various payee accounts. <p>Medicare:</p> <ul style="list-style-type: none"> MCCS prints a check for the amount in the MMIS payment file MCCS forwards the check to Fiscal see Perform Accounting Functions Fiscal voids the check Fiscal processes a wire transfer based on the amount from the CMS billing statement If there is a discrepancy between the MMIS payment file and the CMS billing statement, Medicaid Systems Management staff determines the cause The problem is corrected Rerun payment so MMIS payment file balances with CMS billing statement
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	



Related Business Goals	
Wish List/Needs	TPL staff believe that if the HIPPA program is directly administered by SCDHHS again in the future, it would make sense to pay these premiums through the MMIS so payments could be associated with the recipient file and claims history.

Process Name	SC OM Prepare Provider EFT-Check BP
Parent Process	
Subprocess(es)	In conjunction with Prepare Remittance Advice-Encounter Report
Description	This business process manages the payment of providers by paper check, EFT, or IDT.
Owner Group	DHHS
Purpose (<i>Intent</i>)	This business process manages the payment of providers by paper check, EFT, or IDT.
Input (<i>What is required for the process to execute?</i>)	<ul style="list-style-type: none"> • Processed claims from previous week • Starting check number for each check run
Output (<i>What is the result of the process?</i>)	<ul style="list-style-type: none"> • ACH file • Paper checks • IDT (using GAFRS or SAP, maybe need to revise based on removal of GAFRS) • Payment file (input to SC OM Prepare Remittance Advice Encounter Report)
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	<ul style="list-style-type: none"> • MMIS • Wachovia website • Federal Reserve • Blank paper checks • IDT transaction • EFT transaction
Trigger (<i>Any processes that precede this process?</i>)	Tuesday early morning payment run
Dependency (<i>Any processes dependent on the completion of this process?</i>)	<ul style="list-style-type: none"> • SC OM Prepare Remittance Advice Encounter Report • SC PG Perform Accounting Functions • SC PG Manage State Funds • SC OM Inquire Payment Status
Key Stakeholders	<ul style="list-style-type: none"> • MCCC • Wachovia • DHHS • Provider • Fiscal Area • Other state agencies who contract with DHHS for services • Comptroller General
Frequency/Timing/Events/Cycles	Weekly payment run
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	<ul style="list-style-type: none"> • Check stock and signature plates are necessary to print paper checks. They are under lock and key at MCCC. • Check stock is pre-printed with check numbers and the starting check number given to MMIS must match.



Known Issues	
Procedures/Tasks	<ul style="list-style-type: none"> • MMIS runs Tuesday payment job to create ACH file or paper check EFT: • ACH payment file is sent to Wachovia via EFT MMIS Interface • Wachovia creates and sends error report to DHHS Fiscal Services <ul style="list-style-type: none"> ○ Fiscal Services uses MMIS online to change provider's payment type from EFT to paper check once error is corrected they are once again placed in EFT payment type; those have errors from EFT ○ Fiscal Services cuts paper checks to those providers • Wachovia sends EFT file to Federal Reserve • Federal Reserve routes payments to various provider accounts <p>Paper Checks:</p> <ul style="list-style-type: none"> • CU receives starting check number from DHHS for input to payment job • Clemson creates paper check payment file • Clemson sends paper check payment file to MCCS printer that is loaded with check stock and signature plate • MCCS and DHHS monitors the printing of checks • MCCS and SCDHHS monitor printing of checks • After printing, check stock and signature plate are returned to safe • MCCS staff burst the checks and put in envelopes (these are the same envelopes that remittances are placed in) • Checks mutilated during printing, are sent to Fiscal for regeneration as manual checks • Fiscal records mutilated check number • Manual checks created • Manual checks returned to MCCS for stuffing with remittance packages <p>IDT: Inter Departmental Transfer is another option for paying other state agencies. This process currently involves an interface with GAFRS, but this is being replaced soon as part of a new project/system called SAP and therefore details are not documented here.</p>
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	DHHS would like to be able to enter all debits and credits into the MMIS before the payment is calculated, doing away with the manual check pull process.

Process Name	SC OM Prepare Remittance Advice-Encounter Report BP
Parent Process	
Subprocess(es)	
Description	This business process is responsible for the generation of remittance advice



	reports for providers.
Owner Group	DHHS
Purpose (<i>Intent</i>)	This business process is responsible for the generation of remittance advice reports for providers.
Input (<i>What is required for the process to execute?</i>)	All claims placed in the pay area of the data for payment processing
Output (<i>What is the result of the process?</i>)	Paper Remit and 835 electronic remit
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	<ul style="list-style-type: none"> • MMIS • Courier • HIPAA Mailbox MMIS Interface
Trigger (<i>Any processes that precede this process?</i>)	Tuesday morning Payment run
Dependency (<i>Any processes dependent on the completion of this process?</i>)	HIPAA Mailbox MMIS Interface
Key Stakeholders	DHHS MCCS Provider
Frequency/Timing/Events/Cycles	Every Tuesday
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	
Known Issues	
Procedures/Tasks	<ul style="list-style-type: none"> • MMIS runs Tuesday Payment job to create remits • Clemson prints remits • Clemson sends them to MCCS by Courier • MCCS bursts, hand-stuffs and mails the remits (the remits are placed in the same envelopes as the checks and ECFs [as appropriate]) • If provider is enrolled (via Establish Business Relationship) MMIS creates 835 HIPAA transactions remits and places them into the providers' HIPAA Mailbox MMIS Interface • Note some providers receive both paper and 835
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	Currently in progress: agency plans to discontinue paper remits in the Fall of 2009.

Process Name	SC OM Prepare Capitation Premium Payment BP
Parent Process	
Subprocess(es)	
Description	South Carolina Medicaid currently pays capitated rates to transportation brokers, MCOs, and the MHN. These rates are negotiated as part of the contracts with those entities.
Owner Group	DHHS
Purpose (<i>Intent</i>)	To calculate all capitated payments and send that info to contracted brokers.



Input (<i>What is required for the process to execute?</i>)	<ul style="list-style-type: none"> • MMIS calculations based on beneficiary and provider data • 834 data from Enrollment broker going into MMIS
Output (<i>What is the result of the process?</i>)	Capitated payments to brokers
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	<ul style="list-style-type: none"> • MMIS • X12 834 Transaction • X12 820 Transaction • Recipient Special Programs (RSP) file • File of beneficiary data sent Maximus
Trigger (<i>Any processes that precede this process?</i>)	
Dependency (<i>Any processes dependent on the completion of this process?</i>)	Manage Payment History, Prepare Premium EFT/check
Key Stakeholders	DHHS, Enrollment Broker, Transportation Broker, MCO, MHN
Frequency/Timing/Events/Cycles	<ul style="list-style-type: none"> • Transportation – monthly • MCO – monthly • MHN - monthly
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	Any errors in the calculation of capitated payments must be handled manually. Agency staff must sometimes make adjustments, override gaps in member eligibility, and perform other MMIS functions to correctly prepare capitated payments.
Known Issues	
Procedures/Tasks	<p>Four contracted entities:</p> <p>Transportation</p> <ul style="list-style-type: none"> • Clemson runs a job to calculate the premium payment, which creates a capitated premium claim for each eligible. <p>Managed Care Organizations</p> <ul style="list-style-type: none"> • Based on 834 data received from the Enrollment Broker, the MMIS updates the Recipient Special Programs file and uses this information to calculate the payment. • A second payment is made later each month to reconcile any members who lost and then regained their eligibility within the month. • SCDHHS transmits a collective X12 834 to the Enrollment Broker • The enrollment broker splits out the 834 to the various plans • DHHS transmits a separate 820 to each plan. <p>Medical Homes Network</p> <ul style="list-style-type: none"> • See above.
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	Each month, Clemson runs a job to calculate the payment, which creates a capitated premium claim for each eligible. The claim is not stored; it is merely the mechanism for calculation. The agency would like to store this data in the MMIS and in the DSS/SURS– to show in which months premiums were paid for a member.



Process Name	SC OM Prepare HIPP BP
Parent Process	
Subprocess(es)	
Description	This business process identifies Medicaid beneficiaries for whom payment of health insurance premiums is cost effective. And communicates with them concerning participation in the program.
Owner Group	DHHS, ACS
Purpose (<i>Intent</i>)	Identify and communicate with recipients that are eligible to have their health insurance premiums paid.
Input (<i>What is required for the process to execute?</i>)	Referral from many sources (providers, caseworkers, DSS, CLTC, and beneficiaries)
Output (<i>What is the result of the process?</i>)	Approval or rejection letter
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	<ul style="list-style-type: none"> • MMIS • SC HIPP database • Boilerplates letters • Contact package • SC HIPP Cost Saving Worksheet • Beneficiary records
Trigger (<i>Any processes that precede this process?</i>)	Receipt of referral from many sources
Dependency (<i>Any processes dependent on the completion of this process?</i>)	Process to allocate money to ACS to pay premiums (possible dependency)
Key Stakeholders	<ul style="list-style-type: none"> • ACS • DHHS • Beneficiary • Provider • Employer • COBRA Administrator
Frequency/Timing/Events/Cycles	Redetermination every 6 months
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	
Known Issues	
Procedures/Tasks	<ul style="list-style-type: none"> • Contractor sends out initial contact package to prospective beneficiaries • Contractor receives beneficiary wish to participate • Contractor gathers data for beneficiary cost effectiveness decision (beneficiary EOBs) • Contractor logs all data into SC HIPP Database • Contractor calculates cost effectiveness (based on 40% of billed charges) using SC HIPP Cost Saving Worksheet (using cost of the premium, the deductible, the per-member-per-month admin cost for 6 month period, and any other relevant costs) <ul style="list-style-type: none"> ○ Contractor deems participation cost effective if SC Medicaid can save \$600 every 6 months • Program staff receives and reviews comparative data for beneficiary's



	<p>diagnosis (expected procedures, drugs, and hospitalizations) and then sends it to ACS</p> <ul style="list-style-type: none"> • Update MMIS TPL Policy File with P in source field to show beneficiary is in HIP • If case is approved, Contractor send approval letter • Contractor generates checks • If dropping beneficiary send letter • Image all HIP materials • Contractor receives continuous documentation from beneficiaries • Program Staff perform some outreach to beneficiaries (send letter to every family of a TEFRA beneficiary) see MM Perform Population and Member Outreach BP • Contractor performs a redetermination every 6 months and Contractor performs a redetermination anytime they learn of a change such as an increased or decreased premium or new carrier • DHHS liaison provides policy and oversight
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	<ul style="list-style-type: none"> • SCDHHS would like to expand and enhance outreach. • However, claims data could be used to provide leads in the future. Although SCDHHS are not allowed to target beneficiaries for HIP inclusion based on diagnosis, they may be able to look for high-claim beneficiaries with other insurance, for example.

Process Name	SC OM Prepare Medicare Premium Payment BP
Parent Process	
Subprocess(es)	
Description	Sharing Medicare and Medicaid information for the purpose of determining premium payments to CMS. The system identifies those who are potentially eligible for Buy-In and those who are ineligible and creates the Buy-In transactions to be sent to CMS.
Owner Group	<ul style="list-style-type: none"> • Dept of Interfaces
Purpose (<i>Intent</i>)	Sharing Medicare and Medicaid information for the purpose of determining premium payments to CMS
Input (<i>What is required for the process to execute?</i>)	<ul style="list-style-type: none"> • Billing file from CMS. (the daily Buy-In transactions and monthly billing file) • MEDS member data • Social Security Administration data (State Data Exchange and BENDEX)
Output (<i>What is the result of the process?</i>)	<ul style="list-style-type: none"> • Monthly file to MMIS for processing of premium payments
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	
Trigger (<i>Any processes that</i>	



<i>precede this process?)</i>	
Dependency (<i>Any processes dependent on the completion of this process?</i>)	Manage Payment History, Manage Member Information, Prepare Premium Payment EFT-Check
Key Stakeholders	<ul style="list-style-type: none"> • DHHS • CMS • SSA • Beneficiaries
Frequency/Timing/Events/Cycles	<ul style="list-style-type: none"> • Weekly, the MEDS Buy-In interface transmits the Buy-In (Part A and B) accretions, deletions and changes to CMS. • daily Buy-In transactions and monthly billing file received from CMS • a monthly file to MMIS for processing of premium payments
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	None
Known Issues	See wish list
Procedures/Tasks	<ul style="list-style-type: none"> • Clemson University MEDS receives data from CMS (MMA), SDX, BENDEX, COB. • Clemson receives data from the Medicaid beneficiary • Clemson's Buy-In subsystem extracts Medicare and other data from the MEDS member records to create a Buy-In transaction • Clemson's Buy-In subsystem generates two Buy-In files (one for Medicare Part A and one for Medicare Part B). • Clemson's Buy-In subsystem transmits the Buy-In (Part A and B) to CMS. • CMS processes the file and responds the next day sending multiple types of records • The Buy-In subsystem processes the files received back from CMS automatically, assessing the files for accuracy and completeness. • The Buy-In subsystem produces reports that list unmatched entries and other errors that require SCDHHS manual research. • Workers are notified of discrepant information through reports and alerts. • The SCDHHS workers use these various reports and alerts to research and correct as many as possible. • SCDHHS may also send a problem discrepancy form(s) to the CMS Exceptions Processing if it requires action on their part • The Department of Interfaces workers may make phone calls to CMS, the SSA etc. to resolve issues with the information. • The Buy-In subsystem processes the daily Buy-In transactions and monthly billing file received from CMS and generates a monthly file to MMIS for processing of premium payments (see Prepare Premium Payment EFT-Check for a description of the payment process).
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	<ol style="list-style-type: none"> 1.) SCDHHS would like the Buy-In table to be re-written. The table has many flaws which causes many processing errors. 2.) SCDHHS would like Buy-In to handle retroactive Buy-In eligibility



	<p>automatically (e.g. a case worker approves someone for May – then later determines the beneficiary was eligible for April as well – currently a manual accretion is required SCDHHS).</p> <p>3.) SCDHHS would like for the eligibility office to always take the name of the potential beneficiary from the Social Security card (sometimes SCDHHS has the wrong name – this is an eligibility office issue).</p> <p>4.) SCDHHS would like to have access to the EDB interface (listed on the CMS template). SCDHHS would like Buy-In to correctly update the QMB indicator.</p>
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Process Name	SC OM Inquire Payment Status BP
Parent Process	
Subprocess(es)	
Description	To satisfy providers' inquiries on the status of their claims. IVRS is used to check the amount of the providers' last check. Inquire claims status can be done via phone, Web Tool, or 276/277 transactions using HIPAA mailboxes.
Owner Group	Bureau of Medicaid Systems Management
Purpose (<i>Intent</i>)	To satisfy providers' inquiries on the status of their claims. IVRS is used to check the amount of the providers' last check.
Input (<i>What is required for the process to execute?</i>)	Inquiry with claims and provider information
Output (<i>What is the result of the process?</i>)	Status of the claim
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	<ul style="list-style-type: none"> • Phone • Web Tool • HIPAA Mailbox • IVRS Interface
Trigger (<i>Any processes that precede this process?</i>)	Receipt of inquiry of claims status
Dependency (<i>Any processes dependent on the completion of this process?</i>)	
Key Stakeholders	BMSM Providers
Frequency/Timing/Events/Cycles	As necessary
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	<ul style="list-style-type: none"> • If servers down are down no inquires can be processed • Phone calls only during business hours • Processing time using HIPAA mailbox and Web Tool • Web Tool only maintains 6 months of data
Known Issues	
Procedures/Tasks	<ul style="list-style-type: none"> • Worker looks up claim in MMIS using provided information • Worker responds to provider over phone • Provider executes query to find specific claims using Web Tool • Provider 276 transactions are picked from mailboxes • Translator verifies HIPAA-compliant transaction



	<ul style="list-style-type: none"> Transaction is translated to CU proprietary format Translated transactions are placed on mainframe for processing Mainframe processes transactions 277 transactions are placed in mailboxes for pickup by providers See MMIS HIPAA Mailbox Interface for more details
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	None identified

Process Name	SC OM Manage Payment Information BP
Parent Process	
Subprocess(es)	
Description	Payment information is stored in the MMIS in conjunction with the provider files. Access is managed by roles and user ids. Staff can perform inquiries on payment information by provider through MMIS. Providers can obtain information on their most recent payment via the interactive voice response system (IVRS). Outside agencies can perform inquiries with the required Trading Partner Agreement (TPA). Payment information is also used in many management reports (See Manage Program Information process).
Owner Group	<ul style="list-style-type: none"> DHHS
Purpose (<i>Intent</i>)	To control access to payment data. To make information available to staff and providers on claims and payments for inquiries and research.
Input (<i>What is required for the process to execute?</i>)	<ul style="list-style-type: none"> The date of the payment, the check number and the payment amount are stored in MMIS and connected to the provider.
Output (<i>What is the result of the process?</i>)	<ul style="list-style-type: none"> Payment information via the MMIS Online access, IVRS access and reports.
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	<ul style="list-style-type: none"> MMIS online IVRS Reports
Trigger (<i>Any processes that precede this process?</i>)	Claims and payment runs to create data
Dependency (<i>Any processes dependent on the completion of this process?</i>)	
Key Stakeholders	<ul style="list-style-type: none"> DHHS claims workers, providers, outside agencies with TPA granted access
Frequency/Timing/Events/Cycles	<ul style="list-style-type: none"> Each week, adjudicated claims from the previous week (Tuesday through Monday) are fed into a payment cycle in order to determine the providers' payments Monthly, the payment data is written to electronic archives and is retained forever.
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	<ul style="list-style-type: none"> MMIS Access is based on the person's job role and is controlled by a user id and password... The majority of staff have inquiry-only access. Update access is given to staff who have a specific role requiring update. For example, a claims resolution clerk needs



	<p>update access to the claims; a provider enrollment clerk needs update access to the provider file.</p> <ul style="list-style-type: none"> • SCDHHS requires the use of a Trading Partner Agreement (TPA) for anyone outside of the agency to have inquiry-only access to the MMIS. • Payments cannot be manually altered through the MMIS. • Payment archives are not available online.
Known Issues	None
Procedures/Tasks	<ul style="list-style-type: none"> • Each week, adjudicated claims from the previous week (Tuesday through Monday) are fed into a payment cycle in which stores data (date of the payment, the check number and the payment amount) in MMIS and connects it to the provider file. • Staff perform inquiries on payment information by provider through MMIS. • Providers obtain information on their most recent payment via the interactive voice response system (IVRS). • Outside agencies perform inquiries. • Payment information is passed to the Manage Program Information process for report generation.
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	<ul style="list-style-type: none"> • None

Process Name	SC OM Manage Drug Rebate BP
Parent Process	
Subprocess(es)	
Description	<p>SCDHHS contracts with FirstHealth to manage Drug Rebate, both OBRA and Supplemental.</p> <p>This process describes the DHHS' and MMIS interaction with First Health, not the business process within First Health.</p>
Owner Group	SCDHHS Fiscal Services
Purpose (<i>Intent</i>)	To monitor drug rebate payments. To perform a reconciliation between GAFRS, FirstHealth and Wachovia.
Input (<i>What is required for the process to execute?</i>)	<ul style="list-style-type: none"> • POS claims from MMIS • Claims with J codes from MMIS
Output (<i>What is the result of the process?</i>)	<ul style="list-style-type: none"> • Online access to drug rebate payments • Summarized invoice totals from FH to DHHS • Reconciliation between GAFRS, FirstHealth and Wachovia.
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	<ul style="list-style-type: none"> • Tape listing of all rebate-eligible NDC • Receipt tracking log at Wachovia • Accounts Receivable database (Perform Accounting Functions)
Trigger (<i>Any processes that precede this process?</i>)	
Dependency (<i>Any processes</i>)	



<i>dependent on the completion of this process?)</i>	
Key Stakeholders	DHHS Fiscal Services, Pharmacy area
Frequency/Timing/Events/Cycles	<ul style="list-style-type: none"> Each quarter CMS send DHHS an NDC tape which is forwarded to FH. At the end of the month, Fiscal performs a reconciliation between GAFRS, FirstHealth and Wachovia.
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	<p>Currently, no drug rebate data is fed into the MMIS or the Thomson Reuters DW.</p> <p>CMS is supposed to send the tape within 45 days of the end of the quarter; the contractor then has 15 days to prepare and send out invoices to meet the federal 60-day timeliness standard.</p>
Known Issues	
Procedures/Tasks	<ul style="list-style-type: none"> DHHS passes the NDC tape from CMS to Pharmacy Contractor FH manages the Drug Rebate Program between manufacturers and Wachovia Fiscal Services accesses Wachovia daily online (a receipt tracking log) to monitor drug rebate payments. The pharmacy program area can access this log also. Pharmacy Contractor deposits checks with Wachovia Pharmacy Contractor sends summarized invoice totals to Fiscal Services. Fiscal Services tracks these in the Accounts Receivable database and GAFRS. See Perform Accounting Functions. Fiscal Services splits the drug rebate receivables into three categories using GAFRS journal entries: PDL/Supplemental, CMS/OBRA, or Diabetes Supplies. At the end of the month, Fiscal performs a reconciliation between GAFRS, the Pharmacy Contractor and Wachovia
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	DHHS would like it if drug rebate data were stored along with claims history in the data warehouse, or was somehow made directly accessible to the agency. Attorneys preparing class action lawsuits often seek large volumes of drug rebate data which the agency has to retrieve through FirstHealth.

Process Name	SC OM Manage Estate Recovery BP
Parent Process	
Subprocess(es)	SC PG Perform Accounting Functions BP
Description	Manages the recovery of assets of the deceased to recover certain Medicaid benefits correctly paid on behalf of an individual.
Owner Group	DHHS
Purpose (<i>Intent</i>)	Recover assets
Input (<i>What is required for the process to execute?</i>)	Form 181, Form 238, MMIS death report, DHEC's Dept of Vital Statistics file (to MMIS to sub-database), names of estates potentially in probate.
Output (<i>What is the result of the process?</i>)	<p>No recovery of assets, either nothing owed Medicaid or less than threshold amount</p> <p>Recovery of assets</p>



Mechanism (Systems/Application/Tool/manual or automated)	Blank forms (181, 238, 205) DHEC, MMIS, MEDS, member file, probate court, contact letter, questionnaire, ER database, SURS, member spreadsheet going to probate court, Application Xtender
Trigger (Any processes that precede this process?)	Nursing Home send forms 181 and TAD to MCCS Caseworkers send forms 238 to DHHS ER DHEC sends file MMIS report
Dependency (Any processes dependent on the completion of this process?)	Generic accounting BPs (not defined yet), billing error corrections
Key Stakeholders	DHHS, beneficiary's family
Frequency/Timing/Events/Cycles	No set frequency except for monthly inquiry to probate court for names of estates potentially in probate. After 30 days, re-send letter if no respond comes in to initial letter
Constraints (Location/Interfaces Required for inputs/outputs)	Only CLTC and NH Data in MMIS only within the past 18 months If the estate is worth less than 10,000, the case is always closed Case deferred if there is a spouse or minor child
Known Issues	May take many months to recover assets
Procedures/Tasks	<ul style="list-style-type: none"> • MCCS sends all hard copy form 181s to Estate Recovery • County Caseworkers send hard copy form 238 to Estate Recovery • DHEC file is processed and run against MMIS and this output is run against the ER database to see if the case already exists. • MMIS death report arrives • ER staff searches MEDS for family contact information • ER staff prints the family and recipient screens • ER staff generates initial contact letter and questionnaire from screens • If no case is to be created, scan screens into Application Xtender. • If case is created, create paper file and add screen print to file. • ER staff sends a questionnaire to the deceased's family • ER staff receives the completed questionnaire and either closes or keeps the case open • ER claims analyst researches beneficiary claims history using MMIS, MEDS, SURS, and member physical file (caseworker file from county office) • Analyst compiles a spreadsheet and sends to the probate court • Probate sends ER documentation of the estate's true assets • ER staff researches tax assessments and other sources for complete and accurate information • ER approves real estate sales or actions taken on estate • Check is received by Fiscal Area or the ER department see SC PG Perform Accounting Functions BP • If ER receives check post to ER database, sent to Cash Receipts with form 205 see SC PG Perform Accounting Functions BP • ER analyst researching claims history may discover billing errors and work with provider to correct them. This would most likely result in the provider initiating an adjustment claim. • Manually reconcile ER database and GAFRS monthly • Manually reconcile ER database and AR log weekly. Checks that went



	<p>directly to Fiscal are entered into the ER database during this reconciliation process. Application Xtender is used as a source of information.</p> <ul style="list-style-type: none"> • Track contact during case within ER database • ER staff contacts the probate court for additional information via monthly report based on query of ER database for estates potentially in probate. For some counties the report is not necessary because ER staff can query information online. • When a case is closed the paper file is scanned into Application Xtender and then destroyed.
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	<p>The ER area would like to expand their ability to match deaths against claims for nursing home or CLTC services anytime in the past several years prior to the death.</p> <p>They would also like death notifications and data matches to be more automated.</p> <p>The research process would be much easier if caseworkers' documentation was electronically accessible – perhaps uploaded and attached to the member file. As it is, the ER staff must ask the caseworker to dig up a paper file and send it in; sometimes files can be misplaced or incomplete. The ER staff also find discrepancies between MEDS and MMIS – for example, the TPL indicator is not always the same in both systems.</p> <p>An overhaul of the ER database is planned in the future, including a way to attached scanned documents to files.</p>

Process Name	SC OM Manage Cost Settlement BP
Parent Process	
Subprocess(es)	
Description	The Bureau of Reimbursement Methodology and Policy (BRMP) annually requests cost reports from certain providers via hard copy correspondence to conduct cost settlements which can impact the rate setting process.
Owner Group	Bureau of Reimbursement Methodology and Policy (BRMP)
Purpose (<i>Intent</i>)	Cost settlements are one of the things which impact the rate setting process.
Input (<i>What is required for the process to execute?</i>)	<ul style="list-style-type: none"> • Cost reports • MARS Reports • Decision Support System reports
Output (<i>What is the result of the process?</i>)	<ul style="list-style-type: none"> • Adjustments • Information used in rate setting • Reports to providers
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	<ul style="list-style-type: none"> • Rules for determining provider cost (for cost report) • Federal and State regulations and manuals • Cost limitations based on provider type built into the state plan • 115 form • 1158 form



	<ul style="list-style-type: none"> • Hardcopy BRMP file
Trigger (<i>Any processes that precede this process?</i>)	Done annually
Dependency (<i>Any processes dependent on the completion of this process?</i>)	<ul style="list-style-type: none"> • Manage Rate Setting • Maintain State Plan
Key Stakeholders	<ul style="list-style-type: none"> • BRPM • Provider • Fiscal • MCCS
Frequency/Timing/Events/Cycles	Annually
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	
Known Issues	
Procedures/Tasks	<ul style="list-style-type: none"> • BRMP requests hard copy cost reports from providers. Providers submit cost reports to the BRMP. • Some Nursing Home and Hospital providers undergo a process similar to the cost settlement. However, a final settlement/rate is determined based on audit findings of the cost reports. • All other provider types undergo a retrospective cost settlement. • Home Health providers and RHCs directly file their Medicare cost reports to the BRMP. • The BRMP worker uses the units of service that are listed on the report to calculate the reimbursement rate using liable cost definitions from Federal and State regulations and manuals, as well as cost limitations in the State Plan. • If there is a difference between the units reported and the units paid by Medicaid (which can happen when multiple payers are involved), the BRMP worker will perform manual reconciliations with the provider prior to setting the rate. • The BRMP worker uses MARS reports and/or Thomson/Medstat reports to pull statistics and payment information. • The liable units are multiplied by the rate to determine the maximum amount a provider can receive. • The maximum value is compared to the interim rate payment. • If the provider was underpaid, the BRMP worker requests a gross adjustment by completing a 115 form, which is sent to MCCS for keying. • If the provider was overpaid, the BRMP worker will complete a 1158 Accounts Receivable form, which is sent to the Fiscal area to recoup funds (SC PG Perform Accounting Functions BP). • The debits and credits from different areas for each provider are rolled up to generate one reconciliation amount. • Cost settlement data and any calculations are reviewed by the worker who originally prepared the computations. • Cost settlement data and any calculations are reviewed by a second worker. • The BRMP prepares and sends hard copy letters to providers. • Letters identifying overpayments that require the 1158 form or reconciliation are also sent to the Fiscal area.



	<ul style="list-style-type: none"> For underpayments and overpayments that require debit adjustments, the BRMP verifies that the adjustments were processed through the MMIS. The Fiscal area monitors overpayments that established the 1158 to ensure payment is received. The BRMP maintains hard copy files for each provider. The BRMP documents underpayments when paid to the provider.
Performance Measures (<i>efficient and/or effective</i>)	<ul style="list-style-type: none"> Cost settlements take, ideally, three to four months to complete if all reports are received on a timely basis. Cost settlement can take years to resolve if there are delays, such as not receiving a report in a timely manner or waiting on findings from an independent audit.
Roles (<i>performing</i>)	
Related Business Goals	Rate setting
Wish List/Needs	<ul style="list-style-type: none"> The BRMP would like to receive electronic cost reports from all providers and design agency-specific spreadsheets to reduce re-entry of data. This would reduce the amount of hard copy reports that the BRMP receives and would help to automate this process.

Process Name	SC OM (Gathering Policy Info) BP
Parent Process	Manage TPL Recovery
Subprocess(es)	
Description	Medicaid Insurance Verification Services (MIVS), the TPL contractor, researches TPL information from a variety of referral sources and data matches. These “leads” indicate potential policies that must be added to the TPL Subsystem of the MMIS.
Owner Group	DHHS, TPL Contractor
Purpose (<i>Intent</i>)	To gather third party policy information to ensure that Medicaid is the payer of last resort for beneficiaries claims.
Input (<i>What is required for the process to execute?</i>)	<p>Data to be used to find leads for possible third party policies</p> <ul style="list-style-type: none"> Data matches/exchanges Paper Eligibility form 3230 from county offices to DHHS or MIVS MMIS/MEDS reports Leads
Output (<i>What is the result of the process?</i>)	<ul style="list-style-type: none"> New or updated policies
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	<ul style="list-style-type: none"> MIVS contractor proprietary systems (tracking, policy datastore, automated data entry/user emulation process) MMIS-TPL subsystem MMIS MEDS TRICARE-DEERS Interface ESC BCBSSC Other Insurers (CIGNA, Aetna, and United Healthcare) Eligibility form 3230



	<ul style="list-style-type: none"> • TPL Weekly Claims Processing Reports • Lapse Exception Reports • MCO • Health Insurance Information Referral Forms • Casualty accident questionnaires
Trigger (<i>Any processes that precede this process?</i>)	Data via leads, matches and reports
Dependency (<i>Any processes dependent on the completion of this process?</i>)	
Key Stakeholders	DHHS, TPL contractor, providers, insurers
Frequency/Timing/Events/Cycles	Data matches and reports on regular schedule Forms and other leads as they come in
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	MIVS only adds lapsed policies if they find at least \$500 of recoverable claims in MMIS skeletal history.
Known Issues	
Procedures/Tasks	<p>Gather data via data match with TRICARE-DEERS, ESC, BCBS, other insurers, SSA 8019, and MCOs.</p> <p>Gather paper – Eligibility Form 3230, insurer inquiries, provider refunds, HIRR forms, casualty questionnaires</p> <p>Gather Data from MMIS – TPL Weekly Claims Processing Report, Lapse Exception Report</p> <p>Enter information into MMIS</p>
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	<ul style="list-style-type: none"> • To be implemented February 2010, SCDHHS will exchange data with Child Support Enforcement (within the Department of Social Services). • 3230 – The eligibility form 3230 is faxed or couriered to DHHS or MIVS from eligibility offices. The faxed and hard copy documents are forwarded to MIVS, which images them and researches the lead. TPL would like to streamline and automate this process, eliminating the need for MIVS to key information from paper forms when that information has already been captured by the eligibility worker. • The policy file houses detailed insurance policy information for each relevant beneficiary. Policies are start- and end-dated. Policies are identified by type, though those policy types and their associated codes could be more specific and transparent to the provider (for example, HN = “Health No Restrictions,” the most common and general policy type, could be defined/labeled more clearly in the system -- for example, “dental”, “drug”, “behavioral health”, “LTC,” etc.)

Process Name	SC OM Manage TPL Recovery (Pay and Chase, Retro) BP
Parent Process	
Subprocess(es)	
Description	The pursuit of money from other insurers and providers when other



	insurance should have paid for the claim.
Owner Group	DHHS - TPL area
Purpose (<i>Intent</i>)	To recovery money paid for claims that other insurers are liable for.
Input (<i>What is required for the process to execute?</i>)	<p>Pay and chase</p> <ul style="list-style-type: none"> • Claims identified during claims processing Retro Health • Policy info • Beneficiary info • Skeletal claim info
Output (<i>What is the result of the process?</i>)	<ul style="list-style-type: none"> • Letters/invoices to providers • Letters/invoices to insurers (Prepare COB) • Adjustments to providers accounts (Claim level or Gross Level Adjustments BPs)
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	<ul style="list-style-type: none"> • MMIS – Potential Action • MMIS generates a "worksheet" that lists claims and policy types and a field that indicates some information on coverage. • MMIS generates a terminated provider report for both health and Medicare and MIVS attempts to find a new number under which a manual debit can be performed.
Trigger (<i>Any processes that precede this process?</i>)	<p>Policies added to the MMIS-TPL subsystem</p> <p>Scheduled runs to check for potential recovery of money</p>
Dependency (<i>Any processes dependent on the completion of this process?</i>)	Prepare COB
Key Stakeholders	DHHS, Providers, insurers
Frequency/Timing/Events/Cycles	<ul style="list-style-type: none"> • Weekly, monthly and quarterly runs to process information • Institutional providers are sent MMIS-generated letters notifying them that they must bill the other insurer and that Medicaid will recoup the money if the provider fails to respond. These letters are mailed at the beginning of the quarter, 4 months later, and 6 months after the initial invoice. 9 months after the initial invoice, the provider is sent a notification of automatic debit. • Retro Medicare Providers (all types except pharmacists) are notified by letter at the beginning of the quarter that they should bill Medicare for the affected claim lines. MIVS also mails out these letters. Six weeks later the provider's account is automatically debited.
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	Each quarter, Clemson runs a job to look for claims for which a relevant health policy has been added. The look-back period is this calendar year and the prior calendar year for institutional claims and 35.5 months for all other claims being billed to insurance companies.
Known Issues	
Procedures/Tasks	<ul style="list-style-type: none"> • Pay and chase claims are identified during claims processing and accumulated into quarterly files • Retro Health and Retro Medicare processes run quarterly to identify claims for recovery. • MIVS maintains a list of claims to be excluded from the Retro process (Exclusion File) and MMIS checks claims identified for recovery against this file. • MMIS generates letters and invoices to providers and insurers • Follow-up letters and invoices are sent on preset schedule • If no response from providers from letters and invoices, MMIS generates



	<p>a "worksheet" that lists claims and policy types to post payments coming in before an automatic adjustment is made to their account.</p> <ul style="list-style-type: none"> MMIS generates a terminated provider report to allow MIVS to manually handle adjustments when a provider is in terminated status.
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	<p>MIVS and TPL staff would like a new way to handle exclusions. Currently there is no indication on a claim record that the claim is in the exclusions file; the exclusions file simply lists excluded claims. Exclusion information should be linked to the claim, not in a separate file. The current exclusion arrangement causes problems when, for example, a group of claims are re-priced and recycled, and some of those claims have already been voluntarily refunded. In this case, providers get paid a second time and have to refund Medicaid a second time. If refunds were posted back to the original claim rather than placed in the exclusions file, this would not be a problem. In addition, the exclusions file contains no input logic and does not validate the CCN, so it can contain errors not found on the claim record. For the most part, TPL staff are happy with the functionality of the TPL Subsystem, which was redesigned more recently than the rest of the MMIS. While they would like cosmetic and navigational improvements, the essential functions and abilities of the system support this business process well. They hope any future system will maintain all the functionality of the current system.</p>

Process Name	SC OM Manage TPL Recovery (Refunds to DHHS) BP
Parent Process	
Subprocess(es)	
Description	Providers and insurers send money to MIVS in response to retroactive recovery billings. They may also request that MIVS create an adjustment to return claim payment.
Owner Group	MIVS
Purpose (<i>Intent</i>)	For MIVS To collect money from Providers and insurers in response to retroactive recovery billings. Create adjustment to return claims payment.
Input (<i>What is required for the process to execute?</i>)	<ul style="list-style-type: none"> Refunds and deposits from providers Form 130 to adjust a claim that is in recovery (non-institutional providers)
Output (<i>What is the result of the process?</i>)	<ul style="list-style-type: none"> Reason Code 12 adjustments Credit adjustment on a paper 115 form
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	<ul style="list-style-type: none"> Wachovia's web deposit tool MIVS' various systems MMIS
Trigger (<i>Any processes that precede this process?</i>)	Retroactive recovery process as part of overall Manage TPL Recovery BP
Dependency (<i>Any processes dependent on the completion of</i>)	Gross Level Adjustment Claim Level Adjustment



<i>this process?)</i>	Manage 1099's
Key Stakeholders	MIVS, providers
Frequency/Timing/Events/Cycles	As they come in MIVS sends adjustments weekly to Clemson for processing. Daily reconciliation between MIVS, MMIS and Wachovia
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	Institutional providers cannot use form 130
Known Issues	
Procedures/Tasks	<ul style="list-style-type: none"> • MIVS deposits refunds using Wachovia's web deposit tool • MIVS creates a Reason Code 12 adjustment • MIVS sends adjustments to Clemson weekly (See Perform Gross Level Adjustment BP) • MIVS reconciles refunds between MIVS' various systems, the MMIS, and Wachovia daily. • When MIVS receives refunds in response to retro or pay-and-chase billings, MIVS workers must also post the amounts paid against the appropriate claims in the Potential Action file • MIVS researches claims in Potential Action file, reviews correspondence, and contacts the provider or insurer to determine which claim(s) to post the refund to. • Non-institutional providers can send form 130 to adjust a claim that is in recovery • Debit non-institutional provider's account. See Perform Claim Level Adjustment BP • Occasionally a provider refund and an automated provider debit will overlap, in which case MIVS will initiate a credit adjustment on a paper 115 form and send it to MCCS.
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	Occasionally a provider refund and an automated provider debit will overlap, in which case MIVS will initiate a credit adjustment on a paper 115 form and send it to MCCS. MIVS would like to automate the adjustment process.

Process Name	SC OM Manage TPL Recovery (Casualty) BP
Parent Process	
Subprocess(es)	
Description	The MMIS automatically generates accident questionnaires when certain trauma-related codes appear on claim forms.
Owner Group	
Purpose (<i>Intent</i>)	To research/determine if trauma-related claims are related to an accident and then to pursue costs from a non-Medicaid Casualty policy.
Input (<i>What is required for the process to execute?</i>)	<ul style="list-style-type: none"> • Trauma-related codes appearing on claim forms.



Output (<i>What is the result of the process?</i>)	DHHS TPL Department pursues the casualty insurer to recoup these funds
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	<ul style="list-style-type: none"> • Questionnaire • Tracking file of the TPL subsystem • TPL Casualty Tracking System
Trigger (<i>Any processes that precede this process?</i>)	Trauma related codes detected during claims runs – See Edit Claim BP
Dependency (<i>Any processes dependent on the completion of this process?</i>)	Perform Accounting Functions
Key Stakeholders	DHHS – TPL Division, beneficiaries, other insurance company, attorney
Frequency/Timing/Events/Cycles	Scheduled claims runs (weekly)
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	None
Known Issues	
Procedures/Tasks	<ul style="list-style-type: none"> • Clemson prints and sends questionnaires to DHHS • DHHS mails to beneficiaries • Beneficiaries mail completed questionnaires to TPL Division • When questionnaires are returned, the response is posted in the tracking file of the MMIS TPL subsystem to stop subsequent letters from being mailed. • The TPL Division enters the data from the questionnaire into a SQL database called the TPL Casualty Tracking System. • The system tracks events, generates letters, and reports related to accident claims received by the agency's TPL department. • The TPL Division sends the attorney the itemization form if the info was on the questionnaire • The attorney sends in the completed the itemization form to the TPL Division. • The TPL department then does research to find out if any claims were paid by Medicaid related to the accident. <p>If Medicaid did pay claims related to the accident, and the beneficiary or liable party had insurance coverage that should have paid the claim, the TPL department will make an effort to recoup these funds from the insurance company (see Perform Accounting Functions).</p>
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	

Process Name	SC PG Manage 1099s BP
Parent Process	
Subprocess(es)	



Description	The process by which 1099s are handled, including preparation, maintenance, and corrections.
Owner Group	
Purpose (<i>Intent</i>)	To manage the process and create the 1099 data
Input (<i>What is required for the process to execute?</i>)	<ul style="list-style-type: none"> Payment data
Output (<i>What is the result of the process?</i>)	<ul style="list-style-type: none"> PMT4525R01-Weekly 1099 Payment by Legacy PMT4525R02-Same as PMT4525R01 except data reported is Year to Date MAR1991 –Nonexempt Providers Monthly Payment Totals (these providers get a 1099)¹ MAR1992-Exempt Provider Monthly Payment Totals (these providers are exempt from 1099 reporting)² MAR1993-1099 Form-Individual provider data formatted for printing the 1099 form (Currently stores the text formatted for 1099 printing. Storing the print image on the actual 1099 document is on the wish list.) MAR1994-Grand Total-Total number of providers and total 1099 amount MAR1995-List of Providers-Information for each provider formatted as a report as opposed to a 1099 form. Actual 1099 data
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	<ul style="list-style-type: none"> MMIS Document Direct (storage) IRS website PC for uploading file to IRS website Program Management Reference Materials folder 1099 MMIS Interface IRS Publication 1220
Trigger (<i>Any processes that precede this process?</i>)	<ul style="list-style-type: none"> Weekly payment run to update the files Clemson run schedule for producing the 1099s
Dependency (<i>Any processes dependent on the completion of this process?</i>)	None
Key Stakeholders	<ul style="list-style-type: none"> DHHS, IRS, providers, auditor, DHHS legal area
Frequency/Timing/Events/Cycles	<ul style="list-style-type: none"> Weekly payment runs Annual Clemson run schedule for producing the 1099s See footnote change from monthly to YTD totals
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	<ul style="list-style-type: none"> 1099s are reviewed and prepared at the close of the calendar year. SCDHHS sends 1099s to non-exempt providers before January 31st of each year. Clemson downloads a file from the mainframe to a PC, zips it, and then uploads it to the Internal Revenue Services (IRS) website before March 31st of each year (see 1099 interface for

¹ RFC09-0013-E includes a change to capture YTD totals (instead of monthly totals) for nonexempt providers

² RFC09-0013-E includes a change to capture YTD totals (instead of monthly totals) for exempt providers



	<p>technical details). Due dates are specified in the IRS Publication 1220 each year.</p> <ul style="list-style-type: none"> • Generate a 1099 for each UNLESS the 1099 amount for the provider is zero or a negative number. If the amount is zero or a negative number, do not generate a 1099 or include it on the file to the IRS. See RFC 09-0013-E
Known Issues	
Procedures/Tasks	<ul style="list-style-type: none"> • Weekly and YTD files are created from payment runs • Payment creates 1099 weekly and year-to-date reports • The weekly file is also processed by a balancing program which matches each Pay to amount against the Payment history for the pay to provider. (generating report CLP4527R01 stored in Doc Direct) • If a discrepancy is found, SCDHHS staff in the Bureau of Medicaid Systems Management (MSM) research and resolve it. • (MSM) sends two transaction files to Clemson for input of the correction job. (a program CLP4526) • Program CLP4526 will produce a report of the before and after update amounts and will be stored on Document Direct. (replacing the original Doc Direct reports) • Generate and review test 1099s • Generate final 1099s and MARS reports • SCDHHS sends 1099s to non-exempt providers before January 31st of each year • Clemson downloads a file from the mainframe to a PC, zips it, and then uploads it to the Internal Revenue Services (IRS) website before March 31st of each year (see 1099 interface for technical details) • Providers call the auditor about the 1099. • Auditor maintains documentation of calls received via hard copy. • When a correction is requested (by a provider) to the actual 1099, the auditor will work with the Legal department to review the information before making a change. The auditor or MSM Bureau will do manual research as necessary to answer provider inquiries via telephone. • Communications from providers on official letterhead that request changes to provider records will be honored. (If the provider is a contracted provider, the request for change will be coordinated with the Division of Contracts at SCDHHS.) • The auditor maintains records of hard copy 1099s with the changes made.
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	<ul style="list-style-type: none"> • MAR1993-1099 Form-Individual provider data formatted for printing the 1099 form (Currently stores the text formatted for 1099 printing. Storing the print image on the actual 1099 document is on the wish list.) • The telephone number of an auditor is listed on every 1099



	prepared by SCDHHS. The auditor maintains documentation of calls received via hard copy. The auditing area desires an automated online system to track these inquiries, manage the call volume, and keep a log of any other pertinent information.
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Process Name	SC PG Designate Approved Services and Drug Formulary BP
Parent Process	
Subprocess(es)	
Description	When new codes are issued annually by CMS and other authorities, SCDHHS manually compiles the revisions and disseminates them internally to appropriate program staff. It is the responsibility of individual programs within the agency to decide whether and how they will cover various products and services.
Owner Group	<ul style="list-style-type: none"> DHHS
Purpose (<i>Intent</i>)	To make coverage decisions in different ways depending on the code type and program.
Input (<i>What is required for the process to execute?</i>)	<ul style="list-style-type: none"> New codes from CMS (HCPCS, CPT, and Surgical Codes and Other Codes) NDC (FDA-approved and meeting OBRA'90 Drug Rebate Program guidelines)
Output (<i>What is the result of the process?</i>)	<ul style="list-style-type: none"> Updated Preferred Drug List
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	<ul style="list-style-type: none"> Thomson Reuters tools Preferred Drug List MMIS reports Spreadsheet to track drug authorizations MMIS DHHS actuary
Trigger (<i>Any processes that precede this process?</i>)	<ul style="list-style-type: none"> New codes issued annually by CMS and other authorities NDC codes coming in Physicians also request coverage for certain drugs by calling program staff. See Authorize Service
Dependency (<i>Any processes dependent on the completion of this process?</i>)	Decisions about coverage are tied closely with the Manage Rate Setting business process; the two processes often occur simultaneously.
Key Stakeholders	<ul style="list-style-type: none"> DHHS Pharmacy Contractor Pharmacy & Therapeutics Committee
Frequency/Timing/Events/Cycles	<ul style="list-style-type: none"> New codes issued annually by CMS and other authorities Physicians also request coverage for certain drugs by calling program staff. No frequency for NDCs. When the agency approves unlisted drugs, they place them on a two-year required prior authorization period so their usage can be periodically evaluated.
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	<ul style="list-style-type: none"> SC Medicaid covers drugs that are FDA-approved and meet OBRA'90 Drug Rebate Program guidelines Certain drugs may require prior authorization; others may have guidelines for their use.



Known Issues	
Procedures/Tasks	<p>Service and Supply Coverage</p> <ul style="list-style-type: none"> • SCDHHS manually compiles the revisions and disseminates them internally to appropriate program staff. • Individual program areas decide if a drug or service will be covered. Based on existing coverage, consultations with existing medical staff and Thomson Reuters reports. • Program areas may also consult with the agency actuary to perform impact analysis on potential changes to coverage and rates. <p>Drug Coverage</p> <p>For Pharmacy coverage</p> <ul style="list-style-type: none"> • The pharmacy contractor and the Pharmacy & Therapeutics Committee advise the pharmacy area financial and medical decisions, respectively. • Pharmacy area designates approved drugs. <p>For Physicians/hospitals/infusion centers – non-NDC drugs</p> <ul style="list-style-type: none"> • Program Staff use MMIS reports to monitor usage of particular codes. • Medical Director Review requests for approval of unlisted drugs • The physicians services area also maintains a spreadsheet to track drug authorizations. The agency's medical director reviews all requests for particular drugs to be covered to determine medical effectiveness. • When the program staff approve unlisted drugs, they place them on a two-year required prior authorization period so their usage can be periodically evaluated. • Program staff write the changes on forms which are sent to the contractor for keying. • MCCS, manually keys all code changes into the MMIS. See Maintain Benefits Info BP.
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	<p>The physicians services area also maintains a spreadsheet to track drug authorizations – this log contains information on the diagnosis, treatment, beneficiary and prior authorization and can be used for later decisions on whether to cover particular codes. The program area would like to automate the tracking of such authorizations, perhaps as part of a larger prior authorization system.</p> <ul style="list-style-type: none"> • This business process is inherently hectic, because all program areas must review code changes and make decisions at the same time when the new codes are released each September. However, SCDHHS believes streamlined business processes or automation of code updates might make the process more



efficient.

Process Name	SC PG Develop and Maintain Benefits Package BP
Parent Process	
Subprocess(es)	
Description	This process begins with receipt of coverage requirements and recommendations through new or revised Federal statutes and/or regulations, State law, organizational policies, requests from external parties such as quality review organizations, changes resulting from court decisions, or medical procedures or processes.
Owner Group	
Purpose (<i>Intent</i>)	Create coverage requirements and maintain documents
Input (<i>What is required for the process to execute?</i>)	Info in request
Output (<i>What is the result of the process?</i>)	<ul style="list-style-type: none"> Updated benefits package
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	<ul style="list-style-type: none"> Request Claims history, market based rates Legislation CMS mandates State Employee Health Plan and Medicare benefit programs Sister states benefit programs
Trigger (<i>Any processes that precede this process?</i>)	Received requests for benefits and changes to benefits
Dependency (<i>Any processes dependent on the completion of this process?</i>)	<ul style="list-style-type: none"> Maintain State Plan Manage Program Information Perform Provider Outreach Perform Population and Member Outreach.
Key Stakeholders	<ul style="list-style-type: none"> CMS, DHHS, beneficiaries, program areas, Deputy Director for Medicaid Eligibility and Beneficiary Services, agency director, Governor's office
Frequency/Timing/Events/Cycles	As needed, as they come in
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	None
Known Issues	
Procedures/Tasks	<ul style="list-style-type: none"> Program area reviews the proposed benefit for budgetary impact. The program area may receive assistance from actuaries, the fiscal area, or the Budget and Control Board to conduct the fiscal analysis. The program area may also look to claims history and market-based rates. Program areas will consult other states that have similar programs (known as "sister states") for their level of coverage, as well as the State Employee Health Plan and Medicare. The program area drafts a proposed change Deputy Director for Medicaid Eligibility and Beneficiary Services approves small changes. Large-scale changes require approval from the agency director or governor's office. A change to the benefit package often requires a change to the state plan (see Maintain State Plan)



	<ul style="list-style-type: none"> A change to the benefit package also usually requires a system change. The agency uses the Request for Change (RFC) process to complete these (see Manage Program Information). Benefit package changes are communicated to providers via Perform Provider Outreach and to beneficiaries via Perform Population and Member Outreach.
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	None

Process Name	SC PG Manage Rate Setting BP
Parent Process	
Subprocess(es)	PG Maintain Benefits-Reference Information BP
Description	SCDHHS uses different methods to determine rate setting. The Bureau of Reimbursement Method and Policy determines the budgetary impact of a change in rate setting for institutional providers (hospitals, nursing homes, etc.) as well as non-institutional providers (e.g. RHCs, FQHCs, Home Health, etc.). This process is more difficult during a year with many changes in funding since budget changes may require multiple rate changes for one service in a given year. The bureau looks at cost reports submitted by providers as part of their evaluation in determining a change in rate setting.
Owner Group	
Purpose (<i>Intent</i>)	To determine rate setting and their budgetary impact.
Input (<i>What is required for the process to execute?</i>)	See triggers
Output (<i>What is the result of the process?</i>)	<ul style="list-style-type: none"> Rate settings Rates are updated in MMIS Public Notice of Rate Change
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	<ul style="list-style-type: none"> Cost reports submitted by providers Excel spreadsheets MARS reports Rate change form/reference update sheet Turnaround Document (TAD) MMIS SCDHHS reference files
Trigger (<i>Any processes that precede this process?</i>)	<ul style="list-style-type: none"> Change in Federal rules/ or new legislation The Annual State Appropriations process with the General Assembly (allocates funds for specific rate increases and/or funds for maintenance of effort) Annual agency processes: <ul style="list-style-type: none"> Annual updates for certain programs) Appropriations process (occurs in the Formulate Budget business process and may occur in higher frequency)
Dependency (<i>Any processes dependent on the completion of this process?</i>)	OM Apply Mass Adjustment BP
Key Stakeholders	<ul style="list-style-type: none"> DHHS



	<ul style="list-style-type: none"> • DHHS Actuaries • Bureau of Reimbursement and Policy • Bureau of Medicaid Systems Management • Clemson • MCCS • Division of Contracts
Frequency/Timing/Events/Cycles	When information from triggers come in. At least once a year
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	<ul style="list-style-type: none"> • Currently, the MMIS only houses the current rate and its most recent predecessor • The final notice must be published at least thirty days prior to the effective date of the rate change.
Known Issues	This process is more difficult during a year with many changes in funding since budget changes may require multiple rate changes for one service in a given year
Procedures/Tasks	<ul style="list-style-type: none"> • Actuaries that work with the agency use agency and/or provider generated data to develop capitated rates for various programs that are actuarially sound. They utilize the majority of SCDHHS reference files to run budget and rate analyses. • The Bureau of Reimbursement Method and Policy determines the budgetary impact of a change in rate setting for institutional providers as well as non-institutional providers • The bureau looks at cost reports submitted by providers as part of their evaluation in determining a change in rate setting. • The bureau also uses spreadsheets as a formula tool for many calculations in determining new rates. • The bureau uses MARS reports such as the 14/140 are used as well during the rate setting process. • Currently, nursing home providers send their cost reports electronically. Other providers submit cost reports via hard copy • A Bureau of Medicaid Systems Management (MSM) staff member works with program areas for rate changes relating to other provider • For services covered by Medicare, the Medicaid rate can be determined by taking a percentage of the Medicare rate • BMSM calculates the rate change, and the changes are auto-loaded by Clemson. See SC PG Maintain Benefits-Reference Information BP • Rates for services not covered by Medicare are set by the affected program area with the assistance of a worker in MSM and/or the Bureau of Reimbursement Methodology and Policy • The program area fills out either the spreadsheet or, for smaller updates, a rate change form/reference update sheet with the new rate • The program area sends rate changes for contracted providers require sending a rate change form/reference update sheet to the Division of Contracts and the administrative contractor, MCCS. • or other provider types (physicians, lab, x-ray, ESRD), the rate change form/reference update sheet or spreadsheet is sent to the administrative contractor, MCCS by the program area • MCCS keys rate change. See Maintain Benefits-Reference Information BP • For institutional providers (hospital, nursing home, etc.), the public is notified of a rate change via public notice, which identifies changes to a



	<p>rate and allows for a thirty day comment period from the public (including professional associations) by the program area see PG Maintain State Plan</p> <ul style="list-style-type: none"> • After the comment period, a final public notice is issued • Non-institutional providers also require the release of a public notice which details the rate change by the program area see PG Maintain State Plan • When a retroactive rate change is approved, BMSM does a Mass Adjustment as described under OM Apply Mass Adjustment
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	<ul style="list-style-type: none"> • Currently, nursing home providers send their cost reports electronically. Other providers submit cost reports via hard copy. Management in the Bureau of Reimbursement Method and Policy would like to further automate this process to include electronic submission of all cost reports. • MCCC keys the rate change. This process is very manual. Adding any automation possible would improve this process.

Process Name	SC PG Develop Agency Goals and Objectives BP
Parent Process	
Subprocess(es)	
Description	<p>This business process periodically assesses and prioritizes the current mission statement, goals, and objectives to determine if changes are necessary</p> <p>Note: SCDHHS does not currently have any published goals or objectives. This process describes specific area and/or departmental planning.</p>
Owner Group	<ul style="list-style-type: none"> • DHHS executive management
Purpose (<i>Intent</i>)	<p>This business process periodically assesses and prioritizes the current mission statement, goals, and objectives to determine if changes are necessary</p> <p>Note: SCDHHS does not currently have any published goals or objectives</p>
Input (<i>What is required for the process to execute?</i>)	<ul style="list-style-type: none"> • New ideas • Current agency projects
Output (<i>What is the result of the process?</i>)	
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	<ul style="list-style-type: none"> • "GO sheets" (also known as goals and objectives sheets)
Trigger (<i>Any processes that precede this process?</i>)	<ul style="list-style-type: none"> • Transition to a new agency director • Notification of a state or federal mandate • Federal requirement (HIPAA 5010, ICD-10, DRG updates, SCEIS)
Dependency (<i>Any processes dependent on the completion of this process?</i>)	
Key Stakeholders	<ul style="list-style-type: none"> • DHHS



Frequency/Timing/Events/Cycles	
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	
Known Issues	
Procedures/Tasks	<ul style="list-style-type: none"> The agency holds monthly bureau chief meetings, which are attended by the agency director, deputy directors, bureau chiefs, Public Information Office staff, and other staff as needed. Participants in current projects will report on progress and new information. Any new ideas presented lead to follow-up with affected staff. "GO sheets" (also known as goals and objectives sheets) are sometimes used to propose new ideas.
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	Currently, SCDHHS is writing an RFP to hire someone to assist the agency in developing a strategic plan.

Process Name	SC PG Develop and Maintain Program Policy BP
Parent Process	
Subprocess(es)	
Description	The process of developing and maintaining program policy differs depending on the magnitude of the affected group. Some policy changes may be minor and affect SCDHHS at the staff level in a particular program area. Other policy changes may have agency-wide impact and be expensive to implement.
Owner Group	
Purpose (<i>Intent</i>)	To develop, determine impact, and maintain DHHS program policies.
Input (<i>What is required for the process to execute?</i>)	Information concerning a policy change
Output (<i>What is the result of the process?</i>)	<ul style="list-style-type: none"> Medicaid bulletin A revised provider manual Changes may require revision of policy manuals, staff training, or other internal communications.
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	Provider Manual Medicaid Bulletin
Trigger (<i>Any processes that precede this process?</i>)	A policy change is submitted using a variety of methods (e.g., may come from a provider, program representative, legislator, etc.)
Dependency (<i>Any processes dependent on the completion of this process?</i>)	<ul style="list-style-type: none"> Perform Provider Outreach Award Contract Manage Contract Establish Business Relationship Manage Business Relationship
Key Stakeholders	<ul style="list-style-type: none"> DHHS Bureau Chiefs Medical Director



	<ul style="list-style-type: none"> Advisory Boards Program Areas
Frequency/Timing/Events/Cycles	As needed
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	Inclusion for the meetings is based on past history and shared knowledge on who the change affects
Known Issues	
Procedures/Tasks	<ul style="list-style-type: none"> The affected people meet to analyze the policy change. Often, the medical director also provides input. Advisory boards like DME and transportation offer feedback about the policy change Informal public education sessions may also be held for input from affected stakeholder The program area will research other states' approaches to similar program policy The program area will review best practices or recommended best practices by professional agencies Bureau chiefs approve all such changes For major changes, the bureau chief will seek approval from the agency director Depending on the change, SCDHHS may issue a Medicaid bulleting or revise a provider manual (see Perform Provider Outreach). Some policy changes require renegotiating or amending a contract or creating a new contract (see Award Contract, Manage Contract, Establish Business Relationship, Manage Business Relationship). Internal changes may require revision of policy manuals, staff training, or other internal communications see Perform Provider Outreach BP Policy changes that affect fee-for-service Medicaid also require consultation with actuaries to determine the effect on Managed Care and capitated reimbursement rates (see Manage Rate Setting).
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	

Process Name	SC PG Maintain State Plan BP
Parent Process	
Subprocess(es)	SC PM Perform Provider Outreach BP , SC MM Perform Population and Member Outreach BP
Description	South Carolina maintains a CMS-approved State Plan outlining its Medicaid programs and coverage.
Owner Group	<ul style="list-style-type: none"> DHHS
Purpose (<i>Intent</i>)	To make all required changes to the electronic and hard copy documents.
Input (<i>What is required for the process to execute?</i>)	<ul style="list-style-type: none"> See triggers
Output (<i>What is the result of the process?</i>)	<ul style="list-style-type: none"> Updated State Plan, State Plan Amendment(SPA) HCFA-179, a required document recording details about the change and its impact on federal funds.



Mechanism (Systems/Application/Tool/manual or automated)	<ul style="list-style-type: none"> The master version of the State Plan is a hard copy kept in a secure, locked area with limited access. Electronic version on the network drive Newspapers HCFA-179, a required document recording details about the change and its impact on federal funds. CMS' eSPA web portal State Plan Amendment Review Sheet Request additional information (RAI) CMS approval letter Distribution list
Trigger (Any processes that precede this process?)	<ul style="list-style-type: none"> State budget reductions or increases New state and federal laws Agency goals Provider or beneficiary requests Regular updates (e.g., annual revised blood deductible rates for hospitals)
Dependency (Any processes dependent on the completion of this process?)	Perform Provider Outreach and Perform Population and Member Outreach business processes.
Key Stakeholders	<ul style="list-style-type: none"> DHHS CMS Providers Beneficiaries State Plan Administrator
Frequency/Timing/Events/Cycles	<ul style="list-style-type: none"> No frequency of changes to the State Plan The notice of changes must be available in the county offices for public review for thirty days. CMS has 90 days to approve, disapprove, or send a letter to request additional information (RAI) from the state. Once the RAI is sent, the 90 day clock stops and the state has additional time to make changes in the plan or to answer CMS's questions. Various SCDHHS staff respond to questions from CMS depending on the type of questions. Once the RAI has been returned to CMS a new 90 day clock will start on the SPA.
Constraints (Location/Interfaces Required for inputs/outputs)	The document is not currently publicly available in electronic form
Known Issues	
Procedures/Tasks	<ul style="list-style-type: none"> Program area and reimbursement staff calculate the fiscal impact of the proposed modification Program areas generate and review reports talking with provider associations and other stakeholders. The program area drafts the changes to the State Plan. The program area circulates the draft internally for discussion and revision The program area presents the draft to Medical Care Advisory Committee Executive staff, legal staff, and the bureau chief and division director of the affected program area must sign off on the proposed change.



	<ul style="list-style-type: none"> The State Plan administrator places a public notice in the three leading newspapers in the state, and sends a notice to Eligibility to send to the SCDHHS county offices prior to the effective date of the changes to the State Plan. State Plan administrator completes the HCFA-179 form and sends it to CMS and to CMS' eSPA web portal, along with the proposed change. CMS sends a State Plan Amendment Review Sheet specifying who at CMS will work on the amendment. CMS uses the request additional information (RAI) for more info. The state makes changes in the plan or answer CMS' questions from the request additional information (RAI). State Plan administrator updates the master hard copy document and any electronic versions. The administrator also sends the hard copy amendment to a distribution list of affected staff, other state agencies and libraries, legal staff, and others. The program area notifies providers and beneficiaries of relevant State Plan changes through the Perform Provider Outreach and Perform Population and Member Outreach business processes.
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	

Process Name	SC PG Maintain Benefits-Reference Information BP
Parent Process	Manage Rate Setting (possible parent)
Subprocess(es)	
Description	The process includes revising code information, adding rates associated with those codes, updating/adjusting existing rates, updating/adding member benefits, updating/adding provider information, adding/updating drug formulary information, and updating/adding benefit packages under which the services are available from the receive inbound transaction.
Owner Group	<ul style="list-style-type: none"> DHHS - program areas and/or the Bureau of Medicaid Systems Management
Purpose (<i>Intent</i>)	To enter changes into the MMIS
Input (<i>What is required for the process to execute?</i>)	<ul style="list-style-type: none"> Updated codes, rates, reference information
Output (<i>What is the result of the process?</i>)	<ul style="list-style-type: none"> Turnaround doc Updates to MMIS
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	<ul style="list-style-type: none"> Turnaround doc MMIS Reference update sheet
Trigger (<i>Any processes that precede this process?</i>)	Once program areas and/or the Bureau of Medicaid Systems Management perform the Manage Rate Setting, Develop and Maintain Benefit Package, or Designate Approved Services or Drug Formulary business process, the changes are entered into the MMIS.



Dependency (<i>Any processes dependent on the completion of this process?</i>)	None
Key Stakeholders	<ul style="list-style-type: none"> DHHS - program areas and/or the Bureau of Medicaid Systems Management MCCS DHHS - Bureau of Reimbursement Method and Policy
Frequency/Timing/Events/Cycles	<ul style="list-style-type: none"> Annual rates changes Other changes as they occur
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	None
Known Issues	
Procedures/Tasks	<ul style="list-style-type: none"> Clemson loads updates en masse into a TEST environment Clemson generates and sends reports to the affected program area to verify. Once they are verified, Clemson moves the rates into production. MCCS keys other updates to codes, rates, or other reference file data into MMIS The program area fills out either a spreadsheet or, for smaller updates, a reference update sheet with the new rate and sends it to MCCS for keying If a rate change requires a program change, submit an RFC to Clemson. See PG Manage Program Information BP MMIS produces a Turnaround Document (TAD) and returns it to DHHS The Bureau of Reimbursement Method and Policy and/or the affected program area review the TAD to ensure the accuracy of the changes. Correct errors and send to MCCS for re-keying
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	The manual keying of updates is laborious and prone to error. More automation of updates would help speed the process.

Process Name	SC PG Manage Program Info BP
Parent Process	
Subprocess(es)	
Description	Manage all the operational aspects of the Program Information data store
Owner Group	<ul style="list-style-type: none"> DHHS BMSM
Purpose (<i>Intent</i>)	Manage all the operational aspects of the Program Information data store
Input (<i>What is required for the process to execute?</i>)	<ul style="list-style-type: none"> Requests for changes Reporting requests
Output (<i>What is the result of the process?</i>)	<ul style="list-style-type: none"> Changes Reports
Mechanism (<i>Systems/Application/Tool/manual</i>)	<ul style="list-style-type: none"> Set of standard questions for RFCs RFC form at DHHS



<i>or automated)</i>	<ul style="list-style-type: none"> • Technical Review Committee (TRC) • Change Control process at DS Contractor
Trigger (<i>Any processes that precede this process?</i>)	Receipt of requests for changes or reporting requests
Dependency (<i>Any processes dependent on the completion of this process?</i>)	Identify Candidate Case
Key Stakeholders	<ul style="list-style-type: none"> • Project Management Office in BMSM, Office of Reporting, Research, and Special Projects (ORRSP), CCB, TRC, Clemson, DS Contractor, program areas, Office of Research and Statistics (ORS) of the South Carolina Budget and Control Board Reports
Frequency/Timing/Events/Cycles	
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	<ul style="list-style-type: none"> • Program policies are not loaded into any data store. A comprehensive history of program policy changes that may or may not have resulted in system changes could be found by reviewing the Medicaid Provider Bulletins (see Perform Provider Outreach for further information on bulletins). • Once an implementation date has been established, the program area will have a maximum of five business days to respond to questions concerning business requirements. After that time, the implementation date may be extended on a day-for-day basis. • A user can create a report and save it in his folder to be accessed by another user. Information generated into a report can be exported to Excel, if it doesn't exceed space limitations.
Known Issues	
Procedures/Tasks	<ul style="list-style-type: none"> • Requests are submitted via the online RFC form. When the requestor (usually a program area representative) enters information into the form regarding the scope, requirements, and benefits of the request, as well as the consequence if not completed using the set of standard questions checklist. • After requirements have been gathered from the program area. • Internal SCDDHS design team will meet to perform a high-level review. Possible solutions are examined, and alternatives are evaluated. • The program area makes the presentation to TRC • Clemson then reviews the requirements in order to provide a preliminary level of effort (LOE). • The program area presents the request to the CCB • The CCB reviews and votes on the request • The CCB determines if the request has high, medium, or low priority • The CCB adds the request to the monthly calendar • Upon approval of a request by the CCB, BMSM and the program area will complete the business requirements document (BRD) • Upon completion of the business requirements, Clemson, the program area, and BMSM will develop a detail design document for each request. • The detail design document must be approved by the program area and BMSM prior to Clemson beginning system development. **** Once sign-off has occurred, any change to the business requirements must go through a Change Control process.



	<ul style="list-style-type: none"> • Clemson finalizes the LOE, and sets an implementation date with DHHS. • Project Management Office in BMSM will monitor the project in an effort to keep on schedule. PMO will supply updates to the program area on a weekly basis via the Monthly Calendar. • Clemson and an analyst assigned by BMSM will conduct testing to ensure programming changes meet the requirements specified in the business requirements and detail design documents. • Once QA is complete, the program area will assign qualified staff to participate in user acceptance testing resulting in signoff • Request is moved to production by Clemson • Clemson completes all documentation. If designated as a “large” project, a lessons-learned session will be scheduled with the program area, Clemson and BMSM. <p>Change control with Decision Support Contractor</p> <ul style="list-style-type: none"> • Changes to an existing value are included in the monthly update • An addition of a new value would be held for a build/release on an as needed basis • Contractor sends out user alerts that notify users of changes, new fields, etc. <p>Reporting</p> <ul style="list-style-type: none"> • Program area requests changes to standard agency reports produced by Clemson through the RFC process. • Program areas request a new report via the Office of Reporting, Research, and Special Projects which use DSC tools • The ORRSP and the requesting program area work together to define the report. • Recurring reports are added to the office’s report schedule • Program staff can create reports and share them with other users, export data to spreadsheets. • ORRSP conducts training on the DSC tools • The Division of Program Integrity uses this tool as an investigative measure for testing and developing fraud algorithms. The developed algorithms are used in the Identify Candidate Case business process • The ORRSP (and sometimes in conjunction with the Fiscal staff) will pull reports based on audit requests, legislative inquiries or other formal information requests. • BMSM also has the ability to pull data straight out of the MMIS to compare to information generated via DSC tools. • The Office of Research and Statistics (ORS) of the South Carolina Budget and Control Board Reports also fulfills report requests from the agency (see South Carolina Budget and Control Board-ORS interface for technical details). • DS Contractor puts out releases and sends email updates to users concerning recent changes. • SCDHHS requires the use of a TPA for anyone outside of agency to
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	<p>have viewing access of the MMIS. The specific conditions within the TPA are established in the Business Relationship Management business area</p> <ul style="list-style-type: none"> • The MMIS and MEDS keep all records and archives electronically. • DS Contractor has seven years of basic provider data and complete claims history available. • All data is secured and accessible by anyone that is using the system or receiving data through a TPA with a user ID and password.
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	<p>SCDHHS would like to greatly expand the capabilities of the MMIS. It would like to expand from the current space limitations as some reports are at their maximum size. Fields are being reused instead of adding to the end of a record. They would also like to have an expanded fund code field to eliminate the use of special characters (the use of special characters does not transfer well to interfaces with contractors).</p>

Process Name	SC PG Develop and Manage Performance Measures and Reporting BP (per contract)
Parent Process	
Subprocess(es)	
Description	<p>To develop processes which involve the design, implementation, and maintenance of mechanisms and measures to be used to monitor the business activities and performance of the Medicaid enterprise's processes and programs. The written contract dictates what is monitored such as the deliverables that are in or implied within the contract.</p> <p>SCDHHS uses a third-party system called the Employee Performance Management System (EPMS), which aids in applying the criteria defined by an employee's position.</p>
Owner Group	<ul style="list-style-type: none"> • DHHS -Bureau of Federal Contracts
Purpose (<i>Intent</i>)	To develop processes which involve the design, implementation, and maintenance of mechanisms and measures to be used to monitor the business activities and performance of the Medicaid enterprise's processes and programs.
Input (<i>What is required for the process to execute?</i>)	<ul style="list-style-type: none"> • Contract • RFP • Proposal to develop a format for reporting
Output (<i>What is the result of the process?</i>)	<ul style="list-style-type: none"> • Performance measurements • Standardized deliverables
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	<ul style="list-style-type: none"> • Ad hoc reporting • Contract tracking template (spreadsheet) • Formal and informal meetings • Formal RFC process – See Manage Program Information. • EPMS
Trigger (<i>Any processes that</i>	Manage Contract BP



<i>precede this process?)</i>	
Dependency (<i>Any processes dependent on the completion of this process?</i>)	Manage Program Information BP
Key Stakeholders	<ul style="list-style-type: none"> DHHS -Bureau of Federal Contracts
Frequency/Timing/Events/Cycles	When performance reporting needs change for a contract, the contract is amended. This may occur during a renewal phase of a contract, internal preparation for the release of RFP, or even during a contract phase.
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	None
Known Issues	
Procedures/Tasks	<ul style="list-style-type: none"> The written contract dictates what is monitored such as the deliverables that are in or implied within the contract. The Contract Monitor uses the contract tracking template for this. Additional monitoring measures require collaboration between the contract monitor (within the Bureau of Federal Contracts) and the affected program area(s) to develop a format for measurement and reporting. The contract monitor uses ad hoc reporting and meetings to determine performance measurements. If ad hoc reporting monitoring requirements necessitate a change in MMIS/MEDS reporting abilities submit RFC see Manage Program Information BP When performance reporting needs change for a contract, the contract is amended. See Manage Contract. SCDHHS uses a third-party system called the Employee Performance Management System (EPMS), which aids in applying the criteria defined by an employee's position. Modify hard copy survey form to incorporate changes
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	Contract monitors would like to improve the process of preparing a contract to include enough details in the contract and up-front involvement with everyone that needs to be involved, so that upon award, the contract has definitive measures to monitor and track performance. The contract needs to stipulate specific deliverables, appropriately numbered, for every contract expectation.

Process Name	SC PG Monitor Performance and Business Activity BP Monitoring Contract Performance and Activity
Parent Process	
Subprocess(es)	
Description	Process utilizes the mechanisms and measures that were developed by



	the Develop and Manage Performance Measures and Reporting process.
Owner Group	
Purpose (<i>Intent</i>)	Steps in implementing the mechanisms and measures to track agency activity and effectiveness at all levels of monitoring.
Input (<i>What is required for the process to execute?</i>)	<p>Monitoring Contract Performance and Activity</p> <ul style="list-style-type: none"> • Deliverables and reports <p>Monitoring Employee Performance and Activity</p> <ul style="list-style-type: none"> • EPMS data <p>Monitoring Stakeholder Satisfaction and Performance</p> <ul style="list-style-type: none"> • surveys <p>Conducting Audits</p>
Output (<i>What is the result of the process?</i>)	<p>Monitoring Contract Performance and Activity</p> <ul style="list-style-type: none"> • reports <p>Monitoring Employee Performance and Activity</p> <ul style="list-style-type: none"> • evaluations <p>Monitoring Stakeholder Satisfaction and Performance</p> <ul style="list-style-type: none"> • reports <p>Conducting Audits</p> <ul style="list-style-type: none"> • reports
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	<p>Monitoring Contract Performance and Activity</p> <ul style="list-style-type: none"> • Deliverables • Contract monitoring template • Meetings <p>Monitoring Employee Performance and Activity</p> <ul style="list-style-type: none"> • Employee Performance and Monitoring System • Correction plan <p>Monitoring Stakeholder Satisfaction and Performance</p> <ul style="list-style-type: none"> • surveys <p>Conducting Audits</p> <ul style="list-style-type: none"> • GAGAS (generally accepted government auditing standards), which are issued by the Comptroller General of the United States
Trigger (<i>Any processes that precede this process?</i>)	<p>Monitoring Contract Performance and Activity</p> <ul style="list-style-type: none"> • Receive deliverables and reports <p>Monitoring Employee Performance and Activity</p> <ul style="list-style-type: none"> • Receive EPMS data <p>Monitoring Stakeholder Satisfaction and Performance</p> <ul style="list-style-type: none"> • Receive survey results <p>Conducting Audits</p> <ul style="list-style-type: none"> • An audit request from an agency Deputy Director or Bureau Chief, discussions between staff in the Bureau of Compliance and Performance Review, or audit findings that identify the need for an additional audit.
Dependency (<i>Any processes dependent on the completion of this process?</i>)	<p>Monitoring Contract Performance and Activity</p> <p>Monitoring Employee Performance and Activity</p> <p>Monitoring Stakeholder Satisfaction and Performance</p> <ul style="list-style-type: none"> • Manage Contract BP <p>Conducting Audits</p> <ul style="list-style-type: none"> • Manage Recoupment or Terminate Business Relationship/Contract.



Key Stakeholders	<ul style="list-style-type: none"> Deputy Director and Finance Director (audits) The Division of Audits performs in-house audits, other state agency audits (e.g. those agencies that receive Medicaid money), Managed Care Organization (MCO) audits, or audits for any other entity that is contracted with SCDHHS.
Frequency/Timing/Events/Cycles	<p>EPMS is yearly</p> <p>Other processes are as needed</p>
Constraints (Location/Interfaces Required for inputs/outputs)	
Known Issues	
Procedures/Tasks	<p>Monitoring Contract Performance and Activity</p> <ul style="list-style-type: none"> The monitor uses a contract tracking template (spreadsheet), which contains information on deliverables, responsible parties, performance measures, damages, an issues template, and anything else from the RFP. Formal meetings are scheduled between vendors/contracts and SCDHHS as a form of monitoring The monitor conducts on-site monitoring for a contract using a review plan document to track contract requirements Contract documents and any monitoring documents are on a shared drive only accessible to staff of the Bureau of Federal Contracts. Several areas within the agency (from Executive management to program staff) read information in monitoring a contract's performance. Sometimes, the Office of General Counsel will also review information. The monitor and program area review the actual reports. <p>Monitoring Employee Performance and Activity</p> <ul style="list-style-type: none"> The HR area tracks all the review dates and results generated by the Employee Performance Management System. The EPMS is used to evaluate job performance by state workers on an annual basis. If job performance on some of the duties is not satisfactory, the supervisor and employee will create a correction plan to improve those areas for the following year. If the employee is not performing job duties satisfactorily overall, then termination procedures would begin. Job performance is also monitored on an individual basis by supervisors to address issues throughout the year between reviews. <p>Monitoring Stakeholder Satisfaction and Performance</p> <ul style="list-style-type: none"> Provider Outreach contractor tabulates results from the provider training survey. Provider outreach contractor sends the results to SCDHHS. EDI support center also compiles survey results EDI support center sends the results to SCDHHS. The provider outreach contractor or the EDI support center may meet with SCDHHS based on survey findings to modify



	<p>procedures.</p> <p>Conducting Audits</p> <ul style="list-style-type: none"> • Two audit managers and the Division Director (within the Division of Audits) will meet with the Bureau Chief to discuss potential audits and determine a schedule for identified audits. • The Division of Audits meets with the Division of Surveillance and Utilization Review (SURS) during a planning stage. • SURS staff to pull requested reports from Thomson Reuters tools and look for “flags” (things that would identify a need for an audit). • Each audit has an administration file which includes the planning memo, concerns that led to the audit, information about the outside entity or SCDHHS area, past audit information, and internal controls of the entity. All audit documents are stored on a shared drive accessible by the Division of Audits and the Bureau Chief. • The Division of Audits develops the planning memo. • In-house audits are also developed in conjunction with the Deputy Director and Finance Director. • The Division of Audits prepares a hard copy engagement letter for the auditee. • The letter prompts the auditee to contact the Division of Audits to schedule an entrance meeting to discuss the audit further. • The Division of Audits aims to have open and constant communication with the auditee during the audit via meetings, hard copy correspondence, emails, and phone calls. The auditor will document communication with the auditee on an as needed basis. This is documented in a narrative form (using MS Word) and is included with the audit work papers. Emails may also be incorporated into the work papers, if they provide evidence for the audit. • Auditors will go to the auditee’s site (whether in-house or to an outside entity) and complete field work. This includes requesting records, viewing databases, reviewing policy and procedure guides, conducting interviews, and reviewing any other documentation from the auditee that may be useful to complete audit steps. For internal audits, data in GAFRS may also be used. • Audit work papers document what steps and actions the auditor took during the audit and includes the initial data sample. The audit findings sheet (a standard sheet) is also part of the audit work papers and lists what conditions were examined and the criteria. Information in the work papers will determine if there are any audit findings. • The auditor will review the information and make a recommendation based on any audit findings. • The auditor will meet with the Bureau Chief to discuss the findings (or lack thereof in rare instances). • The Division of Audits will “pre-exit” audit findings with the
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	<p>auditee.</p> <ul style="list-style-type: none"> • The auditee responds and comments on the audit. • • The Division of Audits has an audit tracking report that audit recommendations are entered into to ensure recommendations are addressed by management. • The Division of Audits and the Bureau Chief will review the auditee's comments. If the comments are a disagreement with fact, the auditors will request the supporting documentation. If the comments are a difference of opinion, the Division of Audits may review the report to ensure there is no biased language. • If the auditee does not respond with comments, the Division of Audits will follow up, and if there is still no response, the Division will communicate this to the Bureau Chief and will note that and issue the report as the final report. • If the draft audit report does not include any findings and recommendations, the Division will note that in the report and issue the report as final. The auditee and the auditor get the draft report. • The draft audit will be revised as necessary, and the final audit report is sent to the Deputy Director and auditee. For an MCO audit, the appropriate program area also receives a copy of the report. For an MCO audit, the appropriate program area also receives a copy of the report.
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	<ul style="list-style-type: none"> • The Division of Audits would like an increased ability to access information directly from the MMIS, run reports themselves and have more direct access to reports on Document Direct. The Thomson Reuters tools are difficult to learn since each report that is unique to a particular audit. The Division of Audits' dependence on other areas to gather data and reports can slow the audit process. • The Division of Audits would like to have a common tool to pull data needed from other state agency systems. Currently, each state agency's system is functionally and operationally different, which can make it difficult for the auditors to gather necessary data. • The Division of Audits would like to image all documents and correspondence by acquiring an electronic work paper system or another comparable method. An electronic work paper system would allow for more automated workflow and reduce the reliance on paper. Currently, "cut and paste" is prone to human error and requires checking documents multiple times. Similarly, the indexing process of the draft report is very manual. All work papers are numbered to match the audit program. An auditor notes in the margin of the draft report the



	<p>number of the supporting work paper. Each piece of information is manually traced to supporting documentation, which can take days to complete for a single report. The indexing process is essential to the audit process as it aids in answering inquiries related to the audit. An electronic work paper system would eliminate the manual indexing process as it has the ability to automatically create a link to the supporting documentation.</p> <ul style="list-style-type: none"> • The Division of Audits would like to post audit reports on the SCDHHS wiki. All audit reports are public information and do not require a FOIA request. • Overall, the Division of Audits would like greater access to documents electronically like contracts. Recently, the Division of Audits acquired a portable scanner to help with this request, but a further reduction of paper, increased availability of electronic documents, and additional scanning abilities is desired.
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Process Name	SC BR Establish Business Relationship BP
Parent Process	
Subprocess(es)	
Description	The establishment of Memoranda of Understanding (MOU), business associate agreements, data exchanges, and other agreements/contracts between DHHS and other agencies or entities.
Owner Group	DHHS Operational Areas
Purpose (<i>Intent</i>)	The establishment of agreements between DHHS and other agencies and entities.
Input (<i>What is required for the process to execute?</i>)	Information concerning the data and/or services to be exchanged between DHHS operational areas and the other agencies or entities.
Output (<i>What is the result of the process?</i>)	<ul style="list-style-type: none"> • Memoranda of Understanding (MOU) • Trading Partner Agreement (EDI) • Business Associate Agreements for PHI • Other agreements/contracts
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	<ul style="list-style-type: none"> • Document Boilerplates • Contract Log System (CLS) • SC BR Manage Business Relationship Communication BP
Trigger (<i>Any processes that precede this process?</i>)	The need/want to establish an agreement between with another agency or outside entity
Dependency (<i>Any processes dependent on the completion of this process?</i>)	
Key Stakeholders	<ul style="list-style-type: none"> • SCDHHS Operational Areas • General Counsel • Other agencies and outside entities • Division of Contracts • Medicaid Systems Management (MSM) • EDI Support Center



Frequency/Timing/Events/Cycles	
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	
Known Issues	
Procedures/Tasks	<p>Documents associated with the agreements and contracts are tracked via the Contract Log System in the Division of Contracts. Division of Contracts also keeps hard copies of any of documentation concerning a Business Relationship.</p> <ul style="list-style-type: none"> Identify need for MOU Determine the want to be addressed in the MOU and each party's role Draft the MOU Discuss MOU and receive feedback Modify MOU based on feedback Operational area works closely with MSM to develop the security/authentication protocol for the data exchange If PHI is involved, a secure site for the data exchange must be established When PHI is involved, A business associate agreement is established. Before exchanges of electronic data that are not HIPAA-regulated transactions all conditions must be verified by MSM; currently this is done on a case-by-case basis. DHHS is currently defining standardized procedures for data release. An EDI agreement is completed if the entity wanted to send or receive HIPAA-regulated data <ul style="list-style-type: none"> EDI Support Center reviews the agreement Then the agreements go through legal review at DHHS EDI Support Center works with the Trading Partner to setup their mechanism for data exchange and test the EDI When the conditions of the Trading Partner Agreement are meant, MSM will release the electronic data
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	No wishes identified in problem statement

Process Name	SC BR Manage Business Relationship Communication BP
Parent Process	
Subprocess(es)	
Description	The Business Process maintains communication between the business partners.
Owner Group	Division of Contracts
Purpose (<i>Intent</i>)	Maintain communication between the business partners.
Input (<i>What is required for the process to execute?</i>)	<ul style="list-style-type: none"> Routine Correspondence (scheduled meetings, schedule progress updates, etc.) Unscheduled Communication (unexpected issues, new



	developments, change in the scope of work)
Output (<i>What is the result of the process?</i>)	<ul style="list-style-type: none"> Information communicated to DHHS from business partner information from DHHS to business partner
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	<ul style="list-style-type: none"> phone email fax mail Contract Log System Face-to-face meetings SC BR Manage Business Relationship Communication BP PAs Tracking Systems
Trigger (<i>Any processes that precede this process?</i>)	Request for communication, either routine or unscheduled
Dependency (<i>Any processes dependent on the completion of this process?</i>)	
Key Stakeholders	<ul style="list-style-type: none"> Division of Contracts Program Areas Business Partner
Frequency/Timing/Events/Cycles	
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	
Known Issues	
Procedures/Tasks	<ul style="list-style-type: none"> Directs communication to and from DHHS Program Areas and business partner Directs communication to and from DHHS Division of Contracts and business partner (this utilizes the CLS)
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	No wishes listed in problem statement.

Process Name	SC BR Manage Business Relationship BP
Parent Process	
Subprocess(es)	CO Manage Contract BP (works in conjunction with Manage BR, but is not really a subprocess) SC BR Manage Business Relationship Communication BP
Description	The Manage Business Relationship process maintains any information concerning the agreement between DHHS and its business partner.
Owner Group	Division of Contracts
Purpose (<i>Intent</i>)	To keep the agreements between DHHS and its business partner up to date.
Input (<i>What is required for the process to execute?</i>)	<ul style="list-style-type: none"> Current Memoranda of Understanding (MOU)
Output (<i>What is the result of the process?</i>)	<ul style="list-style-type: none"> An updated MOU Contract Renewal List



Mechanism (Systems/Application/Tool/manual or automated)	<ul style="list-style-type: none"> Current Memoranda of Understanding (MOU) SC BR Manage Business Relationship Communication BP Contract Renewal List
Trigger (Any processes that precede this process?)	<ul style="list-style-type: none"> CO Manage Contract BP(see note in subprocesses) Update MOU based on: <ul style="list-style-type: none"> Change in policy Updated contract Renewal of contract Results of a termination negotiation period (Failed termination negotiations go to the Terminate Business Relationship business process)
Dependency (Any processes dependent on the completion of this process?)	<ul style="list-style-type: none"> CO Manage Contract BP (see note in Subprocesses)
Key Stakeholders	<ul style="list-style-type: none"> Division of Contracts General Counsel Business Partner
Frequency/Timing/Events/Cycles	Contract Renewal list appears to be an annual report
Constraints (Location/Interfaces Required for inputs/outputs)	
Known Issues	
Procedures/Tasks	<ul style="list-style-type: none"> The following tasks were alluded to in Manage BR Communications: <ul style="list-style-type: none"> Schedule meetings Schedule progress updates Resolve unexpected issues Update agreement/contract Legal review of updated agreement/contract (CO Manage Contract is consulted as needed) Generate Contract Renewal List Distribute Contract Renewal List Negotiate to prevent termination
Performance Measures (efficient and/or effective)	
Roles (performing)	
Related Business Goals	
Wish List/Needs	No wishes listed in problem statement.

Process Name	SC BR Terminate Business Relationship BP
Parent Process	
Subprocess(es)	Close Out Contract (works in conjunction, but not really a subprocess)
Description	Terminates the business relationship between DHHS and the business partner.
Owner Group	
Purpose (Intent)	Terminate a business relationship between DHHS and a business partner.
Input (What is required for the process to execute?)	Termination request
Output (What is the result of the process?)	Termination letter to business partner, the contract/MOU is made inactive in Contract Log System, and if necessary contract/MOU is terminated out of



	MMIS
Mechanism (Systems/Application/Tool/manual or automated)	SC BR Manage Business Relationship Communication BP Contract Log System MMIS Certified Mail SC BR Manage Business Relationship (for negotiate of contract termination)
Trigger (Any processes that precede this process?)	Close Out Contract (see comment in Subprocesses) Receipt of a termination request from: <ul style="list-style-type: none"> Operations or program area Program Integrity Another area of DHHS based on Program Integrity findings The Business partner
Dependency (Any processes dependent on the completion of this process?)	Close Out Contract (See comment in Subprocesses)
Key Stakeholders	<ul style="list-style-type: none"> SCDHHS Operational Areas/program manager General Counsel Division of Contracts Medicaid Systems Management (MSM) EDI Support Center SC CO Close Out Contract BP DHHS Fiscal
Frequency/Timing/Events/Cycles	
Constraints (Location/Interfaces Required for inputs/outputs)	
Known Issues	
Procedures/Tasks	<ul style="list-style-type: none"> Send to Manage Business Relationship to negotiate termination Receive results of negotiation Terminate Business Relationship using: General Counsel (if needed), Medicaid Systems Management, EDI Support Center, Contract Log System, and MMIS (if service contract) Send termination letter to business partner, Program Manager, and Fiscal Affairs
Performance Measures (efficient and/or effective)	
Roles (performing)	
Related Business Goals	
Wish List/Needs	Add information concerning the appeals process to the letter.

Process Name	SC PI Identify Candidate Case BP
Parent Process	
Subprocess(es)	
Description	To safeguard against medically unnecessary services, inappropriate use of services, and excessive or improper payments by conducting reviews (cases) to identify waste, fraud, and abuse by Providers and Beneficiaries alike.
Owner Group	Division of Program Integrity
Purpose (Intent)	To identify candidate cases of potential waste, fraud, and abuse by Providers



	and Beneficiaries in the Medicaid Program.
Input (<i>What is required for the process to execute?</i>)	Complaints from DHHS personnel, other agencies, providers, anonymous tips, response letters from REOMB program, regularly run SURS reports
Output (<i>What is the result of the process?</i>)	Cases that warrant further investigation by Program Integrity Staff
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	<ul style="list-style-type: none"> • SURS • SURS reports • Manual analysis of complaints • MMIS • Fraud Abuse Hotline • Email • PI Case Management System <ul style="list-style-type: none"> ○ Complaint Intake Form (screen) ○ Case Management Form (Screen)
Trigger (<i>Any processes that precede this process?</i>)	<ul style="list-style-type: none"> • Receipt of complaint
Dependency (<i>Any processes dependent on the completion of this process?</i>)	<ul style="list-style-type: none"> • SC PI Manage Case BP
Key Stakeholders	<ul style="list-style-type: none"> • Program Integrity Staff • Division of SURS • Division of Care Management • Attorney General's Office
Frequency/Timing/Events/Cycles	<ul style="list-style-type: none"> • Each month MMIS generates letters to random recipients requesting confirmation of services provided in the last 45 days • Post-payment reviews are completed on a regular schedule
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	<ul style="list-style-type: none"> • MMIS MedStat Interface
Known Issues	
Procedures/Tasks	<p>NOTE: These are not in order</p> <ul style="list-style-type: none"> • DRU Staff conduct preliminary reviews and forwards identified cases to SC PI Manage Case BP for further investigation and corrective action. <ul style="list-style-type: none"> ○ If there is enough information in a beneficiary preliminary review to suspect fraud, the case is referred to MRFU in the Attorney General's office. This is done by Identify Candidate Case since it did not require further investigation prior to referral. At this point further management of the case falls under SC PI Manage Case BP. ○ Multiple people have authority to identify a case for referral to SC PI Manage Case BP. These include: <ul style="list-style-type: none"> ▪ Supervisory of fraud hotline ▪ PI supervisor ▪ Division Director of PI ▪ Division Director of SURS • PI Staff and SURS data analysts create rules, algorithms, and parameters for SURS • PI Staff complete initial post-payment review: data mining, analysis, and review of providers • Department of Recipient Utilization (DRU) screens complaints to



	<p>determine action needed for complaint resolution.</p> <ul style="list-style-type: none"> ○ If person associated with complaint is not connected to Medicaid ○ If complaint refers to another agency or professional entity, forward to appropriate contact. <ul style="list-style-type: none"> • IF MCO beneficiary complaint that is not related to eligibility, pass complaint to Division of Care Management. Track complaints and produces annual reports on numbers based on action. See problem statement for more info. This is done using the PI Case Management System. • PI Staff produce SURS reports <ul style="list-style-type: none"> ○ Includes annual report to look at providers who have had a case closed for one year ○ Standard SURS reports ○ Specific special report/queries • Designated PI staff enter cases initiated w/o a complaint (i.e. came from another source) into the case management form within the PI Case Management System. • DRU staff enter complaints into the PI Case Management System via a complaint intake screen. <p>REOMB Process (done by PI admin assistant)</p> <ul style="list-style-type: none"> • Receive REOMB letters • Stuff and mail letters • Maintain a hard copy list of those who receive a letter • Track the number of letters returned • Compile monthly report • If negative response forward to DRU for preliminary review • Contact to update address if returned as undeliverable
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	<ul style="list-style-type: none"> • Data dictionary • Separate department for complaint/referral intake

Process Name	SC PI Manage Case BP
Parent Process	
Subprocess(es)	
Description	The business process is responsible for the review and investigation of the cases identified by the SC PI Identify Candidate Case business process
Owner Group	Division of Program Integrity
Purpose (<i>Intent</i>)	Determine if a case from the SC PI Identify Candidate Case business process is a valid case and to determine course of action and implement
Input (<i>What is required for the process to execute?</i>)	A case from the SC PI Identify Candidate Case business process. Cases derived from a complaint come in as complaint intake forms. Otherwise, there is no formal process for how cases are communicated to this BP.



Output (<i>What is the result of the process?</i>)	A course of action for the case (could be no findings)
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	<ul style="list-style-type: none"> • Medicaid Policy Manuals (online or paper) • PI Case Management System • Licensing entities • Physical Files
Trigger (<i>Any processes that precede this process?</i>)	A case coming from SC PI Identify Candidate Case business process
Dependency (<i>Any processes dependent on the completion of this process?</i>)	SC PM Disenroll Provider BP , SC PM Manage Provider Outreach (Manage Provider Training)
Key Stakeholders	<ul style="list-style-type: none"> • Department of Recipient Utilization (DRU) • Department of Medical Service Review (DMSR) • Department of Medical Service Review/Ancillary Programs (DMSRAP) • Department of Pharmacy and Durable Medical Equipment (DME) Review (DPDMER) • Program Integrity Staff • Providers • DHHS Division of Accounting Operations • AG Medicaid Recipient Fraud Unit (MRFU) • Medical Fraud Control Unit (MFCU)
Frequency/Timing/Events/Cycles	30 day abuse notification letter
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	
Known Issues	
Procedures/Tasks	<p>NOTE: These are not in order</p> <ul style="list-style-type: none"> • DRU investigates fraud, abuse, and/or misuse of the Medicaid program by beneficiaries • DRU can trigger PI to lock-in beneficiary to one pharmacy • DRU refers suspected beneficiary fraud cases to the Medicaid Recipient Fraud Unit (MRFU) in the Attorney General's Office for investigation • During reviews by DMSR, DMSRAP, and DPDMER common actions can include the following. For more details of these actions see problem statement. <ul style="list-style-type: none"> ○ On-site visits to providers ○ Notification that overpayment has been found ○ Desk review of medical and support documentation ○ Provider self-audit • DMSR is responsible for post-payment reviews of physicians, other medical specialists, and out-patient hospital services • PI Reviewers refer cases to the appropriate licensing boards and Medical Fraud Control Unit (MFCU) • DMSRAP is responsible for post-payment reviews of dentists, home health agencies, therapists, clinics, labs, mental health facilities, state agencies, non-emergency transportation providers, and other provider types • DPDMER is responsible for post-payment reviews of drug utilization patterns of pharmacy and DME providers



	<ul style="list-style-type: none"> • DRU assigns cases to the appropriate department for further investigation • DRU enters case into PI's case management system which manages the case files by tracking basic case information (see problem statement for list) • PI Staff documents case findings • PI Staff determines a course of action, based upon case findings (see problem statement for specific courses of action) • PI Staff implements/triggers the course of action • PI Staff closes case.
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	A comprehensive PI review and case management system that would automate the management of the case and replace hard copy files, and improve accessibility of necessary records (policies, medical records, claims screens etc.)

Process Name	SC CM Establish Case BP
Parent Process	
Subprocess(es)	
Description	This document explains the Establish Case component of the care management programs that are actually overseen, administered, or tracked in some way by SCDHHS. SCDHHS does very little care management of its own. Contractors and providers are primarily responsible for care management functions.
Owner Group	<ul style="list-style-type: none"> • DHHS
Purpose (<i>Intent</i>)	This document explains the Establish Case component of the care management programs that are actually overseen, administered, or tracked in some way by SCDHHS.
Input (<i>What is required for the process to execute?</i>)	<ul style="list-style-type: none"> • Enrollment • Standards or rules
Output (<i>What is the result of the process?</i>)	<ul style="list-style-type: none"> • Enrollment or oversight procedures
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	<ul style="list-style-type: none"> • Physicians Provider Manual • CLTC waiting list for each waiver.
Trigger (<i>Any processes that precede this process?</i>)	Receipt of enrollment or standard or rules
Dependency (<i>Any processes dependent on the completion of this process?</i>)	Manage Case PI Identify Candidate Case
Key Stakeholders	<ul style="list-style-type: none"> • DHHS • Beneficiaries • Other state agencies • MCOs
Frequency/Timing/Events/Cycles	<ul style="list-style-type: none"> •



Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	
Known Issues	
Procedures/Tasks	<p>Early & Periodic Screening, Diagnosis & Treatment (EPSDT).</p> <ul style="list-style-type: none"> Identify beneficiaries Schedules and policies listed in the Physicians Provider Manual guide providers in when and how to render these services. <p>Diabetes Education.</p> <ul style="list-style-type: none"> Identify beneficiaries Certified diabetes educators can enroll with Medicaid as providers of diabetes education services. See Enroll Provider BP. <p>Preventive/Rehabilitative Services for Primary Care Enhancement (P/RSPCE)</p> <ul style="list-style-type: none"> DHHS enrolls beneficiaries <p>SCDDSN waivers</p> <ul style="list-style-type: none"> DDSN is responsible for the administration of these waivers with SCDHHS oversight. DHHS enrolls beneficiaries <p>CLTC / HCBS waivers.</p> <ul style="list-style-type: none"> CLTC area of SCDHHS manages these waivers Each CLTC regional office maintains a waiting list for each waiver. CLTC providers create service plans for beneficiaries based on the “problems”—reasons a person may need long-term care services, the “goals”—preferred results for person, and the “intervention”—means to reach the goals. The CLTC Providers enter this information into the CLTC Case Management System (CMS; see CLTC CMS for technical details). <p>Behavioral Health Services</p> <ul style="list-style-type: none"> Certain other state agencies (DSS, etc.) identify individuals who are eligible for these programs.
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	<ul style="list-style-type: none"> SCDHHS no longer sends out EPSDT notices to beneficiaries and their families, nor does it schedule appointments on behalf of beneficiaries. Agency staff would like to resume this practice, perhaps via a more cost effective route than mail.

Process Name	SC CM Manage Case BP
Parent Process	
Subprocess(es)	
Description	This business process uses State-specific criteria and rules to ensure



	appropriate and cost-effective medical, medically related social and behavioral health services are identified, planned, obtained and monitored for individuals identified as eligible for care management services
Owner Group	<ul style="list-style-type: none"> DHHS
Purpose (<i>Intent</i>)	To ensure appropriate and cost-effective medical, medically related social and behavioral health services are identified, planned, obtained and monitored for individuals identified as eligible for care management services
Input (<i>What is required for the process to execute?</i>)	<ul style="list-style-type: none"> Reports and other methods of oversight and monitoring
Output (<i>What is the result of the process?</i>)	<ul style="list-style-type: none"> Oversight and monitoring decisions
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	<ul style="list-style-type: none"> MMIS reports by provider type and services billed Case Management System (CMS)
Trigger (<i>Any processes that precede this process?</i>)	Receipt of inputs
Dependency (<i>Any processes dependent on the completion of this process?</i>)	
Key Stakeholders	<ul style="list-style-type: none"> SCDHHS Diabetes Education staff DHHS Providers Beneficiaries Other state agencies
Frequency/Timing/Events/Cycles	
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	
Known Issues	
Procedures/Tasks	<p>Early & Periodic Screening, Diagnosis & Treatment.</p> <ul style="list-style-type: none"> The SCDHHS Physicians Services program area tracks EPSDT services via MMIS reports of EPSDT procedure codes billed. They use those reports to complete the annual CMS 416 report of EPSDT visits in the state. <p>Diabetes Education</p> <ul style="list-style-type: none"> Providers identify and render services. SCDHHS Diabetes Education staff ensure that providers are billing for diabetes education services regularly, using MMIS reports by provider type and services billed. SCDHHS Diabetes Education staff may reach out to individual providers to remind them about the program and make sure services are being rendered. <p>Preventive/Rehabilitative Services for Primary Care Enhancement (P/RSPCE)</p> <ul style="list-style-type: none"> DHEC manages this program with the assistance of public health nurses, social workers, dietitians, health educators, home economists, and public health assistants. Group and/or individual counseling sessions may be held to



	<p>administer this program, depending on the beneficiary's needs</p> <ul style="list-style-type: none"> • DHHS handles appeals (see Member Grievance and Appeal) • DHHS receives reports from DHEC <p>SCDDSN Waivers</p> <ul style="list-style-type: none"> • These waivers are administered by SCDDSN, though they are billed to SCDHHS. • DHHS handles appeals (see Member Grievance and Appeal) • DHHS receives reports from DDSN <p>CLTC Waivers</p> <ul style="list-style-type: none"> • CLTC providers use the CLTC Case Management System (CMS) for the management of CLTC waivers • The databases are maintained daily by the CLTC regional offices, with nightly updates to the central database. • Providers use the CMS to enter information from assessments based on the service plan created in Establish Case • The CMS is also used for generating reports to track timeliness of assessments, reassessments, care plan development, tracking missed provider visits, and identify participants at risk in the event of an emergency. • CLTC Providers use Care Call to log the time spent at a patient's residence by calling in and entering information at the beginning of the visit and again at the end of the visit. • This information is used later for claims processing (see Enter Claim). <p>Behavioral Health Services</p> <ul style="list-style-type: none"> • Certain other state agencies (DSS, etc.) authorize services and manage care for beneficiaries in these programs. • The agencies pay for the services • though providers submit their claims through the MMIS; the prior authorization number marks the claims with a fund code tied to each agency so SCDHHS uses funds from the appropriate sources. • Treatment plans developed by providers for these beneficiaries undergo postpayment review by SCDHHS' medical review contractor. • The medical review contractor may refer cases of overuse to Program Integrity (see PI Identify Candidate Case)
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	<ul style="list-style-type: none"> • The Physicians Services area would like the MMIS/MEDS to track billed EPSDT visits per beneficiary based on age and periodicity – this would facilitate outreach to parents by eligibility caseworkers, the Enrollment Broker, etc. Staff would also like to be able to search the MMIS based on CPT codes billed.



	<ul style="list-style-type: none"> Behavior Health - SCDHHS would like improved interfaces with these other agencies and the ability to monitor care and authorizations performed by these other agencies and providers.
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Process Name	SC New Enter Claim BP
Parent Process	
Subprocess(es)	
Description	This business process controls the various ways claims can be created and enter the MMIS Claims Processing system.
Owner Group	<ul style="list-style-type: none"> MCCS Data Entry Contractor DHHS CLTC Program Area (possibly, for Care Call)
Purpose (<i>Intent</i>)	Create claims and enter them for processing.
Input (<i>What is required for the process to execute?</i>)	<ul style="list-style-type: none"> Claims in form or paper, physical electronic media.
Output (<i>What is the result of the process?</i>)	<ul style="list-style-type: none"> Claims and encounters in a format ready to be adjudicated.
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	<ul style="list-style-type: none"> Nursing Home TAD process Paper claim forms (CMS-1500, ADA, and UB-04) Web-based claims submission tool Physical electronic media (tapes, diskettes, CDs, zip files; modem; file transfer protocol (FTP)) EDI Translator (HIPAA mailbox interface) T1 line between MCCS and Clemson, used for claims transmission Care Call system Attendant Care financial management services Pharmacy POS system Claim Control Number - Batch Number used for priority sorting and duplicate claim detection
Trigger (<i>Any processes that precede this process?</i>)	Receive a claim from a provider
Dependency (<i>Any processes dependent on the completion of this process?</i>)	<ul style="list-style-type: none"> SC OM Edit Claim-Encounter BP SC OM Price Claim-Encounter BP
Key Stakeholders	<ul style="list-style-type: none"> MCCS Provider Care Call contractor Attendant Care contractor POS contractor MCOs
Frequency/Timing/Events/Cycles	Daily
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	<ul style="list-style-type: none"> There must be a Trading Partner Agreement (TPA) in place in order to use the web tool or submit claims electronically.



Known Issues	
Procedures/Tasks	<p>Professional, Dental, and Institutional Claims</p> <ul style="list-style-type: none"> • Provider sends paper claims (CMS-1500, ADA, and UB-04) to MCCC. • MCCC performs an initial prescreening/verification to determine whether to accept the claims. • MCCC scans paper claims. • MCCC mails rejected claims back to the provider. • MCCC groups the claims into batches and enters claims data using a combination of OCR technology and manual data entry. • Providers send claims on physical electronic media to MCCC. • MCCC transmits claims (both keyed and electronic) to Clemson via a direct line. • Providers enter claims through the Clemson-operated Web-Based Claims Submission Tool. • Clearinghouses and providers place 837s into the HIPAA mailbox. <p>Nursing Facility and OSS Claims</p> <ul style="list-style-type: none"> • Clemson generates a monthly listing (TAD) for each facility of all Medicaid residents from the previous month and mails it to the provider. • The provider makes corrections, additions, and deletions on the paper document. • Provider attaches authorizing documentation, as needed. • Provider mails listing to MCCC. • MCCC keys the TAD information into the MMIS. • MMIS creates claims using TAD information. <p>CLTC Claims</p> <ul style="list-style-type: none"> • Case managers enter the service plans and information obtained during assessments into the Case Management System (CMS) for the management of the Elderly/Disabled, HIV/AIDS, and Ventilator Dependent waivers. • On a nightly basis information on waiver services is transmitted from the CMS to Care Call through an FTP website. • Care Call submits EDI 837 claims to MMIS weekly for the majority of CLTC providers. All providers' claims are processed by MCCC for ECFs, remits, and payment. • MMIS sends an electronic Remit back to the Care Call contractor. • For the purpose of claims payment, CLTC provides financial management services called "Attendant Care" for self-employed providers in order to fulfill (through another contractor) the mandated employer requirements for all CLTC providers. <p>Pharmacy</p> <ul style="list-style-type: none"> • The Pharmacy Benefits administrative contractor adjudicates pharmacy claims through their point of sale (POS) system • Providers have the option to submit claims via hard copy or electronically. Most submit electronically. • The Pharmacy Benefits contractor sends a claims file to SCDHHS weekly



	<p>Encounters</p> <ul style="list-style-type: none"> All encounter data is submitted electronically via file transfers from the MCOs . <p>Claim Control Numbers</p> <ul style="list-style-type: none"> MCCS assigns each paper claim a unique Claim Control Number (CCN) during the scanning process. MMIS assign each claim not submitted through MCCS a unique Claim Control Number (CCN). Duplicate claims (duplicate CCNs) are automatically rejected.
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	<ul style="list-style-type: none"> SCDHHS would like to track claims that fail prescreening and are returned to providers. SCDHHS has released an RFP and is currently seeking a Dental Administrative Service Organization (ASO) to adjudicate claims and handle prior authorization processes for all dental claims. The Dental ASO will send a claims file to SCDHHS weekly for payment. CLTC would like to eventually have all services bill through Care Call.

Process Name	SC New Perform Claim-level Adjustment BP
Parent Process	
Subprocess(es)	Enter Claim
Description	A claim level adjustment is a void (debit) or void/replacement adjustment at the detail/claim level and is tied to a particular claim. This type of adjustment is limited to one claim per adjustment request.
Owner Group	<ul style="list-style-type: none"> DHHS
Purpose (<i>Intent</i>)	To void or adjust a provider's account via a Form 130 which becomes an adjustment claim for a single claim only.
Input (<i>What is required for the process to execute?</i>)	<ul style="list-style-type: none"> Form 130 Coding the UB-04 claim form as an adjustment
Output (<i>What is the result of the process?</i>)	<ul style="list-style-type: none"> Intermediate -completed Form 130 and supporting documentation Intermediate - completed UB-04 claim form Adjustment to the provider's account Claim marked as a voided claim
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	<ul style="list-style-type: none"> Electronic submission of claim Hard copy submission of form 130 and UB-04 MMIS
Trigger (<i>Any processes that precede this process?</i>)	
Dependency (<i>Any processes dependent on the completion of</i>)	Prepare Provider EFT/check



<i>this process?)</i>	
Key Stakeholders	<ul style="list-style-type: none"> DHHS, MIVS, providers, MCCC
Frequency/Timing/Events/Cycles	As necessary
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	<ul style="list-style-type: none"> A claim level adjustment is limited to one claim per adjustment request. A claim can only go through void/replacement adjustment process one time – that is, the MMIS does not allow us to adjust a replacement claim. Claim level adjustments are only for claims in MMIS active claims history -- those paid less than 18 months ago. Institutional providers have to use UB-04
Known Issues	While the adjudication process also includes marking the original claim in the skeletal history database as voided, the MMIS does not treat this as a true claim level adjustment when it comes to reporting.
Procedures/Tasks	<ul style="list-style-type: none"> Provider Initiated: For a void only adjustment, a provider completes Form 130 and indicates the provider as the originator. For a Void/replacement adjustment, a provider completes Form 130, indicates the provider as the originator, and attaches a hard copy claim to the Form 130 as the replacement claim. Providers submit adjustment via Web Tool Clearinghouses etc. can submit HIPAA-compliant adjustments via HIPAA Mailbox Provider submits all forms/documentation to MCCC for keying. Internally Initiated: For a void only adjustment, SCDHHS/MIVS completes Form 130 and indicates SCDHHS/MIVS as the originator. For a Void/replacement adjustment, SCDHHS/MIVS completes Form 130, indicates SCDHHS/MIVS as the originator, and indicates changes to be made on the replacement claim in the “Comments” field or indicates changes on hard copy print-out of the basic screen for the original claim and attaches to the Form 130. SCDHHS/MIVS submits all forms/documentation to MCCC for keying. <p>Pharmacy POS Claim Adjustments:</p> <ul style="list-style-type: none"> Pharmacy providers submit adjustments (“reversals”) to the POS contractor using their POS device. The POS contractor “reverses” the claim in its proprietary system. The POS Contractor sends a gross level adjustment to Clemson in the MMIS proprietary adjustment claim format as part of the weekly transmission of POS claims. The adjustment claim goes through a separate MMIS adjudication process for POS adjustments and is stored in the database for MMIS payment processing. For all adjustments: for voided, the original claim is marked void and the money is debited to the provider’s account. For void/replacement (form 130) a replacement claim is created with indicated changes and processed. The replacement is linked to the original claim via a claim link record. The voided amount is debited and the replacement amount is paid. (See Price claim)



Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	Currently, a claim can only go through void/replacement adjustment process one time – that is, the MMIS does not allow us to adjust a replacement claim. SCDHHS would like to have the functionality to perform an unlimited number of void/replacement adjustments on a claim.

Process Name	SC New Perform Gross-level Adjustment BP
Parent Process	
Subprocess(es)	Enter Claim
Description	A gross-level adjustment is a debit or credit adjustment made at the provider level that is not tied to a particular claim or recipient. Multiple claims can be adjusted on a single gross-level adjustment request.
Owner Group	<ul style="list-style-type: none"> DHHS (and program area, MCCS, and MIVS. The TPL area and the Bureau of Reimbursement Methodology and Policy)
Purpose (<i>Intent</i>)	To create an adjustment (debit or credit) to be applied to a provider's account with an amount not tied to a particular claim.
Input (<i>What is required for the process to execute?</i>)	<ul style="list-style-type: none"> Adjustment Form 115 to MMIS
Output (<i>What is the result of the process?</i>)	<ul style="list-style-type: none"> Debit or credit to the provider account
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	<ul style="list-style-type: none"> Electronic or hard copy transmission of form 115 MMIS Form 115
Trigger (<i>Any processes that precede this process?</i>)	<p>Situations that can cause a form 115 to be filled out:</p> <ul style="list-style-type: none"> Adjustments that are not "claim-specific" (e.g. cost settlements, disproportionate share) Claims no longer available on skeletal history (18 months from paid date) Claims from institutional providers that are pulled into recovery for Medicare or other health insurance when only a portion of the amount is being recouped Claims from non-institutional providers that are pulled into recovery for Medicare when only a portion of the amount is being recouped Any other partial recoupment of a claim
Dependency (<i>Any processes dependent on the completion of this process?</i>)	Prepare Provider EFT/check
Key Stakeholders	<ul style="list-style-type: none"> Program area MCCS MIVS TPL area Bureau of Reimbursement Methodology and Policy



Frequency/Timing/Events/Cycles	As necessary
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	None
Known Issues	None
Procedures/Tasks	<ul style="list-style-type: none"> For in-house adjustments, the program area identifies the exact data to be changed on the claim and calculates the amount of payment difference based on changed data. The program area fills out adjustment form 115 the program area submits form to MCCS MCCS keys in the form For outside adjustments, (MIVS, MCCS, the TPL area, and the Bureau of Reimbursement Methodology and Policy) Same tasks as above the form 115 is transmitted as an adjustment claim from MCCS to Clemson The adjustment claim goes into claims processing and the payment is applied as a debit or credit to the provider's account.
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	SCDHHS would like to eliminate the use of gross-level adjustments wherever possible and instead link all adjustments to claims.

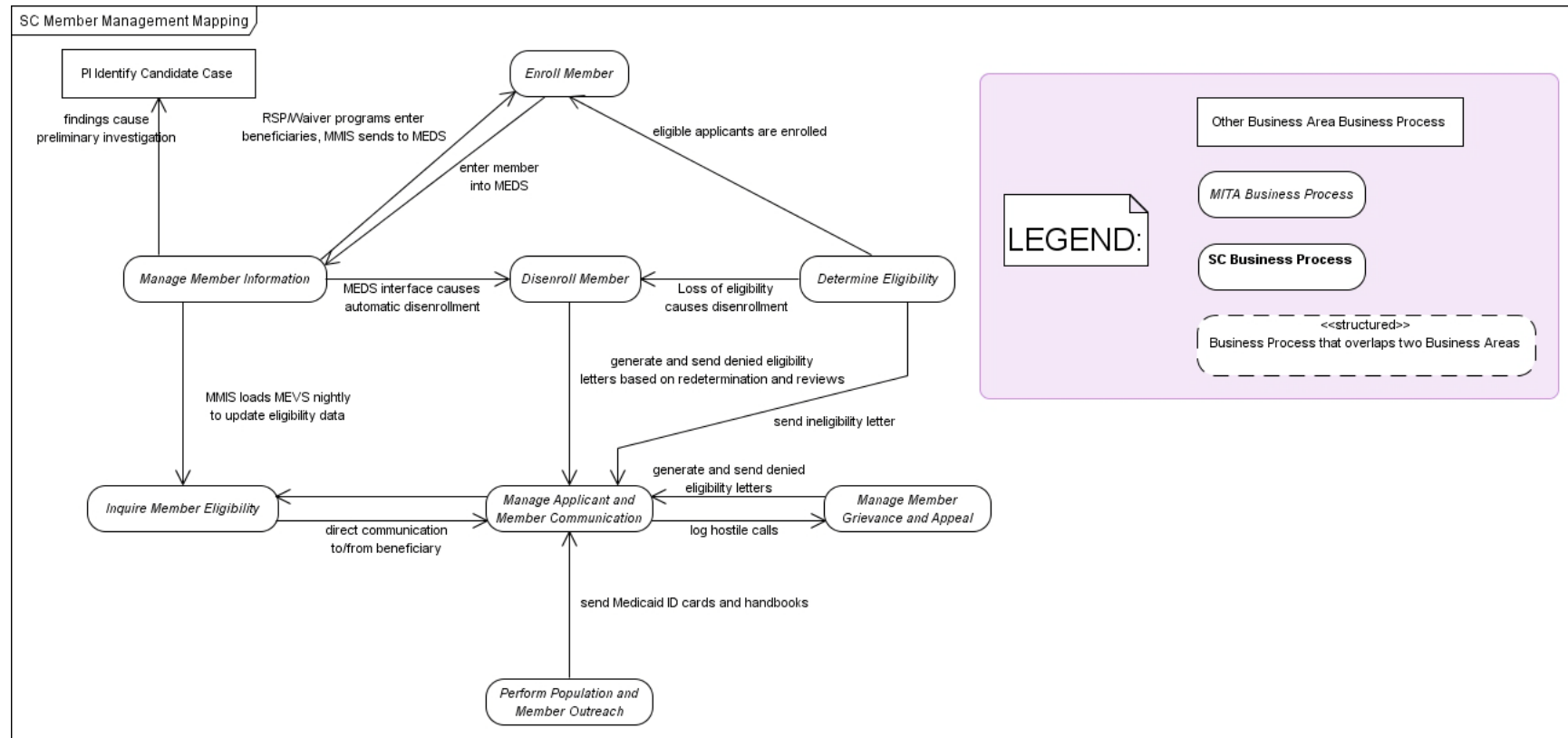
Process Name	SC OM Manage Edit Correction Forms BP (unique to SC)
Parent Process	
Subprocess(es)	
Description	The business process manages the use of Edit Correction Forms by Program Areas and Providers. This process also mails the provider ECFs to the providers.
Owner Group	<ul style="list-style-type: none"> Program Areas MCCS
Purpose (<i>Intent</i>)	Manage the use of Edit Correction Forms.
Input (<i>What is required for the process to execute?</i>)	<ul style="list-style-type: none"> Edit Correction Form Marked up ECF form Providers or Program Areas (from this process)
Output (<i>What is the result of the process?</i>)	Corrected Claim
Mechanism (<i>Systems/Application/Tool/manual or automated</i>)	<ul style="list-style-type: none"> MMIS Edit Correction Form Mail Program Area Edit Code Steps Tracking Stamp Hard copy list of which program area to route ECF to

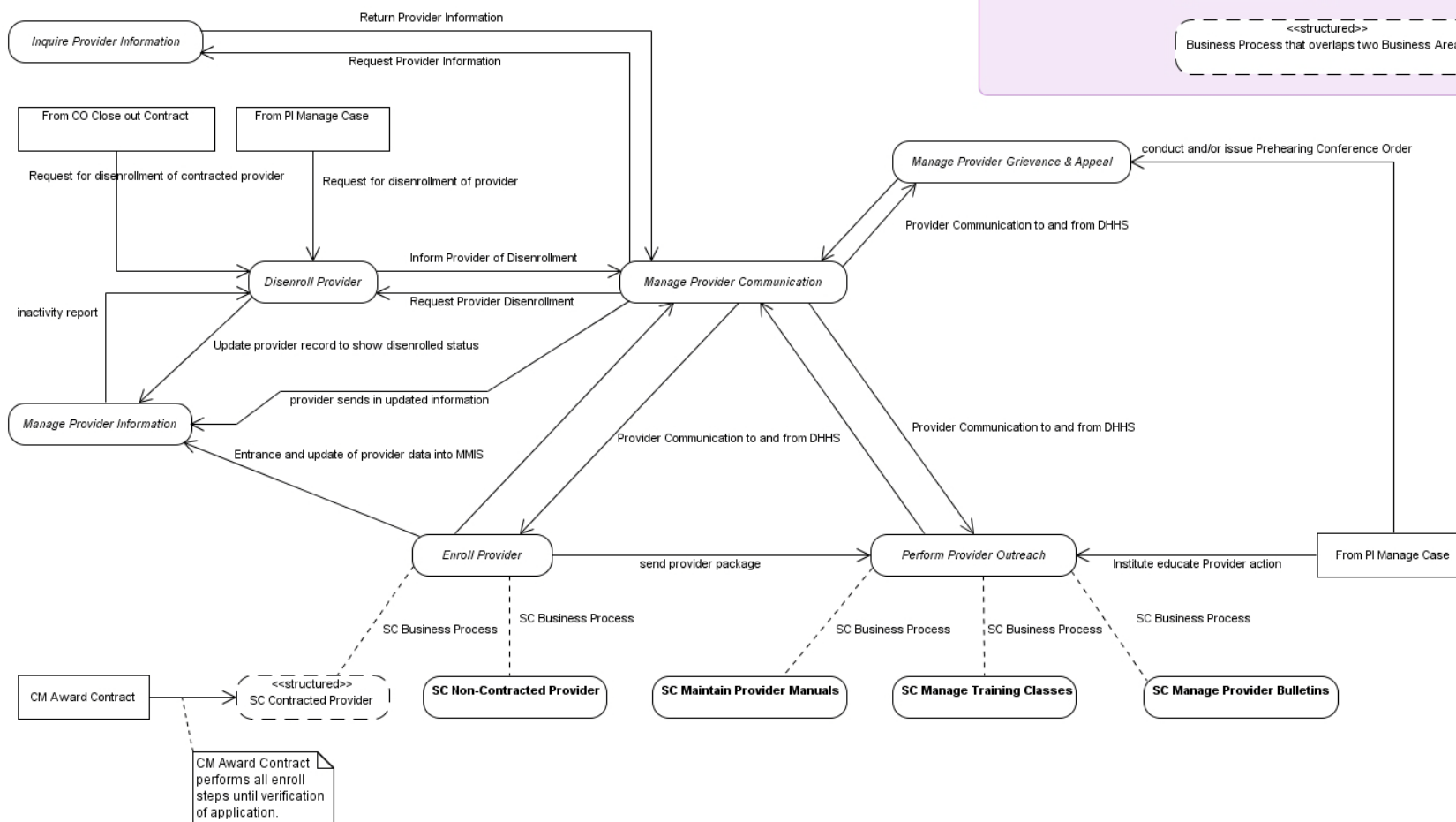


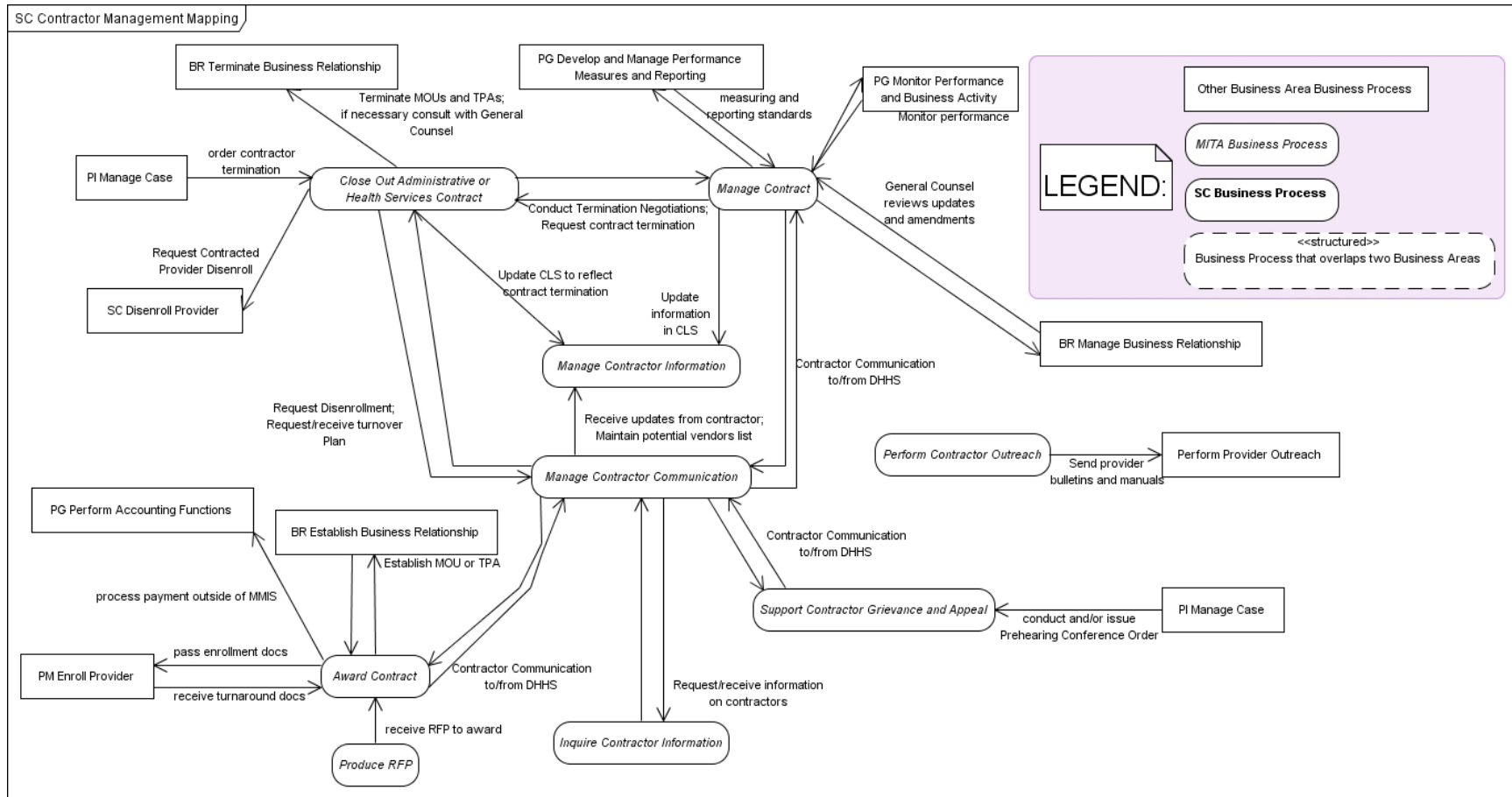
	<ul style="list-style-type: none"> Claim Control Number MMIS Aged Suspense Report
Trigger (<i>Any processes that precede this process?</i>)	Receipt of an Edit Correction form or a Marked up ECF
Dependency (<i>Any processes dependent on the completion of this process?</i>)	
Key Stakeholders	<ul style="list-style-type: none"> Program Areas MCCS Providers
Frequency/Timing/Events/Cycles	After 30 days ECF goes into aged suspense
Constraints (<i>Location/Interfaces Required for inputs/outputs</i>)	
Known Issues	
Procedures/Tasks	<ul style="list-style-type: none"> MMIS generates ECFs <ul style="list-style-type: none"> In-house ECFs are generated during the daily claims run Provider ECFs are generated during the weekly payment run <p>In-house edits (suspended claims):</p> <ul style="list-style-type: none"> MCCS resolves ECF at MCCS MCCS adds tracking stamp MCCS routes ECFs to PAs based on provider and claim type from hard copy list using a unique location number PA resolves the ECF based on PA specific edit code steps If ECF is not resolved within 30 days suspension goes into aged suspense. Tracked with MMIS Aged Suspense Report Tracked by MCCS out of timeliness standards PA marks ECF in red to show resolution or rejection Completes tracking stamp and returns to MCCS <p>Provider ECFs (rejected claims):</p> <ul style="list-style-type: none"> MCCS mails ECFs to providers (mailed with weekly provider payment and remittance advice) Provider corrects any errors in red or can just resubmit new claim Provider returns ECF to MCCS for keying <p>All:</p> <ul style="list-style-type: none"> MCCS uses CCN to bring up claim in MMIS and keys in resolution information or marks claim as rejected
Performance Measures (<i>efficient and/or effective</i>)	
Roles (<i>performing</i>)	
Related Business Goals	
Wish List/Needs	Eliminate use of ECF, providers would always re-submit new claims for each rejected claim



Appendix H: Business Area Business Process Relationship Diagrams

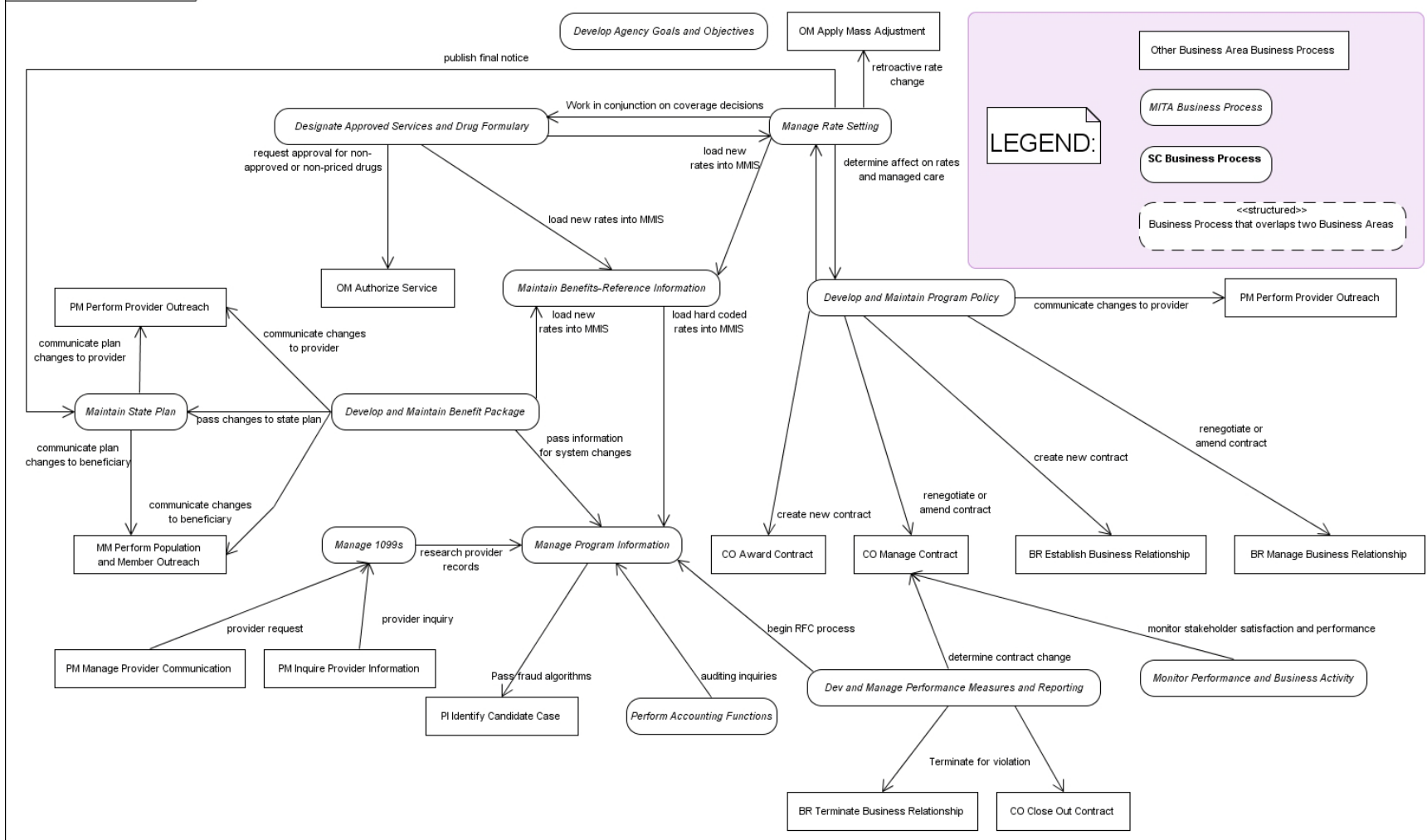






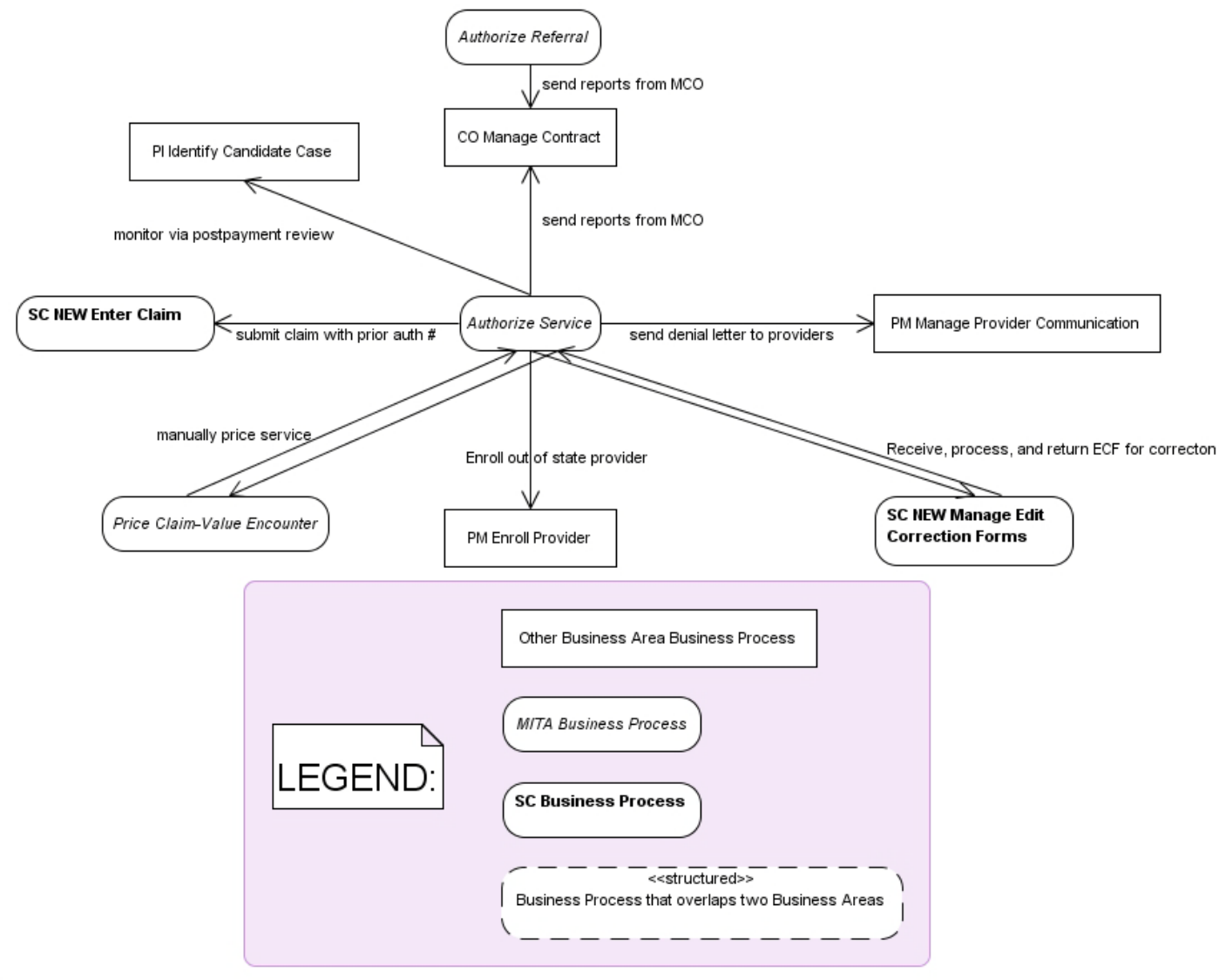


SC Program Management Mapping



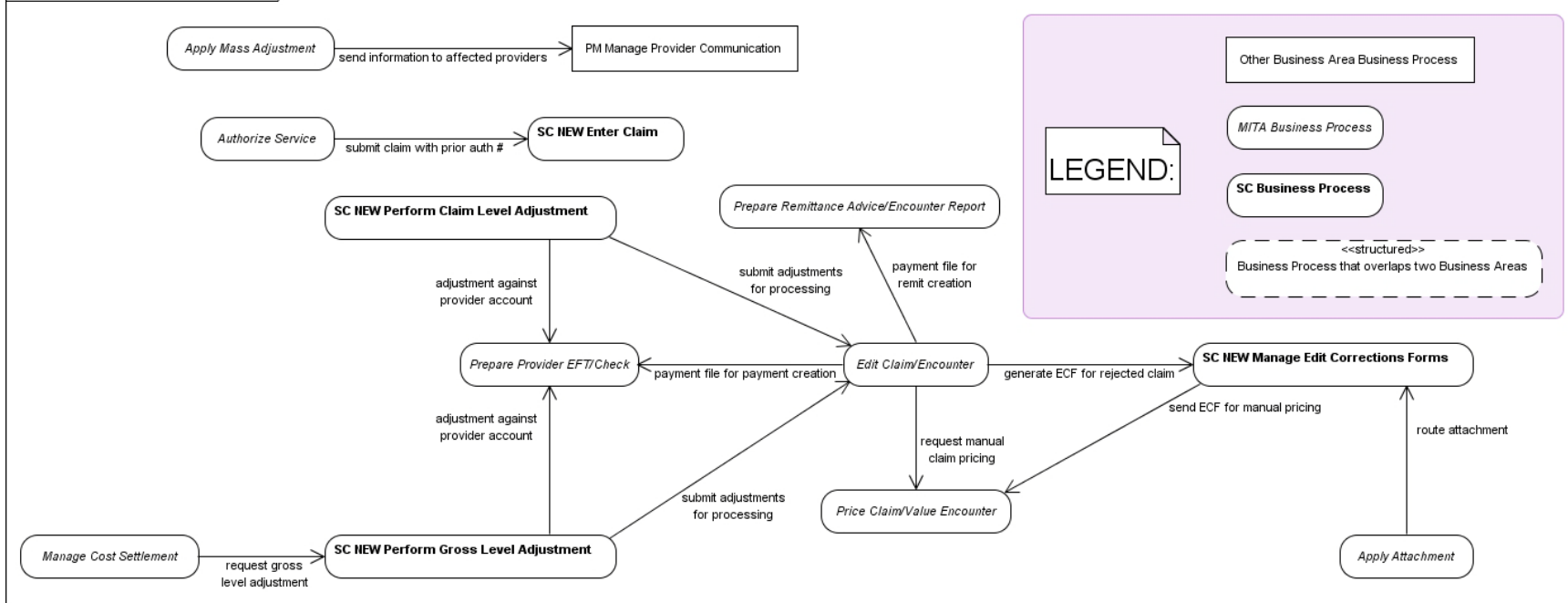


SC Operations Management OM1 Mapping



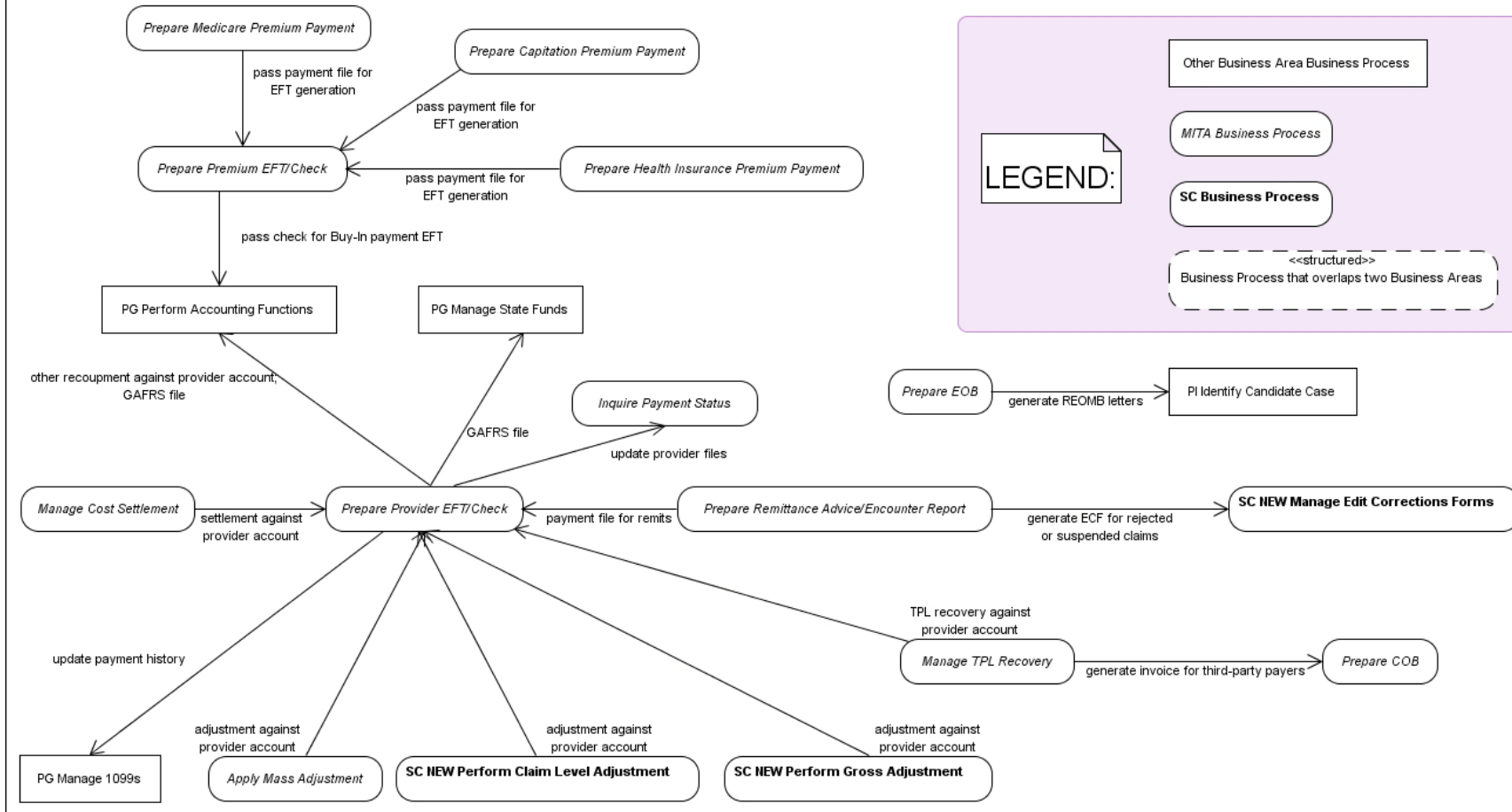


SC Operations Management OM2 Mapping



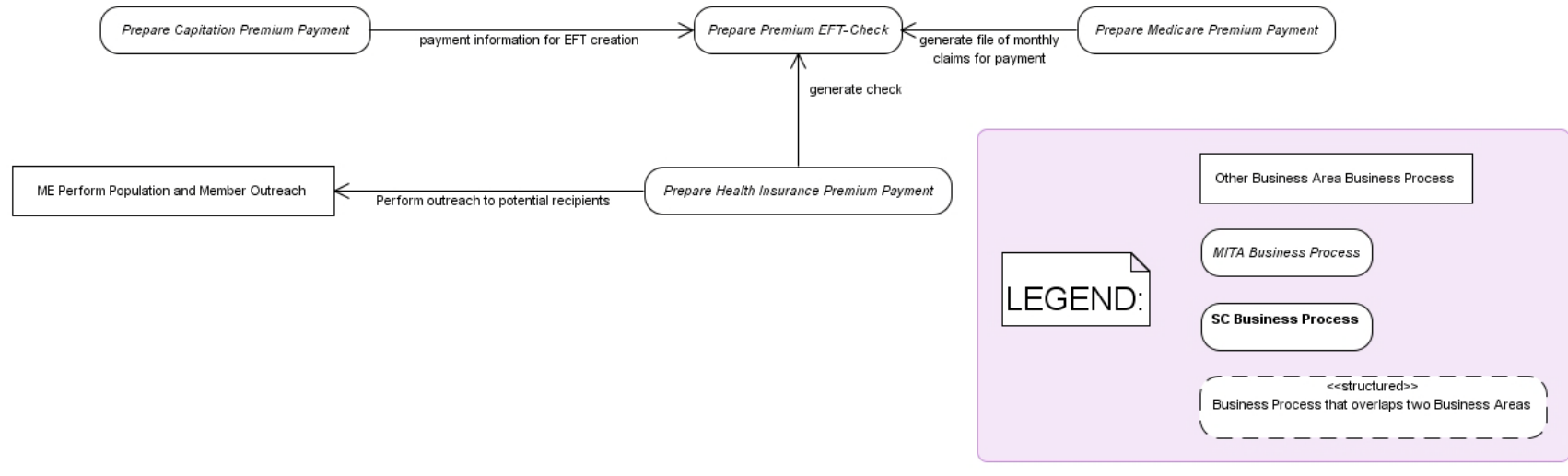


SC Operations Management OM3 Mapping



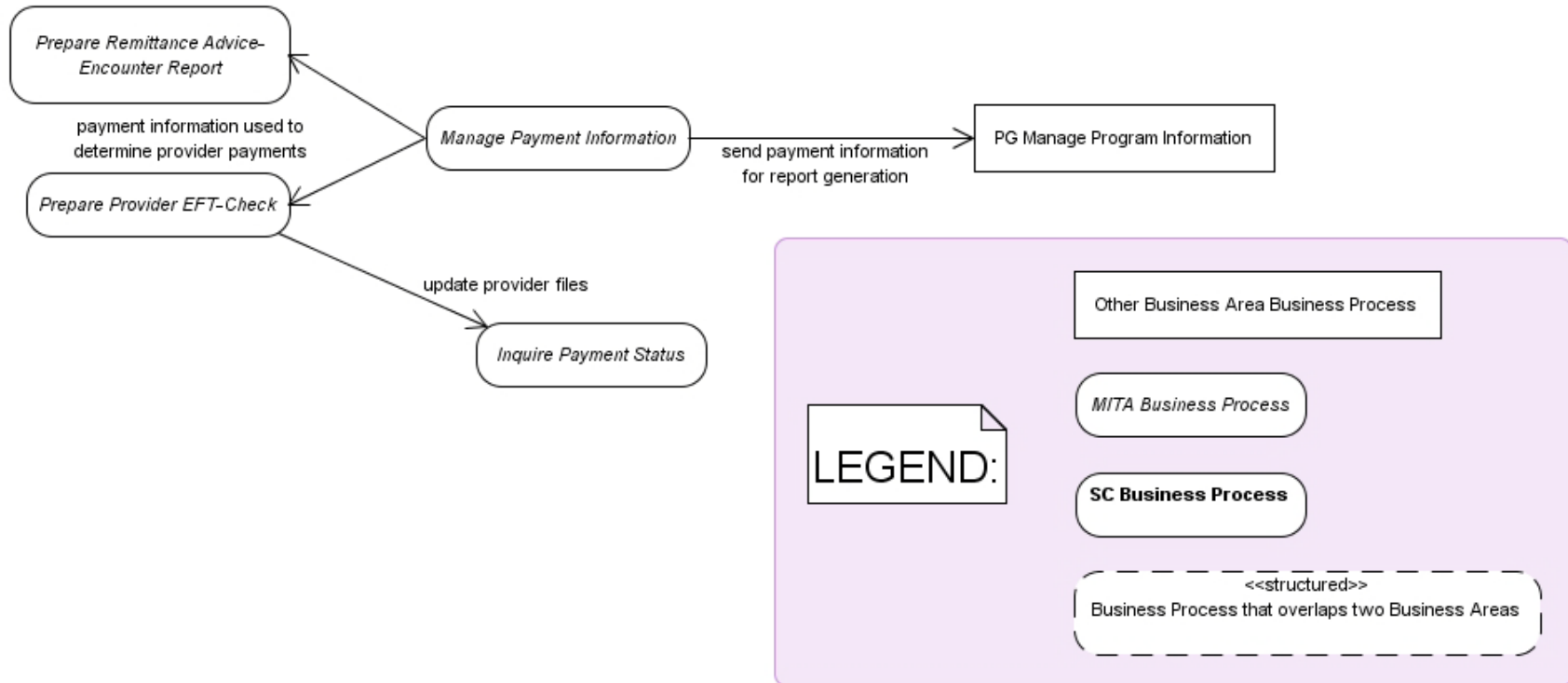


SC Operations Management OM4 Mapping



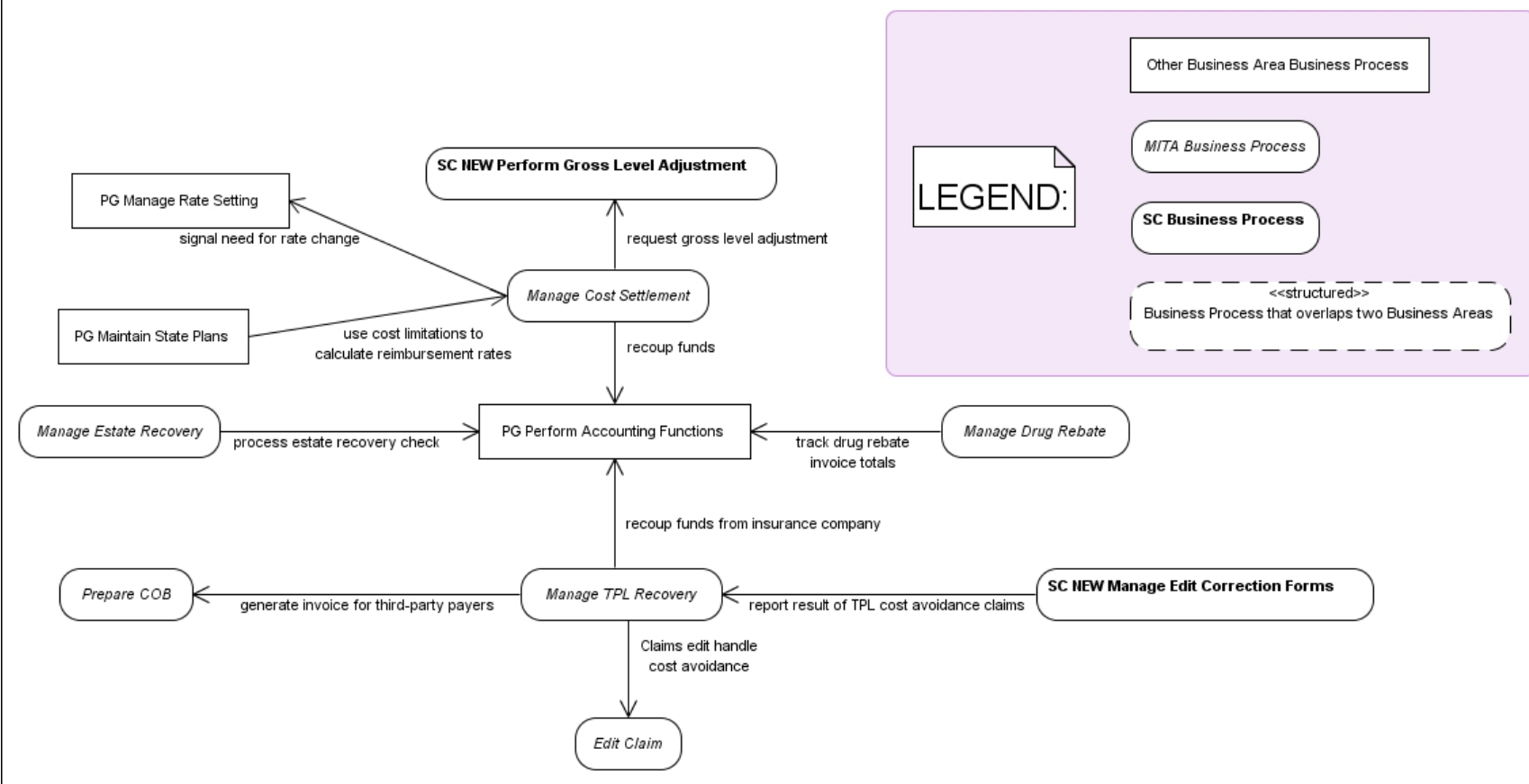


SC Operations Management OM5 Mapping



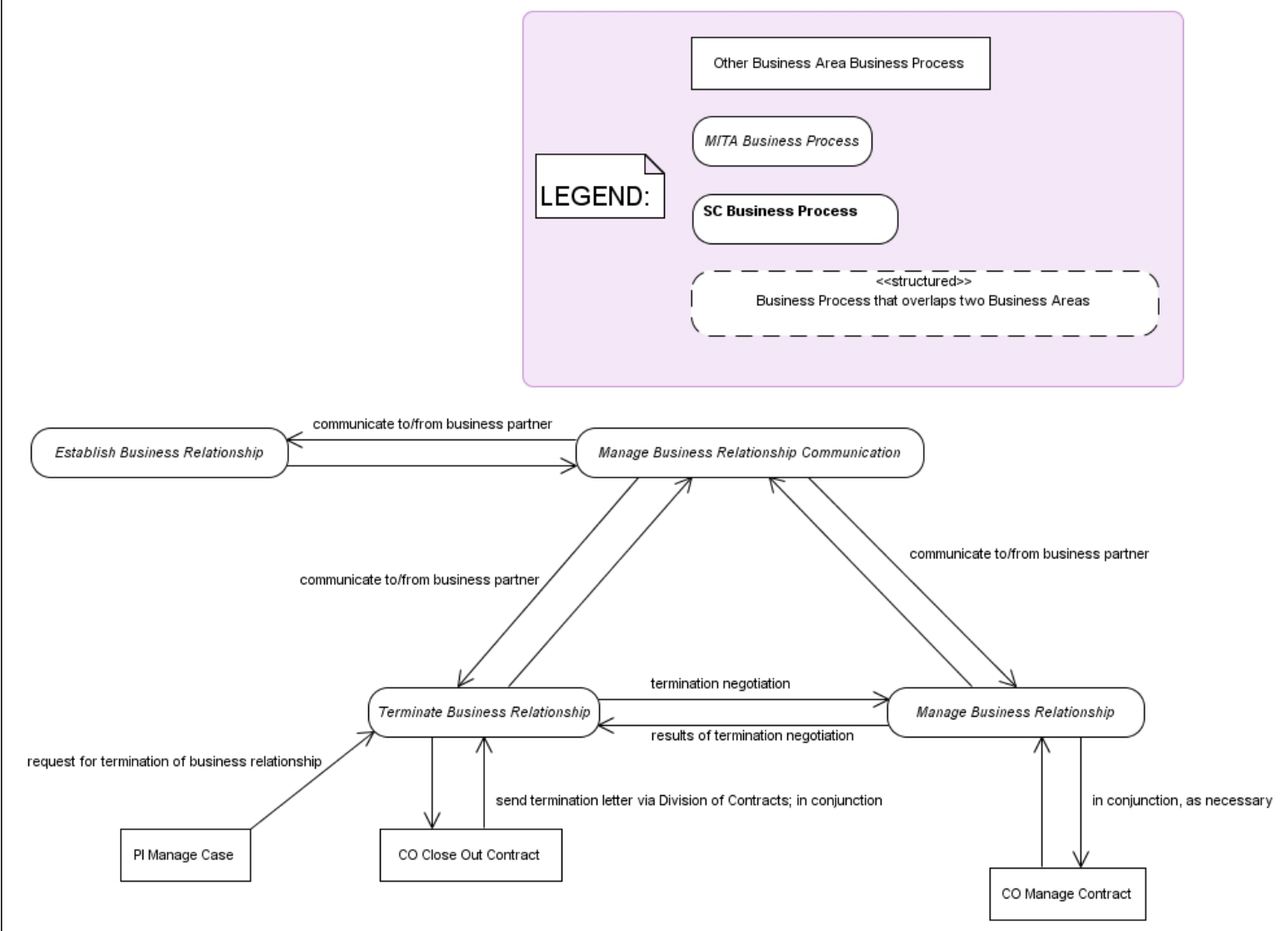


SC Operations Management OM7 Mapping



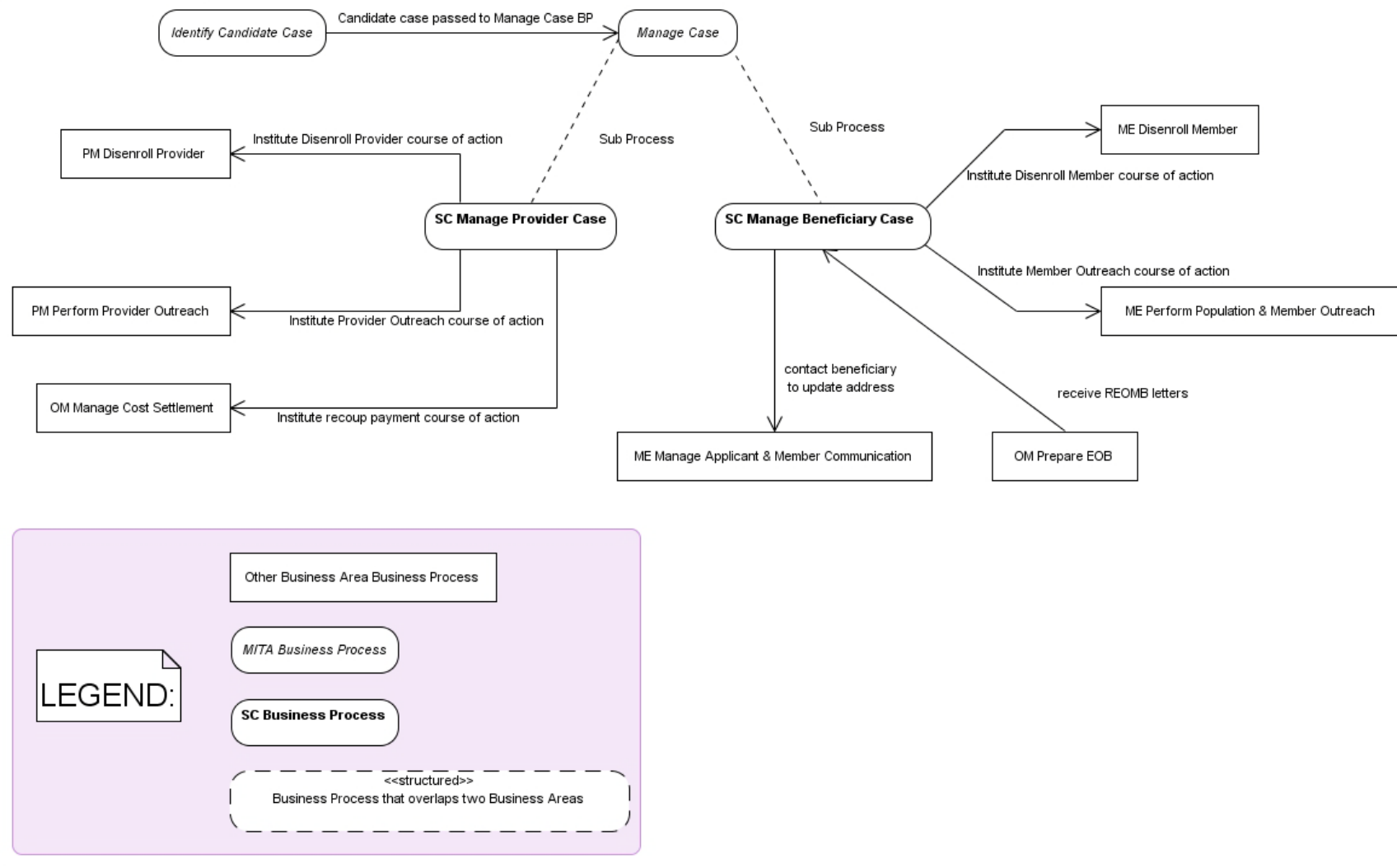


SC Business Relationship Mapping



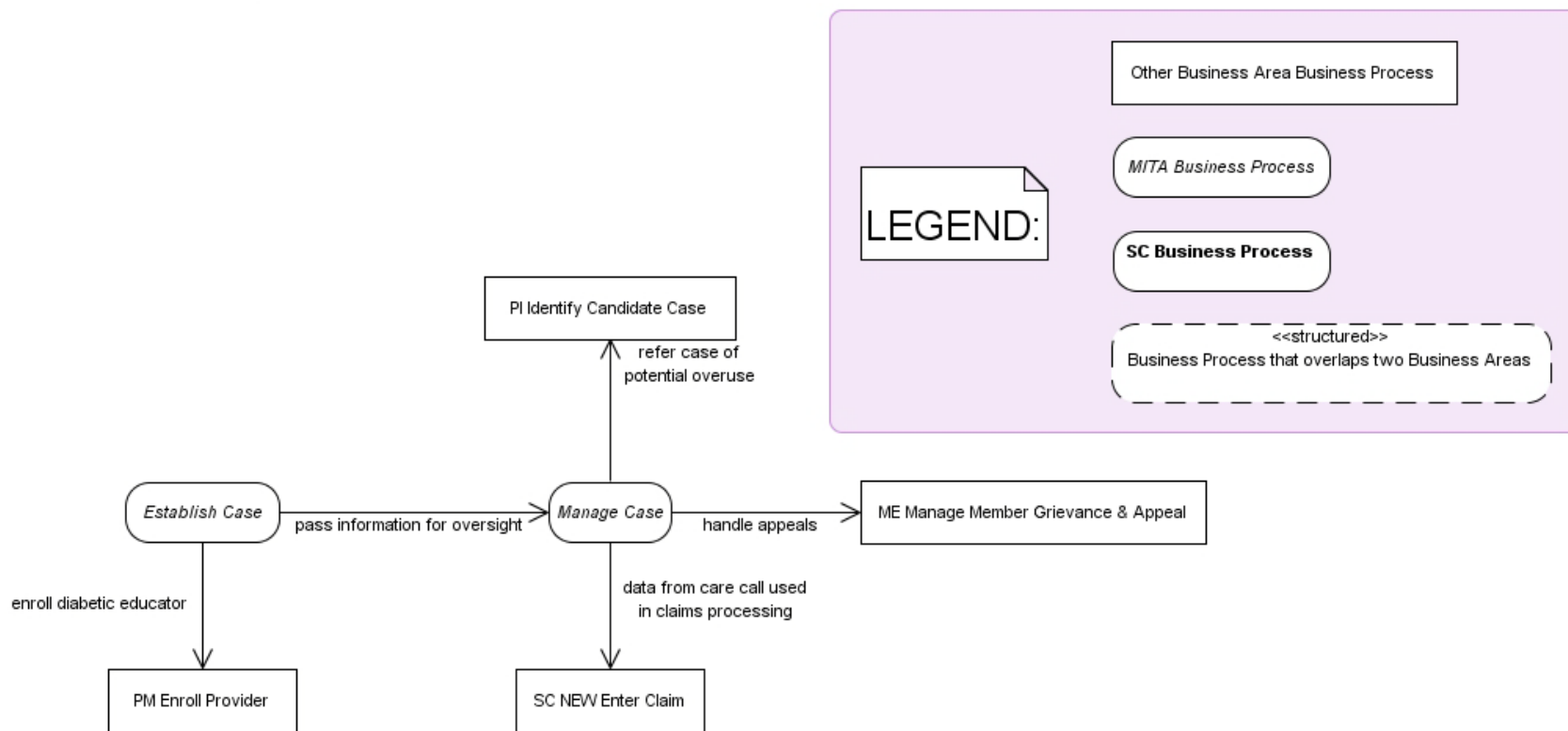


SC Program Integrity Mapping





SC Care Management Mapping



Appendix I: South Carolina Healthy Connections Medicaid Transformation Plan



Medicaid Transformation Plan

Presented by

The
South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Robert Kerr
Director

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I. The Need for Change

Medicaid is a necessary investment for South Carolina. We spend one-fifth of our state budget on health care for almost twenty-five percent of our population. Despite this significant investment, our general health outcomes remain remarkably poor. The truth is our real problem is less about cost than it is about value. We have narrowly measured success by how well we control costs without considering outcomes. Such a narrow focus can actually result in a lower return on investment. By focusing on quality, we can improve outcomes and achieve a higher, more effective return on our investment.

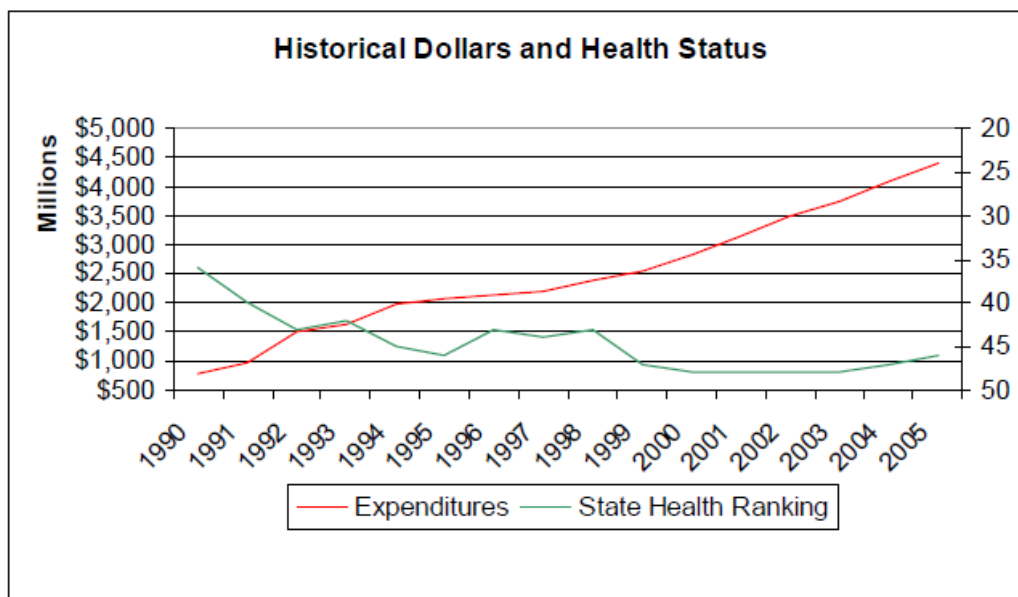
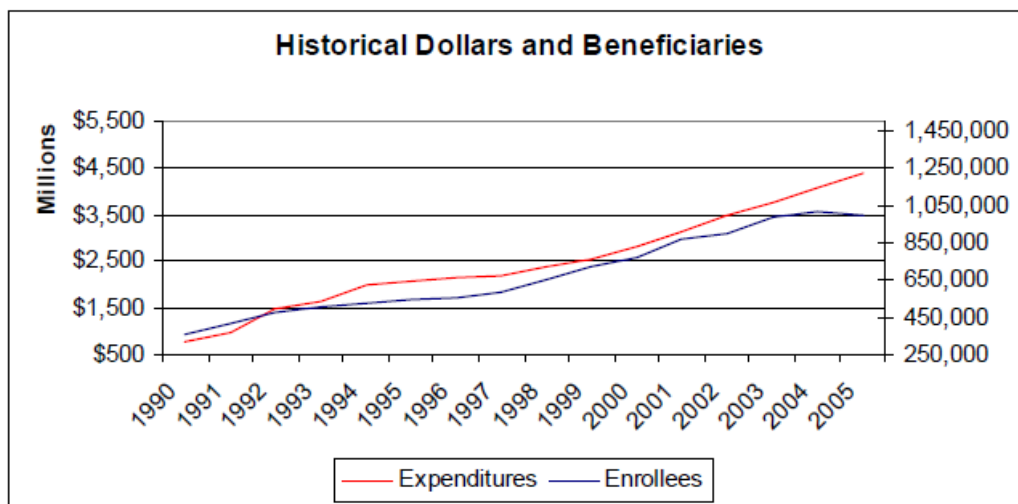
To have any hope of achieving lasting and successful reform we must accept certain realities. One is that we have a massive and diverse health care system; yet, its many parts are inter-dependent. If you change one component you will affect the others. This principle begs for widespread, synchronized change but such global transformation is unlikely. The reality is that change will come incrementally. The key is to identify powerful changes that confront the fundamental inefficiencies driving up cost. We have identified several such underlying issues that, if addressed, can have a dramatic impact on the Medicaid program and the system as a whole.

First is the fact that many South Carolinians are generally of poor health. We currently rank forty-sixth in overall health among the fifty states. Our citizens are some of the more obese in the nation and the state generally falls in the top ten for occurrences of most major diseases. It has been estimated that over half of one's individual health is controlled by personal behavior. If this is the case, then we have an opportunity to significantly improve our present situation. To adequately sustain a health care system over the long term, it is clear that South Carolina must address its attitudes toward healthy behavior.

The second cost driver is best characterized by the so-called eighty/twenty principle. It seems that health care is also subject to this phenomenon of unequal distribution in cause and effect. Roughly twenty percent of Medicaid recipients account for approximately eighty percent of all cost. Acute and sometimes unavoidable conditions contribute to this disparity. However, these costs also include chronic conditions that are treatable and often preventable. To expect critical short-term success in controlling costs and improving health outcomes, Medicaid must identify those manageable conditions within the twenty percent population. More importantly, we must refine our ability to predict who will likely become a high utilizer and encourage timely interventions.

The third issue relates to the lack of an overall coordinating force that demands and rewards continuous value from the system. Historically, the Medicaid agency has functioned primarily as a process or claims payment entity. It has been less effective at controlling costs outside of the traditional options of reducing rates, services, or eligibles. Even if techniques to improve value were identified, the agency lacked an effective delivery system by which such measures could be put into action on the local level. What prevails is a somewhat fragmented system of independent service providers with independent objectives. The result for both patient and provider is often a lack of coordinated care and essential information. To realize lower costs, the agency must realign its focus to become a coordinating influence that promotes innovation, responsibility, quality and efficiency. We must become the binding link to coordinate a fragmented delivery system around the patient and to move the system towards providing quality.

While Medicaid is a necessary investment for South Carolina, it can become a better investment. This plan provides the blueprint for actualizing a better investment by moving the system to focus on quality.



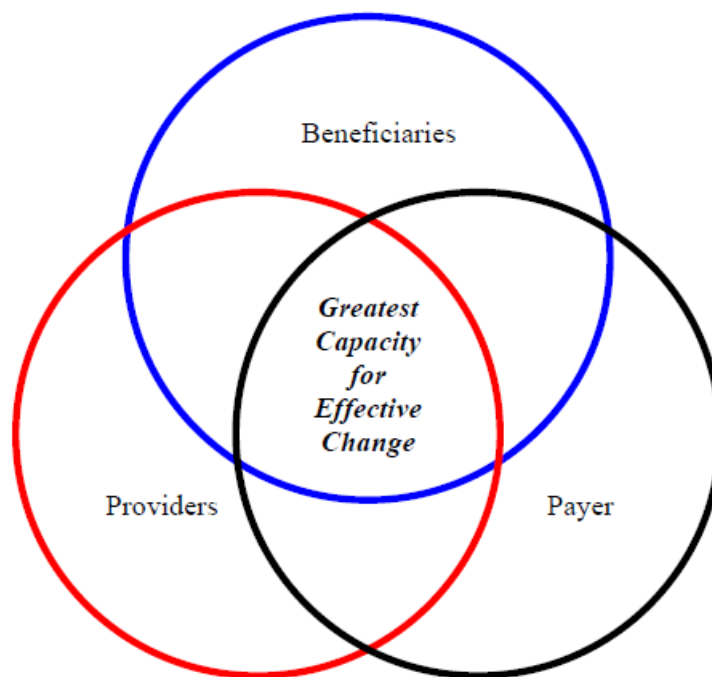
Health Index Rating Source: United Health Foundation

The above charts dramatically show increased coverage, increased expenditures and decreased ranking in health status. South Carolina's Medicaid enrollment and expenditures have more than doubled in the last decade. At the same time, the state's health status has declined.

II. Healthy Connectors

Overview

Health care reform is ultimately about changing behavior and relationships. It involves embracing a cultural change concerning individual health as well as how health care is delivered. Successful reform must bring solutions to bear at the point where the relationships of payer, provider, and beneficiary intersect. It is at this convergence that the capacity for effective change is greatest.



Healthy Connections is designed to create an effective framework that addresses our fundamental cost drivers at this critical point of intersection. The plan's foundation is a delivery system that incorporates competition based on quality, enhances primary care and care coordination, and provides beneficiaries the opportunity to become vested and informed consumers. Beneficiaries should be able to choose from a variety of health plan options that compete on results and quality.

This foundation is then reinforced with unique initiatives or “connectors” that we believe will help drive Medicaid to a value-based health system. These connectors work as catalysts in the form of information and incentives that drive efficiency and innovation. The remainder of this section is devoted to describing these connectors.

Personal Health Account

The Personal Health Account (PHA) will be the primary means to empower the beneficiary to become a well-informed consumer of health care. The PHA is a tool to connect the beneficiary to the status of their own health, health service options, and the cost of health care. Each Medicaid enrollee will be provided a PHA. It will keep the beneficiary informed regarding their use and cost of services. The PHA will reflect the cost of the plan option chosen by the beneficiary against Medicaid’s historical actuarial experience for each risk group. The actuarial experience amount does not function as a cap or limitation on services but only as a cost reference point. For example, if a beneficiary chooses a pre-paid health plan, the PHA will show premium payments made on their behalf. Subsequently, we will incorporate periodic encounter data. If the beneficiary requests a primary care case management plan or fee for service product, then the PHA will indicate all claims activity and related costs. Traditional Medicaid explanation of benefits (EOBs) have been difficult for the beneficiary to understand and have provided no information on cost of services. The PHA will improve this process so that it will provide information to the beneficiary, not only about specific services provided, but also alternative scenarios so that a beneficiary can better understand the choices and benefits of different plan selection. As the PHA is refined, cost savings and health alerts will be phased in. Such alerts might include brand name pharmaceuticals with generic alternatives, the use of the emergency room for non-emergency care, or the cost of alternative treatments that could have been chosen. The PHA may advise beneficiaries of the need for health care interventions such as immunizations, health screenings, and check ups. The PHA becomes the portal to a personal health record.

Electronic Personal Health Records

Data is critical to an efficiently operating system. A provider needs as complete information as possible on a beneficiary to provide the best care. This is true of every level of care from the primary care physician to critical emergency care provided in a trauma center. The PHA not only functions to help the beneficiary become aware of health delivery and costs, it also provides the foundation for the development of an Electronic Personal Health Record (EPHR) which will be an essential tool for providers in enhancing the quality of care provided to a beneficiary.

Physicians can provide better care and more effective preventive and ameliorative care if they have readily accessible information about the medical condition and history of a

patient. Electronic medical records systems are typically expensive, vendor based and not compatible with each other. In order to provide assistance to physicians who treat Medicaid beneficiaries, South Carolina is developing access to a HIPAA compliant Electronic Personal Health Record system based on its data maintained by the State Office of Research and Statistics (ORS). The EPHR will provide information on all services and drugs provided including diagnosis. It will also have the capacity for the physician to add information about health status and laboratory results. We are working on the next generation of the EPHR database to include environmental data such as air quality conditions for a geographic area. The database is dynamic so that an individual EPHR can be matched to environmental data. For example, a physician with a patient who has asthma could determine if the patient lives in an area with air pollution problems. This unique innovation has tremendous potential in aiding practitioners in making accurate diagnosis. Information will be accessible when beneficiaries present to providers including hospital emergency rooms to support comprehensive informed care. Because the state will provide the format and access, the EPHR system will be compatible across all providers, free to providers and generated through a system that will be continuously enhanced. Therefore, it will avoid the pitfalls of independent systems that quickly become obsolete.

Quality Rating System

The most significant change South Carolina Healthy Connections brings to the South Carolina Medicaid program is a shift in focus from simply claims processing to improving the health of our beneficiaries. Developing an environment that encourages effective use of data, measuring outcomes, and making evidence-based decisions will drive this change in focus and provide a constant cycle of health care improvement.

Currently, the majority of staff time and resources are expended on establishing measurement of individual service provision and rates, processing claims, and detecting fraud and/or abuse. Limited resources contribute to a reactive program and inhibit attention to defining and measuring quality of care and related health outcomes. As claims processing responsibilities decrease, State administrative resources will be redirected to measuring quality of care and health outcomes

Measurement and reporting of plan performance to the beneficiaries is vital to encouraging health care quality. By providing consumers information that objectively compares plan performance, Healthy Connections will hold health plans accountable for delivery of quality health care. The purpose of rating participating plans is twofold: to educate the beneficiary and to reward plans that work to enhance quality.

One of the objectives of Healthy Connections is to engage the beneficiary in making health care decisions. To actively engage beneficiaries into the process, they need information about health care plans. A report card will be developed to provide the beneficiaries with pertinent information about participating plans that will allow them to

choose plans that best meet their needs. The report card will rate plans on quality of care and other indicators important to beneficiaries. Examples of report card indicators may include the following:

- Customer Satisfaction
 - 24/7 user friendly access
 - Availability of appointments
 - Distance to provider
 - Referrals to specialists
 - Co-payments
- Services to Beneficiaries
 - Disease management programs
 - Pregnancy and newborn special programs
 - Lifestyle programs such as smoking cessation, weight loss, nutrition classes
- Incentives for Healthy Lifestyles of Beneficiaries
 - Rewards for healthy lifestyles (not smoking, maintaining ideal body weight, exercise, compliance with plan of care for certain conditions) can be in the form of financial rewards, gift certificates, reduction of co-payments, et cetera.

It is anticipated that beneficiaries will make better informed decisions about health plan options when provided with report card results. Public reporting of plan performance should also lead plans to focus on quality improvement and better services to attract the purchasing power represented by the beneficiaries.

The second purpose of the report card is to hold participating plans accountable, measure plan performance and to establish incentives for demonstrated excellence in quality of care. Health plans participating in Healthy Connections will be required to measure and report their performance in a number of nationally recognized quality of care categories. Incentives and pay-for-performance strategies will be implemented to reward plans for improving quality of care for beneficiaries. In addition to monetary incentives and public recognition, plans that receive the highest quality scores will receive a higher number of assignments from the pool of beneficiaries that do not choose a plan.

Examples of report card indicators to evaluate quality of care may include:

- Plan Accreditation
- Provider Qualifications and Performance
 - Percentage of board certified physicians within network

- Percentage of primary care physicians who comply with national best practice guidelines for certain conditions
 - Rates of inpatient infections for network hospitals
 - Readmissions due to infections
- Utilization and Health Status Indicators
 - Inpatient hospitalizations per 1000 beneficiaries
 - Emergency room use per 1000 beneficiaries
 - Percentage of members receiving at least one service during plan year
 - Percentage of members with chronic conditions whose treatment programs conform to national protocols
 - Percentage of diabetics whose hemoglobin A1C levels reflect glycemic control
 - Percentage of asthmatics who do not require an emergency room/hospital visit because of appropriate treatment program based on the severity of their disease
 - Selected Health Plan Employer Data and Information Set (HEDIS) measures
- Incentives to Network Providers
 - Differential rates for board certified physicians
 - Pay-for-performance strategies to reward network providers for improving quality
 - Bonus payments to physicians who provide outstanding primary care including such measures as immunizations, diabetes and asthma care consistent with national guidelines
 - Recognize and reward providers that adopt information technology, such as electronic medical records, to improve care

To ensure that the best information is available to plans regarding quality of care and outcomes, the State will establish a Quality Improvement Advisory Council. The purpose of this council will be to assist in the development of medical standards to promote prevention and improve health for beneficiaries. The Council will include representatives from the provider community, and will receive technical support from the State's medical schools, public health agencies and research and statistics office.

The Council will support the development of standards that shift the focus from improved treatment to improved prevention and on the delivery of appropriate, evidence-based care through:

- Identifying best practices
- Developing health assessments that identify the need for health care interventions for beneficiaries

- Developing provider profiles and peer review processes
- Setting spending benefit plan priorities and limitations
- Providing training for providers to promote evidence-based care and technologies that yield positive health outcomes
- Promoting incentives and rewards for plan providers

The proposed direction in the South Carolina Healthy Connections program is a fundamental shift from reacting to bills from providers to proactively promoting data-influenced policies and procedures to enhance patient care and outcomes while reducing long-term costs. In short, the State will be paying for performance. These changes will be implemented through a system of appropriate reporting and use of data to influence purchasing decisions, measure outcomes of care to provide objective results based data, and adherence to evidence based treatment options. The new system will be based on incentives to improve quality care.

Decision Support System

Every state needs to understand and predict its health care trends. This is necessary to implement policies and procedures to maximize beneficiary outcomes. To successfully do this, the State must understand its data and develop predictive rather than reactive models.

The Department has implemented a decision support system that enables the agency to efficiently use its data to identify problems and opportunities to improve health care and status. With this system, the agency can “drill down” to identify gaps in care, duplicative care and best practices. For example, in the treatment of diabetics, the system could identify all diabetics that used the emergency room for care related to diabetes; identify which of these individuals did not get related prescriptions filled routinely before using emergency room care, and whether routine visits to their primary care physicians were made. Based on the analysis, individuals who would benefit from enrollment in disease management programs and medical homes could be identified and appropriate action taken. Additionally, plans can be provided data on its member providers that are not managing their patients in accordance with recognized standards of health care.

The system is the fundamental backbone for plan performance in our quality rating system. The enrollment counselors receive comparative analysis summarizing individual plan quality performance on selected disease states that have been determined to be priorities based on frequencies or severity. As candidates for plan selection are counseled, known beneficiary disease states are reviewed. A recommendation can then be made that is meaningful to the health status of the beneficiary and presents an opportunity for significant beneficiary health status improvement.

This system also provides the basis for constructive intervention for beneficiaries with advanced chronic diseases - that twenty percent of the beneficiaries who use eighty

percent of the resources. This also provides the basis for a predictive modeling system that allows us to intervene with beneficiaries who are likely to become part of the twenty percent. We provide longitudinal health history to the beneficiary, physicians, and health plans that can be used to improve health care value and decrease costs even during periods of transition.

While addressing beneficiaries who have current chronic conditions, the application also provides data that makes it possible to employ predictive modeling to determine conditions that lead to a beneficiary's eventual treatment of chronic conditions. This one system, on an individual beneficiary basis, provides the framework to move away from the "one size fits all" approach to health care, to individualized care that can make the greatest progress to improving health status and return on investment.

Academic Detailing Program

Prescription drug costs continue to escalate in most sectors of society including state Medicaid programs. Unfortunately, this increased expenditure often does not come with improved patient outcomes. In some cases, the consequence of increased drug use is unwanted side effects, drug interactions, and poly-pharmacy leading to secondary costs for the health care system.

Physicians face many challenges when prescribing medicines for patients. Important factors in prescribing are the quality and quantity of information available to prescribers as decisions are being made. Some readily available sources of drug information are the representatives and marketing literature of pharmaceutical companies. Unfortunately these sources of information can be biased and incomplete. It is well known that drug companies are very effective at marketing their products even though these medicines may not be the best medicine for many patients. South Carolina is addressing this problem by implementing an academic detailing program through the South Carolina College of Pharmacy, which is under the auspices of the Medical University of South Carolina and the University of South Carolina. The purpose of the program is to provide prescribers with the information and motivation for optimizing the use of prescription drugs for the patients they serve by providing timely unbiased information about prescription drugs to clinicians.

The program will have the following four major arms to support the effort:

The academic detailing program will use the College of Pharmacy's center of excellence program to provide unbiased information on the efficacy and optimal use of prescription pharmaceuticals. The College conducts independent analyses of drug use, effectiveness and outcomes through both literature reviews and research. Objective information about pharmaceutical products is the cornerstone of the program. Much objective research is conducted and published that does not reach the attention of most prescribers. The program will focus on identifying

specific drugs that may be over prescribed, inappropriately prescribed, or better therapeutic alternatives.

Identifying both the prescription drugs and prescribers that will be targeted is key to ensuring the effectiveness and cost benefit of the program. By using a current database of Medicaid payments for prescriptions and physician services, both the drugs to be targeted and the prescribers will be identified. It is essential that the database be current because prescribing patterns quickly change in response to the drug detailing efforts of the manufactures. The program will begin by targeting high volume drugs that have been identified as having a high potential for inappropriate or unnecessary use. The prescribers to be targeted will be those who serve the highest number of enrollees who fall into the demographic for receiving the targeted drug.

Once the problems and potential for improvement have been identified through the activities of the College's program to identify best use of drugs and the drugs and prescribers to be targeted have been identified, the program will prepare information for prescribers in a user friendly format and deliver it to the prescribers. Concise information about the targeted drugs will be prepared including clear information sheets on patient conditions, step therapy, and the efficacy of the possible drugs that can be used. Clear and simple data analysis and such tools as "prescription pads" that contain life style directions will be provided to prescribers. In addition, "academic detailers" will visit prescribers, just as manufacturer detailers do now. The academic detailers will have training in presentation methods and tools available to them so that they can compete with the detailers that represent manufacturers. Rather than focusing on selling a specific drug, the academic detailers will focus on the best treatment for a patient with a specific condition.

The final arm of this program will be e-prescribing. The easier it is to access the preferred therapeutic intervention, the more likely the prescriber is to utilize the information provided through the academic detailing program. Additionally, e-prescribing reduces errors in both the writing and filling of prescriptions. The program will identify the best way to provide the high volume Medicaid prescribers with the support of e-prescribing technology. This phase of the program will include identification of barriers to physicians using e-prescribing technology, development of a strategy to overcome these barriers including training in the use of e-prescribing technology and provision of the technology to high prescribers and tailoring the e-prescribing technology to be used to incorporate information developed through the other arms of the academic detailing program.

Enrollment Counseling Services

Prior to Healthy Connections, the Medicaid administration interfaced with the beneficiary only at the point of eligibility determination. Once determined eligible, the beneficiaries was on their own to find providers and manage their health care and life style. Healthy Connections changes this lack of interaction by providing ongoing interaction through enrollment and utilization feedback. The goal of Healthy Connections is to support the beneficiary so that they can make informed consumer choices.

Toward this end, Healthy Connections provides the services of an enrollment counselor and ongoing communication services creating an interface between the beneficiary and the plans available to the beneficiary. As a first step, the enrollment counselor conducts a health assessment to help match the best health plan for the individual beneficiary's health needs. It is this step that brings the benefits of the quality and rating system to the beneficiary.

To ensure that beneficiaries are connected to the best delivery option based on their needs and circumstances, an enrollment counselor will assist the beneficiary in selecting the system of care. The counselor will combine information about the beneficiary's current physician, health status and care needs with the rating information on provider plans and services offered by the plans. The health plans are precluded from both targeted individual marketing activities and directly enrolling members. They present proposed coverage and rate packages to the State for approval. The State evaluates the plan and prepares a plan report card.

The information is presented to the beneficiary in easily understood format, by specially trained enrollment counselors. Services include the use of written and audio/visual materials to explain the Healthy Connections program, benefit plan options, and features of each plan at an appropriate educational level.

The enrollment counselor utilizes health appraisal tools to consider the known needs and prior/projected expense of the beneficiaries' given budget group factors such as:

- Age and sex of member(s)
- Frequency of medical visits during last 12 months
- Access to medical home (regular physician)
- Occurrence of emergency room visits in the last 12 months
- Maintenance drugs
- Known chronic conditions
- Ongoing trauma related conditions
- Other insurance available
- Expected due date, if pregnant

The enrollment counselor uses this information with predictive modeling applications and explains how the different benefit plan options could enhance or limit the beneficiary's ability to meet their specific health care needs. The counselors utilize the State approved marketing and the state developed rating/report card to illustrate how different beneficiaries could benefit from the various plans. Equipped with this information, the beneficiaries will have a determined number of days to select a benefit coverage plan. If a beneficiary chooses not to select a plan, one will be assigned to them.

Finally, the enrollment counselor provides ongoing counseling to the beneficiary upon beneficiary request and processes complaints about the plans from their enrolled members. Beneficiaries can contact a counselor at any time during the enrollment year to discuss any problems or issues or to obtain answers to questions through typical toll-free access call center functions. Written information is mailed to beneficiaries prior to the annual enrollment process to remind them of the enrollment period, provide updates to plan information and to encourage contact with their counselor for assistance and updated plan options.

A toll-free enrollment counseling number allows beneficiaries to speak with enrollment counselors to answer questions and provide assistance regarding the various options available. The call center is staffed with professionals qualified to address the needs of the beneficiaries and applicants including the appeal or grievance process related to plan enrollment. The Department maintains its toll-free beneficiary call center to provide assistance beyond that which is offered by the enrollment counselors.

Prevention and Healthy Living

The Medicaid program continues its efforts to promote prevention and healthy lifestyles. For example, we have recently expanded coverage for smoking cessation products and routine colonoscopy screenings. As described in the Quality Rating System section, emphasis will be placed on robust plan coverage for prevention and healthy lifestyle programs. While coverage issues are a keystone to the promotion of health for our beneficiaries, the Healthy Connections program extends beyond program coverage options. We address this broader responsibility through two major initiatives.

First, the Department is the State's clearinghouse for prevention and healthy lifestyle activities. As a part of this responsibility, the Department reviews all State funded efforts to identify and report gaps and duplication. To address the potential for improvements and new initiatives, the Department is developing a program of community health grants targeted to those communities that are high drivers of Medicaid cost. These grants will be awarded to communities on a competitive basis. Factors determining successful proposals include impact on community health status, reduction of health disparities, innovation and potential for replication. We believe that it is critical that communities play a key role in enhancing the healthy lifestyles of their citizens. It is at the community level that the message of consumer empowerment and responsibility can be reinforced.

Community support and reinforcement is essential to change community culture and move a large number of residents from unhealthy lifestyles toward healthy lifestyles.

Next, one of the most exciting opportunities that Healthy Connections provides to address improved prevention and healthy lifestyles is through the state's geo-coding capacity. Through the Office of Research and Statistics (ORS) data warehouse, health status problems can be identified geographically down to levels as specific as a city block. Using this technology, interventions will be targeted for high risk/high incidence areas. Programs tailored to specific small communities can efficiently address issues that span the spectrum of the environmental problems, cultural issues, and healthcare access. This approach offers the opportunity to engage local community leaders and resources to maximize the awareness and acceptability of new programs and interventions while having the greatest impact on the community residents.

Transportation

Getting the beneficiary to the right place to receive the right health care service at the right time is critical to having an efficient health care system. Beneficiaries who cannot get to physician and therapy appointments end up in emergency rooms with more critical health care needs. The current transportation system has received little attention and priority. Scheduling non-emergency transportation has been difficult and unreliable. No one entity has had this responsibility and it has been an add-on job for staff that is fully employed with other primary responsibilities.

To correct this problem, Healthy Connections is implementing a regional broker model for non-emergency transportation services to control inflationary growth and ensure beneficiary access to covered medical services. The State will pay a broker(s) a per member per month rate based on historical data per region of the state and includes both contractual and individual transportation provider services. The broker(s) will provide a single point of contact for recipients, eligibility verification, determination of least expensive appropriate mode of travel, trip scheduling and dispatching, and cost and trip reporting. Broker(s) will enroll and reimburse non-emergency transportation providers and oversee beneficiary services. This system was initially authorized through a waiver and is now being transitioned under authority of the Deficit Reduction Act.

By providing reliable and routinely available transportation services, patients gain access to primary and preventive care services. It is an integral and essential component of the Medicaid reform offered through Healthy Connections.

Community Choices for Long Term Care

As the State's 1915(c) Independence Plus waiver, *SC Choice*, was set to expire on June 30, 2006, a decision was made to use the renewal of this waiver as an opportunity to combine it with the state's existing 1915(c) elderly/disabled waiver. The purpose of this action was twofold: 1) to simplify administrative functions for waiver administration and

operations and 2) to promote participant direction opportunities through the creation of a continuum of options.

Effective July 1, the more than 11,000 participants in this new waiver, *Community Choices*, have four options to choose from in determining how their long term care services will be delivered. These are:

Option 1 – This option is all agency-based services with no participant direction. Participants may choose to have the traditional home and community-based services provided by agencies.

Option 2 – This option allows for some degree of participant direction in two services: attendant care and companion services. Participants may choose an individual who meets specified qualifications to provide these services and have supervisory authority over the attendant in hiring/firing, scheduling, and determining daily activities. In addition, agency-based services are also available.

Option 3 – In this option, participants receive attendant care services provided by an individual who meets specified qualifications, and they have limited budget authority. In addition to supervisory authority, participants have a budget based upon their personal assistance needs. This option allows them to negotiate salary levels with the attendant and potentially increase the hours of service they receive.

Option 4 – In this option, participants have supervisory authority as well as substantial budget authority. A six-month budget is developed based upon services that would have been received if the participant had chosen agency-directed services. (Adult day health care, in-home personal care services and home-delivered meals are included.) This budget can then be used by the participant for these or similar service as well as for appliances and chores services, which are not available in Option 1, 2 or 3.

Participants may move back and forth among these options so as to determine which option will best meet their particular needs. Case managers are charged with working with participants in explaining and exploring all available options and setting up services within the option chosen. Fiscal intermediary services are utilized in options 2, 3 and 4.

Partnerships for Long Term Care

South Carolina, like most other states, is experiencing a tremendous growth in the aging population. Additionally, the escalating costs of long term care places a significant burden on the Medicaid system. To qualify for assistance through the Medicaid program, individuals must meet financial eligibility guidelines. Those with excess assets must spend down their assets to show financial need. Healthy Connections will utilize Section 6021 of the Deficit Reduction Act to provide for a Qualified State Long-Term Care Insurance Partnership program in South Carolina. The agency will pursue a state plan

amendment that will provide an exemption from state recovery in an amount equal to the benefits paid by qualified long term care insurance policies, where those benefits were disregarded in determining an individual's eligibility for Medicaid. Healthy Connections will promote individual responsibility and planning for long term care services by allowing consumers to purchase a long-term care policy whose benefits must be exhausted before qualifying for Medicaid. Once the insurance coverage is exhausted, individuals may apply for Medicaid while protecting the level of assets as defined in their policy. The partnership program provides an incentive for individuals to purchase long-term care insurance and offset program expenses through private sector insurance products. Through this initiative, fewer citizens should require public assistance to meet their long term care expenses.

Adults with Persistent Mental Illness

Although a significant portion of Medicaid funding is expended on beneficiaries with a mental illness diagnosis, little attention is usually given to this population in Medicaid reform proposals. Any proposal that does not address the needs of this population cannot meet the goals of improving the health of the beneficiary population and achieving efficiency in the program. As individuals with persistent mental illness have become deinstitutionalized, it has become imperative that any effective Medicaid reform address this population.

Generally, beneficiaries with persistent mental illness live in the community. Long-term institutionalization has become the exception and most who had been long-term residents of institutions have been discharged into the community. This change has resulted from developments in pharmaceutical treatments and the resulting availability of atypical drugs that enable the recipient to function in the community most of the time. These recipients' primary use of services is through the community mental health delivery system. There is little, if any, coordinated physical health care. Many do not get identification of or care for physical problems until they are in crisis. Even then, their physical problems may go undiagnosed and their symptoms attributed to their mental illness. Frequently, the site of their crisis care for their mental illness as well as their physical problems is the local acute care hospital emergency room.

Case managers in the community mental health system are limited in their effectiveness because they currently only have the information the patient reports to them as the basis for their understanding of many health care components that affect the patient. While they have access to information prescribed for the patient through the community mental health system, they do not know how the patient complies with the prescriptions for care. For example they may know that a community mental health physician has prescribed an atypical drug; however, they have only the report of the patient regarding whether they are taking the medication routinely. Further, they do not know whether the patient is getting other prescriptions for the same condition from physicians outside the community mental health system. There also is no information available to the case manager about

physical health problems. Patient reporting is often an unreliable source of information, and this is especially so for individuals with persistent mental illness.

The EPHR will provide the case manager a dynamic tool. From the EPHR, the case manager will be able to see whether the patient is routinely getting prescriptions filled and whether, for example, he is getting multiple atypical prescriptions. The case manager can see which patients are frequenting the emergency room and for what diagnoses. By patterns of use, the patients in most critical need of a medical home for primary care can be identified. Information about co-occurring physical health problems can greatly impact the overall care the patient receives. Armed with the information from the EPHR, the case manager will be able to make major improvements in the quality of life for many of the individuals with persistent mental illness and for the first time, become an effective case manager.

As an additional effort to address the needs of this population, the Department is proposing a pilot project. Individuals with persistent mental illness need to have comprehensive care and a medical home that provides care for all of their needs. To provide integrated comprehensive care, the Department will use one all inclusive rate to pay one provider. This provider will be responsible for managing the total care of the individual and meeting or otherwise arrange for all of their health care needs. If it is necessary to arrange services outside of the managing provider's service capacity, the provider is responsible for the financial payment of the services.

This program will begin with a pilot of high utilizers of Medicaid services, who are over the age of 18, and have a diagnosis of persistent mental illness. The initial pilot will provided a capitated rate and will establish risk corridors within which the managed care provider and the Medicaid agency will share risk and/or savings.

Once implemented with success, the program will be expanded to provide the Medicaid service system for adults with persistent mental illness.

Emotionally Disturbed Children

The current system of care for emotionally disturbed children is heavily biased toward institutional services. If placed in a Psychiatric Residential Treatment Facility (PRTF), all of the child's care is covered by Medicaid, providing an incentive for continued institutionalization. However, for this same child, there are no community based alternative services. Services provided in the community setting are not only more cost effective, but also often more effective in strengthening the family. Community services have better outcomes for preparing the child to successfully live with his family and in the community, and to be successful in school. These factors are key to treatment approaches that enable a child to become healthy and have success as an adult.

While RTF care will remain a critical component for some children for a period of time, it should not be the only alternative. The DRA has recognized this inappropriate

institutional bias and has provided for the alternative path of a home and community based waiver for children with serious emotional disturbance. The Department is applying for a waiver and is working on the development of community based services for these children.

Traumatic Head and Spinal Cord Injury

Many people who experience a traumatic head and/or spinal cord injury become disabled for life. At the point of confirmed long term disability, South Carolina offers services through a home and community based waiver. However, South Carolina Medicaid does not offer early rehabilitation services. Lack of access to specialized intensive rehabilitative services as soon as the patient is medically stabilized, not only results in permanent loss of functioning, it also results in extended stays in expensive inpatient hospital care.

In some cases, early intervention with intense rehabilitation could avoid long term disability. In almost all cases the level of disability could be reduced. Many victims could avoid lifelong dependence on Medicaid with early intensive intervention.

The opportunity for maximum rehabilitative impact is immediately after the trauma. The Department will provide a time limited intense rehabilitative program for individuals who experience traumatic head and spinal cord injury. The rehabilitative programs will require national certification for head and spinal cord injury and also must meet detailed state specified qualifications.

Many individuals are not Medicaid eligible before trauma who ultimately receive Medicaid eligibility back to the time of trauma. South Carolina will pilot a presumptive disability determination process. This will expedite entry of patients into rehabilitative care.

The result of this early intervention program should be reduced cost to Medicaid, improved care and outcomes for patients, and an overall decrease in long term disability.

Cost Sharing

Co-payments are an integral part of any health care plan. For Medicaid, its purpose goes beyond just the financial considerations of cost sharing. Co-payments offer an opportunity for consumers to become price sensitive and encourage the use of the most cost efficient health care settings. The obvious challenge within a Medicaid program is to establish meaningful and affordable cost sharing levels, yet not create obstacles to obtaining services. The new co-payment schedule becomes a dynamic force in the Medicaid program. We encourage preventive and primary care by eliminating all co-payments for these services. We encourage prudent use of health care services by imposing higher co-payments for inappropriate use of emergency rooms and use of name brand drugs where equivalent generic drugs are available.

All beneficiaries will be subject to co-payments with the exception of children, pregnant women, institutionalized individuals, and those in home and community based waiver programs. Family planning services will also be exempt from co-payments. Each provider will be responsible for the collection of co-payments when it is a required part of a benefit plan. As provided in Section 6041 of the DRA, it is important to allow providers to withhold non-emergency services until a plan for payment of co-payments is established with the beneficiary. Providers and beneficiaries should establish a plan for payment of co-payments, acceptable to both, before services are rendered. If the beneficiary fails to follow through with the payment plan, the provider may terminate services to the beneficiary. A beneficiary's inability to pay does not eliminate his or her liability for the co-payment.

Proposed Cost Sharing Schedule

	Current	Proposed	Plan Range
Hospital Inpatient	\$25	\$40	\$0 - \$40
Hospital Outpatient	\$3	\$10	\$0 - \$10
Emergency Room	\$0	\$0	\$0
Emergency Room (non-emergency)	\$0	\$25	\$0 - \$25
DME – Supplies	\$3	\$1	\$0 - \$1
DME – Equipment	\$3	\$10	\$0 - \$10
Dentist (Adult emergency services)	\$3	\$6	\$0 - \$6
Pharmacy – Generic	\$3	\$1	
Pharmacy – Brand with no generic	\$3	\$4	\$0 - \$4
Pharmacy – Brand with generic	\$3	\$6	\$0 - \$6
Primary Care Physician	\$2	\$0	\$0
Other Physician with referral	\$2	\$2	\$0 - \$2
Other Physician without referral	\$2	\$4	\$0 - \$4
Nurse Practitioner/Midwife	\$2	\$0	\$0
Ambulatory Surgery Center	\$2	\$10	\$0 - \$10
Home Health	\$2	\$4	\$0 - \$4
Optometrist	\$2	\$4	\$0 - \$4
Chiropractor	\$1	\$2	\$0 - \$2
Podiatrist	\$1	\$2	

III. The Delivery System

Overview

To create a value based delivery system, the role of the state must move from the myopic function of processing individual claims to a management approach that moves the whole system toward quality.

While Healthy Connections will include current market choices such as Prepaid Health Plans and Medical Homes Networks, it will also serve as an incubator for the innovative forces in the marketplace to develop new approaches to the delivery of health care. Healthy Connections intends to harness the competitive and innovative edge of private industry forces to deliver the best possible products and choices to the consumer. The DRA opens opportunities for providers to offer beneficiaries plans that better meet their needs. Through such a competitive, open environment, the market should respond with efficient and more relevant delivery systems. The real winner in this scenario is the health care end user, the beneficiary. Value based choices enable the beneficiary to become a proactive consumer rather than a passive utilizer.

In the following sections, we describe the operational specifics around plan options. The options described run the spectrum from prepaid plans to primary care case management models; however, we believe one of the greatest values from this demonstration will be attained through the new creative models yet to come.

Pre-Paid Plans

Early experiences with Medicaid managed care often resulted in artificial controls on supply and demand. A value-based health system should instead have plans compete on results and quality. Health plans have the means to contribute to overall value. They have the opportunity to form an infrastructure the Medicaid agency lacks to help beneficiaries navigate the health care system, obtain first-rate care, and manage their own health. Plans can be instrumental in improving the health outcomes delivered by the entire health care system, coaching the beneficiary in methods to improve their overall health and reducing their health care expenses and risk. Most importantly, they can support providers as a critical link in care coordination and case management. By collaborating with providers and measuring performance, plans can open up beneficiary choice rather than constraining it.

Under this option, beneficiaries have the ability to use the PHA to choose managed care organization (MCO). The beneficiary is free to shop for benefits that best meet their coverage needs from the approved plans and becomes not only a consumer of medical services but also a consumer of insurance products.

The beneficiary directs the Medicaid program to pay the insurance company the premium on their behalf. Again, better service and better coverage offer the basis for competition.

The Department provides the MCOs the premium structure for coverage to use as a benchmark to develop their pricing. The plans compete for the beneficiary's premium dollars through their service package and pricing. To the extent that the final MCO pricing is less than the target rates published by the Department, the MCO is then required to provide to the beneficiary a stored value card for the value of the difference, rounded down to the nearest \$10. The beneficiary is free to use this residual of their PHA to directly purchase products and services that support health as limited by the MCO. The intent is that plans compete for the beneficiary's business by creating an array of attractive coverage packages or pricing while bringing their expertise in disease management to the market to influence quality, health status and cost.

Medicaid recipients are responsible for any required co-payments that the insurance plan may require. Plans are not required to charge co-payments; however, if charged, co-payments cannot exceed the established cost sharing schedule discussed earlier.

Plan benefit design must comply with Deficit Reduction Act benchmark coverage requirements. Plans may design a package of services that is more limited in scope for one or more individual services. They may also offer optional services that are not covered by the current Medicaid program. This might include vision or dental services for adults. They may also choose not to cover some optional services that SC Medicaid covers. Plans may limit the amount of any service they cover as long as they meet the amount, duration and scope test for that service and requirements for EPSDT coverage for children under age nineteen.

Plans will be required to contract with the State and will be expected to meet certain standards, which are detailed in the South Carolina Medicaid Managed Care Organization Model contract and the Managed Care Organization Policy and Procedure Handbook. These include, but are not limited to, the following:

- SC Department of Insurance regulations
- Administration and Financial Management requirements
- Benefits requirements
- Reporting requirements
- Quality Assessment and Improvement requirements
- Marketing requirements
- Member Services requirements
- Grievance and Appeal requirements
- Provision of encounter data

Compliance with these requirements will be strictly monitored. Failure to meet established benchmarks could result in monetary sanctions, a freeze on enrollment, the withholding of payment, or other administrative remedies. The existing contract and policy manual will be revised to reflect the standards outlined in the proposal.

Primary Care Case Management (PCCM) Plans

The Medical Homes Network Program is a physician-driven service delivery system designed for Medicaid beneficiaries. Beneficiaries who choose to enroll in this program agree to utilize the primary care physician for their medical needs. This “partnership for care” provides the beneficiaries the assurance that they will receive coordinated medical services. It is anticipated that beneficiaries enrolled in a Medical Homes Network will utilize the emergency rooms less and have fewer inpatient hospitalizations as a result of enhanced primary care.

The goals of the Medical Homes Network are to:

- Establish medical homes for Medicaid beneficiaries to promote continuity of care and improve care coordination
- Emphasize wellness and prevention to improve quality of life
- Better utilize resources through increased patient monitoring, evidenced-based practices, and physician accountability
- Enhance the beneficiaries’ ability to participate more fully in health care decisions

The agency will enter into a risk-based contract with a Care Coordination Service Organization (CSO) for the purpose of the development and maintenance of a Medical Homes Network. The network is comprised of participating physician practices, any advisory boards, and the CSO. The CSO shall be the designated agent for the Network. The agency will contract with any qualified network that meets the standards developed for Medical Homes Networks.

The premium for this plan is actuarially equivalent to the current fee-for-services experience and effectively requires the full amount of the PHA. Additionally, the network will receive a prospective per member per month care coordination/management fee. The agency will share documented cost savings with the CSO. If the CSO fails to achieve cost savings, the network could forfeit up to the total amount of the prospective payments.

The CSO may disburse a per member per month care coordination fee to participating providers and is responsible for developing an incentive or risk based formula to distribute shared savings.

While providers claim reimbursement on a fee-for-service basis, the agency would encourage the development of Medical Homes Network arrangements where the CSO and the network assume more risk and perform more administrative functions to include claims processing. It is anticipated that the Medical Homes Network program can migrate from a fee-for-service system into a Prepaid Ambulatory Health Care Program where the CSO is paid a capitated rate for primary care services.

Option-Out Program

A funding source as large as Medicaid has a tremendous impact on the health care system. That impact sometimes occurs in the form of unintended consequences that often include limiting competition and system-wide cost shifting. Under ideal conditions, Medicaid should simply finance a beneficiary's entry into a mainstream health plan. Unfortunately, Medicaid's lower than market pricing and lack of access to mainstream products are often obstacles to this effort. However, families in the workplace who have access to group coverage do offer us an opportunity to move in this direction. The option-out program facilitates this opportunity.

The option-out program allows qualified beneficiaries to choose to receive medical care outside the Medicaid program with Medicaid providing only a defined amount of financial support. Under this program, the potential Medicaid eligible will not be considered a Medicaid beneficiary in the traditional sense. Instead, they will receive a PHA that can be used to purchase group health insurance through their employer. Using the PHA amounts, low-income working families can pay the employee contribution necessary to enroll (or remain enrolled) in Employer-Sponsored Insurance (ESI) coverage that is available to them. South Carolina believes many low income beneficiaries would prefer to be a part of the mainstream system which insures most working people in this country. Therefore, the State wishes to maximize the number of persons covered through private employment-based coverage, using PHAs to fund premiums. Workplace coverage will provide benefit equity for the poor and for those for whom adequate private coverage is not affordable or accessible. Because it builds on enrollment in mainstream, employment-based health coverage, this initiative may be able to reach uninsured children whose parents are otherwise unable to afford the premium and may expand the available coverage to all family members. Worker premiums for employment-based family coverage generally do not vary with family size (and may or may not vary based on whether the worker's spouse is or is not included), while public program costs do vary with family size.

In some instances, using the Personal Health Accounts (PHA) to fund ESI premiums will allow families to enroll together in a single health plan. Because employer-based insurance is family based, payment of premiums will provide health insurance for some family members who would not be eligible for the regular Medicaid program. These family members are an expansion population under the reform proposal and receive benefits in accordance with the employer group benefit plan. This model forges a partnership between Medicaid, private business, and working citizens.

Health Opportunity Plan Pilot

It is essential to both enable and require the Medicaid beneficiary to participate as a prudent buyer of health care services. The Medicaid beneficiary, just like other consumers, needs to be financially vested as a purchaser of health care and needs to be armed with information that enables him to make informed decisions.

The Healthy Connections program is focused on:

Creating patient awareness of the high cost of medical care – The PHA reporting tool provides the HOA participant with routine reporting of the services received and fees paid through the patient's account. Additionally, prevention and healthy lifestyles information is provided through the PHA account reporting.

Providing incentives to patients to seek preventive care and reduce inappropriate use of health care services – through access to enrollment counselor services, the beneficiary is educated regarding the economy of preventive services. Since the beneficiary is able to carry the balance of the account with them, there is an incentive to make routine use of low cost, highly effective services.

Enabling patients to take responsibility for health outcomes – through activities such as smoking cessation, balanced nutrition, exercise and maintenance medication compliance, the beneficiary experiences fewer expenses against the HOA, keeping a larger balance in their account.

Providing enrollment counselors and ongoing educational activities – as described above, the Healthy Connections program provides extensive counseling and educational services to all beneficiaries.

Providing transactions electronically and without cash – the PHA establishes a beneficiary account from which “charges” similar to a credit transaction is processed. Once the account is exhausted, the beneficiary is moved over to the regular Medicaid program.

Providing access to negotiated provider rates - enrolled Medicaid providers will be required to accept the normal fee schedule from HOA participants.

Within Healthy Connections, there will be a self-directed care demonstration utilizing the Health Opportunity Accounts of the DRA. The purpose is to determine:

- The extent beneficiaries consider price when they are in control of their own spending
- Whether a self-directed plan is viable for a Medicaid population
- If successful for some beneficiaries, but not others, for which population this program is beneficial
- Refine criteria for participation

- What education supports and resources are essential for the covered population
- Impact on health status
- Impact on expenditures

The self-directed program will be implemented by geographic area and expanded incrementally based on the success of each area. Initial criteria to identify beneficiaries who may be successful candidates for participation in this option include the following:

- Should not have a history of unstable expensive acute care crises
- Must have a medical home (Primary Care Physician)
- Should demonstrate a reasonable understanding of their health care needs

Beneficiaries in the self-directed plan will receive an age-appropriate deposit to their Personal Health Account (PHA) as set forth under DRA.

Beneficiaries will use their PHA to obtain covered services directly from health care providers. Enrolled Medicaid providers will be required to accept the normal fee schedule from HOA participants. The providers would also be required to accept HOA participants on the same basis as other Medicaid clients. The recipients will not be subject to the current service limits and can use their funds to purchase what is most important to them in relation to their health care. The PHA balance will be accessed using a stored value card and will function under the same premises as existing flexible spending accounts. The flexibility of this account allows a beneficiary to choose to customize their care to meet their needs. For example, one beneficiary may not use other optional services, but choose to cover additional prescriptions per month.

The demonstration will provide protection for the beneficiary by moving the beneficiary to a full service MCO or MHN when the beneficiary exhausts their PHA. This coverage will be limited to mandatory services and prescription drug coverage. The beneficiary will be responsible for cost sharing obligations under the MCO or MHN once the coverage begins. Beneficiary health status and health care utilization will be assessed at their point of entry into the program and annually thereafter. Additionally, beneficiary satisfaction will be assessed annually.

The State will contract with a vendor to develop and provide the administrative frameworks for this project that will include:

- A system for provider participation
- Consumer education on the use of the Health Opportunity Account
- Pricing information

The vendor's design may create opportunities for reduced administration such as capitated payments for primary care and pharmacy discount cards.

Fee-for-Service

The current fee-for-service will be maintained for eligibility categories excluded from participation in Healthy Connections. Fee-for-service will also be maintained as an option as the state transitions to Healthy Connections; however, it will not be considered the primary default option during enrollment.

Fee-for-service is the mechanism used to pay for retro-active services; however, this coverage is limited. Retroactive coverage extends only to the date of receipt of a complete application or up to thirty days prior for an emergency service or pregnancy related service. Dual eligibles are limited to participation under the Fee-for- service option. The Department is open to negotiations with Medicare in the event that a joint program allowing participation with a MHN or MCO would be beneficial.

Other Considerations:

Risk Adjustment and risk sharing - A risk adjustment methodology will be used which will consider health status in addition to age, gender and eligibility group. Risk adjustment reduces the affects of adverse selection and provides a better match of payment level and risk. The Adjusted Clinical Group (ACG) method developed by Johns Hopkins University is the risk adjustment method that will be used for Healthy Connections.

The State has an interest in encouraging plans to participate in Healthy Connections to promote maximum competition and beneficiary choice. The State also recognizes that the risk of covering the relatively small number of beneficiaries with extremely high cost cases may present a barrier to participation for some plans. In such cases, the state excludes these costs from the managed care rate. For example, transplants will continue to be covered separately by the State under contract with the Medical University of South Carolina.

Drug Rebates - It is necessary for the State to continue to realize the savings under the national Medicaid drug rebate agreements with drug manufacturers. MCO's participating in Healthy Connections will be assigned through their contracts with the State the authority and responsibility to report the required drug claim information to the manufacturers and to collect the drug rebates on behalf of the State. In setting the rates for the MCO's an adjustment will be made by the actuaries based on the assumption that the MCO's will realize the full Medicaid rebate on drug claims paid by the MCO. This approach is cost neutral to the federal government because the rate paid to the MCO is net of the drug rebate amount, thus no federal expenditure has been incurred for the federal share of the drug rebate.

Hospital Payments - The State is proposing three alternatives for the treatment of hospital payments in relation to the Healthy Connections proposal. First, the State intends to exclude the Medicaid Disproportionate Share Hospital (DSH) Payment Program and

the Hospital Upper Payment Limit (UPL) Program from the Healthy Connections proposal. An alternative proposal is to treat the inpatient and outpatient hospital services provided to South Carolina Medicaid recipients enrolled in a managed care setting or any other health insurance plan (that provides coverage for inpatient and outpatient hospital services) in a similar manner as those federal regulations (Section 1902 (bb) (5)) that pertain to Medicaid FQHC and RHC services provided to Medicaid recipients enrolled in a managed care plan. The third alternative that the State proposes is to create a Safety Net Pool for qualifying hospitals using the funds currently designated for hospital UPL payments. The qualifying hospitals will be those identified in accordance with Attachment 4.19-A of the South Carolina State Plan.

Third Party Liability - Under Healthy Connections the same assumptions that are currently used to adjust the capitated rates for MCO's to allow for third party collections by the MCO's will be used in the rate-setting for all types of plans and providers. In other words, the rates will be adjusted based on our current experience in third party collections and the providers will be allowed to collect and retain all third party revenues. This will be cost neutral to the federal government because the rates will be net of third party recoveries, thus no federal expenditure has been incurred for the federal share of the costs that were covered by third party insurance. To facilitate this process and to maintain the current level of third party recoveries during the demonstration period, the State will continue to capture third party coverage information on Healthy Connections beneficiaries and will make this data available to plans and providers. The state is pursuing additional legislation to ensure that all reasonable measures are taken to ascertain the legal liability for a health care claim.

South Carolina Healthy Connections Improving Medicaid for South Carolinians in Need		
Healthy Connections will bring the benefits of consumer choice to South Carolina's Medicaid system to improve the long-term fiscal health of Medicaid and the physical health of its recipients.		
Current 20th Century Model	Reform	Healthy Connections 21st Century Model
<ul style="list-style-type: none"> - A "one-size-fits-all" plan for 850,000 recipients - Medicaid program is the only choice for Medicaid-eligible workers - Most recipients lack an appropriate medical home - Reactive, uncoordinated care results in Medicaid recipients using emergency room 66% more than other patients - DHHS is an input focused, volume driven state health provider - Outcomes are under-measured - Providers are rewarded for filing more claims and providing increased, more expensive services. - Patient is too often seen as part of the problem as utilization and health care costs escalate - Medicaid program is financially unsustainable, raising the possibility of future cuts in services or beneficiaries 		<ul style="list-style-type: none"> + Patients have a choice of several plans tailored to individual needs + Medicaid-eligible workers can choose to join Medicaid or opt to receive help with paying their employer insurance premium + Most recipients have a medical home with a primary care physician who knows them and understands their needs + Proactive, coordinated care keeps more recipients healthy and out of the emergency room + DHHS is a results-focused, patient-centered manager of health plans + Outcomes are more closely measured and used to increase quality + Providers are rewarded for quality care and share in program savings + Patient becomes a part of the solution as their consumer choices improve quality and stabilize the growth in cost + Medicaid program placed on more sustainable financial footing, making future benefits more secure

South Carolina Department of Health and Human Services



Appendix J: Technical Components Self-Assessment Report for the Medicaid Information Technology Architecture State Self-Assessment



November 2009



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Appendix J: MMIS Interfaces

Record layouts, file layouts, jobs, files, reports, and other supplementary materials related to these interfaces are stored in the MITA project repository.

1.1. 1099 Process

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

Annual 1099 Process

Owner Information

Name, phone, email, etc. of user and support contacts

See MMIS Interfaces: Common Answers document.

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

As required by IRS regulations, SCDHHS provides all non-exempt Medicaid providers with a 1099 by January 31st of each year for payments (including various types of adjustments) that they received during the previous calendar year. Duplicate information is provided to the IRS via electronic data interchange (EDI). The current transfer method is FTP to the IRS Web site. This process is a combined effort between SCDHHS and Clemson.

Objectives

What are the goals of the system / interface? Why was it initiated?

The objectives are to comply with all federal regulations concerning the production and distribution of 1099s, to provide Medicaid providers with accurate and timely 1099 information and to produce a data file for electronically transmitting duplicate information to the IRS. The IRS determines the format of the data file.

Business Processes

What business processes require the interface?

See Interfaces Related to BPs document.

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

None

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

A data file is transfer to the IRS annually. It is transferred via FTP.

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, Connect:Direct (C:D) etc.).

Custom

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

The file is transferred to the IRS via FTP. The transmission method is changing this year from tape mailed to the IRS to an upload to the IRS "fire" website at <http://fire.irs.gov> Instructions are available in the IRS publication 1220 on the IRS website: <http://www.irs.gov/> The 1220 publication for 2008 is at <http://www.irs.gov/pub/irs-pdf/p1220.pdf>



Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

Although there is significant testing during the last quarter of each year, the last payment run of the year is the trigger that begins the process to produce 1099s and the data file. This is not an automated trigger, it must be initiated.

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

The 1099 file includes all payments, adjustments, refunds, cancelled checks, etc. that will impact the total amount received by a Medicaid provider. This file is then evaluated to identify exempt and non-exempt Providers based upon criteria established by the IRS. Non-exempt providers receive a 1099, and the duplicate data file is sent to the IRS.

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

Various types of claims, adjustments, etc. are processed through the payment system. At the end of each payment cycle, this information is added to the database. Balancing reports for each payment cycle are posted to D:D. After the last payment run, exempt and non-exempt providers are identified. This information is used to produce 1099 and the file to the IRS.

Outputs

List all system / interface outputs -- e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

The 1099s are generated for each non-exempt provider and a data file with duplicate information is sent to the IRS. Program MAR03BB runs the 1099 program producing the transmittal file, the forms, a balancing reports, and a provider log. Job @MARS199 produces the 1099s. It executes program MAR03BB.

Record Layout

Attach sample layout if applicable.

The current file format is available from the IRS and is maintained by Clemson.

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

Data is transmitted to the IRS via FTP.

Governing Policies

Policies that govern use or other activity involving the system / interface.

IRS regulations govern the production and distribution of 1099s.

Access Control Policies and Security

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

List data security levels, security requirements etc.

Access to the IRS Web site for data transfer is controlled by a secure username and password.

Data is maintained in a confidential manner.

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

N/A



System / Interface Data Processing Standards

If a service level agreement (SLA) or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

The 1099s and the data file to the IRS must be distributed by no later than January 31st of each year.

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

N/A

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

The accuracy and distribution of 1099s is critical to the business function of SCDHHS. There are penalties associated with failing to distribute 1099 information timely and for failure to submit 1099 information to the IRS.

Disaster Recovery

Attach any disaster recovery plans.

See MMIS Interfaces: Common Answers document.

Contract

Legal agreement status and document location.

N/A

Data Storage & System Attributes

*What programming languages were used in creating the system / interface, or what **Commercial, off-the-shelf (COTS)** software was acquired?*

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format / schema documentation if possible.

N/A

Transaction processing

Type (batch / real-time).

Batch

Data Quality Control

Describe quality control policies / procedures.

N/A

Backup

Describe / attach backup procedures and policies.

See MMIS Interfaces: Common Answers document.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

N/A

Support

Support hours and response times. Who handles user support, and how? Explain escalation / levels, if applicable.

See MMIS Interfaces: Common Answers document.

The Production Support Team at Clemson provided support for the 1099 process. Standard response time is usually sufficient unless a problem occurs during the production of the 1099s or the file to be sent to the IRS.

Incident Management

Process / constraints by which incidents are handled.

See MMIS Interfaces: Common Answers document.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.



Data Center

Where are the system / interface housed?

See MMIS Interfaces: Common Answers document.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

See MMIS Interfaces: Common Answers document.

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens? Include medium, etc.

N/A

Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

See MMIS Interfaces: Common Answers document.

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

See MMIS Interfaces: Common Answers document.

Plans for the System / Interface

How long will the system / interface continue?

The interface will exist separately from the future MMIS and may change as IRS-directed.

What upgrades and replacements are planned?

The data source may change next year (2010 filing for 2009) which means the program name and job name could change.

Legislative climate and other forces affecting system / interface?

N/A

Comments?

N/A



1.2. Affiliated Computer Services (ACS)

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

ACS (Third Party Liability (TPL) contractor) Healthcare Solutions MMIS Interface.

Owner Information

Name, phone, email, etc. of user and support contacts

See MMIS Interfaces: Common Answers document

SCDHHS Bureau of Fiscal Affairs Division of Accountability and Collections

TPL Contractor

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

SCDHHS contracts for certain TPL services including following TPL leads, maintaining policy information (except for automated data match done in MMIS), mailing invoices and letters as part of the TPL Recovery functions and posting responses to the TPL Recovery database in MMIS.

Objectives

What are the goals of the system / interface? Why was it initiated?

The goal of TPL is to ensure that other insurance policies covering Medicaid recipients pay before Medicaid. There are categories of claims/services/policies that fall under waivers allowing SC Medicaid to pay the claims first and then pursue reimbursement from the provider ("pay and chase" claims). TPL also includes a recovery process to recoup money for claims processed prior to the policy being added to the MMIS.

Business Processes

What business processes require the interface?

See Interfaces Related to BPs document.

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

None

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

There are daily, weekly and monthly files. The contractor interfaces with the MMIS online through a proprietary automated data entry/user emulation process (see an important note about this under System Modification and Change Control). The TPL Policy and TPL Potential Action/Retro Recovery areas are updated via this MMIS online interface.

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, C:D etc.).

Custom

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

C:D

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

Files are created by Clemson on a daily, weekly or monthly basis and are set up in Zeke.

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

TPL Policy, Carrier, TPL Potential Action and Retro Recovery, Provider, Recipient/family, RSP, Provider payment, adjustment, drug codes, Claims (HIC, Dental, Drug, Hospital)



Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

See list of filenames in the project repository. The input files are those starting with "HHSMMIS.ARS". These input files are created by a series of jobs originally set up for populating an ad-hoc reporting system, ARIES. The input for those jobs is the MMIS database. The exception is the carrier file which is copied from a file created for the decision support contractor.

Outputs

List all system / interface outputs -- e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

See attached list of filenames. The output files are names beginning with "HHSCD010."

The files are created by the following jobs: @ACS1000, @ACS2000, @ACS4000, @ACS6000, @PMT4800

Record Layout

Attach sample layout if applicable.

See attached file of record layouts.

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

C:D, standard control file that accompanies each file

Governing Policies

Policies that govern use or other activity involving the system / interface.

SCDHHS agreement with contractor

Access Control Policies and Security

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

List data security levels, security requirements etc.

See Common Answers document.

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

N/A

System / Interface Data Processing Standards

If a SLA or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

N/A

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

Varies. There are daily, weekly and monthly files that make up this interface. The interface with the MMIS online is during standard business hours.



Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

This interface is critical and updates the MMIS with data required to perform TPL functions.

Disaster Recovery

Attach any disaster recovery plans.

See [MMIS Interfaces: Common Answers](#) document.

Contract

Legal agreement status and document location.

N/A

Data Storage & System Attributes

What programming languages were used in creating the system / interface, or COTS software was acquired?

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format / schema documentation if possible.

See [MMIS Interfaces: Common Answers](#) - mainframe files.

Transaction processing

Type (batch / real-time).

Extract files are batch. Interface with MMIS online is real time.

Data Quality Control

Describe quality control policies / procedures.

Control files are created for each file and are used by ACS to verify transmission of data.

Backup

Describe / attach backup procedures and policies.

See [MMIS Interfaces: Common Answers](#) document.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

N/A

Support

Support hours and response times. Who handles user support, and how? Explain escalation / levels, if applicable.

See [MMIS Interfaces: Common Answers](#) document.

Incident Management

Process / constraints by which incidents are handled.

See [MMIS Interfaces: Common Answers](#) document.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?

See [MMIS Interfaces: Common Answers](#) document.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

See [MMIS Interfaces: Common Answers](#) document.

IMPORTANT: The proprietary data entry emulator that interfaces with the MMIS online must be considered whenever the MMIS online screens it emulates are modified. This includes screens used to sign on to the online.

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens? Include medium, etc.

N/A



Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

See MMIS Interfaces: Common Answers document.

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

See MMIS Interfaces: Common Answers document.

Plans for the System / Interface

How long will the system / interface continue?

N/A

What upgrades and replacements are planned?

N/A

Legislative climate and other forces affecting system / interface?

N/A

Comments?

N/A



1.3. First Data Voice Services - Care Call

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

Care Call

Owner Information

Name, phone, email, etc. of user and support contacts

See [MMIS Interfaces: Common Answers](#) document.

Bureau of Long Term Care & Behavioral Health Services

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

This is an interface where CLTC service providers log their time at patients' residences via telephone by calling in and entering information at the beginning and end of the visit. Care Call uses this information to generate an 837 transaction that comes in through the translator and is then processed like any other claims. 837s are transmitted to Clemson on Thursdays and Sundays to include in the Tuesday payment run.

Objectives

What are the goals of the system / interface? Why was it initiated?

To increase the accuracy, efficiency, and ease of tracking Home Health Nurses time with patients.

Business Processes

What business processes require the interface?

See [Interfaces Related to BPs](#) document.

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

None.

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

Care Call

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, C:D etc.).

X12 837

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

SFTP, async - modems (most likely ending July 1, 2009)

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

Thursday and Tuesday Care Call schedule

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

CLTC claims

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.



Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

X12 837s

Outputs

List all system / interface outputs – e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

N/A

Record Layout

Attach sample layout if applicable.

N/A

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

N/A

Governing Policies

Policies that govern use or other activity involving the system / interface.

X12 transactions

Access Control Policies and Security

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

List data security levels, security requirements etc.

N/A

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

N/A

System / Interface Data Processing Standards

If a SLA or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

X12 997 sent back once 837 is successfully received and logged.

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

24/7

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

Care Call is vital and critical to the operation of SCDHHS Medicaid. Claims are given priority.

Disaster Recovery

Attach any disaster recovery plans.

See [MMIS Interfaces: Common Answers](#) document.

Contract

Legal agreement status and document location.

SCDHHS has a contractor that runs the Care Call system.

Data Storage & System Attributes

What programming languages were used in creating the system / interface, or what COTS software was acquired?

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format / schema documentation if possible.



N/A

Transaction processing

Type (batch / real-time).

Batch

Data Quality Control

Describe quality control policies / procedures.

N/A

Backup

Describe / attach backup procedures and policies.

See [MMIS Interfaces: Common Answers](#) document.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

N/A

Support

Support hours and response times. Who handles user support, and how? Explain escalation / levels, if applicable.

See [MMIS Interfaces: Common Answers](#) document.

Care Call Contractor

Incident Management

Process / constraints by which incidents are handled.

See [MMIS Interfaces: Common Answers](#) document.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?

See [MMIS Interfaces: Common Answers](#) document.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

See [MMIS Interfaces: Common Answers](#) document.

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens?

Include medium, etc.

N/A

Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

See [MMIS Interfaces: Common Answers](#) document.

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

See [MMIS Interfaces: Common Answers](#) document.

Plans for the System / Interface

How long will the system / interface continue?

N/A

What upgrades and replacements are planned?

N/A

Legislative climate and other forces affecting system / interface?

N/A

Comments?

N/A



1.4. Carolinas Center for Medical Excellence (CCME)

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

Carolinas Center for Medical Excellence (CCME)

Owner Information

Name, phone, email, etc. of user and support contacts

See MMIS Interfaces: Common Answers document.

CCME Overview

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

SCDHHS contracts with an External Quality Review Organization (EQRO), CCME. Through this interface, SCDHHS is transmitting monthly encounter files as needed to support the terms of the CCME contract. CCME audits managed care organizations.

Objectives

What are the goals of the system / interface? Why was it initiated?

The objective is to support the requirements defined in the contracts with the CCME.

Business Processes

What business processes require the interface?

See Interfaces Related to BPs document.

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

None

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

Job @ENC0011 currently in HHSMMIS.REVIEW.JCL creates the file of encounter data. Monthly files are created using SAS, and run with Zeke scheduler. Files are transferred to CCME using C:D.

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, C:D etc.).

Fixed length flat mainframe file.

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

C:D

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

EOM – monthly encounter files are transmitted to CCME once a month.

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

Managed Care encounter data.

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.



Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

HHSMMIS.ENC5000.GOOD.ARCH(0) which is produced by @ENC0006 in HHSMMIS.PROD.JCL

Outputs

List all system / interface outputs – e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

MCO encounter data monthly. HHCD007.ENCARC1 and HHCD007.ENCARC1.MCF (control file).

Record Layout

Attach sample layout if applicable.

See MMIS interface - MCO for the encounter layouts.

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

C:D is used and provides encryption and security of data.

Governing Policies

Policies that govern use or other activity involving the system / interface.

Established by SCDHHS Executive Management and Program Areas.

Access Control Policies and Security

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

List data security levels, security requirements etc.

See Appendix L (Common Answers).

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

N/A

System / Interface Data Processing Standards

If a SLA or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

N/A

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

24/7

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

Non-mission critical for SCDHHS.

Disaster Recovery

Attach any disaster recovery plans.

See MMIS Interfaces: Common Answers document.

Contract

Legal agreement status and document location.

N/A

Data Storage & System Attributes

What programming languages were used in creating the system / interface, or what COTS software was acquired?

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format / schema documentation if possible.



N/A

Transaction processing

Type (batch / real-time).

Batch

Data Quality Control

Describe quality control policies / procedures.

N/A

Backup

Describe / attach backup procedures and policies.

See [MMIS Interfaces: Common Answers](#) document.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

N/A

Support

Support hours and response times. Who handles user support, and how? Explain escalation / levels.

See [MMIS Interfaces: Common Answers](#) document.

Incident Management

Process / constraints by which incidents are handled.

See [MMIS Interfaces: Common Answers](#) document.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?

See [MMIS Interfaces: Common Answers](#) document.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

See [MMIS Interfaces: Common Answers](#) document.

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens?

Include medium, etc.

N/A

Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

See [MMIS Interfaces: Common Answers](#) document.

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

See [MMIS Interfaces: Common Answers](#) document.

Plans for the System / Interface

How long will the system / interface continue?

Until the contract ends (unless renewed).

What upgrades and replacements are planned?

N/A

Legislative climate and other forces affecting system / interface?

N/A

Comments?

N/A



1.5. CMS Medical Statistical Information System (MSIS)

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

CMS-Medical Statistical Information System (MSIS)

Owner Information

Name, phone, email, etc. of user and support contacts

See MMIS Interfaces: Common Answers document.

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

The following edited version was taken from the entire document found at the CMS website (<http://www.cms.hhs.gov/MSIS/>): Prior to Federal fiscal year 1999, the MSIS was a voluntary program and those states participating in the MSIS project provided data tapes from their claims processing systems to CMS in lieu of the hard-copy statistical 2082 tables. However, in accordance with the Balanced Budget Act (BBA) of 1997, all claims processed are submitted electronically through MSIS.

The MSIS Tape Specification and Data Dictionary contains instructions on the file submissions. Release 3, effective for files submitted on or after February 15, 2009, provided information for the expansion of all four MSIS claims files to collect the NPI, the provider taxonomy code and claims internal control numbers (ICN). In addition, filler space has been added for future data needs. The current version updates references to CHIP.

The purpose of MSIS is to collect, manage, analyze and disseminate information on eligibles, beneficiaries, utilization and payment for services covered by State Medicaid programs. States provide CMS with quarterly computer files containing specified data elements for: (1) persons covered by Medicaid (Eligible files); and, (2) adjudicated claims (Paid Claims files) for medical services reimbursed with Title XIX funds. These data are furnished on the Federal fiscal year quarterly schedule, which begins October 1 of each year.

Each state eligible file contains one record for each person covered by Medicaid for at least one day during the reporting quarter. Individual eligible records consist of demographic and monthly enrollment data. Paid claims files contain information from adjudicated medical service related claims and capitation payments. Four types of claims files representing inpatient, long term care, prescription drugs and non-institutional services are submitted by the states. These are claims that have completed the state's payment processing cycle for which the state has determined it has a liability to reimburse the provider from Title XIX funds. Claims records contain information on the types of services provided, providers of services, service dates, costs, types of reimbursement, and epidemiological variables.

The current uses of MSIS data include health care research and evaluation activities, program utilization and expenditures forecasting, analyses of policy alternatives, responses to congressional inquiries, and matches to other health related databases.

At Clemson:

MSIS MARS system is run on a quarterly basis (Jan, Apr, July, and Oct). Specific jobs operations submit from HHSMMIS.PROD.JCL are @MSS5100, @MSS5200, @MSS5400, and @MSS5500.

Output files sent off-site are:

HHSMMIS.MSS5400C.CLAIMIP ===== MW00.SC.YRXX.QTRX.CLAIMIP
HHSMMIS.MSS5400C.CLAIMLT ===== MW00.SC.YRXX.QTRX.CLAIMLT
HHSMMIS.MSS5400C.CLAIMOT ===== MW00.SC.YRXX.QTRX.CLAIMOT
HHSMMIS.MSS5400C.CLAIMRX ===== MW00.SC.YRXX.QTRX.CLAIMRX



The following is a brief description of each processing program:

MSS5100 - Program sweeps the claims area looking for HIC, Dental, Drug, or Hospital claims with a TPL error (TPL paid more than Medicaid would have, and we rejected the claim). Claims are written out for MSS5300 to put into the 2082 files.

MSS5200 - Program sweeps the adjustment area, for adjustment claims that were credited debited within the specified time period. The claims are written out for MSS5300 to put into the 2082 files.

MSS5310 - Program sweeps MMIS-REF-AREA to retrieve diagnosis records whose program indicator is "3", and is written to a file.

MSS5320 - Program sweeps MMIS-REF-AREA to retrieve surgical procedure records whose program indicator is "3", and is written to a file.

MSS5400 - Program reads the archive files, determines which MSIS file to put the data in. Claims with line items will generate a record for each line. the first record in each file is a header record If the Clemson files did not pass a CMS tolerance level, Clemson would have to send explanations and/or corrected files.

Objectives

What are the goals of the system / interface? Why was it initiated?

Under MSIS, states submit quarterly tape extracts to CMS to report eligibility and claims data from their claims processing and administrative systems.

Business Processes

What business processes require the interface?

See [Interfaces Related to BPs](#) document

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

None

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

This interface is between the MMIS and CMS.

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, C:D etc.).

Mainframe flat file, custom by CMS.

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

C:D

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

MSIS MARS is run on a quarterly basis (Jan, Apr, July, and Oct), a CMS scheduling requirement.

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

States submit four types of claims files representing inpatient, long term care, prescription drugs and non-institutional services to CMS.

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?



Claims data in MMIS

Outputs

List all system / interface outputs – e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

Quarterly files are sent to CMS

HHSMMIS.MSS5400C.CLAIMIP ===== MW00.SC.YRXX.QTRX.CLAIMIP

HHSMMIS.MSS5400C.CLAIMLT ===== MW00.SC.YRXX.QTRX.CLAIMLT

HHSMMIS.MSS5400C.CLAIMOT ===== MW00.SC.YRXX.QTRX.CLAIMOT

HHSMMIS.MSS5400C.CLAIMRX ===== MW00.SC.YRXX.QTRX.CLAIMRX

Record Layout

Attach sample layout if applicable.

The MSIS File Specifications and Data Dictionary (Version 3) can be found at
<http://www.cms.hhs.gov/MSIS/> in its entirety.

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

N/A, other than those required by CMS

Governing Policies

Policies that govern use or other activity involving the system / interface.

Directed by CMS

Access Control Policies and Security

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

List data security levels, security requirements etc.

See Appendix L (Common Answers)

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

N/A

System / Interface Data Processing Standards

If a SLA or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

N/A

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

MMIS must be available to process the files to MMIS on a quarterly basis.

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

Critical for CMS requirements, but not critical for SCDHHS operations.

Disaster Recovery

Attach any disaster recovery plans.

See MMIS Interfaces: Common Answers document.

Contract

Legal agreement status and document location.

No contract.



Data Storage & System Attributes

What programming languages were used in creating the system / interface, or what COTS software was acquired?

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format / schema documentation if possible.

COBOL language

IDMS database

Transaction processing

Type (batch / real-time).

batch

Data Quality Control

Describe quality control policies / procedures.

N/A

Backup

Describe / attach backup procedures and policies.

See [MMIS Interfaces: Common Answers](#) document.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

N/A

Support

Support hours and response times. Who handles user support, and how? Explain escalation / levels, if applicable.

See [MMIS Interfaces: Common Answers](#) document.

Incident Management

Process / constraints by which incidents are handled.

See [MMIS Interfaces: Common Answers](#) document.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where is the system / interface housed?

See [MMIS Interfaces: Common Answers](#) document.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

See [MMIS Interfaces: Common Answers](#) document.

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens?

Include medium, etc.

N/A

Continuous Business Process Improvement

Is a methodology in place? Explain.

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

See [MMIS Interfaces: Common Answers](#) document

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

See [MMIS Interfaces: Common Answers](#) document

Plans for the System / Interface

How long will the system / interface continue?

What upgrades and replacements are planned?

Legislative climate and other forces affecting system / interface?

Comments?



1.6. South Carolina Continuum of Care (COC)

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

South Carolina Continuum of Care (COC)

Owner Information

Name, phone, email, etc. of user and support contacts

See MMIS Interfaces: Common Answers document.

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

After the MARS EOM cycle, an extract file is created for COC

(http://www.continuum.sc.gov/directors_message.html) using SAS. COC uses this file to reconcile claims data. These are claims that are sent to SCDHHS and are eligible for Medicaid reimbursement. The file is extracted based upon sponsor code (COC) and is created in a format defined by COC. COC uses this file to review claims information and to provide an audit trail for these claims. A file is provided to COC that contains monthly data via C:D.

Objectives

What are the goals of the system / interface? Why was it initiated?

The output file is provided to COC in a format that allows reconciliation of claims data.

Business Processes

What business processes require the interface?

See Interfaces Related to BPs document. This interface provides COC with the means to review and validate claim information and provide an audit trail for these claims.

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

Would like the job set up to be automatically triggered by the same event that sends the email (if possible). This would eliminate manual intervention.

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

The job creates the extract file that is distributed to COC via C:D monthly, generally the first week of the following month. The file name is:HHS.COCSPON.MMM08, where MMM is the month of the extract. This job is run @agency.

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, Connect:Direct etc.).

The extract is created from MARS data using SAS in a custom format and then downloaded to the extranet for retrieval by COC via C:D.

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

The extracts is created from MARS data as stated above and then downloaded to the extranet for retrieval by COC via C:D.

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

The file is created monthly once an email is received stating that MARS job @MARS027 has run. This interface then runs to produce the COC data file. The input file is HHSMMS.MAR0171C.SU MM08(-0). Upon receiving email, the request to run this job is submitted manually.

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

The file contains recipient, provider name, NPI, procedure codes, modifiers, number of units, cost, fund code, date claim was paid, and check number by month and in summary. The information



comes from the MARS output file.

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency. Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?
HHSMMIS.MAR0171C.SUMM08(-0) is the input file.

Outputs

List all system / interface outputs – e.g., names and contents of specific reports, data files, etc. Include media and frequency. Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?
HHS.COCSPON.MMM08 is the output file – where MMM is the month of the extract.

Record Layout

Attach sample layout if applicable.
N/A

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.
C:D

Governing Policies

Policies that govern use or other activity involving the system / interface.
Interagency requirements.

Access Control Policies and Security

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.) What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

List data security levels, security requirements etc.
See Common Answers document.

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.
N/A

System / Interface Data Processing Standards

If a SLA or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?
The time period is flexible as DSS uses the data to request reimbursement in a future period.

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)
File is provided monthly usually the first week of the month.

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

This interface is non-critical to the business functions of SCDHHS.

Disaster Recovery

Attach any disaster recovery plans.
See MMIS Interfaces: Common Answers document.



Contract

Legal agreement status and document location.

Interagency agreements.

Data Storage & System Attributes

What programming languages were used in creating the system / interface, or what COTS software was acquired?

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format / schema documentation if possible.

N/A

Transaction processing

Type (batch / real-time).

Batch

Data Quality Control

Describe quality control policies / procedures.

N/A

Backup

Describe / attach backup procedures and policies.

See [MMIS Interfaces: Common Answers](#) document.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

N/A

Support

Support hours and response times. Who handles user support, and how? Explain escalation / levels, if applicable.

See [MMIS Interfaces: Common Answers](#) document.

Incident Management

Process / constraints by which incidents are handled.

See [MMIS Interfaces: Common Answers](#) document.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?

See [MMIS Interfaces: Common Answers](#) document.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

See [MMIS Interfaces: Common Answers](#) document.

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens?

Include medium, etc.

Continuous Business Process Improvement

Is a methodology in place? Explain.

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

See [MMIS Interfaces: Common Answers](#) document.

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

See [MMIS Interfaces: Common Answers](#) document.

Plans for the System / Interface

How long will the system / interface continue?

What upgrades and replacements are planned?

Legislative climate and other forces affecting system / interface?

Comments?



1.7. HealthPort

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

HealthPort

Owner Information

Name, phone, email, etc. of user and support contacts

See MMIS Interfaces: Common Answers document.

HealthPort

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

The interface involves the transfer of provider and NPI information on a weekly basis and procedure code information on a weekly basis. The provider/NPI and procedure code files are sent to HealthPort, and are used to provide high level front-end editing for their customers (providers). Providers send their claims to HealthPort for editing and submission to SCDHHS for claims processing (837 transactions). HealthPort does preliminary edits including edits to determine if the provider number/NPI is valid, and if the procedure code is valid and covered. In addition to these weekly file exchanges, HealthPort utilizes MEVS to exchange 270/271 Inquire Eligibility transactions via a direct line.

Objectives

What are the goals of the system / interface? Why was it initiated?

To provide HealthPort with provider, NPI, procedure code information and access to MEVS so they can perform preliminary edits on claims for their customers (providers).

Business Processes

What business processes require the interface?

See Interfaces Related to BPs document.

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

None – this interface will probably be discontinued at some point in the future with the advancement of the new MITA aligned system for the Medicaid Enterprise.

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

EDI 837 claims are sent to Clemson.

The following files are produced by mainframe job @MEE5000 in

HHSMMIS.PROD.JCL(@MEE5000)

HHCD025.MEE5000.NPI

HHCD025.MEE5000.NPI.WCF (control file)

HHCD025.MEE5000.PROVIDER

HHCD025.MEE5000.PROVIDER.WCF (control file)

The following files are produced by mainframe job MM817AP in HHSMMIS.PROD.JCL(MM817AP)

HHCD025.BCBS.PROC

HHCD025.BCBS.PROC.WCF (control file)

The vendor also has a connection with MEVS for 270/271 inquire eligibility transactions.

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, C:D etc.).

EDI 837 claims. Custom format – mainframe. Transfer is done via C:D.

MEVS interface – X12 270/271.



Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

EDI 837 claims sent via Connect:Direct.

HealthPort also sends/receives X12 270/271 transactions via a direct line with Clemson.

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

@MEV3100 is a predecessor for @MEE5000. This runs weekly usually in the very early morning hours on Tuesday. (note: @MEV3100 runs daily but is only a trigger for @MEE5000 for the Monday night/early Tuesday morning occurrence.)

No trigger for MM817AP other than as set up in Zeke. This runs weekly on Mondays.

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

Procedure code information. Provider information including NPI crosswalk.

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

HHSMMIS.MEV3100.PROVIDER.FILE

HHSMMIS.MEV3100.NPI.FILE

MMIS database - The following database records are processed:

PCR-PROCEDURE

PAE-PROC-EDIT

MEVS – X12 270 Inquire Eligibility Transaction

Outputs

List all system / interface outputs -- e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

The following files are produced by mainframe job @MEE5000 in

HHSMMIS.PROD.JCL(@MEE5000)

HHCD025.MEE5000.NPI (VSM – virtual storage media)

HHCD025.MEE5000.NPI.WCF (control file) (disk)

HHCD025.MEE5000.PROVIDER (VSM – virtual storage media)

HHCD025.MEE5000.PROVIDER.WCF (control file) (disk)

The following files are produced by mainframe job MM817AP in HHSMMIS.PROD.JCL(MM817AP)

HHCD025.BCBS.PROC (Disk)

HHCD025.BCBS.PROC.WCF (control file) (Disk)

MEVS – X12 271 response transaction

Record Layout

Attach sample layout if applicable.

Layouts for HHCD025.MEE5000.PROVIDER, HHCD025.MEE5000.PROVIDER.WCF,

HHCD025.MEE5000.NPI, HHCD025.MEE5000.NPI.WCF, and HHCD025.BCBS.PROC are available in the project repository.

MEVS X12 270/271 format information available on SCDHHS website.

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

X12 HIPAA Implementation Guide for 270/271 transaction.



Governing Policies

Policies that govern use or other activity involving the system / interface.

See MEVS interface template.

Access Control Policies and Security

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

List data security levels, security requirements etc.

See MMIS Interfaces: Common Answers document.

See MEVS interface template concerning the MEVS portion of this interface.

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

N/A

System / Interface Data Processing Standards

If a SLA or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

Mainframe files are normally available weekly by Tuesday morning. If there is a problem with one of the weekly files, HealthPort waits for the next weekly transmission to update their information.

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

Weekly Files – Tuesday morning.

MEVS – 24 X 7

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

This interface is critical to HealthPort to provide preliminary editing for its customers.

Disaster Recovery

Attach any disaster recovery plans.

See MMIS Interfaces: Common Answers document.

Contract

Legal agreement status and document location.

N/A

Data Storage & System Attributes

What programming languages were used in creating the system / interface, or what COTS software was acquired?

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format / schema documentation if possible.

N/A

Transaction processing

Type (batch / real-time).

Batch

Data Quality Control

Describe quality control policies / procedures.

N/A

Backup

Describe / attach backup procedures and policies.

See MMIS Interfaces: Common Answers document.

See MEVS template for the 270/271 portion of the interface.

Mainframe files - The NPI and Provider files are kept for up to 10 days or until the next time the job runs – whichever occurs first. The 10 most recent versions of the files from which these are copied are kept.



Procedure code file is on disk and only retained per Clemson retention for disk datasets.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

N/A

Support

Support hours and response times. Who handles user support, and how? Explain escalation / levels, if applicable.

See [MMIS Interfaces: Common Answers](#) document.

Incident Management

Process / constraints by which incidents are handled.

See [MMIS Interfaces: Common Answers](#) document.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?

See [MMIS Interfaces: Common Answers](#) document.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

See [MMIS Interfaces: Common Answers](#) document.

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens? Include medium, etc.

N/A

Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

Provide interface files to HealthPort. Also provide MEVS to HealthPort.

See [MMIS Interfaces: Common Answers](#) document.

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

See [MMIS Interfaces: Common Answers](#) document.

Plans for the System / Interface

How long will the system / interface continue?

SCDHHS has plans to discontinue sometime in the future.

What upgrades and replacements are planned?

5010 version of X12 270/271 transaction.

Legislative climate and other forces affecting system / interface?

N/A

Comments?

N/A



1.8. Bureau of Medicaid Systems Management (BMSM) Data Match

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

Data Match

Owner Information

Name, phone, email, etc. of user and support contacts

See MMIS Interfaces: Common Answers document.

Authorized consultants and providers.

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

SCDHHS receives recipient data from providers, contractors and authorized consultants (those who work on behalf of a provider) to compare against data in the MMIS to verify eligibility for the dates of service. This process is only used to request recipient data that is older than 13 months. There are various reasons that providers and authorized consultants would need to validate eligibility prior to 13 months (e.g. disproportionate share, checking PDP eligibility, a lawsuit, checking student eligibility so a school can ensure they got reimbursed properly, an audit reviewing claims denied etc.). If the data being requested is less than 13 months old, the request would go through the normal 270 process.

Currently, this is a manual task. Providers and authorized consultants submit request on CD's, disks or cassettes and eligibility data is returned to them on diskette and, if requested, in hard copy.

BMSM has lowered the number of providers who participate in this process to less than 18. The larger number of providers that used this process in the past has changed their business model in order to make requests via a 270/271 transaction.

Objectives

What are the goals of the system / interface? Why was it initiated?

To give providers and authorized consultants access to eligibility information.

Business Processes

What business processes require the interface?

See Interfaces Related to BPs document.

To provide access to SCDHHS eligibility data to allow accurate processing of claims and provisioning of services by providers and authorized consultants

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

BMSM would like to automate this process in the future as noted in the template. A review will need to be completed to determine if 270/271 is the most efficient way to replace the current process. Ideally the 270/271 would accommodate requests for eligibility information for longer than 13 months of claims. This interface will probably be discontinued at some point in the future with the advancement of the new MITA aligned system for the Medicaid Enterprise.

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

SCDHHS receives data either on CDs, disks, or cassettes through UPS. or FedEx. Data Match is executed on the 3rd working day of the month. Providers and authorized consultants are requested to have CDs, disks or cassettes to SCDHHS at least a week prior.



The media must be received by the 3rd working day of the month in order to return the requested data back to the provider early in the month to aid in their processing of claims, requests, services, etc.

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, C:D etc.).

Input Format is sequential, fixed blocked, 88 bytes; ASCII preferred zipped, and password protected.

Output format is sequential, fixed length, 344 bytes, ASCII text formatted file, zipped, encrypted and password protected.

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

Exchange of CDs, disks, or cassettes.

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

Data Match is executed on the 3rd working day of the month. Providers and authorized consultants are requested to have CDs, disks, or cassettes to SCDHHS at least a week prior.

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

Providers and authorize consultants submit the following information to SCDHHS: Recipient number, Medicaid number or Railroad number (if applicable), Medicare number (if applicable), SSN, First/Middle/Last name, DOB; County Code, First Date of Inquires, and Last Date of Inquires. A Data Match Methodology Document for data returned to providers and authorized consultants is available in the project repository.

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

A Data Match Request Form accompanies requests from providers and authorized consultants: Data is loaded to HHSMMIS.RSS.DATAMTCH.INPUT so that Clemson can execute the data match. Prior to the data being loaded, the analyst opens the input text file, inspects the layout, and then uploads it to the mainframe Partition Data Set (PDS) Library input file. The analyst inspects the file to make sure it matches the file format set forth in the instructions document to allow the matching process to occur. The file can be returned if it does not match up correctly. HHSMMIS.PROD.JCL(@RSS3200) is then executed by Clemson.

Outputs

List all system / interface outputs – e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

The output is stored in HHSMMIS.RSS.DATAMTCH.OUTPUT by Clemson then downloaded, zipped, and encrypted by the analyst for distribution to the provider or authorized consultant. The normal procedure is to mail the output by first class mail, but the requestor may supply a FedEx account information if next day delivery is needed.

Record Layout

Attach sample layout if applicable.

Record layouts for the input and output files are included in the Data Match Methodology Document available in the project repository



Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

N/A

Governing Policies

Policies that govern use or other activity involving the system / interface.

Providers and consultants must be authorized by SCDHHS to participate in data match process.

Access Control Policies and Security

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

List data security levels, security requirements etc.

Providers and consultants must be authorized by SCDHHS to participate in data match process.

Both input and output files are encrypted and password protected.

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

N/A

System / Interface Data Processing Standards

If a SLA or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

There is no specific deadline for this process. Processing generally occurs on the 3rd working day of the month and is normally completed within one day. If hard copy (a printout) is requested, a courier delivers the report from Clemson to SCDHHS and the process takes an additional day.

This processing date was selected to provide the data to the provider early in the month for their processing of claims, requests, services, etc.

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

Business hours (8 am-5 pm)

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

This interface allows providers to more accurately submit claims, request information, and provide services to Medicaid recipients and is therefore of critical importance.

Disaster Recovery

Attach any disaster recovery plans.

See MMIS Interfaces: Common Answers document.

Contract

Legal agreement status and document location.

N/A

Data Storage & System Attributes

What programming languages were used in creating the system / interface, or what COTS software was acquired?

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format / schema documentation if possible.

N/A

Transaction processing

Type (batch / real-time).

N/A

Data Quality Control

Describe quality control policies / procedures.

N/A



Backup

Describe / attach backup procedures and policies.

See MMIS Interfaces: Common Answers document.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

N/A

Support

Support hours and response times. Who handles user support, and how? Explain escalation / levels, if applicable.

See MMIS Interfaces: Common Answers document.

Incident Management

Process / constraints by which incidents are handled.

See MMIS Interfaces: Common Answers document.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?

See MMIS Interfaces: Common Answers document.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

See MMIS Interfaces: Common Answers document.

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens? Include medium, etc.

N/A

Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

See MMIS Interfaces: Common Answers document.

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

See MMIS Interfaces: Common Answers document.

Plans for the System / Interface

How long will the system / interface continue?

N/A

What upgrades and replacements are planned?

N/A

Legislative climate and other forces affecting system / interface?

N/A

Comments?

N/A



1.9. South Carolina Department of Disabilities and Special Needs (DDSN)

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

Dually Eligible Recipients - DDSN

Owner Information

Name, phone, email, etc. of user and support contacts

See MMIS Interfaces: Common Answers document.

DDSN

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

Monthly, SCDHHS produces a data file and two reports for DDSN for recipients in the following programs that are eligible for both Medicaid and Medicare: DMRE, DMRN, and HSCN. The data file and the reports are created by the 5th working day of the month using Cobol and SAS to extract paid claims data from archives and to transmit that data to DDSN via C:D. The file and data reports are sent directly from Clemson to DDSN.

Objectives

What are the goals of the system / interface? Why was it initiated?

To provide DDSN with a data file and reports for management, auditing, and cost recovery.

Business Processes

What business processes require the interface?

See Interfaces Related to BPs document.

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

None – this does not support a SCDHHS business process.

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

This is an outbound interface that includes a data file and two reports listing the dually eligible recipients in the DMRE, DMRN and HSCN Programs. The file and two reports are created monthly and transmitted to DDSN via C:D.

The name of the jobs are "HHSMDIEW.@.T01262.DUALLY.ELIG(@DDSN01)" and "HHSMDIEW.@.T01262.DUALLYELIG(@GEN1262)". And the program used to extract the paid claims is "HHSMDIEW.@.T01262.DUALLY.ELIG(DDSN01)". The "@GEN1262" job is used to send the files to DDSN through C:D. Attached are copies of all jobs and the COBOL program.

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, C:D etc.).

Data is transmitted via C:D. The format of the data file is a fixed length text file.

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

Data is encrypted and transmitted to DDSN via C:D.

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

The data file and reports are extracted from MMIS using Cobol and SAS and transmitted to DDSN by the 5th working day of the month. The job is run and accesses the paid claims archives files for the previous month's paid claims. The reports are based on the previous months paid claims.

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?



The data file and reports that are transmitted to DDSN contain the following information for each recipient: Medicaid Number, Medicare Number, SSN, First/Middle/Last Name, County Code, RSP Number, RSP Begin and End Date.

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

The paid claims archives input files are used to extract the paid claims information, and the RSP database and Recipient database are used to qualify the recipients. Dual eligibles are defined as any recipient with current enrolled in RSPs who have current Medicaid and Medicare eligibility.

Outputs

List all system / interface outputs -- e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

The project repository contains scrubbed reports. The examples only have the report numbers, report headers, and column headers. The output file names of the jobs are:

HHS.T01262.DDSN01.STEP04.D0904.RCPRECS <-- This data file is created during the process of the job. It is a delimited file with fields separated by ";".

HHS.T01262.DDSN01.STEP05.D0904.REPORT1 <-- This report is SNAPPED out of the IOF after the job has completed processing to create this file.

HHS.T01262.DDSN01.STEP06.D0904.REPORT2 <-- This report is SNAPPED out of the IOF after the job has completed processing to create this file.

Record Layout

Attach sample layout if applicable.

Record layout for data file is attached.

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

C:D is used and provides encryption and security of data.

Governing Policies

Policies that govern use or other activity involving the system / interface.

DDSN defined data requirements.

Access Control Policies and Security

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

List data security levels, security requirements etc.

See MMIS Interfaces: Common Answers document.

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

N/A

System / Interface Data Processing Standards

If a SLA or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?



Processing occurs by the 5th working day of the month with data file and report production.

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

Business hours (8 am-5 pm)

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

This interface is not critical to the daily business functions of SCDHHS or DDSN.

Disaster Recovery

Attach any disaster recovery plans.

See [MMIS Interfaces: Common Answers](#) document.

Contract

Legal agreement status and document location.

N/A

Data Storage & System Attributes

What programming languages were used in creating the system / interface, or what COTS software was acquired?

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format / schema documentation if possible.

N/A

Transaction processing

Type (batch / real-time).

Batch

Data Quality Control

Describe quality control policies / procedures.

N/A

Backup

Describe / attach backup procedures and policies.

See [MMIS Interfaces: Common Answers](#) document.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

N/A

Support

Support hours and response times. Who handles user support, and how? Explain escalation / levels, if applicable.

See [MMIS Interfaces: Common Answers](#) document.

Incident Management

Process / constraints by which incidents are handled.

See [MMIS Interfaces: Common Answers](#) document.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?

See [MMIS Interfaces: Common Answers](#) document.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

See [MMIS Interfaces: Common Answers](#) document.

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens?

Include medium, etc.

N/A

Continuous Business Process Improvement

Is a methodology in place? Explain.



N/A

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

See MMIS Interfaces: Common Answers document.

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

See MMIS Interfaces: Common Answers document.

Plans for the System / Interface

How long will the system / interface continue?

The dually eligible recipient interface may remain functional after the future MMIS is created.

How this interface will be handled in the future will be determined as part of the MITA initiatives.

What upgrades and replacements are planned?

N/A

Legislative climate and other forces affecting system / interface?

N/A

Comments?

N/A



1.10. Department of Health and Environmental Control (DHEC) – Breast and Cervical Cancer Program (BCCP)

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

Breast and Cervical Cancer - DHEC

Owner Information

Name, phone, email, etc. of user and support contacts

See MMIS Interfaces: Common Answers document.

Department of Health and Human Services

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

Monthly, SCDHHS produces five data files for DHEC of claims that were paid during the previous month for recipients in PCAT 71 (BCCP). The Breast and Cervical Cancer Prevention and Treatment Act of 2000 allows states to provide full Medicaid benefits to uninsured women who are found in need of treatment for breast and/or cervical cancer or pre-cancerous lesions (CIN 2/3 or atypical hyperplasia). SCDHHS creates a data file for Professional, Drug, Dental, Nursing Home and Hospital claims. These files are created around the 5th working day of the month and are copied to DHEC via HHCD033 server.

Objectives

What are the goals of the system / interface? Why was it initiated?

To provide DHEC with a data files for management, auditing, cost and budgeting purposes.

Business Processes

What business processes require the interface?

See [Interfaces Related to BPs](#) document.

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

None – this does not support a SCDHHS business process.

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

This is an outbound interface that includes five data files listing all paid claims for Medicaid recipient in PCAT 71. These files are created monthly and transmitted to DHEC via C:D.

The name of the jobs are:

[HHSMDEW.@.T00853.BCCP.FOR.DHEC\(@DHECCLM\)](#) <-- Used to extract claims from Paid Claims Archives.

[HHSMDEW.@.T00853.BCCP.FOR.DHEC\(@DHECRPT\)](#) <-- Used to split claims into separate file and then sent the files to DDSN through Connect:Direct.

[HHSMDEW.@.T00853.BCCP.FOR.DHEC\(DHECCLM\)](#) <-- Program used to extract claims from Paid Claims Archives.

[HHSMDEW.@.T00853.BCCP.FOR.DHEC\(DHECRPT\)](#) <-- Program used to separate claims in to individual delimited files for each claim type.

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, C:D etc.).

Custom

File formats are available in the project repository that are sent in program "DHECRPT". Each claim type has a different format. Each file is a delimited file that has it's fields separated by ";".



Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

Data is encrypted and transmitted DHEC via C:D.

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

The data files are extracted from MMIS using Cobol and SAS and transmitted to DHEC.

These jobs are run each month during the first five working days of the month (complete by the 5th working day of the month). The claims must have paid dates within the previous month.

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

The data files that are transmitted to DHEC contain paid claim information for each recipient to include, but not limited to: CCN, Recipient Number, SSN, First/Middle/Last Name, County Code, Provider, Provider Practice Specialty, Provider Type, Diagnosis Code(s), and, as appropriate, Procedure Code(s), Dental Code(s), Drug Code(s), Nursing Home Code(s) and Hospital Code(s).

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

Claims data from MMIS to include: Professional, Drug, Dental, Nursing Home and Hospital claims.
Reads the paid claims archive file for the previous month's paid claims. To qualify for extraction the claim must be for recipient with a payment category of "71".

Outputs

List all system / interface outputs -- e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

Five data files of paid claims information for all recipients in PCAT 71.

HHS.T00853.DHEC.A.CLMS.D0904 <-- These files are created through the processing of program "DHECRPT".

HHS.T00853.DHEC.B.CLMS.D0904

HHS.T00853.DHEC.D.CLMS.D0904

HHS.T00853.DHEC.G.CLMS.D0904

HHS.T00853.DHEC.Z.CLMS.D0904

HHCD033.HHS.T00853.DHEC.A.CLMS.D0904 <-- These files are copied from the above 5 files to the HHCD033 server.

HHCD033.HHS.T00853.DHEC.B.CLMS.D0904

HHCD033.HHS.T00853.DHEC.D.CLMS.D0904

HHCD033.HHS.T00853.DHEC.G.CLMS.D0904

HHCD033.HHS.T00853.DHEC.Z.CLMS.D0904

OIRS.HHSMMS.SDE.SPON.ACLM0904 <-- These files are copied from the first 5 files and sent through Connect:Direct to the OIRS server.

OIRS.HHSMMS.SDE.SPON.BCLM0904

OIRS.HHSMMS.SDE.SPON.DCLM0904

OIRS.HHSMMS.SDE.SPON.GCLM0904

OIRS.HHSMMS.SDE.SPON.ZCLM0904

Record Layout

Attach sample layout if applicable.



Record layout for data file is attached.

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

C:D is used and provides encryption and security of data.

Governing Policies

Policies that govern use or other activity involving the system / interface.

DHEC defined data requirements.

Access Control Policies and Security

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

List data security levels, security requirements etc.

See MMIS Interfaces: Common Answers document.

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

N/A

System / Interface Data Processing Standards

If a SLA or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

Processing and sending data files occurs by the 5th working day of the month .

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

Business hours (8 am-5 pm)

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

DHEC relies on the data files for management, auditing, cost and budgeting purposes.

Disaster Recovery

Attach any disaster recovery plans.

See MMIS Interfaces: Common Answers document.

Contract

Legal agreement status and document location.

N/A

Data Storage & System Attributes

What programming languages were used in creating the system / interface, or what COTS software was acquired?

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format / schema documentation if possible.

N/A

Transaction processing

Type (batch / real-time).

Batch

Data Quality Control

Describe quality control policies / procedures.

N/A

Backup

Describe / attach backup procedures and policies.

See MMIS Interfaces: Common Answers document.



Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

N/A

Support

Support hours and response times. Who handles user support, and how? Explain escalation / levels, if applicable.

See [MMIS Interfaces: Common Answers](#) document.

Incident Management

Process / constraints by which incidents are handled.

See [MMIS Interfaces: Common Answers](#) document.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?

See [MMIS Interfaces: Common Answers](#) document.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

See [MMIS Interfaces: Common Answers](#) document.

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens? Include medium, etc.

N/A

Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

See [MMIS Interfaces: Common Answers](#) document.

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

See [MMIS Interfaces: Common Answers](#) document.

Plans for the System / Interface

How long will the system / interface continue?

The Breast and Cervical Cancer interface may remain functional after the future MMIS is created.

How this interface will be handled in the future will be determined as part of the MITA initiatives.

What upgrades and replacements are planned?

N/A

Legislative climate and other forces affecting system / interface?

N/A

Comments?

N/A



1.11. South Carolina Department of Mental Health (DMH)

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

South Carolina Department of Mental Health (DMH)

Owner Information

Name, phone, email, etc. of user and support contacts

See MMIS Interfaces: Common Answers document.

DMH

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

After the MARS EOM cycle, two extract files are created for DMH using SAS by BMSM. DMH uses these files to reconcile claims data. These are claims that are sent to SCDHHS and are eligible for Medicaid reimbursement. The files are extracted based upon sponsor code (DMH) and are created in a format defined by DMH. DMH uses these files to review claims information and to provide an audit trail for these claims. A monthly file and a summary file are provided to DMH.

Objectives

What are the goals of the system / interface? Why was it initiated?

Provide two output files in a format that allows reconciliation of claims data by DMH. The creation of this interface doesn't satisfy a SCDHHS business need.

Business Processes

What business processes require the interface?

See Interfaces Related to BPs document.

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

None – this does not support a SCDHHS business process.

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

SAS job name: @agency.

The job creates two extract files one by Sponsor Code (DMH) and a Summary, and these are distributed to DMH via the extranet on a monthly basis, generally the first week of the following month. The file names are:

HHS.DMHSUMM.MMM08

HHS.DMHSPON.MMM08

Where MMM is the month of the extract.

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, C:D etc.).

Extracts are created from MARS data using SAS in a custom format and then downloaded to the extranet for retrieval by DMH.

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

C:D is the exchange protocol.

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

Files are created monthly once an email is received stating that MARS job @MARS027 has run.

This interface then runs to produce the DMH data files. The input file is

HHSMMIS.MAR0171C.SUMM08(-0).



Upon receiving email, the request to run this job is submitted manually.

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

Files contain recipient, provider name, NPI, procedure codes, modifiers, number of units, cost, fund code, date claim was pay and check number by month and in summary.

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

HHSMMIS.MAR0171C.SUMM08(-0) is the input file.

Outputs

List all system / interface outputs -- e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

HHS.DMHSUMM.MMM08 and HHS.DMHSPON.MMM08 are the output files -- where MMM is the month of the extract.

Record Layout

Attach sample layout if applicable.

Record layout for data file is attached.

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

Connect:Direct is used and provides encryption and security of data.

Governing Policies

Policies that govern use or other activity involving the system / interface.

Interagency requirements.

Access Control Policies and Security

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

List data security levels, security requirements etc.

See MMIS Interfaces: Common Answers document.

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

N/A

System / Interface Data Processing Standards

If a SLA or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

Time period is reasonable flexible as they use the data to request reimbursement in a future period. So, not critical that data be available on/by a specific day of month.

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

Files are provided monthly usually the first week of the month.



Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

This interface is non-critical to the function of SCDHHS. The information comes from the MARS output file, as long as the file is available, information can be provided to DMH.

Disaster Recovery

Attach any disaster recovery plans.

See [MMIS Interfaces: Common Answers](#) document.

Contract

Legal agreement status and document location.

N/A

Data Storage & System Attributes

What programming languages were used in creating the system / interface, or what COTS software was acquired?

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format / schema documentation if possible.

N/A

Transaction processing

Type (batch / real-time).

Batch

Data Quality Control

Describe quality control policies / procedures.

N/A

Backup

Describe / attach backup procedures and policies.

See [MMIS Interfaces: Common Answers](#) document.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

N/A

Support

Support hours and response times. Who handles user support, and how? Explain escalation / levels, if applicable.

See [MMIS Interfaces: Common Answers](#) document.

Incident Management

Process / constraints by which incidents are handled.

See [MMIS Interfaces: Common Answers](#) document.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?

See [MMIS Interfaces: Common Answers](#) document.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

See [MMIS Interfaces: Common Answers](#) document.

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens?

Include medium, etc.

N/A

Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A



System / Interface Roles and Responsibilities

SCDHHS Responsibilities

See MMIS Interfaces: Common Answers document.

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

See MMIS Interfaces: Common Answers document.

Plans for the System / Interface

How long will the system / interface continue?

The DMH interface would remain functional after the future MMIS is created. The interface that SCDHHS has with DMH may change (i.e. the means by which SCDHHS delivers claims data to DMH may change). This will be decided by Clemson.

What upgrades and replacements are planned?

N/A

Legislative climate and other forces affecting system / interface?

N/A

Comments?

N/A



1.12. South Carolina Department of Education (DOE)

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

South Carolina Department of Education (DOE).

Owner Information

Name, phone, email, etc. of user and support contacts

See MMIS Interfaces: Common Answers document.

DOE

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

After the MARS EOM cycle, an extract file is created for DOE using SAS. DOE uses this file to reconcile claims data. These are claims that are sent to SCDHHS and are eligible for Medicaid reimbursement. The file is extracted based upon sponsor code (DOE) and is created in a DOE-defined format. DOE uses this file to review claims information and to provide an audit trail for these claims. A file is provided to DOE that contains monthly data. The file is provided to DOE via C:D.

Objectives

What are the goals of the system / interface? Why was it initiated?

The output file is provided to DOE in a format that allows reconciliation of claims data. Provides DOE with the means to review and validate claim information and provide an audit trail for these claims.

Business Processes

What business processes require the interface?

See Interfaces Related to BPs document.

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

None – this does not support a SCDHHS business process.

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

SAS job name: @agency.

The job creates the extract file that is distributed to DOE via the extranet on a monthly basis, generally the first week of the following month. The file name is: HHS.DOESPON.MMM08

Where MMM is the month of the extract.

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, C:D etc.).

The extract is created from MARS data using SAS in a custom format and then downloaded to the extranet for retrieval by DOE via C:D.

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

The extract is created from MARS data using SAS in a custom format and then downloaded to the extranet for retrieval by DOE via C:D.

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

The file is created monthly once an email is received stating that MARS job @MARS027 has run.

This interface then runs to produce the DOE data file. The input file is

HHSMMIS.MAR0171C.SUMM08(-0).



The file is initiated manually once the email has been received.

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

The file contains recipient, provider name, NPI, procedure codes, modifiers, number of units, cost, fund code, date claim was pay and check number by month and in summary.

The two files are exactly the same except that the Sponsor file contains three additional fields at the end - SSN, Recipient Name and DOB. Otherwise, the sponsor and summary provide exactly the same information.

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

HHSMMIS.MAR0171C.SUMM08(-0) is the input file.

Outputs

List all system / interface outputs – e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

HHS.DOESPON.MMM08 is the output file – where MMM is the month of the extract.

Record Layout

Attach sample layout if applicable.

Record layout for data file is attached.

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

C:D is used and provides encryption and security of data.

Governing Policies

Policies that govern use or other activity involving the system / interface.

Interagency requirements.

Access Control Policies and Security

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

List data security levels, security requirements etc.

See MMIS Interfaces: Common Answers document.

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

N/A

System / Interface Data Processing Standards

If a SLA or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

Time period is flexible as they use the data to request reimbursement in a future period.

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

Files are provided monthly usually the first week of the month.



Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

This interface is non-critical to the function of SCDHHS.

Disaster Recovery

Attach any disaster recovery plans.

See [MMIS Interfaces: Common Answers](#) document.

Contract

Legal agreement status and document location.

N/A

Data Storage & System Attributes

What programming languages were used in creating the system / interface, or what COTS software was acquired?

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format / schema documentation if possible.

N/A

Transaction processing

Type (batch / real-time).

Batch

Data Quality Control

Describe quality control policies / procedures.

N/A

Backup

Describe / attach backup procedures and policies.

See [MMIS Interfaces: Common Answers](#) document.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

N/A

Support

Support hours and response times. Who handles user support, and how? Explain escalation / levels, if applicable.

See [MMIS Interfaces: Common Answers](#) document.

Incident Management

Process / constraints by which incidents are handled.

See [MMIS Interfaces: Common Answers](#) document.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?

See [MMIS Interfaces: Common Answers](#) document.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

See [MMIS Interfaces: Common Answers](#) document.

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens? Include medium, etc.

N/A

Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A



System / Interface Roles and Responsibilities

SCDHHS Responsibilities

See MMIS Interfaces: Common Answers document.

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

See MMIS Interfaces: Common Answers document.

Plans for the System / Interface

How long will the system / interface continue?

The DOE interface will continue, but the means the data delivery to DOE may change.

What upgrades and replacements are planned?

N/A

Legislative climate and other forces affecting system / interface?

N/A

Comments?

N/A



1.13. South Carolina Department of Social Services (DSS)

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

South Carolina Department of Social Services (DSS)

Owner Information

Name, phone, email, etc. of user and support contacts

See MMIS Interfaces: Common Answers document.

DSS

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

After the MARS EOM cycle, two extract files are created for DSS using SAS. DSS uses these files to reconcile claims data. These are claims that are sent to SCDHHS and are eligible for Medicaid reimbursement. The files are extracted based upon sponsor code (DSS) and are created in a format defined by DSS. DSS uses these files to review claims information and to provide an audit trail for these claims. A monthly file and a summary file are provided to DSS.

Objectives

What are the goals of the system / interface? Why was it initiated?

Provide two output files in a format that allows reconciliation of claims data by DSS.

Business Processes

What business processes require the interface?

See Interfaces Related to BPs document.

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

None – this does not support a SCDHHS business process.

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

The job creates two extract files one by Sponsor Code (DSS) and a Summary, and these are distributed to DSS via the extranet on a monthly basis, generally the first week of the following month. The file names are:

HHS.DSSSUMM.MMM08

HHS.DSSSPON.MMM08

Where MMM is the month of the extract.

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, C:D etc.).

The extract is created from MARS data using SAS in a custom format and then downloaded to the extranet for retrieval by DSS via C:D.

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

C:D is the exchange protocol.

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

Files are created monthly once an email is received stating that MARS job @MARS027 has run.

This interface then runs to produce the DSS data files. The input file is

HHSMMIS.MAR0171C.SUMM08(-0). The process is manual – it begins once the email is received.



Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

Files contain recipient, provider name, NPI, procedure codes, modifiers, number of units, cost, fund code, date claim was pay and check number by month and in summary.

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

HHSMMIS.MAR0171C.SUMM08(-0) is the input file.

Outputs

List all system / interface outputs – e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

HHS.DSSSUMM.MMM08 and HHS.DSSSPON.MMM08 are the output files – where MMM is the month of the extract.

Record Layout

Attach sample layout if applicable.

Record layout for data file is attached.

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

C:D is used and provides encryption and security of data.

Governing Policies

Policies that govern use or other activity involving the system / interface.

Interagency requirements.

Access Control Policies and Security

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

List data security levels, security requirements etc.

See MMIS Interfaces: Common Answers document.

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

N/A

System / Interface Data Processing Standards

If a SLA or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

Time period is flexible as they use the data to request reimbursement in a future period.

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

Files are provided monthly usually the first week of the month.

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?



This interface is non-critical to the function of SCDHHS.

Disaster Recovery

Attach any disaster recovery plans.

See [MMIS Interfaces: Common Answers](#) document.

Contract

Legal agreement status and document location.

N/A

Data Storage & System Attributes

What programming languages were used in creating the system / interface, or what COTS was acquired?

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format / schema documentation if possible.

N/A

Transaction processing

Type (batch / real-time).

Batch

Data Quality Control

Describe quality control policies / procedures.

N/A

Backup

Describe / attach backup procedures and policies.

See [MMIS Interfaces: Common Answers](#) document.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

N/A

Support

Support hours and response times. Who handles user support, and how? Explain escalation / levels, if applicable.

See [MMIS Interfaces: Common Answers](#) document.

Incident Management

Process / constraints by which incidents are handled.

See [MMIS Interfaces: Common Answers](#) document.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?

See [MMIS Interfaces: Common Answers](#) document.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

See [MMIS Interfaces: Common Answers](#) document.

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens?

Include medium, etc.

N/A

Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

See [MMIS Interfaces: Common Answers](#) document.

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

See [MMIS Interfaces: Common Answers](#) document.



Plans for the System / Interface

How long will the system / interface continue?

The DSS interface will continue, but the means of data delivery may change.

What upgrades and replacements are planned?

N/A

Legislative climate and other forces affecting system / interface?

N/A

Comments?

N/A



1.14. Wachovia - Electronic Funds Transfer (EFT)

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

EFT MMIS Interface

Owner Information

Name, phone, email, etc. of user and support contacts

See MMIS Interfaces: Common Answers document.

Wachovia Bank

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

This interface is used to electronically send an ACH file to Wachovia to transfer funds to the different provider reimbursement accounts. This interface is also used to electronically send a Med recon (medical reconciliations) file with all paper check payments to Wachovia so that reconciliation can occur when the providers cash the checks. A provider is only in one file, which is based upon whether or not the provider is enrolled in EFT.

Objectives

What are the goals of the system / interface? Why was it initiated?

To transfer electronic payment information to Wachovia for the purpose of funds transfers and the reconciliation of paper checks.

Business Processes

What business processes require the interface?

See Interfaces Related to BPs document.

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

None

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

ACH file is sent to Wachovia for EFT

Flat file for Med recon

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, C:D etc.).

ACH for EFT

Flat file for Med recon

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

Wachovia's FTP website has separate usernames and passwords for EFT and Med recon.

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

A transaction Pre-note is sent to the bank to ensure that the routing information for the provider is valid. to ensure the successful transfer of funds. It is a different transaction code in the file than an EFT. It is only done the first 2 weeks in a row for new providers. If no flags are received the EFT transfers can begin. The Pre-note transaction file is created by job @PRV9700 which runs on Monday nights.

@CLM4597 runs on Wednesday at 1:30 to produce ACH for EFT. The pre-note transaction file is also input to this job as the EFTs and pre-notes are combined into one file.

@MDR0040 runs on Tuesday to produce the file for Med recon.



Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

Payment data for a week of claims per providers.

Med Recon: Check issuance data from weekly payment run as well as cancellations.

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

EFT: Payment data for a week of claims per provider HHSMMIS.CLM4500.EFT

MMIS Provider database is input to the prenote process (@PRV9700) which produces

HHSMMIS.PRV9700A.PRENOTES(+1) which also serves as input to @CLM4597.

Med Recon: HHSMMIS.MR025MP.ISSREISS(0)

Outputs

List all system / interface outputs -- e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

ACH EFT file: HHSMMIS.CLM4597C.EFTBATCH(+1) is copied to HHSMMIS.BATCHED.EFT for transfer to Wachovia.

Med recon flat file: HHSMMIS.MR040AP.BANKTAPE

Record Layout

Attach sample layout if applicable.

Record layout for data file is available in the project repository.

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

ACH and mutually agreed upon legacy flat file.

Governing Policies

Policies that govern use or other activity involving the system / interface.

ACH, Wachovia agreement, SCDHHS payment policies.

Access Control Policies and Security

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

List data security levels, security requirements etc.

See MMIS Interfaces: Common Answers document.

Wachovia FTP website logins, Mainframe RACF, HIPAA Privacy policies.

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

N/A

System / Interface Data Processing Standards

If a SLA or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

Instant.



Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

Wachovia has to receive both the EFT and the Med recon by 11 am on Thursdays.

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

Vital to the operation of SC Medicaid.

Disaster Recovery

Attach any disaster recovery plans.

See MMIS Interfaces: Common Answers document.

Contract

Legal agreement status and document location.

N/A

Data Storage & System Attributes

What programming languages were used in creating the system / interface, or what COTS software was acquired?

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format / schema documentation if possible.

MMIS databases and tables for payment system. ACH and flat file removed immediately for security reasons.

Transaction processing

Type (batch / real-time).

Batch

Data Quality Control

Describe quality control policies / procedures.

N/A

Backup

Describe / attach backup procedures and policies.

See MMIS Interfaces: Common Answers document.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

Number of providers that filed claims in a week.

Support

Support hours and response times. Who handles user support, and how? Explain escalation / levels, if applicable.

See MMIS Interfaces: Common Answers document.

Incident Management

Process / constraints by which incidents are handled.

See MMIS Interfaces: Common Answers document.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?

See MMIS Interfaces: Common Answers document.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

See MMIS Interfaces: Common Answers document.

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens?

Include medium, etc.

Visio flow charts; M:\MMIS\HIPAA\System Flow for EDS\EFT - Electronic Funds

Med Recon: M:\MMIS\HIPAA\System Flow for EDS\Medical Recon. These flowcharts were created using Chartist software.



Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

See MMIS Interfaces: Common Answers document.

Request changes and set payment policies.

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

See MMIS Interfaces: Common Answers document.

Implement changes, execute interface, and to upload files to Wachovia.

Plans for the System / Interface

How long will the system / interface continue?

N/A

What upgrades and replacements are planned?

N/A

Legislative climate and other forces affecting system / interface?

N/A

Comments?

N/A



1.15. First Health

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

First Health (for drug utilization review contract).

Owner Information

Name, phone, email, etc. of user and support contacts

See MMIS Interfaces: Common Answers document.

First Health

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

SCDHHS sends claims data to First Health under drug utilization review contract. The jobs/programs are in the SCDHHS libraries and executed from the HHS JCL library.

Objectives

What are the goals of the system / interface? Why was it initiated?

To fulfill drug utilization contract by sending claims data to the contractor First Health.

Business Processes

What business processes require the interface?

See Interfaces Related to BPs document.

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

None

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

Files are transferred at the first of the month via C:D server-to-server version. The paid claims file must be created; then the 'A' and 'Z' claims can be pulled.

HHS.PROD.JCL(@FIQCLMS) is the job name that pulls the claims.

HHS.PROD.JCL(@FIQPSH) creates the Connect:Direct files for claims above.

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, C:D etc.).

The extract is created from MARS data using SAS in a custom format and then downloaded to the extranet for retrieval by the drug utilization review contractor via Connect:Direct.

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

C:D is the exchange protocol.

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

Job is executed on the first day of the month by Clemson University using Zeke.

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

Z claims (institutional) and A (professional) -- the entire database record. CCN and void date is sent on voided claims.

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.



Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

Monthly claim archive files are used to create the output files.

Outputs

List all system / interface outputs -- e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

HHS.FIQCLMSB.A.DYMM and HHS.FIQCLMSB.A.DYMM.MCF

HHS.FIQCLMSB.Z.DYMM and HHS.FIQCLMSB.Z.DYMM.MCF

HHS.FIQVOIDB.VOIDS.ADZ.DYMM and HHS.FIQVOIDB.VOIDS.ADZ.DYMM.MCF

Record Layout

Attach sample layout if applicable.

VOID FILE

Types A, D and Z

WO-VOID-REC.

04 WO-VOID-CCN PIC X(17).

04 WO-VOID-DATE PIC X(08).

CLAIM FILE

Types A and Z

HIO-HIC-CLAIM.

UZO-UB92-BASIC-CLAIM

01 O-OUTPUT-REC PIC X(2264).

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

C:D is used and provides encryption and security of data.

Governing Policies

Policies that govern use or other activity involving the system / interface.

N/A

Access Control Policies and Security

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

List data security levels, security requirements etc.

See MMIS Interfaces: Common Answers document.

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

N/A

System / Interface Data Processing Standards

If a SLA or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

N/A

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

N/A



Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

The job is not a critical MMIS business function but is critical for the contractor to fulfill the contractual obligation.

Disaster Recovery

Attach any disaster recovery plans.

See [MMIS Interfaces: Common Answers](#) document.

Contract

Legal agreement status and document location.

N/A

Data Storage & System Attributes

What programming languages were used in creating the system / interface, or what COTS software was acquired?

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format / schema documentation if possible.

N/A

Transaction processing

Type (batch / real-time).

Batch

Data Quality Control

Describe quality control policies / procedures.

N/A

Backup

Describe / attach backup procedures and policies.

See [MMIS Interfaces: Common Answers](#) document.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

Capacity: one month of claims.

Support

Support hours and response times. Who handles user support, and how? Explain escalation / levels, if applicable.

See [MMIS Interfaces: Common Answers](#) document.

Incident Management

Process / constraints by which incidents are handled.

See [MMIS Interfaces: Common Answers](#) document.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?

See [MMIS Interfaces: Common Answers](#) document.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

See [MMIS Interfaces: Common Answers](#) document.

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens?

Include medium, etc.

N/A

Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A



System / Interface Roles and Responsibilities

SCDHHS Responsibilities

See MMIS Interfaces: Common Answers document.

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

See MMIS Interfaces: Common Answers document.

Plans for the System / Interface

How long will the system / interface continue?

N/A

What upgrades and replacements are planned?

N/A

Legislative climate and other forces affecting system / interface?

N/A

Comments?

N/A



1.16. Government Accounting and Financial Reporting System (GAFRS)

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

Government Accounting and Financial Reporting System (GAFRS)

Owner Information

Name, phone, email, etc. of user and support contacts

See MMIS Interfaces: Common Answers document.

Bureau of Fiscal Affairs

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

GAFRS is the accounting system used SCDHHS and other state agencies. The system is housed at the Budget and Control Board; the system is maintained by their Chief Information Officer (CIO). The Bureau of Fiscal Affairs uses GAFRS to track financial transactions at SCDHHS from within GAFRS. Every financial transaction that happens at the agency (e.g. MMIS service payments to providers, administrative expenditures etc.) is entered into this system. No actual money resides in the Fiscal program area (the money is located at the South Carolina Treasurer's Office). SCDHHS receives the Chart of Accounts from the Comptroller General's Office with the annual appropriations by Mini Code (also known as Budget Unit Code). The Medicaid Finance and Accounting Operations departments prepare an AFI file and send it to the Financial Systems department for loading appropriations into GAFRS. Appropriations are loaded into GAFRS by Mini Code, Fund and Expenditure Object codes 1100 and 1201.

Based on the approved funding levels, allotments are developed for each Bureau/Division. The information is entered into EXCEL spreadsheets and must be approved by executive staff. When allotments are approved by executive staff, Accounting Operations prepares an AFI file to send to Financial Systems for loading into GAFRS. This is both a manual and electronic process handled through EXCEL, ACCESS, FTP and GAFRS. Allotments are loaded for Other Operating and Salary by Index, PCA and Expenditure Object.

After Appropriations and Allotments are loaded into GAFRS, beginning cash balances for state 1001 funds are loaded into the Grants. Total amounts allocated by Mini Code are allocated to each grant based on the previous year's expenditures. Borrowing limits for Federal funds are loaded into GAFRS. This is a manual and electronic process via EXCEL, ACCESS, FTP and GAFRS.

SCDHHS has contractors that receive refund payments and checks from insurance companies, providers, and pharmaceutical companies. The contractors deposit funds into a Lock Box account at Wachovia Bank. The State Treasurer's Office sweeps that account daily and posts these funds to J02 (SCDHHS). Each night, the Comptroller General's office sweeps the State Treasurer's Office for transactions completed by SCDHHS. A Revenue Interface posts funds into GAFRS. The next morning, the batch is available in GAFRS for Financial Systems staff to release, activate and post.

Funding can be moved between grants, appropriations, and allotments. Funds from a grant can be moved between grants. Appropriations are moved between Mini Codes. Allotments are moved between the program areas. Fiscal Affairs staff monitors the process using GAFRS reports or error messages. After GAFRS processes the weekly MMIS data, the staff reviews reports and alerts to ensure there is sufficient money appropriated to each fund to fund the week's MMIS payments. Staff make manual "journal entries" in GAFRS to adjust the source of funds.

GAFRS flags any errors it finds and provides a description of what happened. A Fiscal Affairs worker makes manual adjustments (e.g. journal entry) in GAFRS to correct the error. Supervisors



will sometimes address the error, or they will email the appropriate division making them aware of the issue requiring action. Supervisors have the ability to monitor every user's activity that is logged into GAFRS.

Reports are generated each month from GAFRS and MMIS, and are used to reconcile the systems. Any errors identified are resolved quickly. The Fiscal Affairs accounting operation are monitored with reports generated from GAFRS. All financial reports are generated in GAFRS. They are created Daily, Weekly, Monthly, Quarterly, Annually, and ad-hoc, and are available for viewing electronically in Document Direct. The primary reports used for monitoring cash, appropriations, allotments, etc., are as follows: DAFR9424 - Appropriation Summary Status Report; DAFR9427 - Program Structure Appropriation Summary Status Report; DAFR 9428 - GAFRS Financial Data Summary Analysis Report; DAFR 9053 - Allotment Detail by Selected Expend Object & BUC Report; DAFR 9213 - Summary Pre-Encumbrance/Encumbrance Status Report;

Objectives

What are the goals of the system / interface? Why was it initiated?

The objective of GAFRS is to provide an efficient and effective way to track all of the financial transactions for SCDHHS.

Business Processes

What business processes require the interface?

See Interfaces/PC Applications related to Business Processes document.

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

GAFRS will be replaced with SAP in the near future (scheduled for the end of 2009).

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

See attached legacy interfaces for overview, description, and business triggers.

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, C:D etc.).

N/A

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

N/A

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

See attached legacy interfaces for overview, description, and business triggers.

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

See attached legacy interfaces for overview, description, and business triggers.

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

N/A

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

See attached legacy interfaces for overview, description, and business triggers.



Outputs

List all system / interface outputs – e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

GAFRS runs various reports. The primary reports used for monitoring cash, appropriations, allotments, etc., are as follows:

DAFR9424 - Appropriation Summary Status Report; DAFR9427 - Program Structure Appropriation Summary Status Report; DAFR 9428 - GAFRS Financial Data Summary Analysis Report; DAFR 9053 - Allotment Detail by Selected Expend Object & BUC Report; DAFR 9213 - Summary Pre-Encumbrance/Encumbrance Status Report;

These reports are available to staff electronically via D:D. Additional reports can be generated by some interfaces – see legacy interfaces for a description of those reports in the project repository.

Record Layout

Attach sample layout if applicable.

N/A

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

N/A

Governing Policies

Policies that govern use or other activity involving the system / interface.

N/A

Security

List data security levels, security requirements etc.

There are 2 security levels; Administrator, and User. An Administrator has full access, while a User only has access to certain transaction codes that are related to the job he/she is performing for Fiscal Affairs. A transaction code is used when any task is performed within the program area.

Access Control Policies

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

Refer to Security section. Access is restricted by transaction codes.

Security and Confidentiality Procedures

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

See security levels above.

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

See attached legacy interfaces for overview, description, and business triggers.

Response Time

Within what timeframe must the system / interface respond?

N/A

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

Standard business hours.

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

The system is critical to the financial operations of SCDHHS. If the system were unavailable, claims could still be paid, but there would be no record (outside of the MMIS) of these service transactions. GAFRS also keeps record of all of the administrative transactions made by the agency, and there would be no way to monitor this (outside of the specific program areas records of the transactions). The system also keeps track of the appropriations, allocations, and grants – it would be very difficult to monitor all of these funding sources (e.g. what has been spent, and



how much is left) without this financial system.

Disaster Recovery

Attach any disaster recovery plans.

DSIT has a disaster recovery contract with SunGard. Recovery from tape to like-hardware at the SunGard facility is the method of disaster recovery used. There is a written plan for recovery maintained by the CIO.

In addition to nightly backups, there are also "GAFRS" batch-cycle files kept offsite.

Contract

Legal agreement status and document location.

N/A

System / Interface Data Processing Standards

Data Storage

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format/schema documentation if possible.

The DBMS is IDMS. Data files are stored on disk, and on tape. Files are sequential and perhaps some VSAM. Applications are responsible for running the batch cycles.

Transaction processing

Type (batch / real-time).

N/A

Capacity

Including peak intervals.

N/A

Data Quality Control

Describe quality control policies / procedures.

N/A

Backup

Describe / attach backup procedures and policies.

On a daily basis, SCDHHS incrementally backs up any files that are modified to the onsite Virtual Tape System (VTS) only. There are batch cycles for the system; they are the responsibility of Applications.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

There are no limitations to the number of users that connect to the DB. Connectivity can be established via TN3270 emulators. Users must have RACF authority.

Support

Support hours and response times.

See Common Answers

Incident Management

Process / constraints by which incidents are handled.

Fiscal staff are the first line of support. Additional support is managed by the CIO helpdesk, which resolves issues like password and printer resets. Fiscal staff and the CIO work together for any programming changes.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?

GAFRS is located at the Budget and Control Board, at the Broad River Road facility. Much of the technical staff is located at SCEIS (part of the Budget and Control Board); this facility is on Browning Road.

See Owner Information above for the technical contact(s).

Help Desk

Who handles user support, and how? Explain escalation / levels, if applicable.



Fiscal staff are the first line of support. Additional support is managed by the CIO helpdesk, which resolves issues like password and printer resets. Fiscal staff and the CIO work together for any programming changes.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

For programming changes, the Fiscal Affairs program area works with the CIO come to an agreed upon timeline. Billy Crout and Danny Stokes are the staff assigned to handle most system issues.

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens?

Include medium, etc.

N/A

Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

N/A

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

N/A

Plans for the System / Interface

How long will the system / interface continue?

GAFRS will be replaced with SAP in the near future (scheduled for the end of 2009).

What upgrades and replacements are planned?

SAP

Legislative climate and other forces affecting system / interface?

N/A



1.17. HIPAA Mailbox

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

HIPAA Mailbox

Owner Information

Name, phone, email, etc. of user and support contacts

See MMIS Interfaces: Common Answers document.

MCCS (contractor for SCDHHS).

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

The HIPAA Mailbox is the interface for sending and receiving files of HIPAA X12 EDI transactions to/from trading partners and also from the South Carolina Web Claim Submission Tool. The EDI Support Center, provided as part of a contract with MCCS, is involved in setting up the mailboxes. TPAs specifies which transactions are legal for the trading partners to send in. Setting up the mailboxes includes setting these restrictions. The mailboxes are managed as part of a system often referred to as the EDI Translator System. Functions of the Translator System include:

- Archiving all inbound and outbound files
- Acknowledging receipt of X12 Files
- HIPAA X12 Compliancy Checking
- Translation between proprietary and X12 formats
- Repository for incoming transaction data
- Notifying Trading Partner and/or EDI Support Center of translation/compliancy errors
- Tracking
- Hourly uploads of 837 transaction files to the mainframe

Objectives

What are the goals of the system / interface? Why was it initiated?

The goal of the interface is to provide a way to exchange EDI X12 transactions with trading partners. The HIPAA Mailbox holds input/output files for the Translator System which converts between X12 and proprietary mainframe formats. The majority of Medicaid claims processed in MMIS come through the HIPAA Mailbox. See "Information Processed" in the Interface Summary section of this template for other types of HIPAA X12 transactions.

Business Processes

What business processes require the interface?

See Interfaces Related to BPs document.

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

Phase out the Sybase Repository

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

EDI Support Center uses Active Directory and Sybase EC Gateway to setup HIPAA mailboxes.

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, C:D etc.).

HIPAA X12



Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

SFTP, async - modems (potentially ending July 1, 2009), or web tool (SFTP).

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

Varies according to the type transaction. EC Gateway Scheduler.

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

The following X12 transactions: Claims(837), Remittance Advices(835), Eligibility Inquiries/response (270/271), Premium Payments(820), Managed Care Enrollment Listings (834), Claim status inquiry/response (276,277), Prior Authorization(278 rarely used), Acknowledgement transactions (TA1 and 997)

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

No standard for filenames that Trading partners put in the mailboxes.

Outputs

List all system / interface outputs – e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

Output names (Inbound transactions end up in these files when uploaded to the mainframe):

- CLHTR1D.XMIT.FTP(+1)
- CLHTR1I.XMIT.FTP(+1)
- CLHTR1P.XMIT.FTP(+1)
- CLH276.XMIT.FTP(+1)

Output names (Outbound transaction files from the mainframe):

- 271_RunID.271
- 277_HHSPFTP.CLH277o.TRN277
- 820_HHSPFTP.CLH5000.TRN820
- 834_HHSPFTP.RSS2150A.OUTPUT
- 835_HHSPFTP.CLH5010.TRN835

Outbound File names for placing in the mailboxes are composed of an identification number called the RunID and “.edi”.

Record Layout

Attach sample layout if applicable.

X12 implementation guides

Companion Guides are available on the SCDHHS website.

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

HIPAA X12

Governing Policies

Policies that govern use or other activity involving the system / interface.

Trading Partner Agreements, HIPAA regulations, and SCDHHS policies.



Access Control Policies and Security

*Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)
What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?*

List data security levels, security requirements etc.

Active Directory controls access to mailboxes for ftp and web tool. Async comm channel setup with EC Gateway.

CCIT Security, SCDHHS Security, HIPAA Privacy and Security

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

M:\MMIS\TranslatorDoc\

System / Interface Data Processing Standards

If a SLA or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

The expectations of the trading partners are receipt of 997 and trace files within an hour.

835s are expected on Tuesdays.

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

24/7

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

Critical: gateway for incoming claims and outgoing remittance advices among other transactions.

Disaster Recovery

Attach any disaster recovery plans.

See MMIS Interfaces: Common Answers document.

Contract

Legal agreement status and document location.

N/A

Data Storage & System Attributes

*What programming languages were used in creating the system / interface, or what **Commercial, off-the-shelf (COTS)** software was acquired?*

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format / schema documentation if possible.

Mailboxes only hold data in files. There are databases that are used in tracking as well as a Sybase

EDI Repository database where incoming transaction data is stored. The configuration of EC

Gateway is stored in SQL Server databases. Claim counts also stored in SQL Server databases.

Transaction processing

Type (batch / real-time).

Batch

Data Quality Control

Describe quality control policies / procedures.

Compliance of incoming and outgoing X12 transactions is checked by the translator using compliance maps that are part of the Sybase EDI product.

Backup

Describe / attach backup procedures and policies.

See MMIS Interfaces: Common Answers document.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

Capacity: one month of claims.



Support

Support hours and response times. Who handles user support, and how? Explain escalation / levels, if applicable.

See MMIS Interfaces: Common Answers document.

Incident Management

Process / constraints by which incidents are handled.

See MMIS Interfaces: Common Answers document.

EDI Support Center – 1st and 2nd level support for trading partners

Clemson Medicaid Services non-mainframe support group – 3rd level and above

CCIT for hardware issues.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?

See MMIS Interfaces: Common Answers document.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

See MMIS Interfaces: Common Answers document.

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens?

Include medium, etc.

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Documentation for Trading Partners: Companion Guides are available on the SCDHHS website for additional guidance (more South Carolina specific instructions beyond what is in the X12

Implementation guides).

Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

See MMIS Interfaces: Common Answers document.

Policies governing Trading Partner Agreements.

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

See MMIS Interfaces: Common Answers document.

Clemson is responsible for maintaining the Translator System.

Plans for the System / Interface

How long will the system / interface continue?

N/A

What upgrades and replacements are planned?

N/A

Legislative climate and other forces affecting system / interface?

N/A

Comments?

N/A



1.18. First Data Government Solutions – Interactive Voice Response System (IVRS)

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

Interactive Voice Response System (IVRS)

Owner Information

Name, phone, email, etc. of user and support contacts

See MMIS Interfaces: Common Answers document.

First Data Government Solutions (SCDHHS contractor).

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

Provider uses the phone to create an eligibility query that is sent first to First Data Government Solutions. A 270 transactions is created and sent to the Clemson University MEVS server. A response is then sent from MEVS to IVRS and message containing the eligibility information is played back on the phone for the provider.

Objectives

What are the goals of the system / interface? Why was it initiated?

Allows providers to verify Medicaid eligibility and last check date and payment amount.

Business Processes

What business processes require the interface?

See Interfaces Related to BPs document.

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

None

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

IVRS includes a voice recognition server to convert voice commands.

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, C:D etc.).

The eligibility transaction is X12 270/271 format. There is separate provider payment file sent from the mainframe using fixed block data.

The payment file is a custom format.

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

The 270/271 and payment file are both sent via VPN.

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

The 270/271 file is triggered by the provider calling the IVRS phone line. The payment file is sent every weekday morning allowing new providers eligibility access the next business day. The Medicaid Provider ID or NPI, whichever is applicable, is required to access the IVRS. Even though payment runs weekly, new providers are able to be added daily. If there is no payment for the provider, the date is listed as 01-01-1900 and this causes a message to be played by IVRS "No payment info available".

HHSMMIS.PROD.JCL(@PMT4700), which is the job that updates the MMIS database, must have run on Tuesday before a new payment file can be created.



Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

270/271:

Eligibility information about beneficiaries, including: Name, Date of Birth, Medicaid ID, RSP program, Payment Category, Medicare Eligibility (Yes/No) including Medicare Number.

Payment File:

Check Date, Payment Amount.

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

Data on the Medicaid Eligibility Verification Server (MEVS) is used to create the 271 response.

Extract of eligibility data from the MMIS mainframe is used to populate the database on the MEVS server.

Outputs

List all system / interface outputs -- e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

X12 270 is the output transaction.

Extract file of payment data: The job that creates the payment file for IVRS is HHS.PROD.JCL(IVRSFTP).

Record Layout

Attach sample layout if applicable.

X12 270/271 transactions.

Payment file

Field Name	Number of Bytes
------------	-----------------

Detail Record	
---------------	--

Type Record	1
-------------	---

Provider Number 10	
--------------------	--

Provider Type	2
---------------	---

Check Date	8
------------	---

Check Number	7
--------------	---

Check Paid Amount	11
-------------------	----

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

HIPAA X12

Governing Policies

Policies that govern use or other activity involving the system / interface.

Trading Partner Agreements, HIPAA regulations, and SCDHHS policies.

Access Control Policies and Security

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

List data security levels, security requirements etc.

N/A

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.



N/A

System / Interface Data Processing Standards

If a SLA or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

Payment file is sent every weekday morning. The goal is to have the payment file available by 11:30 PM, this is the time the First Data Government Solutions posts the new file to the IVRS.
270/271 response on demand from provider request.

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

24/7

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

This is not a critical for the agency but is critical for providers to access eligibility information.

Disaster Recovery

Attach any disaster recovery plans.

See MMIS Interfaces: Common Answers document.

Contract

Legal agreement status and document location.

N/A

Data Storage & System Attributes

What programming languages were used in creating the system / interface, or what COTS software was acquired?

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format / schema documentation if possible.

N/A

Transaction processing

Type (batch / real-time).

Batch for provider payment file. Real-time for 270/271 files.

Data Quality Control

Describe quality control policies / procedures.

N/A

Backup

Describe / attach backup procedures and policies.

See MMIS Interfaces: Common Answers document.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

N/A

Support

Support hours and response times. Who handles user support, and how? Explain escalation / levels, if applicable.

See MMIS Interfaces: Common Answers document.

Requires the monitoring of operators at First Data on 15 minute intervals. Requires support from BMSM for troubleshooting of problems on next business day.

Incident Management

Process / constraints by which incidents are handled.

See MMIS Interfaces: Common Answers document.

First Data sends a test transaction through every 15 minutes and notifies SCDHHS and Clemson if there is a failure (i.e. First Data will contact Clemson and SCDHHS if the connection is down).



Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?

See MMIS Interfaces: Common Answers document.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

See MMIS Interfaces: Common Answers document.

Documentation (User / System)

*What kind of technical documentation has been produced? Are there any user manuals or help screens?
Include medium, etc.*

N/A

Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

See MMIS Interfaces: Common Answers document.

Make sure provider payment file is completed daily.

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

See MMIS Interfaces: Common Answers document.

Plans for the System / Interface

How long will the system / interface continue?

N/A

What upgrades and replacements are planned?

5010 is a federal initiative to update X12 that more than likely will change the format of 270/271 transaction sets.

Legislative climate and other forces affecting system / interface?

N/A

Comments?

N/A



1.19. *Managed Care Organizations (MCOs)*

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

Managed Care Organization (MCO)

Owner Information

Name, phone, email, etc. of user and support contacts

See MMIS Interfaces: Common Answers document.

MCO

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

SCDHHS contracts with MCOs to provide medical services for Medicaid recipients using a per member per month (PMPM) fee structure. Recipients are assigned to MCOs by SCDHHS through an enrollment counselor, and MCOs receive an agreed upon amount monthly, regardless of the number of services provided for a member. For each service, the MCO submits encounter data to SCDHHS, which include MCO and recipient information, procedure codes, physician information, dates, times, etc. This interface allows MCOs to submit encounter data to SCDHHS. This data is submitted using a proprietary format via C:D. SCDHHS validates the data to determine whether it is valid or invalid. A number of data files are also returned to the MCO by SCDHHS for reporting and management purposes. SCDHHS currently has contracts with seven MCOs.

Objectives

What are the goals of the system / interface? Why was it initiated?

SCDHHS uses encounter data to evaluate the level, quality and completeness of the services provided to Medicaid recipients. This data will eventually be used to establish PMPM rates for services provided by MCOs.

Business Processes

What business processes require the interface?

See Interfaces Related to BPs document.

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

None

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

C:D is a secure point-to-point (PPP) medium that transfers data between the MCO and SCDHHS. Data must be 100% accurate. The data is submitted to SCDHHS using the new file submissions instruction. There are a number of file layouts depending on the data being submitted. In addition to the information below - please reference the MCO New File Submission document available on SharePoint.

FILES FROM THE MCO TO SCDHHS:

*All of these files are sent via C:D

1. Their non par provider file which consists of all of the Non Medicaid providers the MCO uses, must be sent to SCDHHS with every encounter submission and no later than the 25th of each month.
2. Their TPL file which consists of all TPL info for each of the MCOs members and must be received no later than the 8th of every month.
3. Their monthly encounter file which is the encounters from the prior month must be sent no later than the 25th of each month.



FILES FROM SCDHHS TO THE MCO:

1. The enhanced/return file from the MCO's encounter submission. Sent 1 to 2 business days after processing the incoming encounter file.
2. The Medicaid Provider file sent to the MCOs every month of all SCDHHS Medicaid providers. Sent 2 to 3 business days after cutoff.
3. The MLE file is created at the first of the month and after cutoff. Sent 1 to 2 business days after the 1st and 2 to 3 business days after cutoff.
4. Monthly EPSDT file is created on or before the 5th of every month.
5. The recertification file is sent on or around the 5th of every month.
6. The sync file is created 2 to 3 business days after cutoff and 1st Saturday of every month.
7. Fee Schedule, Carrier Codes and Contract Rate files are created no later than the 5th of every month.

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, C:D etc.).

Some files are custom formats and some are X12 (834 and 820).

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

C:D is a secure PPP medium that is use to transfer data between the MCO and SCDHHS.

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

In addition to the information below - please reference the MCO New File Submission document attached on SharePoint.

FILES FROM THE MCO TO SCDHHS:

*All of these files are sent via C:D

1. Their non par provider file which consists of all of the Non Medicaid providers the MCO uses, must be sent to SCDHHS with every encounter submission and no later than the 25th of each month.
2. Their TPL file which consists of all TPL info for each of the MCOs members and must be received no later than the 8th of every month.
3. Their monthly encounter file which is the encounters from the prior month must be sent no later than the 25th of each month.

FILES FROM SCDHHS TO THE MCO:

1. The enhanced/return file from the MCO's encounter submission. Sent 1 to 2 business days after processing the incoming encounter file.
2. The Medicaid Provider file sent to the MCOs every month of all SCDHHS Medicaid providers. Sent 2 to 3 business days after cutoff.
3. The MLE file is created at the first of the month and after cutoff. Sent 1 to 2 business days after the 1st and 2 to 3 business days after cutoff.
4. Monthly EPSDT file is created on or before the 5th of every month.
5. The recertification file is sent on or around the 5th of every month.
6. The sync file is created 2 to 3 business days after cutoff and 1st Saturday of every month.
7. Fee Schedule, Carrier Codes and Contract Rate files are created no later than the 5th of every month.

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

Encounter data is being exchanged between MCOs and SCDHHS.

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.



Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

In addition to the information below - please reference the MCO New File Submission document attached on SharePoint.

FILES FROM THE MCO TO SCDHHS:

*All of these files are sent via C:D

1. Their non par provider file which consists of all of the Non Medicaid providers the MCO uses, must be sent to SCDHHS with every encounter submission and no later than the 25th of each month.
2. Their TPL file which consists of all TPL info for each of the MCOs members and must be received no later than the 8th of every month.
3. Their monthly encounter file which is the encounters from the prior month must be sent no later than the 25th of each month.

Outputs

List all system / interface outputs – e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

In addition to the information below - please reference the MCO New File Submission document attached on SharePoint.

FILES FROM SCDHHS TO THE MCO:

1. The enhanced/return file from the MCO's encounter submission. Sent 1 to 2 business days after processing the incoming encounter file.
2. The Medicaid Provider file sent to the MCOs every month of all SCDHHS Medicaid providers. Sent 2 to 3 business days after cutoff.
3. The MLE file is created at the first of the month and after cutoff. Sent 1 to 2 business days after the 1st and 2 to 3 business days after cutoff.
4. Monthly EPSDT file is created on or before the 5th of every month.
5. The recertification file is sent on or around the 5th of every month.
6. The sync file is created 2 to 3 business days after cutoff and 1st Saturday of every month.
7. Fee Schedule, Carrier Codes and Contract Rate files are created no later than the 5th of every month.

Record Layout

Attach sample layout if applicable.

Attached

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

N/A

Governing Policies

Policies that govern use or other activity involving the system / interface.

MCO activities are governed by the contracts between the MCO and SCDHHS and the MCO Policies and Procedures Manual.

Link to MCO documentation on SCDHHS website:

<http://www.scdhhs.gov/dhhsnew/insideDHHS/Bureaus/BureauofHealthServicesandDeliverySystems/Managed%20Care%20Organizations.asp>

Access Control Policies and Security

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

List data security levels, security requirements etc.

See MMIS Interfaces: Common Answers document.



Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

File layouts are attached. Edits have been documented. Sample contract and a MCO Policies and Procedures Manual are available on the SCDHHS Web site.

[http://www.scdhhs.gov/dhhsnew/insideDHHS/Bureaus/BureauofHealthServicesandDeliverySystems/Managed Care Organizations.asp](http://www.scdhhs.gov/dhhsnew/insideDHHS/Bureaus/BureauofHealthServicesandDeliverySystems/Managed%20Care%20Organizations.asp)

System / Interface Data Processing Standards

If a SLA or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

See response times in the NEW FILE SUBMISSIONS instructions.

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

Interface must be available during standard business hours (8-5).

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

Interface is critical to allow processing of encounter data and the payment of MCOs.

Disaster Recovery

Attach any disaster recovery plans.

See [MMIS Interfaces: Common Answers](#) document.

Contract

Legal agreement status and document location.

Each MCO is contracted with SCDHHS. General Counsel assists in the preparation of contracts.

Data Storage & System Attributes

What programming languages were used in creating the system / interface, or what COTS software was acquired?

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format / schema documentation if possible.

N/A

Transaction processing

Type (batch / real-time).

Batch

Data Quality Control

Describe quality control policies / procedures.

N/A

Backup

Describe / attach backup procedures and policies.

See [MMIS Interfaces: Common Answers](#) document.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

Load is projected to increase as SCDHHS moves beneficiaries from FFS to managed care.

Support

Support hours and response times. Who handles user support, and how? Explain escalation / levels, if applicable.

See [MMIS Interfaces: Common Answers](#) document.

Incident Management

Process / constraints by which incidents are handled.

See [MMIS Interfaces: Common Answers](#) document.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.



Data Center

Where are the system / interface housed?

See MMIS Interfaces: Common Answers document.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

See MMIS Interfaces: Common Answers document.

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens? Include medium, etc.

N/A

Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

See MMIS Interfaces: Common Answers document.

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

See MMIS Interfaces: Common Answers document.

Plans for the System / Interface

How long will the system / interface continue?

The MCO interface will remain functional after the future MMIS is created. However, this interface may change. This will be determined as part of the MITA Project.

What upgrades and replacements are planned?

N/A

Legislative climate and other forces affecting system / interface?

N/A

Comments?

N/A



1.20. **Maximus (Managed Care Enrollment Broker/Counselor)**

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

Maximus (Managed Care Enrollment Counselor)

Owner Information

Name, phone, email, etc. of user and support contacts

See [MMIS Interfaces: Common Answers](#) document.

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

SCDHHS contracts with an Enrollment Counselor to manage the enrollment and outreach to beneficiaries into Managed Care. MMIS sends 834s to the Enrollment Counselor for eligible individuals, based on PCAT and RSP. The Enrollment Counselor sends enrollment decisions to the MMIS, which confirms that enrollment decisions have been accepted. After receipt of the 834s, the Enrollment Broker/Counselor sends enrollment packets to managed care eligibles.

Objectives

What are the goals of the system / interface? Why was it initiated?

Used to manage the data necessary for the outreach to potential Managed Care members, and their subsequent enrollment into Managed Care.

Business Processes

What business processes require the interface?

See [Interfaces Related to BPs](#) document.

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

None

Glossary / Acronyms of Terms

What specific terms and acronyms might be unfamiliar to outsiders?

PCAT – Payment Category

RSP – Recipient Special Program

MGC – Managed Care

MLE – Member Listing Eligibility

IDD – Integrated Data Dictionary

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

C:D is a secure PPP medium that transfers data between MMIS and the Enrollment Counselor.

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, C:D etc.).

All MMIS files are X12 834 format. MEDS Authorized Representative file is a proprietary format, controlled by Clemson/SCDHHS.

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

C:D is a secure PPP medium that transfers data between MMIS and the Enrollment Counselor.

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

N/A

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

Members eligible for managed care, enrollment decisions, and confirmations.



Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

N/A

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency. Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

File from MMIS to Enrollment Broker. Sent daily. Created by @RSS2150.

File from Enrollment Broker to MMIS with updates to enrollments. Sent daily. Processed by @RSS2250. File is edited at Clemson. Database is updated. Clemson sends confirmations or errors appended to the daily (@RSS2150) MMIS to Enrollment Broker file.

Roster file from MMIS to Enrollment Broker. Sent twice per month. Created by @RSS2300. File sent at MGC cut-off contains all individuals, whether added or removed from Managed Care plan or who have continuing enrollment. The Gap file (1st of the month) contains individuals who were reenrolled in their old plan.

Authorized Representative file from MEDS to Enrollment Broker. Sent weekly. Created by @MIS3070.

Outputs

List all system / interface outputs -- e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

Described under Inputs. Two-way interface.

Record Layout

Attach sample layout if applicable.

Record layout used in programs is in the MMIS IDD, RSS-834-RECORD. This mainframe format is sent to the translator for conversion to the X12 834 transaction.

Authorized Representative file layout in MEDS.PROD.SOURCE(MIS3070), WS-AUTHREP-REC.

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

N/A

Governing Policies

Policies that govern use or other activity involving the system / interface.

See SCDHHS contract with Maximus.

Access Control Policies and Security

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

List data security levels, security requirements etc.

See [MMIS Interfaces: Common Answers](#) document.

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

The Maximus User Guide describes the outgoing (from MMIS) files to Maximus.

M:\MMIS\MARC\Documentation\Recipient\Maximus - MMIS User Guide.doc

System / Interface Data Processing Standards

If a SLA or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?



N/A

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

24/7

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

This interface is critical to the enrollment of members into Managed Care.

Disaster Recovery

Attach any disaster recovery plans.

See [MMIS Interfaces: Common Answers](#) document.

Contract

Legal agreement status and document location.

SCDHHS contract with Enrollment Broker (Maximus).

Data Storage & System Attributes

What programming languages were used in creating the system / interface, or what COTS software was acquired?

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format / schema documentation if possible.

N/A

Transaction processing

Type (batch / real-time).

Batch

Data Quality Control

Describe quality control policies / procedures.

N/A

Backup

Describe / attach backup procedures and policies.

See [MMIS Interfaces: Common Answers](#) document.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

Daily File 6,000-10,000

Monthly Roster 400,000

Gap File 2,000

Auth Rep 175,000

Note: These are the current processing average records processed, not the capacity limits.

Support

Support hours and response times. Who handles user support, and how? Explain escalation / levels, if applicable.

See [MMIS Interfaces: Common Answers](#) document.

Incident Management

Process / constraints by which incidents are handled.

See [MMIS Interfaces: Common Answers](#) document.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?

See [MMIS Interfaces: Common Answers](#) document.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

See [MMIS Interfaces: Common Answers](#) document.

Documentation (User / System)



What kind of technical documentation has been produced? Are there any user manuals or help screens? Include medium, etc.

N/A

Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

See MMIS Interfaces: Common Answers document.

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

See MMIS Interfaces: Common Answers document.

Plans for the System / Interface

How long will the system / interface continue?

The Managed Care interface will remain functional for the foreseeable future.

What upgrades and replacements are planned?

N/A

Legislative climate and other forces affecting system / interface?

N/A

Comments?

N/A



1.21. Medicaid Claims Control System (MCCS)

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

Medicaid Claims Control System (MCCS)

Owner Information

Name, phone, email, etc. of user and support contacts

See MMIS Interfaces: Common Answers document.

MCCS

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

Providers submit claims to MCCS in paper form as well as on electronic media. MCCS uses OCR technology and manual data entry to enter claims. MCCS then groups the claims into batch and transmits them to Clemson via a direct line. They are sent to the internal reader (INTRDR) using remote job entry (RJE), and arrive at Clemson as a batch job to be run.

Weekly, after the MMIS Payment process, checks are printed at MCCS. These are merged with paper Remittance Advices and Provider ECFs (which are printed at Clemson and delivered to MCCS) and mailed to the Providers.

The file of Medicaid cards originates within the MEDS system (for newly eligible beneficiaries and replacement cards). This file is sent MMIS nightly, where it is further processed and sent to the card vendor (currently MCCS).

Objectives

What are the goals of the system / interface? Why was it initiated?

MCCS is the collection point for paper claims and claims on various electronic media. MCCS is the common point for post-payment information sent to providers.

Business Processes

What business processes require the interface?

See Interfaces Related to BPs document.

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

None

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

MCCS

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, C:D etc.).

Claims come to Clemson via RJE in a proprietary format. Card requests are sent to MCCS in a proprietary format.

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

SNA

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

Claims, checks (printed at MCCS), card requests.



Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

N/A

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency. Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

Claims from providers to be transmitted to Clemson.

Card requests to be sent to MCCS.

Outputs

List all system / interface outputs -- e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

Claims input jobs on the Clemson mainframe. MM010APN, @CLZ0010, MM093AP, @CLZ0093

Record Layout

Attach sample layout if applicable.

Claims format is best documented in program MM030HT.

Card request format is documented in HHSMMIS.PROD.RSS.SOURCE(RSS0600). It can also be found in M:\MMIS\DOC\RECIP\plastic card layout vendor with family#.doc

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

N/A

Governing Policies

Policies that govern use or other activity involving the system / interface.

N/A

Access Control Policies and Security

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

List data security levels, security requirements etc.

N/A

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

N/A

System / Interface Data Processing Standards

If a SLA or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

Claims are transmitted from MCCS to Clemson during the day every weekday.

Card request file is sent to MCCS daily.

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

Daily.

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?



This is critical to the claims transmission to Clemson, Remit printing, and Medicaid card creation.

Disaster Recovery

Attach any disaster recovery plans.

See [MMIS Interfaces: Common Answers](#) document.

Contract

Legal agreement status and document location.

See contract between SCDHHS and MCCS.

Data Storage & System Attributes

What programming languages were used in creating the system / interface, or what COTS software was acquired?

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format / schema documentation if possible.

RJE, JCL, COBOL, IDMS

Transaction processing

Type (batch / real-time).

Batch

Data Quality Control

Describe quality control policies / procedures.

N/A

Backup

Describe / attach backup procedures and policies.

See [MMIS Interfaces: Common Answers](#) document.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

Approximately 10,000 claims per day are transmitted.

Approximately 1000 cards are requested each day.

Support

Support hours and response times. Who handles user support, and how? Explain escalation / levels, if applicable.

See [MMIS Interfaces: Common Answers](#) document.

Incident Management

Process / constraints by which incidents are handled.

See [MMIS Interfaces: Common Answers](#) document.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?

See [MMIS Interfaces: Common Answers](#) document.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

See [MMIS Interfaces: Common Answers](#) document.

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens?

Include medium, etc.

N/A

Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

See [MMIS Interfaces: Common Answers](#) document.



Contractor Responsibilities

See MMIS Interfaces: Common Answers document.

Plans for the System / Interface

How long will the system / interface continue?

N/A

What upgrades and replacements are planned?

N/A

Legislative climate and other forces affecting system / interface?

N/A

Comments?

N/A



1.22. MMIS to MEDS

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

MIS (MMIS to MEDS)

Two files are sent from MMIS to MEDS. One is used in the Managed Care process to have particular recipients inserted into the process. The second is used to update the RSP indicator for Members.

Owner Information

Name, phone, email, etc. of user and support contacts

See MMIS Interfaces: Common Answers document.

Clemson University is the contractor responsible for the MMIS and MEDS systems.

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

The first file is a listing of recipients that MMIS wants included in the Managed Care process. The second file is a read by MEDS to update the RSP indicator on the MEDS member data.

(Note: This interface represents a data exchange between the MMIS and MEDS.)

Objectives

What are the goals of the system / interface? Why was it initiated?

To request recipient be inserted into the Managed Care process (which will cause them to be included in the file that is sent to MMIS, and eventually to the Enrollment Broker).

To keep the recipient RSP indicators in sync.

Business Processes

What business processes require the interface?

See Interfaces Related to BPs document.

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

None

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

MMIS

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, C:D etc.).

Mainframe flat files. Format/layout controlled by MMIS.

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

None. Files are created by MMIS subsystems and read by MEDS subsystems. Files are not physically moved.

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

The MMIS-initiated need for member to be in the managed care file.

RSP is a nightly process.

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

Member managed care and RSP data.



Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

MMIS family and recipient ID numbers. File: HHSMMIS.MEE0300.MEDS.FILE.COPY

MMIS recipient and RSP indicator. File: HHSMMIS.MEV1100.RECIP(0)

Outputs

List all system / interface outputs -- e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

File of recipient to be included in Managed Care process.

Updated RSP indicator on MEDS.

Record Layout

Attach sample layout if applicable.

01 MMISCHG-DATA-RECORD-INPUT.

04 MMISCHG-DATA-KEY-INPUT.

08 MMISCHG-KEY-INPUT-BG PIC X(08).

08 MMISCHG-KEY-INPUT-MBR PIC X(10).

08 FILLER PIC X(04).

04 FILLER PIC X(58).

01 RSP-INPUT-RECORD.

04 RSP-MEMBER-ID PIC X(10).

04 FILLER PIC X(354).

04 RSP-RSP-IND PIC X(1).

04 FILLER PIC X(470).

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

N/A

Governing Policies

Policies that govern use or other activity involving the system / interface.

N/A

Access Control Policies and Security

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

List data security levels, security requirements etc.

Access to files is controlled by RACF. Employees have direct read-access only.

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

N/A

System / Interface Data Processing Standards

If a SLA or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:



Response Time

Within what timeframe must the system / interface respond?

Recipients received by MEDS are put into the next Managed Care file. RSP updates are done daily.

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

Weeknights and Sunday for Managed Care.

Daily for RSP.

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

Important to keeping the MEDS and MMIS recipient data in sync.

Disaster Recovery

Attach any disaster recovery plans.

See [MMIS Interfaces: Common Answers](#) document.

Contract

Legal agreement status and document location.

SCDHHS MEDS contract.

Data Storage & System Attributes

What programming languages were used in creating the system / interface, or what COTS software was acquired?

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format / schema documentation if possible.

N/A

Transaction processing

Type (batch / real-time).

Batch

Data Quality Control

Describe quality control policies / procedures.

N/A

Backup

Describe / attach backup procedures and policies.

See [MMIS Interfaces: Common Answers](#) document.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

Managed Care is very small with often none at all. RSP receives full file from MMIS and process current day transactions. 10,000 out of 2+ million.

Support

Support hours and response times. Who handles user support, and how? Explain escalation / levels, if applicable.

See [MMIS Interfaces: Common Answers](#) document.

Incident Management

Process / constraints by which incidents are handled.

See [MMIS Interfaces: Common Answers](#) document.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?

See [MMIS Interfaces: Common Answers](#) document.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

See [MMIS Interfaces: Common Answers](#) document.



Documentation (User / System)

*What kind of technical documentation has been produced? Are there any user manuals or help screens?
Include medium, etc.*

N/A

Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

See MMIS Interfaces: Common Answers document.

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

See MMIS Interfaces: Common Answers document.

Plans for the System / Interface

How long will the system / interface continue?

N/A

What upgrades and replacements are planned?

N/A

Legislative climate and other forces affecting system / interface?

N/A

Comments?

N/A



1.23. Medicaid Eligibility Verification System (MEVS)

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

Medicaid Eligibility Verification System (MEVS)

Owner Information

Name, phone, email, etc. of user and support contacts

See [MMIS Interfaces: Common Answers](#) document.

Clemson University (Clemson Medicaid Services Team)

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

This interface creates files by extracting data from MMIS, on a daily basis, to populate the MEVS database. The MEVS database is completely repopulated every day, not updated. Recipient eligibility and some information on eligibility for Medicaid programs are kept. Vendors query via EDI X12 270 transaction as to whether or not on this date the recipient is eligible.

The Translator interfaces with MEVS by X12 270 EDI transactions coming in via mailboxes. It forwards the transactions from the mailboxes to MEVS, via SFTP, for processing. MEVS then makes available the response files so that the translator can retrieve and place them into the mailboxes for pickup. The Eligibility portion of the SC Medicaid Web Submission Tool queries MEVS using EDI X12 270 and 271.

Objectives

What are the goals of the system / interface? Why was it initiated?

To provide 24/7 access as to whether or not a recipient is eligible for Medicaid, and what programs. This is accomplished by the processing of an X12 270 transaction and the response of an X12 271 transaction.

Business Processes

What business processes require the interface?

See [Interfaces Related to BPs](#) document.

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

None

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

Internal interface with MMIS to extract data to populate the MEVS database. The X12 270 transactions can come in through the Translator, the Web Submission Tool, and via a direct connection from the vendors.

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, C:D etc.).

X12 270 for incoming and X12 271 for outgoing transactions.

Custom format for mainframe extract files.

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

FTP for transfer from mainframe (Initiated by MEVS for security reasons).

SFTP for translator interface files.

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface



Zeke scheduler triggers the creation of extraction files from MMIS to populate MEVS database.
UNIX cron scheduler is used to initiate download of mainframe extracts and loading of data into MEVS database.

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

RSP information, Provider information, NPI, Recipient data, TPL Policy Information

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

HHSMMIS.MEVS.RECIP.DISK (@MEV1100 currently in HHSMMIS.REVIEW.JCL)

Source code in HHSMMIS.PROD.MEV.SOURCE(MEV1000)

HHSMMIS.MEVS.RSP.DISK (@MEV2100 in HHSMMIS.PROD.JCL)

Source code in HHSMMIS.PROD.MEV.SOURCE(MEV2000)

HHSMMIS.MEVS.PROVIDER.DISK (@MEV3100 in HHSMMIS.PROD.JCL)

Source code in HHSMMIS.PROD.MEV.SOURCE(MEV3000)

HHSMMIS.MEVS.NPI.DISK (@MEV3100)

Source code in HHSMMIS.PROD.MEV.SOURCE(MEV3100)

HHSMMIS.MEVS.POLICY.DISK (@MEV4100)

HHSMMIS.MEVS.POLAUX.DISK (@MEV4100)

HHSMMIS.MEVS.POLRECIP.DISK(@MEV4100)

HHSMMIS.MEVS.CARRIER.DISK (@MEV4100)

Source code for above 4 files is HHSMMIS.PROD.MEV.SOURCE(MEV4000)

HHSMMIS.MEVS.RECON (@MEV5100)

Outputs

List all system / interface outputs -- e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

X12 271 EDI transaction with Medicaid recipient and program eligibility data

Record Layout

Attach sample layout if applicable.

For the Mainframe extract files record layouts are in the mainframe programs listed in the Inputs section.

HHSMMIS.MEVS.RECON

01 WS-RECON-TABLE-RECORD.

04 WS-RECON-TARGET-TBL PIC X(26).

04 WS-RECON-RECORD-COUNT PIC 9(7).

Note: Final file record layout is padded with 47 spaces to make an 80 byte record.

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

X12 270/271

FTP – transfer of data from MMIS mainframe to MEVS SyBase Database

SFTP – transfer to/from translator mailboxes

TCP/IP



Governing Policies

Policies that govern use or other activity involving the system / interface.

N/A

Access Control Policies and Security

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

List data security levels, security requirements etc.

FTP(initiated by MEVS for security reasons) for the transfer of data from the MMIS to MEVS SyBase Database.

For real-time transactions the providers directly connect to MEVS via socket connection. The only connections that are accepted by the system are those that have their IP address on file in the MEVS system and whose SubmitterID exists in the MEVS Databases' Client_tbl. This ensures that only approved providers can access MEVS. The provider must go through SCDHHS to receive permission for direct submission to MEVS. At this time their IP address is logged and entered into the system. Also, a SubmitterID is assigned to the provider. If the SubmitterID is not found when the Client_tbl is queried the transaction is rejected as invalid. For batch submission of transactions, the provider uses SFTP to transfer their batch jobs to their translator mailbox.

SFTP over TCP/IP connection

Mainframe RACF

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

N/A

System / Interface Data Processing Standards

If a SLA or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

For online real-time transactions the response time is less than a minute. The MEVS system processes the query in less than 2 – 3 seconds. The remainder of the response time is the speed of the response over the internet to and from the provider. For batch transactions the turnaround time is 24 hours or less.

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

24/7

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

Highly Critical – vital to the operation of SC Medicaid.

Disaster Recovery

Attach any disaster recovery plans.

See MMIS Interfaces: Common Answers document.

Contract

Legal agreement status and document location.

N/A

Data Storage & System Attributes

What programming languages were used in creating the system / interface, or what COTS software was acquired?

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format / schema documentation if possible.

Sybase Database – Relational.

Available on request as part of the SQL jobs which create the tables.



Transaction processing

Type (batch / real-time).

Batch and real-time

Data Quality Control

Describe quality control policies / procedures.

Reconciliation files used for mainframe extracts download. Parsing of 270 transactions based on X12 270 Implementation guide.

Backup

Describe / attach backup procedures and policies.

See MMIS Interfaces: Common Answers document.

Logs are kept of queries and responses and are archived after 30 days. Retrieval only database.

Data backup is not necessary since the Sybase database is repopulated every day from MMIS.

System has redundancy via load balancing to server at Clemson redundant data center site

(Poole).

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

10,000 queries for batch file processing -1 per real-time.

Capacity: Over 1 million queries a day. Peak interval is usually the first of the month

Support

Support hours and response times. Who handles user support, and how? Explain escalation / levels, if applicable.

See MMIS Interfaces: Common Answers document.

Incident Management

Process / constraints by which incidents are handled.

See MMIS Interfaces: Common Answers document.

The maximum amount of time MEVS can be down unless it is a hardware problem is 10 minutes.

Every 5 minutes the unix Cron scheduler starts the MEVS monitoring script, written in Perl, to check the status of MEVS by:

Online Real-time:

sending an actual transaction into the system for processing. Based upon the return of the transaction the script takes the necessary steps to resolve the issue. If the script sees that the process is hanging, it kills the process and wait up to 10 minutes for the socket binding to be freed and for system resources to be freed. Then the script restarts the MEVS system.

If the script runs and sees that the control files are not present then it automatically restarts the system and recreates the files.

Batch:

checking for two things: does the status control files exist and it queries the database for connectivity. Based upon the return code from the database query, the script takes the action to restart the MEVS system as in the Online Real-Time case. If 0 is returned there is no problem with the database.

An e-mail is sent to the non-mainframe on call group with the issues the monitoring script has found.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?

See MMIS Interfaces: Common Answers document.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

See MMIS Interfaces: Common Answers document.



Documentation (User / System)

*What kind of technical documentation has been produced? Are there any user manuals or help screens?
Include medium, etc.*

N/A

Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

See MMIS Interfaces: Common Answers document.

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

See MMIS Interfaces: Common Answers document.

Hardware, data, and processing.

Plans for the System / Interface

How long will the system / interface continue?

Until SCDHHS cancels MEVS.

What upgrades and replacements are planned?

This will be determined during MITA, 5010 X12 upgrade, and Request for Changes.

Legislative climate and other forces affecting system / interface?

N/A

Comments?

N/A



1.24. Medical Homes Network (MHN)

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

Medical Homes Network (MHN)

Owner Information

Name, phone, email, etc. of user and support contacts

See MMIS Interfaces: Common Answers document.

MHN

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

Provides data for Medical Homes Network sure recipients and boards (Last 6 months of any FFS claims for boards eligible recipients) to MHN. The data is used by the plan to coordinate care for the participating recipients.

Objectives

What are the goals of the system / interface? Why was it initiated?

Creation of monthly data files consisting of MLE (member listing extracts) data, MHN eligible* RSP records, MHN sure claims monthly and 6 months claims history data. This data is used by the plan to coordinate care for the participating recipients.

- The following paycats are excluded (as of August 2004): NURSING HOME, SILVERCARD, FAMILY PLANNING, SLMB, MAO WAIVERS, QUALIFIED JWORKING DISABLED, USCEDC/COSY, REFUGEE ASSISTANCE, HOSPICE

Business Processes

What business processes require the interface?

See Interfaces Related to BPs document.

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

None – this does not support a SCDHHS business process.

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

Data files are created weekly and monthly by programs written by BSM Analyst within SCDHHS. Files are transferred using C:D. Job names: @MHN0110, @MHN0120, @MHN0125, @MHN0210, @MHN0240, @MHN0245, @MHN0250

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, Connect:Direct etc.).

The extract is created from MARS data using SAS in a custom format and then downloaded to the extranet for retrieval by MHN via C:D.

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

Connect:Direct is the exchange protocol.

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

Weekly payment run and monthly created archive files.

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

MHN Board data, Recipient records, Recipient RSP records, Claims data, Reference files.



Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

Data files are created weekly and monthly by programs written by a BMSM Analyst within SCDHHS using archived information.

Outputs

List all system / interface outputs – e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

Outputs are fixed length text data files.

MONTHLY:

HHCD004.MHN0250.PCM100.SURE.CLAIM.HIST

HHCD003.MHN0250.PCM110.SURE.CLAIM.HIST

HHCD004.MHN0250.PCM120.SURE.CLAIM.HIST

Record Layout

Attach sample layout if applicable.

RECIPIENT, FAM-FAMILY, RECIP-AUX-KEY, RSI-RSP-INFO

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

C:D is used and provides encryption and security of data.

Governing Policies

Policies that govern use or other activity involving the system / interface.

N/A

Access Control Policies and Security

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

List data security levels, security requirements etc.

See MMIS Interfaces: Common Answers document.

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

Documentation is contained in BMSM procedure forms, the job master, JCL in the job stream and job run sheets.

System / Interface Data Processing Standards

If a service level agreement (SLA) or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

The monthly files must be completed by the fifth day of the month before it becomes an issue.

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

Files are provided monthly usually the first week of the month.



Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

The MHN needs the data for further processing to fulfill contractual obligations with SCDHHS.

Disaster Recovery

Attach any disaster recovery plans.

See MMIS Interfaces: Common Answers document.

Contract

Legal agreement status and document location.

N/A

Data Storage & System Attributes

What programming languages were used in creating the system / interface, or what COTS software was acquired?

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format / schema documentation if possible.

N/A

Transaction processing

Type (batch / real-time).

Batch

Data Quality Control

Describe quality control policies / procedures.

N/A

Backup

Describe / attach backup procedures and policies.

See MMIS Interfaces: Common Answers document.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

Volume will vary depending on monthly claims submitted. Approximately 2 million per month.

Support

Support hours and response times. Who handles user support, and how? Explain escalation / levels, if applicable.

See MMIS Interfaces: Common Answers document.

1 – 2 business days to resolve transfer problems.

1 -2 business days to re-run the jobs.

Incident Management

Process / constraints by which incidents are handled.

See MMIS Interfaces: Common Answers document.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?

See MMIS Interfaces: Common Answers document.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

See MMIS Interfaces: Common Answers document.

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens?

Include medium, etc.

N/A

Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A



System / Interface Roles and Responsibilities

SCDHHS Responsibilities

See MMIS Interfaces: Common Answers document.

Ensure file extracts are created and transferred in a timely manner

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

See MMIS Interfaces: Common Answers document.

Produce reports per executive staff requirements to fulfill contractual obligations.

Plans for the System / Interface

How long will the system / interface continue?

N/A

What upgrades and replacements are planned?

N/A

Legislative climate and other forces affecting system / interface?

N/A

Comments?

N/A



1.25. Milliman (Actuaries)

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

Milliman Actuaries

Owner Information

Name, phone, email, etc. of user and support contacts

See MMIS Interfaces: Common Answers document.

Milliman Actuaries

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

This is an Executive Staff contract for actuarial services and associated reporting.

Objectives

What are the goals of the system / interface? Why was it initiated?

See Overview.

Business Processes

What business processes require the interface?

See Interfaces Related to BPs document.

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

None – this does not support a SCDHHS business process.

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

Claims data transmitted weekly. Encounter data, recipient, provider, associated files transmitted monthly.

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, C:D etc.).

The extract is created from MARS data using SAS in a custom format and then downloaded to the extranet for retrieval by the Milliman actuaries via C:D.

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

Connect:Direct is the exchange protocol.

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

Weekly payment run and monthly created archive files.

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

Claims and associated data

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.



If input is a form, are these documents imaged, indexed, stored, and accessed electronically?
Archived claims data.

Outputs

List all system / interface outputs – e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

DSU files

Record Layout

Attach sample layout if applicable.

DSU record layouts

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

C:D is used and provides encryption and security of data.

Governing Policies

Policies that govern use or other activity involving the system / interface.

N/A

Access Control Policies and Security

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

List data security levels, security requirements etc.

See MMIS Interfaces: Common Answers document.

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

N/A

System / Interface Data Processing Standards

If a SLA or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

Files are sent on a scheduled weekly, monthly basis.

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

When client is ready to download files.

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

Low criticality.

Disaster Recovery

Attach any disaster recovery plans.

See MMIS Interfaces: Common Answers document.

Contract

Legal agreement status and document location.

N/A

Data Storage & System Attributes

*What programming languages were used in creating the system / interface, or what **Commercial, off-the-shelf (COTS)** software was acquired?*

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format / schema documentation if possible.

IBM 390 Mainframe.



Transaction processing

Type (batch / real-time).

Batch

Data Quality Control

Describe quality control policies / procedures.

N/A

Backup

Describe / attach backup procedures and policies.

See [MMIS Interfaces: Common Answers](#) document.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

N/A

Support

Support hours and response times. Who handles user support, and how? Explain escalation / levels, if applicable.

See [MMIS Interfaces: Common Answers](#) document.

Incident Management

Process / constraints by which incidents are handled.

See [MMIS Interfaces: Common Answers](#) document.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?

See [MMIS Interfaces: Common Answers](#) document.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

See [MMIS Interfaces: Common Answers](#) document.

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens? Include medium, etc.

N/A

Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

See [MMIS Interfaces: Common Answers](#) document.

Ensures files are ready for transmission at designated times.

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

See [MMIS Interfaces: Common Answers](#) document.

Plans for the System / Interface

How long will the system / interface continue?

Based on contractual obligation.

What upgrades and replacements are planned?

N/A

Legislative climate and other forces affecting system / interface?

N/A

Comments?

N/A



1.26. South Carolina Budget and Control Board – Office of Research and Statistics (ORS)

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

South Carolina Budget and Control Board - Office of Research and Statistics (ORS).

Owner Information

Name, phone, email, etc. of user and support contacts

See MMIS Interfaces: Common Answers document.

ORS

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

This interface is used to submit ad hoc requests for data that come from ORS. The interface gives ORS data they need to fulfill research request to various agencies requiring Medicaid statistics.

Objectives

What are the goals of the system / interface? Why was it initiated?

Creates daily, weekly and monthly data files for further processing by ORS staff.

Business Processes

What business processes require the interface?

See Interfaces Related to BPs document.

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

None – this does not support a SCDHHS business process.

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

Data files are created weekly and monthly by programs written by BMSM Analyst within SCDHHS.

Files are transferred to ORS using C:D.

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, Connect:Direct etc.).

The extract is created from MARS data using SAS in a custom format and then downloaded to the extranet for retrieval by ORS via Connect:Direct.

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

Connect:Direct is the exchange protocol.

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

Weekly payment run and monthly created archive files.

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

Recipient-family records, daily Recipient records, Recipient RSP records, Encounters, Providers, TPL records, Claims data, Claim Voids. The following code tables: diagnostic, drug, provider, surgical, procedure.

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.



Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

Data files are created weekly and monthly by programs written by BSM Analyst within SCDHHS.

HHSMMIS.ENC5000.GOOD.ARCH

HHSMMIS.ENCOUNT.VOID.ARCH

HHSMMIS.DSU0145.MPROV

HHSMMIS.DSU0030.CLMS

HHSMMIS.DSU0045.NDC

Recipient and Void files are created from BSM analyst written programs.

Outputs

List all system / interface outputs – e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

Outputs are fixed length text data files.

Daily:

HHCD006.ORS.DAILY.RECIPFAM.FILE

HHCD020.DAILY.RECIP

HHCD006.ORS.DAILY.RECIP.RSPFILE

HHCD006.ORS.DAILY.TPL

Weekly:

HHCD006.CLMS

HHCD006.NDC.FILE

MONTHLY:

HHCD006.ORS.MONTHLY.RCPFAM.FILE

HHCD006.ORS.MONTHLY.RCPFAM.MCF

HHCD006.ORS.ALLVOIDS.MONTHLY.FILE

HHCD006.ORS.ALLVOIDS.MONTHLY.MCF

HHCD006.ORS.MONTHLY.ENCOUNTR.FILE

HHCD006.ORS.MONTHLY.ENCOUNTR.MCF

HHCD006.ORS.MONTHLY.ENCOUNT.VOID

HHCD006.ORS.MONTHLY.ENCOUNT.MCF

HHCD006.ORS.MONTHLY.MPROV

HHCD006.ORS.MONTHLY.MPROV.MCF

Record Layout

Attach sample layout if applicable.

Associated record layouts to file names:

HHSMMIS.ENC5000.GOOD.ARCH

HMOENDEC,HMOENHEC,HMOENZEC

HHSMMIS.ENCOUNT.VOID.ARCH

HMOENHOSP,HMOENHIC,HMOENDRUG

HHSMMIS.DSU0145.MPROV

HMOPRVIN

HHSMMIS.DSU0030.CLMS

BASIC-DB-CLAIM

HHSMMIS.DSU0045.NDC

NDC-CLAIM-RECORD

HHCD006.ORS.DAILY.RECIPFAM.FILE

RECIPIENT FAM-FAMILY

HHCD020.DAILY.RECIP

RECIPIENT

HHCD006.ORS.DAILY.TPL

CLAIM-TPL-REC

HHCD006.ORS.DAILY.RECIP.RSPFILE

RSRI-RSP-INFORMTN

HHCD006.ORS.MONTHLY.RCPFAM.FILE

RECIPIENT FAM-FAMILY

HHCD006.ORS.ALLVOIDS.MONTHLY.FILE

VOIDED-DRUG-REC



HHCD006.ORS.MONTHLY.ENCOUNTR.FILE
HMOENDEC,HMOENHEC,HMOENZEC
HHCD006.ORS.MONTHLY.ENCOUNTR.VOID
HMOENHOSP,HMOENHIC,HMOENDRUG
HHCD006.ORS.MONTHLY.MPROV HMOPRVIN

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

C:D is used and provides encryption and security of data.

Governing Policies

Policies that govern use or other activity involving the system / interface.

N/A

Access Control Policies and Security

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

List data security levels, security requirements etc.

See MMIS Interfaces: Common Answers document.

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

Documentation is contained in BMSM procedure forms, the Jobs Master (MS Access database used by BMSM to keep track of all incoming projects, requests, assignments and documentation from start to finish) , JCL in job stream, or job run sheets.

System / Interface Data Processing Standards

If a SLA or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

Daily files must be received by the next business day. Weekly files have one week to process.

Monthly files have until the 5th day of every month to process.

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

N/A

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

ORS needs the data to fulfill contractual obligations with SCDHHS.

Disaster Recovery

Attach any disaster recovery plans.

See MMIS Interfaces: Common Answers document.

Contract

Legal agreement status and document location.

N/A

Data Storage & System Attributes

What programming languages were used in creating the system / interface, or what COTS software was acquired?

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format / schema documentation if possible.

N/A

Transaction processing

Type (batch / real-time).

Batch



Data Quality Control

Describe quality control policies / procedures.

N/A

Backup

Describe / attach backup procedures and policies.

See MMIS Interfaces: Common Answers document.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

Approximately 2 million per month. Volume will vary depending on monthly claims submitted.

Support

Support hours and response times. Who handles user support, and how? Explain escalation / levels, if applicable.

See MMIS Interfaces: Common Answers document.

1 -2 Business days to resolve transfer problems.

1 -2 Business days to re-run the job.

Incident Management

Process / constraints by which incidents are handled.

See MMIS Interfaces: Common Answers document.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?

See MMIS Interfaces: Common Answers document.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

See MMIS Interfaces: Common Answers document.

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens?

Include medium, etc.

N/A

Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

See MMIS Interfaces: Common Answers document.

Ensure that file extracts are created and transferred in a timely manner.

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

See MMIS Interfaces: Common Answers document.

Produce reports per executive staff requirements to fulfill contractual obligations.

Plans for the System / Interface

How long will the system / interface continue?

Based on contractual obligation.

What upgrades and replacements are planned?

N/A

Legislative climate and other forces affecting system / interface?

N/A

Comments?

N/A



1.27. Medicare Part D GAPS Coverage

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

Medicare Part D GAPS Coverage

Owner Information

Name, phone, email, etc. of user and support contacts

See MMIS Interfaces: Common Answers document.

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

PDP insurance carriers participating in the GAPS Program are required to submit encounter data to SCDHHS monthly along with a paper invoice. The Pharmacy Program Area processes the paper invoice and compares it to the report from processing the encounters. This report is also posted in D:D. The Pharmacy program area uses D:D to save a report as a text file when needed for transfer to the PDP. This transfer is made via the SCDHHS Extranet. Encounter data is submitted to SCDHHS by each PDP. The data is stored on the MMIS mainframe at Clemson. SCDHHS analyzes data and provides a report to the Pharmacy Program Area. Reports are provided to each PDP when needed.

Objectives

What are the goals of the system / interface? Why was it initiated?

Medicare Part D GAPS Coverage is paid by State funds. The goal is to identify the encounters that qualify for this coverage.

Business Processes

What business processes require the interface?

See Interfaces Related to BPs document.

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

None – this does not support a SCDHHS business process.

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

Each PDP submits encounter data to SCDHHS on a monthly basis via C:D. The record layout is proprietary. The name of the file is PDP.ENC and is uploaded to the appropriate RACF at Clemson.

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, C:D etc.).

Data is transmitted to SCDHHS via C:D. The format is a fixed length text file.

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

C:D is the exchange protocol.

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

SCDHHS makes the requests (manually) to Clemson to process the encounter file.

Data transfer occurs each month.

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

Encounter data is submitted to SCDHHS by each PDP. The data is stored on the MMIS mainframe at Clemson. SCDHHS analyzes data and provides a report to the Pharmacy Program Area.

Reports are provided to each PDP when needed.



Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

Encounter data submitted to SCDHHS by each PDP as an encrypted text file.

Outputs

List all system / interface outputs -- e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

Output is a report for submitted files. The report is posted in D:D Pharmacy program area uses

D:D to save report as a text file when needed and transfers to the PDP via the SCDHHS Extranet.

Record Layout

Attach sample layout if applicable.

Record layout for data file is attached.

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

C:D is used and provides encryption and security of data.

Governing Policies

Policies that govern use or other activity involving the system / interface.

This program is governed by policies established by the Pharmacy Program Area.

Access Control Policies and Security

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

List data security levels, security requirements etc.

See MMIS Interfaces: Common Answers document.

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

N/A

System / Interface Data Processing Standards

If a SLA or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

N/A

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

24/7

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

While this interface is not critical to the daily business functions of SCDHHS, encounters must be processed in a timely manner each month.

Disaster Recovery

Attach any disaster recovery plans.



See [MMIS Interfaces: Common Answers](#) document.

Contract

Legal agreement status and document location.

N/A

Data Storage & System Attributes

What programming languages were used in creating the system / interface, or what COTS software was acquired?

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format / schema documentation if possible.

N/A

Transaction processing

Type (batch / real-time).

Batch

Data Quality Control

Describe quality control policies / procedures.

Program area reviews reports of data submitted.

Backup

Describe / attach backup procedures and policies.

See [MMIS Interfaces: Common Answers](#) document.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

N/A

Support

Support hours and response times. Who handles user support, and how? Explain escalation / levels, if applicable.

See [MMIS Interfaces: Common Answers](#) document.

Pharmacy program area as required.

Incident Management

Process / constraints by which incidents are handled.

See [MMIS Interfaces: Common Answers](#) document.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?

See [MMIS Interfaces: Common Answers](#) document.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

See [MMIS Interfaces: Common Answers](#) document.

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens?

Include medium, etc.

N/A

Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

See [MMIS Interfaces: Common Answers](#) document.

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

See [MMIS Interfaces: Common Answers](#) document.



Plans for the System / Interface

How long will the system / interface continue?

This interface will remain functional after the future MMIS is created. However, the interface may change. This will be determined by the Pharmacy area.

What upgrades and replacements are planned?

N/A

Legislative climate and other forces affecting system / interface?

Legislation determines the annual reimbursement rate and size of the part D GAP.

Comments?

N/A



1.28. First Health – Pharmacy Point-of-Sale (POS)

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

Pharmacy POS MMIS Interface

Owner Information

Name, phone, email, etc. of user and support contacts

See MMIS Interfaces: Common Answers document.

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

SC Medicaid holds pharmacy POS contract to adjudicate pharmacy claims and a limited set of DME procedure codes (diabetic testing supplies). Pharmacies can check eligibility, submit claims for drugs and DME procedures codes, and call the help center. The contractor adjudicates the claims using their FirstSX system. Clemson sends them data (Recipient File, Policy File, and Drug File). The adjudicated claims are placed directly on the mainframe at Clemson weekly, mostly on Wednesday. An e-mail is also sent to Clemson containing the number of claims. Clemson manually verifies this and alerts the contractor. Basic front end processing is then done on the claims. MMIS only does very basic edits on these claims during claims processing.

Objectives

What are the goals of the system / interface? Why was it initiated?

Adjudicate pharmacy claims.

Business Processes

What business processes require the interface?

See Interfaces Related to BPs document.

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

Clemson - Automate frontend processing

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

Pharmacy POS contractor.

Exchange Format

Data structure of data exchange. Attach description if needed. Format (XML, custom, X12, C:D etc.).

Clemson propriety pharmacy claim file claim type D. Clemson propriety DME claim file type A

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

C:D is the exchange protocol.

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

Receipt of file from POS contractor. Expected every Wednesday at noon (goal).

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

Pharmacy claims and limited DME procedure code claims.

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.



Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

Pharmacy claims on POS Contractor side.

Limited DME procedure codes claims on POS Contractor side.

Outputs

List all system / interface outputs -- e.g., names and contents of specific reports, data files, etc. Include media and frequency. Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

Pharmacy claims on Clemson side.

Limited DME procedure codes claims on POS Contractor side.

Record Layout

Attach sample layout if applicable.

N/A

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

Connect:Direct is used and provides encryption and security of data.

Governing Policies

Policies that govern use or other activity involving the system / interface.

Agreement and contract with POS Contractor and SCDHHS.

Access Control Policies and Security

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure? List data security levels, security requirements etc.

See MMIS Interfaces: Common Answers document.

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

N/A

System / Interface Data Processing Standards

If a SLA or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

File must be transferred to Clemson by Friday.

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

On Wednesday through Friday of each workweek.

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

Highly critical to the operation of SC Medicaid. Must run on schedule.

Disaster Recovery

Attach any disaster recovery plans.

See MMIS Interfaces: Common Answers document.

Contract

Legal agreement status and document location.

N/A

Data Storage & System Attributes

What programming languages were used in creating the system / interface, or what **COTS** software was acquired? What DBMS, file systems, etc., does the system use for storing transactional / operational data?



Attach data formats or schemas or provide location of format / schema documentation if possible.

N/A

Transaction processing

Type (batch / real-time).

Batch

Data Quality Control

Describe quality control policies / procedures.

N/A

Backup

Describe / attach backup procedures and policies.

See [MMIS Interfaces: Common Answers](#) document.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

Pharmacy 160,000 a week

DME 400 a week

Support

Support hours and response times. Who handles user support, and how? Explain escalation / levels, if applicable.

See [MMIS Interfaces: Common Answers](#) document.

POS contractor.

Incident Management

Process / constraints by which incidents are handled.

See [MMIS Interfaces: Common Answers](#) document.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?

See [MMIS Interfaces: Common Answers](#) document.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

See [MMIS Interfaces: Common Answers](#) document.

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens? Include medium, etc.

N/A

Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

See [MMIS Interfaces: Common Answers](#) document.

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

See [MMIS Interfaces: Common Answers](#) document.

Plans for the System / Interface

How long will the system / interface continue?

What upgrades and replacements are planned?

Legislative climate and other forces affecting system / interface?

Comments?



1.29. Qualis Health – Quality Improvement Organization (QIO)

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

QIO for hospital utilization review services.

Owner Information

Name, phone, email, etc. of user and support contacts

See MMIS Interfaces: Common Answers document.

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

Produces QIO claims data for Qualis Health

Objectives

What are the goals of the system / interface? Why was it initiated?

Produces QIO claims data for Qualis Health

Business Processes

What business processes require the interface?

See Interfaces Related to BPs document.

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

Clemson - Automate frontend processing

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

Files are transferred at the first of the month via to the QIO contractor via C:D. Files are produced by MMIS mainframe then picked up by the vendor.

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, C:D etc.).

Fixed block mainframe file

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

C:D

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

Job is executed on the first day of the month by Clemson using the ZEKE job scheduler.

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

Z claims(institutional), D claims(drug) A(professional), the entire database record.

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

Monthly claim archive files are used to create the output files. Recipient file is copy of

HHCD006.ORS.MONTHLY.RCPFAM.FILE



Outputs

List all system / interface outputs – e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

HHCD001.QIOCLMSB.A and HHCD001.QIOCLMSB.A.MCF

HHCD001.QIOCLMSB.D and HHCD001.QIOCLMSB.D.MCF

HHCD001.RCPFAM and HHCD001.RCPFAM.MCF

HHCD001.QIOUBSB.Z and HHCD001.QIOUBSB.Z.MCF

Record Layout

Attach sample layout if applicable.

CLAIM FILE

Types A, D and Z

HIO-HIC-CLAIM.

PHO-PHARMACY-CLAIM

UZO-UB92-BASIC-CLAIM

01 O-OUTPUT-REC PIC X(2264).

RECIPIENT FILE

Recipient database record PIC X(1500)

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

C:D is used and provides encryption and security of data.

Governing Policies

Policies that govern use or other activity involving the system / interface.

Agreement and contract with POS Contractor and SCDHHS.

Access Control Policies and Security

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure? List data security levels, security requirements etc.

See MMIS Interfaces: Common Answers document.

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

N/A

System / Interface Data Processing Standards

If a SLA or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

Files are created and made available for pick up on the 1st day of the month.

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

On Wednesday through Friday of each workweek.

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

The job is not a critical MMIS business function but is critical for the contractor's obligations.

Disaster Recovery

Attach any disaster recovery plans.

See MMIS Interfaces: Common Answers document.

Contract

Legal agreement status and document location.



N/A

Data Storage & System Attributes

What programming languages were used in creating the system / interface, or what **COTS** software was acquired? What DBMS, file systems, etc., does the system use for storing transactional / operational data? Attach data formats or schemas or provide location of format / schema documentation if possible.

N/A

Transaction processing

Type (batch / real-time).

Batch

Data Quality Control

Describe quality control policies / procedures.

N/A

Backup

Describe / attach backup procedures and policies.

See [MMIS Interfaces: Common Answers](#) document.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

N/A

Support

Support hours and response times. Who handles user support, and how? Explain escalation / levels, if applicable.

See [MMIS Interfaces: Common Answers](#) document.

Incident Management

Process / constraints by which incidents are handled.

See [MMIS Interfaces: Common Answers](#) document.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?

See [MMIS Interfaces: Common Answers](#) document.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

See [MMIS Interfaces: Common Answers](#) document.

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens? Include medium, etc.

N/A

Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

See [MMIS Interfaces: Common Answers](#) document.

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

See [MMIS Interfaces: Common Answers](#) document.

Plans for the System / Interface

How long will the system / interface continue?

What upgrades and replacements are planned?

Legislative climate and other forces affecting system / interface?

Comments?



1.30. DHEC – South Carolina Community Access Network (SCAN) – Medicaid Eligibility Module

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

South Carolina Community Access Network (SCAN) – Medicaid Eligibility Module.

Owner Information

Name, phone, email, etc. of user and support contacts

See MMIS Interfaces: Common Answers document. DHEC.

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

SCAN is an interactive data retrieval website provided via the Internet for community assessment, planning, and viewing of health information (more specifically, Medicaid eligibility data). This information is used by legislative staff, county officials, planners, researchers, citizens, etc. Users can create tables, charts, and maps according to their interests and specifications. In essence, users can query the system for information related to Medicaid eligibility data. DHEC manages/maintains the SCAN website. SCDHHS sends two Medicaid eligibility data files via C:D to DHEC. The first file includes monthly eligibility data and the second file includes fiscal year (unduplicated) eligibility data. The website contains an introduction, list of definitions, list of payment categories, standard queries for frequently requested information, etc.

Objectives

What are the goals of the system / interface? Why was it initiated?

SCAN will provide the general public (including: legislative staff, county officials, planners, researchers, citizens, etc.) with direct access to Medicaid eligibility data. This information has often been requested from SCDHHS by outside entities – which have historically take time and effort on SCDHHS' part to research the information. The SCAN website provides this health information to any interested entity. This reduces the number of calls to SCDHHS for this data.

Business Processes

What business processes require the interface?

See Interfaces Related to BPs document.

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

None

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

There are two data files produced for SCAN. One is produced on a monthly basis and the second is produced annually. The files contain Medicaid eligibility summary data and are created by Clemson and posted using C:D. DHEC retrieves the files for use by the SCAN website. The two files are as follows:

The monthly data file will be created by extracting data from MMIS and MEDS and feeding it through the same logic that produces the input files to the RSS3870R02 Report - MEDICAID ELIGIBLES FINAL MONTHLY REPORT. This is file - HHCD033.RFS08377.SCAN.DHEC.MTHLY. This file is sent to DHEC via C:D on a monthly basis.

The fiscal year data file will be created by extracting data from MMIS and MEDS and feeding it through the same logic that produces the input files to the RSS3870R04 Report - MEDICAID ELIGIBLES FINAL SFY REPORT. This is file - HHCD033.RFS08377.SCAN.DHEC.SFY. This file is sent to DHEC via C:D on an annual basis.

Exchange Format

Data structure of data exchange. Attach description if needed.



Format (XML, custom, X12, C:D etc.).

Data is transmitted to DHEC via C:D by SCDHHS.

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

Data is transmitted to DHEC via C:D by SCDHHS.

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

SCAN files are automatically produced after the monthly and fiscal year Medicaid eligibility reports are produced by SCDHHS. These files are then sent to DHEC to be integrated into the SCAN website.

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

Non-recipient specific Medicaid eligibility data (number, age, sex and race of Medicaid recipients by county, month, year, etc.).

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

The input to the series of jobs (by Clemson) that ultimately produce the SCAN files is a merge of the extract file from MMIS that is used to populate MEVS, and an SLMB file from MEDS. This merge happens in job @RSS3840.

Outputs

List all system / interface outputs -- e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

HHCD033.RFS08377.SCAN.DHEC.MTHLY

HHCD033.RFS08377.SCAN.DHEC.SFY

The files that are sent to SCAN (by SCDHHS) are produced by job @RSS3860 and program RSS3860. These files are not report files. The program that produces these files also produces files that are input to the program that produces the RSS3870R02 and RSS3870R04 reports.

Record Layout

Attach sample layout if applicable.

See project repository.

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

C:D is used and provides encryption and security of data.

Governing Policies

Policies that govern use or other activity involving the system / interface.

Data to be distributed via SCAN is approved by SCDHHS senior staff.

Access Control Policies and Security

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

List data security levels, security requirements etc.

See [MMIS Interfaces: Common Answers](#) document.

SCAN is a public web site -- anyone and everyone have access to the non-recipient specific



Medicaid eligibility data.

No PHI data is provided via this interface; it is summary data only that is used for community assessment planning, research studies, and general viewing of Medicaid eligibility data.

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

N/A

System / Interface Data Processing Standards

If a SLA or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

N/A

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

SCAN is available 24/7.

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

The system that DHEC maintains and that we interface with is not critical to SCDHHS business functions, but it does put less stress on SCDHHS resources. The processes are in place today to provide the health information (that SCAN offers) manually when a request is submitted to SCDHHS - using the above referenced files as sources. DHEC has offered to make this information available electronically via SCAN – to enhance public access to state health information. This in turn reduces the number of calls SCDHHS receives for Medicaid eligibility data requests. While the system is not business critical to SCDHHS, it provides a cost savings because less resources are used by the agency to answer questions related Medicaid eligibility data.

Disaster Recovery

Attach any disaster recovery plans.

See [MMIS Interfaces: Common Answers](#) document.

Contract

Legal agreement status and document location.

N/A

Data Storage & System Attributes

What programming languages were used in creating the system / interface, or what COTS software was acquired?

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format / schema documentation if possible.

N/A

Transaction processing

Type (batch / real-time).

N/A

Data Quality Control

Describe quality control policies / procedures.

N/A

Backup

Describe / attach backup procedures and policies.

See [MMIS Interfaces: Common Answers](#) document.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

N/A

Support

Support hours and response times. Who handles user support, and how? Explain escalation / levels, if applicable.



See MMIS Interfaces: Common Answers document. Standard hours and response time. DHEC is responsible for technical problems with web site. SCDHHS responsible for accuracy of data provided via the SCAN website and for responding to user inquiries.

Incident Management

Process / constraints by which incidents are handled.

See MMIS Interfaces: Common Answers document.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?

See MMIS Interfaces: Common Answers document.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

See MMIS Interfaces: Common Answers document.

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens? Include medium, etc.

N/A

Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

See MMIS Interfaces: Common Answers document.

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

See MMIS Interfaces: Common Answers document.

Plans for the System / Interface

How long will the system / interface continue?

The DHEC system would remain functional after the future MMIS is created. The interface that SCDHHS has with DHEC may change (i.e. the means by which SCDHHS delivers the health information data to DHEC for incorporation into the SCAN website may change). This will be decided by Clemson.

What upgrades and replacements are planned?

N/A

Legislative climate and other forces affecting system / interface?

N/A

Comments?

N/A



1.31. South Carolina School for the Deaf and the Blind (SCSD&B)

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.
South Carolina School for the Deaf and the Blind (SCSD&B).

Owner Information

Name, phone, email, etc. of user and support contacts

See MMIS Interfaces: Common Answers document.

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

After the MARS EOM cycle, two extract files are created for SCSD&B using SAS. These files are used by SCSD&B to reconcile claims data. These are claims that are sent to SCDHHS and are eligible for Medicaid reimbursement. The files are extracted based upon sponsor code (SCSD&B) and are created in a format defined by SCSD&B. SCSD&B uses these files to review claims information and to provide an audit trail for these claims. A monthly file and a summary file are provided to SCSD&B. The files are provided to SCSD&B via C:D.

Objectives

What are the goals of the system / interface? Why was it initiated?

Provide two output files in a format that allows reconciliation of claims data by SCSD&B.

Provides SCSD&B with the means to review and validate claim information and provide an audit trail for these claims.

Business Processes

What business processes require the interface?

See Interfaces Related to BPs document.

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

None

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

The job creates two extract files one by Sponsor Code (SCSD&B) and a Summary, and these are distributed to SCSD&B via the extranet on a monthly basis, generally the first week of the following month. The file names are:

HHS.SDBSUMM.MMM08

HHS.SDBSPON.MMM08

Where MMM is the month of the extract.

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, C:D etc.).

Extracts are created from MARS data using SAS in a custom format and then downloaded to the extranet for retrieval by SCSD&B via C:D.

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

Extracts are created from MARS data as stated above and then downloaded to the extranet for retrieval by SCSD&B C:D.

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

Files are created monthly once an email is received stating that MARS job @MARS027 has run.

This interface then runs to produce the SCSD&B data files. The input file is

HHSMMIS.MAR0171C.SUMM08(-0).



Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

Files contain recipient, provider name, provider number (NPI), procedure codes, modifiers, number of units, cost, fund code, date claim was pay and check number by month and in summary.

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

HHSMMIS.MAR0171C.SUMM08(-0) is the input file.

Outputs

List all system / interface outputs -- e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

HHS.SDBSUMM.MMM08 and HHS.SDBSPON.MMM08 are the output files -- where MMM is the month of the extract.

Record Layout

Attach sample layout if applicable.

Attached.

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

C:D is used and provides encryption and security of data.

Governing Policies

Policies that govern use or other activity involving the system / interface.

Interagency requirements.

Access Control Policies and Security

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

List data security levels, security requirements etc.

See MMIS Interfaces: Common Answers document.

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

N/A

System / Interface Data Processing Standards

If a SLA or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

N/A

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

Files are provided monthly usually the first week of the month.



Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

This interface is non-critical to functions of the agency.

Disaster Recovery

Attach any disaster recovery plans.

See [MMIS Interfaces: Common Answers](#) document.

Contract

Legal agreement status and document location.

N/A

Data Storage & System Attributes

What programming languages were used in creating the system / interface, or what COTS software was acquired?

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format / schema documentation if possible.

N/A

Transaction processing

Type (batch / real-time).

N/A

Data Quality Control

Describe quality control policies / procedures.

N/A

Backup

Describe / attach backup procedures and policies.

See [MMIS Interfaces: Common Answers](#) document.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

N/A

Support

Support hours and response times. Who handles user support, and how? Explain escalation / levels, if applicable.

See [MMIS Interfaces: Common Answers](#) document.

Incident Management

Process / constraints by which incidents are handled.

See [MMIS Interfaces: Common Answers](#) document.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?

See [MMIS Interfaces: Common Answers](#) document.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

See [MMIS Interfaces: Common Answers](#) document.

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens? Include medium, etc.

N/A

Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A



System / Interface Roles and Responsibilities

SCDHHS Responsibilities

See MMIS Interfaces: Common Answers document.

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

See MMIS Interfaces: Common Answers document.

Plans for the System / Interface

How long will the system / interface continue?

The SCSD&B interface would remain functional after the future MMIS is created. The interface that SCDHHS has with SCSD&B may change (i.e. the means by which SCDHHS delivers claims data to SCSD&B may change). This will be decided by Clemson.

What upgrades and replacements are planned?

N/A

Legislative climate and other forces affecting system / interface?

N/A

Comments?

N/A



1.32. Social Security Administration (SSA) through DSS – SSA8019

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

SSA8019 interface

Owner Information

Name, phone, email, etc. of user and support contacts

See MMIS Interfaces: Common Answers document.

SSA through DSS

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

Clemson receives files from SSA via DSS and sends a processed file and report to the MIVS contractor.

SSA 8019 is a form called the "TPL Information Statement," which the SSA uses for TPL information and provides to state Medicaid agencies. SCDHHS uses this information to bill third parties liable for medical care, support, or services rendered to beneficiaries.

This interface consists of three weekly jobs which process a data file from SSA via DSS. The jobs verify data, process the file and create a file going to ACS.

The jobs also produce a report to indicate possible leads for ACS of new Medicaid beneficiaries with third party insurance.

This interface is the responsibility (on-call) of SCDHHS, not Clemson, although it runs on the Clemson mainframe.

JOBS:

SSAVERI - VERIFIES 'HHCD010.SSA8019.WCF' from DSS

SSA8019 - PRODUCES 'HHS.FTP2.SSA8019'

SSAHHCD - CREATES 'HHCD010.SSA8019' and WCF to ACS

Objectives

What are the goals of the system / interface? Why was it initiated?

This interface produces a report and file for ACS of possible leads of new Medicaid beneficiaries with third party insurance.

Business Processes

What business processes require the interface?

See Interfaces Related to BPs document.

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

None

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

SSA, DSS, ACS

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, C:D etc.).

Custom from DSS

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

C:D

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface



Weekly file from DSS, normally arrives Friday morning and is sent to ACS that same day. Jobs are setup in ZEKE to run automatically when the file arrives.

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

Beneficiary information, third party insurance information.

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

DATASET 'HHSMMIS.CDIR.SSA8019.WEEKLY'

Outputs

List all system / interface outputs -- e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

DATASET 'HHS.FTP2.SSA8019' IS GENER'D TO
'HHCD010.FTP2.SSA8019' FOR MARK BEDENBAUGH, SYSTEMS
ADMINISTRATOR WITH ACS HEALTHCARE SOLUTIONS, TO PICK
UP VIA CLIENT CONNECT:DIRECT.

Record Layout

Attach sample layout if applicable.

N/A

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

C:D is used and provides encryption and security of data.

Governing Policies

Policies that govern use or other activity involving the system / interface.

SSA 8019 is a form called the "TPL Information Statement," which the SSA uses TPL information and provides to state Medicaid agencies. SCDHHS uses this information to bill third parties liable for medical care, support, or services rendered to a beneficiary.

Access Control Policies and Security

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

List data security levels, security requirements etc.

See MMIS Interfaces: Common Answers document.

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

Documentation and run schedules are in the DOCBASEs of the three mainframe jobs.

System / Interface Data Processing Standards

If a SLA or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

Runs weekly on Friday. Jobs are not critical. SCDHHS on-call is to be notified.



Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

The jobs run on Clemson's mainframe, but do not access the MMIS or MEDS database.

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

This interface is non-critical to the function of the agency.

Disaster Recovery

Attach any disaster recovery plans.

See [MMIS Interfaces: Common Answers](#) document.

Contract

Legal agreement status and document location.

N/A

Data Storage & System Attributes

What programming languages were used in creating the system / interface, or what COTS software was acquired?

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format / schema documentation if possible.

Programming language – SAS

No DBMS, only flat files coming from DSS and sent to ACS

Transaction processing

Type (batch / real-time).

Batch

Data Quality Control

Describe quality control policies / procedures.

N/A

Backup

Describe / attach backup procedures and policies.

See [MMIS Interfaces: Common Answers](#) document.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

None

Support

Support hours and response times. Who handles user support, and how? Explain escalation / levels, if applicable.

See [MMIS Interfaces: Common Answers](#) document.

Incident Management

Process / constraints by which incidents are handled.

See [MMIS Interfaces: Common Answers](#) document.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?

See [MMIS Interfaces: Common Answers](#) document.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

See [MMIS Interfaces: Common Answers](#) document.

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens?

Include medium, etc.

N/A

Continuous Business Process Improvement

Is a methodology in place? Explain.



N/A

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

See MMIS Interfaces: Common Answers document.

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

See MMIS Interfaces: Common Answers document.

Plans for the System / Interface

How long will the system / interface continue?

N/A

What upgrades and replacements are planned?

N/A

Legislative climate and other forces affecting system / interface?

N/A

Comments?

N/A



1.33. Thomson Reuters MMIS/MEDS Interface

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

Thomson Reuters MMIS/MEDS Interface.

Owner Information

Name, phone, email, etc. of user and support contacts

See MMIS Interfaces: Common Answers document.

SCDHHS Office of Medicaid Reporting.

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

The purpose of the interface is to provide agency data to the vendor (Thomson Reuters) for the purpose of populating the DSS and SURS System. These systems are used by the agency for reporting and program integrity research.

A collection of mainframe jobs run on weekly and monthly basis to extract data from MMIS and MEDS databases and the resulting files are transferred to the vendor via Connect:Direct.

Objectives

What are the goals of the system / interface? Why was it initiated?

The purpose of the interface is to provide agency data to the vendor and to keep the data up to date.

Business Processes

What business processes require the interface?

See Interfaces Related to BPs document.

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

None

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

See O:\MMIS\DSS_SURS\Interface Files and Calendar\070710 MMIS and MEDS File Extracts v4b.xls – Note the filenames in this document need have “HHSCDR3.” added as the prefix

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, C:D etc.).

Custom format – mainframe.

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

C:D

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

See M:\MMIS\DSS SURS\documentation for lists of jobs:

DSS Weekly JCL.doc

DSS Monthly.doc

All weekly jobs run the day after claims payment is run.

All monthly jobs are run independently other those that are paired for the creation of the file and the control file. See JCL and/or Zeke for monthly triggers for individual jobs.

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

See O:\MMIS\DSS_SURS\Interface Files and Calendar\070710 MMIS and MEDS File Extracts v4b.xls each file has a description of the data that is processed.



Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

MMIS and MEDS Databases.

Outputs

List all system / interface outputs -- e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

See O:\MMIS\DSS_SURS\Interface Files and Calendar\070710 MMIS and MEDS File Extracts v4b.xls for complete list of outputs.

A control file is produced for each data file. The control file contains the number of records in the file and a hash total on a field in the data file. These are created using SAS and more information can be found in the JCL.

Record Layout

Attach sample layout if applicable.

In the majority of the files, the record layout is the same as the data dictionary record. For other see the JCL jobs that would reference the COBOL program. M:\MMIS\DSS SURS\documentation: DSS Weekly JCL.doc and DSS Monthly.doc

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

Connect:Direct is used and provides encryption and security of data.

Governing Policies

Policies that govern use or other activity involving the system / interface.

See SCDHHS agreement with Thomson Reuters.

Access Control Policies and Security

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

List data security levels, security requirements etc.

See MMIS Interfaces: Common Answers document.

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

M:\MMIS\DSS SURS\documentation: DSS Weekly JCL.doc and DSS Monthly.doc

O:\MMIS\DSS_SURS\Interface Files and Calendar\070710 MMIS and MEDS File Extracts v4b.xls

System / Interface Data Processing Standards

If a service level agreement (SLA) or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

N/A

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

Availability is based upon the agreed upon schedule in the agreement between SCDHHS and Thomson Reuters.



See SCDHHS for agreement details.

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

The interface is highly important to the successful operation of SCDHHS.

Disaster Recovery

Attach any disaster recovery plans.

See [MMIS Interfaces: Common Answers](#) document.

Contract

Legal agreement status and document location.

N/A

Data Storage & System Attributes

What programming languages were used in creating the system / interface, or what COTS software was acquired?

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format / schema documentation if possible.

This interface does not create or add to a database system. Files are created via extracts from the mainframe databases which are MMIS and MEDS. Then the files are uploaded to Thomson Reuters. Thomson Reuters deletes control files after downloading. This is a signal that Clemson can delete files in accordance with policy.

Transaction processing

Type (batch / real-time).

Batch

Data Quality Control

Describe quality control policies / procedures.

Control files are created for each file and are used by Thomson Reuters to verify the successful transmission of the data.

Backup

Describe / attach backup procedures and policies.

See [MMIS Interfaces: Common Answers](#) document.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

N/A

Support

Support hours and response times. Who handles user support, and how? Explain escalation / levels, if applicable.

See [MMIS Interfaces: Common Answers](#) document.

Incident Management

Process / constraints by which incidents are handled.

See [MMIS Interfaces: Common Answers](#) document.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?

See [MMIS Interfaces: Common Answers](#) document.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

See [MMIS Interfaces: Common Answers](#) document.

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens? Include medium, etc.

N/A



Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

See MMIS Interfaces: Common Answers document.

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

See MMIS Interfaces: Common Answers document.

Plans for the System / Interface

How long will the system / interface continue?

N/A

What upgrades and replacements are planned?

N/A

Legislative climate and other forces affecting system / interface?

N/A

Comments?

N/A



1.34. Transportation Brokers

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

Transportation Broker Interface for MMIS

Owner Information

Name, phone, email, etc. of user and support contacts

Department of Transportation within with Bureau of Care Management and Medical Support Services.

See [MMIS Interfaces: Common Answers](#) document.

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

SCDHHS Contracts with several Transportation Brokers who provide non-emergency transportation services to Medicaid beneficiaries. This interface exists to support a process for SCDHHS payment to Transportation Brokers based on a monthly capitation rate for each Medicaid beneficiary residing within an established region. The interface also collects essential Broker and transportation provider encounter data in support of the Transportation Broker Program.

Objectives

What are the goals of the system / interface? Why was it initiated?

See Overview.

Business Processes

What business processes require the interface?

See [Interfaces Related to BPs](#) document.

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

N/A

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

Daily (except for Saturday) files of recipient and RSP data are sent to each broker. Member Listing file created monthly. See attached document for job names, file names and the record layout for the Member Listing File (MLE) and for the edited encounter file and encounter report file. The encounter record layout is in the encounter record layout documents available in the project repository.

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, C:D etc.).

X12 (Encounters)

Custom (Member Listing File, Encounter File and Encounter report file, Daily Recipient/RSP files)

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

C:D

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

Recipient files created daily after the nightly recipient update job. Member Listing is created monthly. Encounters are submitted as 837 X12 transactions and can come in at any point during the month.



Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

Beneficiary eligibility information and encounter data.

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

The input from the transportation brokers is encounter data which comes in as EDI X12 837 transactions.

Outputs

List all system / interface outputs – e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

Outputs to the transportation brokers include:

Recipient/RSP daily files

Monthly MLE Files

Edited encounter file

Encounter report file

Record Layout

Attach sample layout if applicable.

See attached.

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

Encounters use the HIPAA X12 837 transaction.

Governing Policies

Policies that govern use or other activity involving the system / interface.

Access Control Policies and Security

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

List data security levels, security requirements etc.

See MMIS Interfaces: Common Answers document.

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

Record layouts are maintained in the BMSM.

System / Interface Data Processing Standards

If a SLA or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

Jobs run on a schedule out of Zeke. Recipient file is sent to transportation brokers nightly and is mission critical. Encounters come in through the HIPAA Mailbox Interface.

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

When the Recipient/RSP, MLE, encounter report, and edited encounter files are created they are



available during and after business hours until the broker retrieves them.

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

This interface is critical to providing non-emergency transportation services to Medicaid beneficiaries through the transportation broker. The Recipient file is sent nightly.

Disaster Recovery

Attach any disaster recovery plans.

See [MMIS Interfaces: Common Answers](#) document.

Contract

Legal agreement status and document location.

General Counsel maintains the transportation broker contracts.

Data Storage & System Attributes

What programming languages were used in creating the system / interface, or what COTS software was acquired?

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format / schema documentation if possible.

See [MMIS Interfaces: Common Answers](#) document.

Transaction processing

Type (batch / real-time).

Batch.

Data Quality Control

Describe quality control policies / procedures.

Control files are created for each file and are used by the brokers to verify the successful transmission of the data.

Backup

Describe / attach backup procedures and policies.

See [MMIS Interfaces: Common Answers](#) document.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

N/A

Support

Support hours and response times. Who handles user support, and how? Explain escalation / levels, if applicable.

See [MMIS Interfaces: Common Answers](#) document.

Incident Management

Process / constraints by which incidents are handled.

See [MMIS Interfaces: Common Answers](#) document.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where is the system / interface housed?

See [MMIS Interfaces: Common Answers](#) document.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

See [MMIS Interfaces: Common Answers](#) document.

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens? Include medium, etc.

Continuous Business Process Improvement

Is a methodology in place? Explain.



System / Interface Roles and Responsibilities

SCDHHS Responsibilities

See MMIS Interfaces: Common Answers document.

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

See MMIS Interfaces: Common Answers document.

Plans for the System / Interface

How long will the system / interface continue?

According to the duration of the contract.

What upgrades and replacements are planned?

Legislative climate and other forces affecting system / interface?

Comments?



1.35. TRICARE DEERS Data Match

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

TRICARE DEERS Data match (TRICARE is the healthcare program for active duty and retired members of the uniformed services, their families, and survivors.)

Owner Information

Name, phone, email, etc. of user and support contacts

See MMIS Interfaces: Common Answers document.

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

This is a yearly interface in which SCDHHS/Clemson sends a file of Medicaid eligible beneficiaries to TRICARE. TRICARE processes the data against the DEERS data store to identify and extract policy coverage information, which is sent for updating the MMIS policy database.

Objectives

What are the goals of the system / interface? Why was it initiated?

The objective of the interface is to learn about new or changed TRICARE policies covering SC Medicaid beneficiaries for use in TPL recovery.

Business Processes

What business processes require the interface?

See Interfaces Related to BPs document.

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

This interface is supposed to be converted to use the X12 270/271 transaction when TRICARE DEERS is ready to use them. SC has submitted test files in the past but has not received any 271 responses.

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

Outgoing query file. Incoming file is response file.

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, C:D etc.).

Custom format specified by TRICARE-DEERS. C:D

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

C:D

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

Query File is produced based on a schedule and instructions from CMS. The schedule and instructions are sent to the state Medicaid agency via email. Historically the match date for SC has been in May. The query file is normally due to TRICARE one week prior to the match date. Processing of response file is scheduled when it is received. The goal is to apply updates to the policies in MMIS prior to the October quarterly Retro Recovery process.

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

Recipient and TPL Policy data.



Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

Response file from TRICARE-DEERS. See attachment for details.

Outputs

List all system / interface outputs -- e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

Query File to be sent to TRICARE-DEERS as well as files/reports created during file processing .

Record Layout

Attach sample layout if applicable.

See attachment.

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

Instructions from CMS.

Governing Policies

Policies that govern use or other activity involving the system / interface.

Instructions from CMS

Access Control Policies and Security

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

List data security levels, security requirements etc.

See MMIS Interfaces: Common Answers document.

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

System / Interface Data Processing Standards

If a SLA or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

The query file is produced and sent to TRICARE based on schedule from TRICARE. The response file must be processed and applied before the October quarterly Retro Recovery process runs.

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

States are required by CMS to use this interface but this needs to be confirmed.

Disaster Recovery

Attach any disaster recovery plans.

See MMIS Interfaces: Common Answers document.

Contract

Legal agreement status and document location.



Data Storage & System Attributes

What programming languages were used in creating the system / interface, or what COTS software was acquired?

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format / schema documentation if possible.

See [MMIS Interfaces: Common Answers](#) document.

Transaction processing

Type (batch / real-time).

Batch

Data Quality Control

Describe quality control policies / procedures.

Backup

Describe / attach backup procedures and policies.

See [MMIS Interfaces: Common Answers](#) document.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

Support

Support hours and response times. Who handles user support, and how? Explain escalation / levels, if applicable.

See [MMIS Interfaces: Common Answers](#) document.

Incident Management

Process / constraints by which incidents are handled.

See [MMIS Interfaces: Common Answers](#) document.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where is the system / interface housed?

See [MMIS Interfaces: Common Answers](#) document.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

See [MMIS Interfaces: Common Answers](#) document.

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens?

Include medium, etc.

There is documentation at Clemson in the M:\MMIS\Doc\Policy\CHAMPUS folder which includes the following: Champus Tricare process flow.docx dated 6/2008

Continuous Business Process Improvement

Is a methodology in place? Explain.

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

See [MMIS Interfaces: Common Answers](#) document.

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

See [MMIS Interfaces: Common Answers](#) document.

Plans for the System / Interface

How long will the system / interface continue?

What upgrades and replacements are planned?

interface is supposed to change to use X12 270/271 but that option is not available yet from TRICARE.

Legislative climate and other forces affecting system / interface?

Comments?



1.36. University of South Carolina (USC) – Institute of Families in Society (IFS and HEDIS Measures) and the USC School of Pharmacy

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

University of South Carolina (USC) - Institutes for Families in Society (IFS and HEDIS Measures) and School of Pharmacy.

Owner Information

Name, phone, email, etc. of user and support contacts

See MMIS Interfaces: Common Answers document.

USC - Institutes for Families in Society (IFS and HEDIS Measures) and School of Pharmacy.

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

For analyzing the cost effectiveness of Medicaid services provided to Medicaid eligible children and adults residing in South Carolina and to conduct epidemiological research.

Objectives

What are the goals of the system / interface? Why was it initiated?

Creates weekly and monthly claim files and NDC files for USC use in the development of statistics, measurements, evaluations, and recommendations for services provided under the IFS Program and MCOs. Pharmacy Services provides information to USC for development of academic programs.

Business Processes

What business processes require the interface?

See Interfaces Related to BPs document.

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

None

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

Data files are created weekly and monthly by BMSM analyst-written programs. Monthly files are created using Zeke. Files are transferred to USC using Connect:Direct.

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, C:D etc.).

Custom format – mainframe.

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

C:D

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

Weekly payment run and monthly created archives In addition, @ORSMTH must run prior to job @MFUSCMT and @USCPHMR which creates some of the monthly files for this USC interface.

@ORSEFG must run prior to @MFREFG which creates the remaining monthly files. @DSU0030 and @DSU0045 must run prior to @MFUSCCG which creates the weekly files of claims.

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

Files sent: POS Recipient, Recipient-Family, POS Recipient RSP, Providers, HIC Claims, Voids, Reference File, Transportation Broker and Drugs. USC receives claims weekly after payment run.



Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

Data files are created weekly and monthly by BMSM analyst-written programs. Note: The input data files are created for other purposes/interfaces and utilized as inputs to this USC interface.

The monthly inputs are from the ORS interface jobs @ORSMTH and @ORSEFG. The weekly inputs are from the Thomson Reuters interface jobs @DSU0030 and @DSU0045. Exceptions are the School of Pharmacy Monthly.Claims file which reads paid claims archives and Monthly.RCPFAM which uses the MMIS database.

Outputs

List all system / interface outputs -- e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

Outputs are fixed length text data files. Job names for the monthly files are @MFUSCMT and @MFREFG. Job @MFUSCCG creates the weekly files. Job @USCPHMR creates the monthly School of Pharmacy files. These jobs are in "HHS.PROD.JCL or 'HHS.REVIEW.JCL. A list of the file names at this point in time (5/2009) is available in the project repository.

Record Layout

Attach sample layout if applicable.

See Attachments Layout 1 - Recipient Family

Layout 2 - POS RSP

Layout 3 - Provider

Layout 4 - HIO-HIC-Claim (Physician claim record layout)

Layout 5 - VOID

Layout 6 - Reference records

USC- Recip - POS Recipient

USC- Transp - Transportation Broker Recipient Layout

The record layouts for the School of Pharmacy files are:

MONTHLY.RCPFAM: Recipient database record layout followed by Fam-Family database record layout. Total record length is 1500. Created by program USCRCPFM in @USCPHMR.

MONTHLY.CLAIMS: Basic-db-claim database record layout. (record length 2259). Created by program USCTAPE in @USCPHMR.

ALLVOIDS.MONTHLY: copied from HHCD006.ORS.ALLVOIDS.MONTHLY.FILE in @USCPHMR

Record layout taken from HHS.PROD.SOURCE(VOIDMTHP) executed in @ORSMTH is:

01 WS-OUTPUT-RECORD.

04 WS-CCN.

08 CCN-FIRST16 PIC X(16).

08 CCN-TYPE PIC X.

04 FILLER PIC X(01).

04 WS-VOID-DATE-8 PIC X(08).

04 FILLER PIC X(04).

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

C:D is used and provides encryption and security of data.



Governing Policies

Policies that govern use or other activity involving the system / interface.

Established by SCDHHS Executive Management and Program Areas.

Access Control Policies and Security

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

List data security levels, security requirements etc.

See MMIS Interfaces: Common Answers document.

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

Documentation may be contained in the BMSM procedure forms, jobs master, JCL in job stream or job run sheets.

System / Interface Data Processing Standards

If a SLA or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

N/A

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

N/A

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

USC needs data to perform other tasks in fulfilling contractual obligations with SCDHHS. Data provided weekly and monthly in accordance with timeframe defined in contract.

Disaster Recovery

Attach any disaster recovery plans.

See MMIS Interfaces: Common Answers document.

Contract

Legal agreement status and document location.

N/A

Data Storage & System Attributes

What programming languages were used in creating the system / interface, or what COTS software was acquired?

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format / schema documentation if possible.

N/A

Transaction processing

Type (batch / real-time).

Batch

Data Quality Control

Describe quality control policies / procedures.

Control files are created for some of the files. They can be used by USC to verify the successful transmission of the data.

Backup

Describe / attach backup procedures and policies.

See MMIS Interfaces: Common Answers document.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

N/A



Support

Support hours and response times. Who handles user support, and how? Explain escalation / levels, if applicable.

See MMIS Interfaces: Common Answers document.

Incident Management

Process / constraints by which incidents are handled.

See MMIS Interfaces: Common Answers document.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?

See MMIS Interfaces: Common Answers document.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

See MMIS Interfaces: Common Answers document.

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens? Include medium, etc.

N/A

Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

See MMIS Interfaces: Common Answers document.

Ensure data files are created and transferred to USC in a timely manner.

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

See MMIS Interfaces: Common Answers document.

USC: Produce statistical information, measures, and reports per executives staff requirements to fulfill contractual obligations.

Plans for the System / Interface

How long will the system / interface continue?

Until the contract ends (unless renewed).

What upgrades and replacements are planned?

N/A

Legislative climate and other forces affecting system / interface?

N/A

Comments?

N/A



1.37. South Carolina Medicaid Web-Based Claims Submission Tool

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

Web Tool Interface

Owner Information

Name, phone, email, etc. of user and support contacts

See MMIS Interfaces: Common Answers document.

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

The Web Tool is an alternative method in the creation, editing, submission, and adjustment (void and void/replacement) of CMS-1500, UB-04, and Dental claims. It allows for the creation and modification of personalized lists (provider, recipient, payer, insured etc.) which when used, decrease the need to enter repetitive data. It enables a provider to check the status of any submitted claim or to view/copy previously submitted web claims (Reports feature) for refactoring, which reduces claims preparation. Medicaid eligibility queries of a single recipient or in batches of up to 50 to provide instant "at a glance" verification of eligibility.

To view or copy previously submitted claims (Reports feature) or to view claims status, the Web Tool server queries the Web Tool SQL Server database and displays the results in the provider's web browser.

For eligibility verification requests the web server sends a 270 transaction to MEVS. MEVS responds to each of the requests in real time and passes 271 transaction(s) back to the Web Tool for display in the provider's web browser.

For the creation of personalized lists, entering of claims, and the editing of claims no transactions are sent to the mailbox for processing by MMIS. All data is stored on the SQL server for future use. The claims data is kept for submission to claims processing.

For submission of claims, the claim first has to be entered as above. Then the provider may choose to submit the entire batch or selectively submit each claim. When submitted, the Web Tool sends an 837 X12 transaction file to a mailbox for processing by the Translator. The Translator then "pushes" the data to MMIS (see HIPAA Mailbox MMIS Interface). After the claims have been submitted successfully, the provider receives a confirmation message in the web browser that includes the batch ID number for the claims. The claims are processed in a claims run (SC OM Edit Claim BP) and appear on the provider's monthly remits and payments.

Objectives

What are the goals of the system / interface? Why was it initiated?

To allow the quick and efficient submission and status check of claims, eligibility verification, claim reusability, and the creation and/or modification of lists by providers.

Business Processes

What business processes require the interface?

See Interfaces Related to BPs document.

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

Provider to MEVS Processing System and MMIS via Web Tool

After each claims run, there is a nightly upload of claims information to the web tool SQL database.

Exchange Format

Data structure of data exchange. Attach description if needed.



Format (XML, custom, X12, C:D etc.).

HIPAA X12 837, 270, and 271

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

HTTPS submission of X12 837, 270, and 271 to and from mailbox and MEVS Processing System.

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

Provider entrance/submission of claims, eligibility requests, creation or modification of a list, and claims copy request.

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

Claims, eligibility requests, claim status

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

HIPAA X12 270 (eligibility) and 837 (claims) transactions from providers

Outputs

List all system / interface outputs – e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

Provider is alerted to successful submission and batch ID number for claims (837 transactions are sent to HIPAA Mailbox). Eligibility verifications (271 transaction(s)) are generated and displayed in the provider's web browser

Record Layout

Attach sample layout if applicable.

N/A

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

HIPAA standards

Governing Policies

Policies that govern use or other activity involving the system / interface.

Agreement between Clemson and SCDHHS

Access Control Policies and Security

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

List data security levels, security requirements etc.

Active Directory

Provider information is linked to submitter ID's allowing that submitter to see only those providers assigned to him or her.

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

N/A



System / Interface Data Processing Standards

If a service level agreement (SLA) or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

2 – 3 seconds. In rare instances, the request can reach the SQL Server timeout limit if there are many transactions at once.

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

24/7

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

The interface is critical and vital to the operation of SC Medicaid

Disaster Recovery

Attach any disaster recovery plans.

See [MMIS Interfaces: Common Answers](#) document.

Contract

Legal agreement status and document location.

N/A

Data Storage & System Attributes

What programming languages were used in creating the system / interface, or what COTS software was acquired?

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format / schema documentation if possible.

See [MMIS Interfaces: Common Answers](#) document.

Transaction processing

Type (batch / real-time).

Real-time

Data Quality Control

Describe quality control policies / procedures.

N/A

Backup

Describe / attach backup procedures and policies.

See [MMIS Interfaces: Common Answers](#) document.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

More than the total number of providers using the Web Tool

No load problems reported

Support

Support hours and response times. Who handles user support, and how? Explain escalation / levels, if applicable.

See [MMIS Interfaces: Common Answers](#) document.

Incident Management

Process / constraints by which incidents are handled.

See [MMIS Interfaces: Common Answers](#) document.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?

See [MMIS Interfaces: Common Answers](#) document.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?



See MMIS Interfaces: Common Answers document.

Documentation (User / System)

*What kind of technical documentation has been produced? Are there any user manuals or help screens?
Include medium, etc.*

See Provider Outreach Contractor

Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

See MMIS Interfaces: Common Answers document.

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

See MMIS Interfaces: Common Answers document.

Plans for the System / Interface

How long will the system / interface continue?

N/A

What upgrades and replacements are planned?

Incorporating the viewing of provider remits

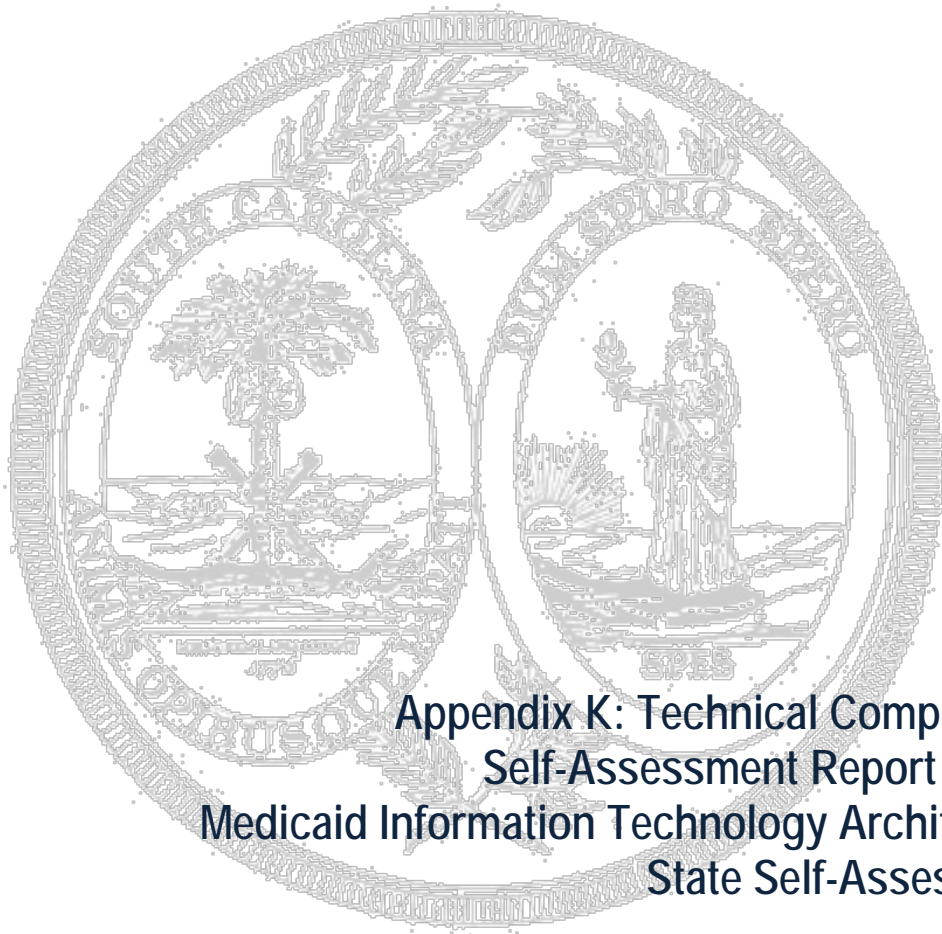
Legislative climate and other forces affecting system / interface?

N/A

Comments?

N/A

South Carolina Department of Health and Human Services



Appendix K: Technical Components Self-Assessment Report for the Medicaid Information Technology Architecture State Self-Assessment



Medicaid
Information
Technology
Architecture

November 2009



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Appendix K: MEDS Interfaces

Record layouts, file layouts, jobs, files, reports, and other supplementary materials related to these interfaces are stored in the MITA project repository.

1.1. Beneficiary Earnings and Data Exchange System (BENDEX)

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

BENDEX

Owner Information

Name, phone, email, etc. of user and support contacts

See Common Answers document

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

BENDEX is part of the Income Eligibility Verification System (IEVS). IEVS is an automated system that matches Medicaid applicants/recipients with the Employment Security Commission (ESC), the Social Security Administration (SSA), BENDEX, BEER, and the Internal Revenue Service (IRS not implemented). The IEVS assists in the eligibility determination process by looking at past and present income. All applicants must be matched at application time. Information obtained through IEVS is confidential.

BENDEX is an ongoing nightly data exchange with SSA. For every new Medicaid recipient, an initial request is made to establish the exchange. A request is resent when the SSN, SSCN, Medicare number, disability dates, or date of death changes. There is an online screen where a worker can initiate a request, takes priority over a nightly exchange.

Initial entitlement and material changes in entitlement to SSA benefits are automatically reported to the state as well as Medicare data and disability information. The benefit information is used to update the Medicaid member's financial information and is used for applications, re-budgets and reviews. Discrepant information and exceptions are reported through alerts and reports. Every November, MEDS uses the information from BENDEX to automatically recalculate the countable income for budget groups containing persons that have received the annual cost of living increase in their SSA benefit check (COLA occurs in Jan or March). The BENDEX interface also provides the SSA benefit information to use in recalculating continued eligibility for GAPS on an ongoing basis.

Objectives

What are the goals of the system / interface? Why was it initiated?

The goal is to obtain SSA benefit and Medicare information for applicants through an automated exchange with SSA. Input records are submitted daily and responses are processed daily. This interface was mandated by the Deficit Reduction Act of 1984.

Business Processes

What business processes require the interface?



See Interfaces related to Business Processes document

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

Improved tracking of records sent and received

Auto resubmission when SSA does not respond to a request.

Updates when demographic information is different.

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

SSA, DSS

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, Connect:Direct etc.).

Mainframe flat file

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

Connect:Direct

Note: SSA requires SCDHHS to send BENDEX requests through the DSS. DSS is the HUB for data to be sent and received from SSA. DSS merges SCDHHS BENDEX requests with their requests and sends a combined file to SSA. When the response is received, DSS forwards the entire file (including the responses to the DSS requests) to Clemson.

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

A BENDEX request is created when:

- A new application is added to MEDS (BG is pending, application is locked)
- The SSN, name or DOB is changed for a member of a pending or active BG.
- A New Medicaid recipient is added to MEDS.
- A user initiates a request.

Also see the Send request matrix available in the project repository.

@IEV6000

When a response file is received from SSA, the BENDEX interface:

- Edits for valid data and transactions.
 - Generates alerts and reports when invalid transactions, rejections, and other exceptional situations are received.
 - Updates Medicare, SSA, QMB, and Blind/Disabled data to the MEDS member record.
 - Alerts the eligibility worker if the information from provided by BENDEX requires a redetermination.
- Applies data to the BENDEX Master file.
 - Generates alerts when the BENDEX transaction cannot be updated to the BENDEX Master file.



- Creates new input records based on certain communication codes.

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

SSA benefit and Medicare information for a member of an active or pending BG. Because MEDS stores the combined responses from DSS and SCDHHS requests, so there may be overlaps in exchange requests. Once an SSN is entered in MEDS, information is available.

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

Information System

N/A

Input Characteristics

N/A

Output Characteristics

N/A

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

Mainframe with income data and Medicare data.

IEV7000

The purpose of IEV7000 is to update the IEV_BENEFICIARY and IEV_BDX_AUDIT table for all BENDEX records received. IEV7000 reads the control file from IEV7008.

- A list of reports is attached
- A list of alerts is attached.

IEV7000 is a nightly job.

Outputs

List all system / interface outputs -- e.g., names and contents of specific reports, data files, etc.

Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

Medicaid recipient data that has changed:

A BENDEX request is sent and a response file is processed daily.

@IEV6000 is a nightly job that processes requests for BENDEX data from either the MEDS system, online worker requests, or from @IEV7000 processing BENDEX data.

IEV6100 processes requests for BENDEX generated by MEDS through MIS4000 and COM1000. MIS4000 searches the MEDS database for changes that were made either by a worker using the online, or by a batch process.

IEV6200 processes requests for BENDEX that were entered by the worker using the IEV05 Request BENDEX Information screen, or those requests generated by IEV7011 during the IEV Response process (@IEV7000).



@IEVCNDR sends the file to SSA.

Record Layout

Attach sample layout if applicable.

M:\MEDS\Production Documentation\IEV see IEV Subsystem Documentation.doc for a detailed list of jobs.

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

SSA policies, Connect:Direct

Governing Policies

Policies that govern use or other activity involving the system / interface.

- CMS policies in general.
- Effective May 29, 1986, Section 2651 of the Deficit Reduction Act of 1984 (Pub. L. 98-369) amended the Social Security Act, the Food Stamp Act, and Internal Revenue Code. It requires State agencies that administer Food Stamps, Family Independence, Medicaid, etc. to develop an Income and Eligibility Verification System which meets certain statutory requirements. The major statutory changes reflected in the regulations provide state agencies with additional sources of useful information in verifying applicant and recipient reported circumstances and also ensure that appropriate privacy and procedural safeguards are applied in the use of the information.
- 42 CFR sections 435.940-435.960 provide regulations for the IEVS.
- Section 42 CFR 435.953 allows states to exclude certain categories of Medicaid eligibles from the IEVS reporting requirements. A targeting plan was submitted in 1998.
- SSA developed SDX/BENDEX/SVES to implement Section 1137 of the Social Security Act which requires State agencies administering specific programs (TANF, Medicaid, Food Stamps, and Unemployment) to implement an income and eligibility verification system.

Access Control Policies and Security

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

See Appendix L (Common Answers).

Security and Confidentiality Procedures

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

One file is sent from DSS and SCDHHS, which means some records do not apply to Medicaid recipients. These records are not available to MEDS.

Documentation Types (technical, administrator, etc.) and where the documentation can be found.

N/A

Contract and Service Level Information

If a service level agreement (SLA) or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:



Response Time

Within what timeframe must the system / interface respond?

Normally a couple days to a week.

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

Nightly

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

Absence of this information would increase agency workload. The availability of data expedites eligibility determinations and reviews. Receipt of the BENDEX with the annual cost of living increases provides the information MEDS needs to automatically rebudget increases in Social Security income.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

Up to 900,000 recipients (not all of them are currently eligible for Medicaid)

Support

Support hours and response times.

See Common Answers document

Incident Management

Process / constraints by which incidents are handled.

See Common Answers document

Disaster Recovery

Attach any disaster recovery plans.

See Common Answers document

Contract

Legal agreement status and document location.

There is an agreement with SSA for the BENDEX interface, which expires December 31, 2009. In the future, SSA plans to streamline the agreement process. SSA will have one Computer Matching and Privacy Protection Act (CMPPA) agreement per state, negotiated through the Governor's office. This agreement will be recertified after 18 months and then renewed after another 12 months. The individual agreements with the state agencies, referred to as the Master IEA (Information Exchange Agreement) will be open ended once signed with no expiration unless changes are required.

System / Interface Data Processing Standards

Data Storage

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format/schema documentation if possible.

See Common Answers Document

Transaction processing

Type (batch / real-time).

Batch

Capacity

Including peak intervals.



Approximately 25,000 are processed nightly and several hundred thousand on the weekend. This is based on the mainframe job window.

Data Quality Control

Describe quality control policies / procedures.

MEDS edits incoming and outgoing data.

Backup

Describe / attach backup procedures and policies.

See Common Answers document

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?

See Common Answers document

Help Desk

Who handles user support, and how? Explain escalation / levels, if applicable.

MARCI and TigerTracks for Clemson

MS Help Desk and GroupLink – are used by SCDHHS. Issues are submitted via email and escalated to the Department Head.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

See Common Answers document

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens? Include medium, etc.

Medicaid Systems Support maintains a Users' Guide for MEDS that is under revision.

Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

See Common Answers document

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

See Common Answers document

Plans for the System / Interface

How long will the system / interface continue?

The BENDEX interface will continue until it is replaced by SSA or it is no longer mandated.

What upgrades and replacements are planned?

N/A

Legislative climate and other forces affecting system / interface?

N/A



1.2. Buy-In Interface

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

Buy-In Interface

Owner Information

Name, phone, email, etc. of user and support contacts

See Common Answers document

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

The MEDS Buy-In interface exchanges weekly, in a batch mode, information with CMS in Baltimore to transmit all Buy-In (Part A and Part B) accretions, deletions and changes. It processes the daily Buy-In transactions and monthly billing file received from CMS and generates a monthly file to MMIS for processing of premium payments. It captures and maintains the Medicare claim number to support this interface and also builds a history of the Buy-In eligibility based on the incoming transactions from CMS. Workers are notified of discrepant information through online alerts and reports. The system identifies those who are potentially eligible for Buy-In and those who are ineligible and creates the Buy-In transactions to be sent to CMS according to the schedule defined in user-maintained system table structures.

Objectives

What are the goals of the system / interface? Why was it initiated?

The purpose of the Buy-In program is to permit states to provide Medicare to certain groups of needy individuals. This benefits the states in that it transfers some medical costs for those who are eligible for Medicaid from the Medicaid program to the Medicare Program (which is funded by the Federal government and by the payment of premiums).

Payment of Medicare premiums is a service provided by SCDHHS to S.C. Medicaid recipients. For some payment categories, i.e. SLMB, QMB and QI1, payment of the Buy-In Part B premium is the only Medicaid benefit provided. The Buy-In system must be operational to provide this service.

Business Processes

What business processes require the interface?

See Interfaces related to Business Processes document

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

When CMS rejects a Buy-In request, the system should perform automated checks for name, DOB, or MCN mismatches and resubmit with correct data.

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.



CMS

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, Connect:Direct etc.).

Proprietary file format controlled by CMS.

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

Connect:Direct.

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

The BUY interface creates an accretion transaction when a:

- newly eligible Medicare/Medicaid recipient is added to MEDS
- newly eligible SLMB, QI, or QMB only recipient is added to MEDS, or
- an existing Medicaid recipient becomes eligible for Medicare.

The BUY interface creates a deletion transaction when:

- Medicaid is terminated for someone who is currently eligible for Buy-In, or
- Someone who is currently eligible for Buy-In moves to a category that is not covered.

The BUY interface creates change transactions to update the Buy-In eligibility code.

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

Medicare and Medicaid data for a person. Hard copies of the data layouts from CMS are available upon request (Clemson).

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

N/A

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

CMS transmits daily files consisting of multiple types of records:

- RIC A – SSI alert Record (Part B only)
- RIC C – Medicare Claim Number Change Record (Part A and B)
- RIC D – State Agency Reply Record (Part A and B)
- RIC E – Personal Characteristics Change Record (Part A and B)
- RIC F – State Agency Reject Record (Part A and B)

CMS transmits the RIC B, State Agency Billing file monthly (Part A and B).

SCDHHS transmits a weekly file of accretions, deletions and changes as described in Triggers.

Outputs

List all system / interface outputs – e.g., names and contents of specific reports, data files, etc.

Include media and frequency.



Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

The Buy-Interface generates alerts and reports for information and for necessary action

- A list of reports is attached.
- A list of alerts is attached.

Record Layout

Attach sample layout if applicable.

N/A

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

Connect:Direct

Governing Policies

Policies that govern use or other activity involving the system / interface.

- The statutory authority for the program is Section 1843 of the Social Security Act.
- Section 301 of the Medicare Catastrophic Care Act mandated that the State Medicaid programs pay the Medicare cost sharing expenses for QMB eligibles.
- The State Plan.
- Medicaid Policy.
- Medicare Policy.

Access Control Policies and Security

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

List data security levels, security requirements etc.

See Appendix L (Common Answers).

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

N/A

System / Interface Data Processing Standards

If a service level agreement (SLA) or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

Data is sent to CMS weekly on Wed/Thurs. Responses received are processed on Sat.

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

Tues-Thurs for data sent. Sat for data received.



Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

Payment of Medicare premiums is a service provided by SCDHHS to S.C. Medicaid recipients. For some payment categories, i.e. SLMB, QMB and QI1, payment of the Buy-In Part B premium is the only Medicaid benefit provided. The Buy-In system must be operational to provide this service.

Disaster Recovery

Attach any disaster recovery plans.

See Common Answers document

Contract

Legal agreement status and document location.

N/A

Data Storage & System Attributes

*What programming languages were used in creating the system / interface, or what **Commercial, off-the-shelf (COTS)** software was acquired?*

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format / schema documentation if possible.

See Common Answers document

Transaction processing

Type (batch / real-time).

Batch

Data Quality Control

Describe quality control policies / procedures.

The MEDS edits the incoming and outgoing data.

Backup

Describe / attach backup procedures and policies.

See Common Answers document

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

Unknown – has not been an issue.

Support

Support hours and response times. Who handles user support, and how? Explain escalation / levels, if applicable.

See Common Answers document

Incident Management

Process / constraints by which incidents are handled.

See Common Answers document

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?



See Common Answers document

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

See Common Answers document

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens? Include medium, etc.

Medicaid Systems Support maintains a Users' Guide for MEDS that is under revision.

Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

See Common Answers document

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

See Common Answers document

Plans for the System / Interface

How long will the system / interface continue?

The Buy-In interface will continue until it is replaced by CMS or it is no longer required.

What upgrades and replacements are planned?

A change in the way the billing record is processed is scheduled to be implemented in late 2009.

Legislative climate and other forces affecting system / interface?

N/A

Comments?

N/A



1.3. Coordination of Benefits (COB)

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

Coordination of Benefits (COB)

Owner Information

Name, phone, email, etc. of user and support contacts

See Common Answers document

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

The COBC Interface is a monthly data exchange between states and the COB Contractor to share information related to the Medicare Part D program. The purpose of the COBC process is to coordinate the prescription drug benefits between Medicare Part D plans and the State Pharmaceutical Assistance Programs (SPAP), which serve as supplemental payers. This collection of all prescription drug related benefits will facilitate the tracking of TrOOP (True Out-of-Pocket) expenses incurred by each Medicare beneficiary. MEDS transmits a file of persons enrolled in the SPAP to the COBC monthly. South Carolina's SPAP is the Gap Assistance Pharmacy Program for Seniors (GAPS). It was established to assist low income Medicare beneficiaries with prescription drug costs during periods when Medicare Part D does not pay. Only persons eligible for GAPS are sent to COBC.

The COBC notifies the state whether the SPAP recipient is enrolled in Medicare Part D and/or Low Income Subsidy and provides other information related to the prescription drug coverage such as the plan number and enrollment date. Online screens display the information received from the COBC. Certain parts planned to be implemented in MEDS for the COB interface are still outstanding. These are:

- Automated closures with the new notices.
- Automated updates to include but not limited to date of death, LIS dates, Medicare coverage dates, LIS coverage dates, and Part D coverage dates.
- Create Audit and History tables and screens to display audit and history data.
- Purge aged data

Objectives

What are the goals of the system / interface? Why was it initiated?

The purpose is to coordinate the prescription drug benefits between Medicare Part D plans and the SPAP.

Business Processes

What business processes require the interface?

See Interfaces related to Business Processes document

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

- Automated closures with the new notices.
- Automated updates to include but not limited to date of death, LIS dates, Medicare coverage dates, LIS coverage dates, and Part D coverage dates.



- Create Audit and History tables and screens to display audit and history data.
- Purge aged data.

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

COB Contractor (see Overview).

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, Connect:Direct etc.).

Mainframe flat file.

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

Secure HTTPS.

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

The COB1000 program creates a file monthly to send to the COB Contractor of persons currently eligible for GAPS (PCAT 92) and persons who were eligible for GAPS within the past 27 months (but not earlier than 01/01/2006 when GAPS was implemented). The file submitted by states is a full-file replacement. The entire base of enrollees is submitted to the COBC on this file each month. The submission includes any corrections from the previous month's file. Each month's input file fully replaces the previous month's input file. Required fields are SSN or HICN, Surname, First Initial, Date of Birth, Sex Code, Network Indicator, SPAP Effective Date, SPAP Termination Date, Coverage Type Indicator, Insurance Type Indicator, and SPAP ID.

Upon receipt of a response file, the COB2000 program validates and stores the incoming data from the COBC on the COB Transaction and COB Transaction History tables.

The COB2000 also:

- sorts off duplicate records prior to processing;
- validates the incoming records;
- creates exception and control total reports;
- creates/updates the COB-Transaction table and the COB-TRANS_HIST table;
- creates a verified file for COB2100;
- generates alerts and reports when invalid transactions, rejections, and other exceptional situations are received; and
- generates informational reports.

The COB2100 program determines whether the member chose a participating plan and package, and updates the COB participating indicator and Medicare information.

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

- SPAP enrollment dates



- Part D enrollment dates;
- Part D plan number and plan benefit number;
- Low Income Subsidy enrollment dates and levels.

(see Record layouts)

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

N/A

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

A COBC request is sent monthly. The request file is usually created on the first day of the month. COBC usually returns a response file monthly between the 15th-20th.

Outputs

List all system / interface outputs – e.g., names and contents of specific reports, data files, etc.

Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

The COBC Interface generates alerts and reports for information and for necessary action.

- A list of reports is attached
- COB generates the following alerts:
 - a) If the below information is received on the incoming file
 - disposition code is '51' and PCAT 92 is currently eligible, send alert 303, COBC REPORTS PCAT 92 NOT IN FILE. VERIFY MEDICARE. CMS has reported this recipient has no Medicare coverage. Worker needs to verify Medicare and update MEDS.
 - disposition code is '55' and PCAT 92 is currently eligible, send alert 304, NAME, DOB, SEX OR MCN DOES NOT MATCH CMS RECORDS. Worker needs to obtain correct name, DOB, sex or MCN and update MEDS.
 - Denial Code 2 = 'Y' and PCAT 92 is currently eligible, send alert 305; COBC REPORTED PCAT 92 DOES NOT RESIDE IN USA. Worker needs to verify correct residence address. If recipient does not reside in SC, GAPS should be terminated.
 - CMS has reported this recipient has no Medicare coverage, send alert 306, ACTIVE PCAT 92 DOES NOT HAVE A MCN OR SSN. Worker needs to verify Medicare and update MEDS.
 - If the COBC file has an invalid SSN or invalid date and the transaction is for an **active PCAT 92**, send alert 307, INVALID DATA RECEIVED FROM COBC. The



Department of Interfaces staff should investigate and notify COBC they have returned invalid data.

- If SSN, last name, DOB, gender, etc. are blanked or zeroed out on the incoming file, send alert 312, COBC REPORTS MEDICARE NOT FOUND. Worker needs to verify Medicare and update MEDS.
 - If CMS reports a DOD and the member is still active in PCAT 92, send alert 313, DEATH REPORTED BY COBC. MEDICAID STILL ACTIVE.
- b) The record is not added to the outgoing file:
- If both MCN and SSN are blank in MEDS and the PCAT 92 is active, send alert 306, ACTIVE PCAT 92 DOES NOT HAVE A SSN OR MCN).
 - Note: There is an outstanding request for a new alert to be generated when MEDS has an eligible GAPS recipient (PCAT 92) with a blank or invalid DOB, ACTIVE PCAT 92 DOES NOT HAVE A VALID DOB. An SSN that has an invalid DOB cannot be sent to the COB contractor by COB1000. These need to be corrected so that Part D and LIS data can be received.

Record Layout

Attach sample layout if applicable.

Records layouts can be found at: M:\MEDS\Maint\SR05041 - COBC Interface

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

N/A

Governing Policies

Policies that govern use or other activity involving the system / interface.

- SCDHHS has signed the SPAP data sharing agreement with CMS.
- Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173 Sec. 1860D—23. State Pharmaceutical Assistance Programs
States with pharmacy assistance programs will be permitted to participate in Part D by purchasing supplemental benefits through a Medicare Part D plan or by having their own supplemental benefit wrap around Part D. States must provide such assistance to individuals in all Part D plans and cannot discriminate based upon the Part D plan.

The Secretary will establish a process to ensure the coordination between SPAPs and Part D, including enrollment file sharing; processing of claims, electronic processing, claims payment, claims reconciliation reports, application of the out-of-pocket limit, and other administrative processes specified by the Secretary. Enrollees will be given a single plan benefit card to use for both programs

States may pay cost sharing on behalf of enrollees. The costs incurred by the state may be counted toward the out-of-pocket limit for catastrophic coverage.

- Medicare is the primary payer for SPAPs. Also see the Medicaid Program Manual.



Access Control Policies and Security

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

List data security levels, security requirements etc.

See Appendix L (Common Answers).

Uploaded and downloaded to/from COB Contractor website via HTTPS.

M:\MEDS\Production Documentation\Batch\COB\Instructions for downloading COB1000 file.doc

M:\MEDS\Production Documentation\Batch\COB\Instructions for downloading COB2000 file.doc

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

M:\MEDS\Production Documentation\Batch

M:\MEDS\Maint\SR05041 - Coordination of Benefits Contractor (COBC) Interface

System / Interface Data Processing Standards

If a service level agreement (SLA) or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

Response from SPAP is 14 days.

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

7 am to 7 pm online and 24/7 for batch.

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

South Carolina established the GAPS for Seniors in accordance with MMA-established.

The GAPS pays 10% of prescription drug costs incurred during the period when the beneficiary is responsible for paying the total amount of their prescription drug expenses (doughnut hole). This interface is necessary for States to exchange SPAP enrollment data with the COBC and to insure the beneficiary is not responsible for payments that should be made by the S.C. Medicaid program.

Disaster Recovery

Attach any disaster recovery plans.

See Common Answers document.

Contract

Legal agreement status and document location.

SCDHHS has signed the SPAP Data Sharing Agreement with CMS.

Data Storage & System Attributes

*What programming languages were used in creating the system / interface, or what **Commercial, off-the-shelf (COTS)** software was acquired?*



*What DBMS, file systems, etc., does the system use for storing transactional / operational data?
Attach data formats or schemas or provide location of format / schema documentation if possible.*

See Common Answers document; Cobol, JCL, SAS, IDMS-R

Transaction processing

Type (batch / real-time).

Batch

Data Quality Control

Describe quality control policies / procedures.

MEDS edits incoming and outgoing data.

Backup

Describe / attach backup procedures and policies.

See Common Answers document.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

50,000 recipients.

Support

Support hours and response times. Who handles user support, and how? Explain escalation / levels, if applicable.

See Common Answers document.

Incident Management

Process / constraints by which incidents are handled.

See Common Answers document

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?

See Common Answers document.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

See Common Answers document.

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens? Include medium, etc.

Medicaid Systems Support maintains a Users' Guide for MEDS that is under revision.

SPAP user guide

M:\MEDS\Production Documentation\Batch\COB\SPAP User Guide FEB2007.pdf

Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

See Common Answers document.



Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

See Common Answers document.

Plans for the System / Interface

How long will the system / interface continue?

Indefinitely, unless the GAPS program is eliminated. This interface is required to exchange Medicare Part D data for persons eligible for GAPS.

What upgrades and replacements are planned?

N/A

Legislative climate and other forces affecting system / interface?

N/A

Comments?

N/A



1.4. Department of Social Services Data Sharing

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

South Carolina Department of Social Services (DSS) Data Sharing

Owner Information

Name, phone, email, etc. of user and support contacts

See Common Answers document.

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

Once a week an unduplicated file of Medicaid eligibility and enrollment information for all members in active, pending, or closed budget groups is generated and sent to DSS for the purpose of administration including determining eligibility and providing or arranging for services as allowed by SC Code Regs. 126-170 *et seq.* The data is used by the Child Support Enforcement Program under Title IV-D for enforcing medical support obligations. It is used by the Temporary Assistance to Needy Families (TANF) and Supplemental Nutrition Assistance Program (SNAP) programs as lead information for eligibility determinations and for referrals.

DSS has contracted with SABER to implement a new Child Support Enforcement system. The new system is scheduled for implementation in March 2011. Many system changes will be required for SCDHHS to provide the information that the DSS Child Support Enforcement Department is federally mandated to receive from Medicaid. SCDHHS also has future plans to receive information from DSS that will be used to automatically establish Medicaid eligibility for Title IV E Foster Care and Adoption Assistance children.

Objectives

What are the goals of the system / interface? Why was it initiated?

To provide DSS with a list of Medicaid Members and family grouping for DSS tracking.

Business Processes

What business processes require the interface?

See Interfaces related to Business Process document

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

Child Support Phase II

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

Department of Social Services

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, Connect:Direct etc.).



Mainframe flat file – DSS supplied file format

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

Connect:Direct

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

Weekly for 5 hours, processes 2+ million records on Saturday or Sunday. Production Control runs @CSECNDR after @CSE1000 runs successfully. The File MEDS.CSE1000B.DATA(0) is sent to DSS. This transmission takes 16 hours on average. The following jobs are submitted in the Connect:Direct process:

- @CSE1010 sends an email to PCA and PS(Production Support) that the file was successfully transmitted.
- @CSE1020 send an email to PCA and PS that the file was not successfully transmitted.

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

All Medicaid member data dealing with personal identification and family/budget groups. Demographic data is also included on the MEDS.CSE1000B.DATA(0) file. See data layout.

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

N/A

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

N/A

Outputs

List all system / interface outputs – e.g., names and contents of specific reports, data files, etc.

Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

Medicaid Member data

WS-MEDS-CSE-RECORD-OUT defined in program MEDS.PROD.SOURCE(CSE1000)

Record Layout

Attach sample layout if applicable.

N/A

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

SCDHHS and DSS policies and Connect:Direct



Governing Policies

Policies that govern use or other activity involving the system / interface.

MOA between SCDHHS and DSS for data sharing.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Access Control Policies

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

See Appendix L (Common Answers).

Security and Confidentiality Procedures

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

N/A

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

M:\MEDS...

[M:\MMIS\MARC\Production Documentation\CSE10F011data layout - Lrecl 2818R.doc](#)

[M:\MMIS\MARC\Production Documentation\CSE1000.vsd](#)

M:\MEDS\Maint\SR 2004's\SR04108 - Child Support - CSE

Contract and Service Level Information

If a service level agreement (SLA) or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

5 hours

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

Every weekend

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

DSS is federally mandated to electronically interface with the State Title XIX system to automatically exchange information required to enforce medical support provisions.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

All MEDS members.

Support

Support hours and response times.

See Common Answers document.

Incident Management

Process / constraints by which incidents are handled.

See Common Answers document.

Disaster Recovery

Attach any disaster recovery plans.



See Common Answers document.

Contract

Legal agreement status and document location.

There is an agreement between DSS and SCDHHS to share data. It is currently in the process of being renegotiated. Once signed, it will take effect as of July 1, 2007 and continue through June 30, 2012.

System / Interface Data Processing Standards

Data Storage

What DBMS, file systems, etc., does the system use for storing transactional / operational data? Attach data formats or schemas or provide location of format/schema documentation if possible

See Common Answers documents

Transaction processing

Type (batch / real-time).

Batch

Capacity

Including peak intervals.

All MEDS members.

Data Quality Control

Describe quality control policies / procedures.

MEDS edits the outgoing data and will have edits for any incoming data.

Backup

Describe / attach backup procedures and policies.

See Common Answers document.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?

See Common Answers document

Help Desk

Who handles user support, and how? Explain escalation / levels, if applicable.

24/7 Medicaid Systems (MS) Helpdesk and GroupLink:

User submit issues via email or GroupLink and are escalated to the Department Head.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

See Common Answers document.

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens? Include medium, etc.

N/A

Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A



System / Interface Roles and Responsibilities

SCDHHS Responsibilities

See Common Answers document.

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

See Common Answers document.

Plans for the System / Interface

How long will the system / interface continue?

Since DSS is federally mandated to receive Medicaid data for Child Support enforcement, the interface must exist.

What upgrades and replacements are planned?

N/A

Legislative climate and other forces affecting system / interface?

N/A



1.5. Employment Security Commission (ESC) Interface

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

Employment Security Commission (ESC) Interface

Owner Information

Name, phone, email, etc. of user and support contacts

See Common Answers document.

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

This interface consists of three parts. ESC provides to SCDHHS a full wage file quarterly and changes monthly (1), a weekly file of unemployment compensation benefits (2), and a monthly file of persons receiving special benefits (3). This interface is an unencrypted tape that is delivered to SCDHHS via courier.

The following is a description of what the ESC provides to SCDHHS:

- **ESC-Wage** – The wage file includes the name and address of the employer and up to 6 quarters of wage data for an individual. The ESC wage data is updated to a master file. Workers access the master file through an online screen. Exceptions are reported through reports. Note: ESC provides a separate file of employers that must be used in conjunction with the wage file to identify the employer name and address.
- **Unemployment Compensation Benefits (UCB)** – The weekly file of South Carolina residents receiving UCB is updated to a master file and to the MEDS member's financial record. Up to 52 weeks of UCB data is maintained. Workers access the master file through an online screen. MEDS automatically terminates eligibility if the UCB data received for a person eligible for GAPS (PCAT 92) exceeds the income limit.
- **Special Benefits** – This portion of ESC has not yet been implemented, but the file is currently being received. The monthly file of special benefits identifies South Carolina residents receiving special assistance such as Trade Adjustment. MEDS will update the amount of the special benefit to the Medicaid member's financial information so that it could be used for initial determinations, re-budgets and reviews. The receipt of or increase in special benefits will automatically trigger a redetermination and recalculation of countable income. Exceptions will be reported through alerts and reports. Screens will show Special Benefit information received from ESC.

Objectives

What are the goals of the system / interface? Why was it initiated?

The purpose is to verify receipt or non-receipt of wages and other benefits for Medicaid applicants and recipients and for other programs administered by SCDHHS. A match with the Employment Security Administration is mandated by the Federal government as part of the IEVS regulations. ESC provides information for all South Carolina residents. This



data is stored in the master files but can be accessed only for SSNs that have been entered in MEDS. When new applicants or recipients are added to MEDS, if there is ESC information available, the information may be immediately accessed.

Business Processes

What business processes require the interface?

See Interfaces related to Business Processes document

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

None

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

ESC

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, Connect:Direct etc.).

Connect:Direct

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

Tapes via courier.

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

Upon receipt of an ESC monthly wage file, ESC quarterly wage file, weekly UCB file or monthly Special Benefits, the ESC interface:

- Edits for valid data and transactions.
- Applies data to the appropriate Master files.
- For UCB, the SSNs from the incoming file are matched to MEDS Members whose income and resources are used to determine the eligibility for a Budget Group. If a match is found, the program checks to see if UCB is recorded as an unearned income source (in the Asset tables) and compares any UCB information found associated with the Member to the incoming amount. If there is no UCB associated with the Member or if the amount recorded in MEDS is different from the incoming amount then an eligibility redetermination is triggered for each open Budget Group the Member is in. The unearned income indicator and unemployment compensation indicator on the Member Period are updated if needed and the asset information is updated with the new amount. An IEV_ACTION row is stored for each Member who was matched as having UCB income. If the UCB income was for someone eligible for GAPS (PCAT 92), MEDS re-determines eligibility and terminates if applicable.
- The incoming wage file is matched to MEDS and a file is produced for MMIS. The person must be eligible for Medicaid or is a member of an active BG in MEDS and had income greater than \$3000.00 per employer in the first quarter on the file. Persons in categories 52, 56, 90, 50 48 or 92 are not included. MMIS uses this file to produce TPL lead letters.



SCDHHS does not provide any information to the ESC.

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

ESC provides income information for all South Carolina residents:

- Amount of wages, name and address of the employer and up to 6 quarters of wage data for an individual.
- Maximum benefit amount of UCB, benefit balance, weekly UCB benefit amounts, and issue dates.
- Amount of special benefits, the type of special benefit, issue dates.

Incoming file:

Employer

EMP-VALID-RECORD.

FILLER PIC X(08).
VAL-ACCT-NO PIC 9(06) COMP-3.
FILLER PIC X(33).
VAL-NAME PIC X(35).
VAL-ADDR1 PIC X(35).
VAL-ADDR2 PIC X(35).
VAL-ADDR3 PIC X(35).
VAL-ADDR4 PIC X(35).
VAL-CITY PIC X(20).
VAL-STATE PIC X(05).
VAL-ZIP PIC 9(05) COMP-3.
VAL-TRD-NAME PIC X(25).
FILLER PIC X(27).

Wage

V-WAGE-RECORD.

V-IN-SSN PIC 9(09) USAGE COMP-3.
V-IN-ACCT PIC 9(07) USAGE COMP-3.
FILLER PIC X(03).
V-IN-KEY-QTR PIC 9(03) USAGE COMP-3.
V-IN-NAME PIC X(05).
V-IN-WAGES-1 PIC 9(05)V99 USAGE COMP-3.
V-IN-WAGES-2 PIC 9(05)V99 USAGE COMP-3.
V-IN-WAGES-3 PIC 9(05)V99 USAGE COMP-3.
V-IN-WAGES-4 PIC 9(05)V99 USAGE COMP-3.
V-IN-WAGES-5 PIC 9(05)V99 USAGE COMP-3.
V-IN-WAGES-6 PIC 9(05)V99 USAGE COMP-3.

UCB

ESC-UCB-INPUT in the data dictionary.

04 ESC-UCB-INPUT.

07 FILLER PIC X(0033).
07 EUI-NUM-SSN PIC X(9).
07 FILLER PIC X(4).
07 EUI-NAM-LAST-16 PIC X(16).



07 EUI-NAM-FIRST-15 PIC X(15).
 07 EUI-NAM-MIDDLE-INITIAL PIC X(1).
 07 FILLER PIC X(4).
 07 EUI-ADR-1-30 PIC X(30).
 07 EUI-ADR-2-30 PIC X(30).
 07 EUI-ADR-CITY-22 PIC X(22).
 07 EUI-ADR-STATE PIC X(2).
 07 EUI-ADR-ZIP-5 PIC 9(5).
 07 FILLER PIC X(27).
 07 EUI-AMT-BFTS-MAX-X5 PIC X(5).
 07 EUI-AMT-BFTS-MAX-95 REDEFINES EUI-AMT-BFTS-MAX-X5
 PIC 9(5).
 07 EUI-AMT-BFTS-BAL-X5 PIC X(5).
 07 EUI-AMT-BFTS-BAL-95 REDEFINES EUI-AMT-BFTS-BAL-X5
 PIC 9(5).
 07 EUI-AMT-BFTS-WKLY-X4 PIC X(4).
 07 EUI-AMT-BFTS-WKLY-94 REDEFINES EUI-AMT-BFTS-WKLY-X4
 PIC 9(4).
 07 FILLER PIC X(3).
 07 EUI-GRP-BFTS-PAY OCCURS 11.
 11 FILLER PIC X.
 11 EUI-AMT-BFTS-PAY-X3 PIC X(3).
 11 EUI-AMT-BFTS-PAY-93 REDEFINES EUI-AMT-BFTS-PAY-X3
 PIC 9(3).
 11 EUI-DTE-BFTS-PAY.
 15 EUI-DTE-BFTS-PAY-YY PIC X(2).
 15 EUI-DTE-BFTS-PAY-MM PIC X(2).
 15 EUI-DTE-BFTS-PAY-DD PIC X(2).
 11 EUI-DTE-BFTS-PAY-9 REDEFINES EUI-DTE-BFTS-PAY.
 15 EUI-DTE-BFTS-PAY-9-YY PIC 9(2).
 15 EUI-DTE-BFTS-PAY-9-MM PIC 9(2).
 15 EUI-DTE-BFTS-PAY-9-DD PIC 9(2).
 11 FILLER PIC X(6).
 07 FILLER PIC X(9).
 07 EUI-GRP-BFTS-PAY2 OCCURS 3.
 11 FILLER PIC X.
 11 EUI-AMT-BFTS-PAY2-X3 PIC X(3).
 11 EUI-AMT-BFTS-PAY2-93 REDEFINES EUI-AMT-BFTS-PAY2-X3
 PIC 9(3).
 11 EUI-DTE-BFTS-PAY2.
 15 EUI-DTE-BFTS-PAY2-YY PIC X(2).
 15 EUI-DTE-BFTS-PAY2-MM PIC X(2).
 15 EUI-DTE-BFTS-PAY2-DD PIC X(2).
 11 EUI-DTE-BFTS-PAY2-9 REDEFINES EUI-DTE-BFTS-PAY2.
 15 EUI-DTE-BFTS-PAY2-9-YY PIC 9(2).



15 EUI-DTE-BFTS-PAY2-9-MM PIC 9(2).

15 EUI-DTE-BFTS-PAY2-9-DD PIC 9(2).

11 FILLER PIC X(6).

07 FILLER PIC X(32).

*There is no outgoing file to ESC.

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

N/A

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency. Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

- Wages – Changes/additions are provided monthly with a full file quarterly. Two files are needed to make up the wage file. ESC provides an employer file and a wage file. The employer ID number must match to the employer file to obtain the name and address.
- UCB - The Unemployment Compensation Benefits is provided weekly.
- Special benefits file is sent monthly.
- TPL Leads – File is produced for MMIS from the Wage file.

Outputs

List all system / interface outputs – e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

The ESC Interface generates alerts and reports for information and for necessary action.

- A list of reports is available in the project repository
- Several alerts were planned for ESC, but they have not been made operational.
 - Text: ESC REPORTED UCB CHANGE - Description: This alert would be sent when ESC reports a change in the unemployment compensation benefit. A change includes starting, stopping, and change.
 - Text: WAGE FROM NEW EMPLOYER REPORTED FOR RECIPIENT - This alert would be sent when ESC reports wages from an employer not previously reported.
 - Text: WAGES INCREASE REPORTED FOR RECIPIENT SSN - This alert would be sent when ESC reports an increase in the earned income.
 - Text: ESC REPORTED SPECIAL BENEFITS FOR THIS RECIPIENT - This alert would be sent when ESC reports receipt of a special benefit.
 - Text: SPECIAL BENEFITS INCREASED FOR THIS RECIPIENT. This alert would be sent when ESC reports an increase in the special benefit.

Record Layout

Attach sample layout if applicable.

N/A



Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

SCDHHS and DSS policies and Connect:Direct

Governing Policies

Policies that govern use or other activity involving the system / interface.

- Effective May 29, 1986, Section 2651 of the Deficit Reduction Act of 1984 (Pub. L. 98-369) amended the Social Security Act, the Food Stamp Act, and Internal Revenue Code. It requires State agencies that administer Food Stamps, Family Independence, Medicaid, etc. to develop an IEVS which meets certain statutory requirements. The major statutory changes in the regulations provide state agencies with additional information sources to verify applicant and recipient reported circumstances and also ensure that appropriate privacy and procedural safeguards are applied in the use of the information.
- 42 CFR sections 435.940-435.960 provide regulations for the Income Eligibility Verification System.
- Section 42 CFR 435.953 allows states to exclude certain categories of Medicaid eligibles from the IEVS reporting requirements. A targeting plan was submitted in 1998.
- There is also a memorandum of agreement with the South Carolina Employment Security Commission.

Access Control Policies and Security

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

List data security levels, security requirements etc.

See Appendix L (Common Answers).

The RACF security for ESC data is more strict due to the extreme sensitivity of the data.

Also, tapes are physically locked in a secure location when not in use.

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

N/A

System / Interface Data Processing Standards

If a service level agreement (SLA) or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

Employer/Wage job runs monthly on the weekend, apprx 5 hrs. UCB runs weekly on Monday, 1 hr.

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

Monday (UCB), one weekend per month (Emp/Wage).



Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

The ESC file created for MMIS is necessary to create the Employer letters regarding primary health insurance (TPL Leads). This is federally mandated and is critical to cost avoidance savings and to the SCDHHS MIVS contract. The availability of verification expedites eligibility determinations and reviews. The employer names and addresses provided by ESC can be used as lead information to identify employment that may not have been previously reported.

Disaster Recovery

Attach any disaster recovery plans.

See Common Answers document

Contract

Legal agreement status and document location.

N/A

Data Storage & System Attributes

*What programming languages were used in creating the system / interface, or what **Commercial, off-the-shelf (COTS)** software was acquired?*

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format / schema documentation if possible.

See Common Answers document; Cobol, JCL, SAS, IDMS-R

Transaction processing

Type (batch / real-time).

Batch

Data Quality Control

Describe quality control policies / procedures.

Edits with ESC Program.

Backup

Describe / attach backup procedures and policies.

See Common Answers document.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

Employer 260,000, Wage 3.5 million, UCB 206,000.

Support

Support hours and response times. Who handles user support, and how? Explain escalation / levels, if applicable.

See Common Answers document

Incident Management

Process / constraints by which incidents are handled.

See Common Answers document.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?



See Common Answers document.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

See Common Answers documentation.

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens? Include medium, etc.

N/A

Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

See Common Answers document.

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

See Common Answers document.

Plans for the System / Interface

How long will the system / interface continue?

Indefinitely or as long as it is mandated as part of IEVS.

What upgrades and replacements are planned?

N/A

Legislative climate and other forces affecting system / interface?

N/A

Comments?

N/A



1.6. Enumeration Verification System (EVS) Interface

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

Enumeration Verification System (EVS) Interface

Owner Information

Name, phone, email, etc. of user and support contacts

See Common Answers document.

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

EVS is a batch interface with SSA that assists Medicaid eligibility workers in verifying and obtaining a valid SSN, particularly for newborns. EVS identifies persons with no SSN and creates a request to SSA to obtain the SSN. SSA matches the name and date of birth to their records and communicates their findings through a verification code. The SSA response is displayed online and the worker is notified through alerts of the result of the match. A notice is sent to the primary individual if SSA was not able to match the states' information to their records. The notice requests they apply for an SSN or notify their eligibility worker if they have already obtained an SSN.

Objectives

What are the goals of the system / interface? Why was it initiated?

To assist Medicaid eligibility workers in verifying and obtaining a valid SSN.

Business Processes

What business processes require the interface?

See Interfaces related to Business Processes document

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

There are outstanding defects with the EVS subsystem and does not operate as intended.

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

SSA

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, Connect:Direct etc.).

Mainframe flat file. Format specified by SSA.

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

Connect:Direct

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

The selection criteria for sending an EVS request are:



- The MEDS application is locked and the individual does not have an SSN.
 - The application is pending or approved, and
 - The individual application status (Field name - Applying/Not applying) = A, and
 - The DOB indicates the MEDS member is one month of age or greater.
- An EVS validation request is resent if the DOB or name is changed in MEDS.

Note: There is an outstanding system request (SR 03196) to not send an EVS request if the name = Baby Girl, Baby Boy, Miscar, Miscarr, or Miscarriage.

Upon receipt of an EVS response file, MEDS validates the incoming data, updates the EVS Master file and processes the incoming transactions based on the SSN verification code. See below.

Note: An action for all EVS SSN verification codes is included below, although it is not likely that codes 2, 3, 4, 5, *, A or B would be received since these would result from an attempted match of an SSN and EVS will only send records without an SSN.

CODE
DESCRIPTION

Blank

Description: The SSN provided by the state agency was verified on name, DOB, and sex code.

Action: MEDS updates the SSN verification code to V.

1

Description: The SSN provided by the state agency is not in file (impossible SSN/never issued to anyone, OR **NO** SSN found if all 000's submitted.

Action: MEDS creates an automated notice to recipient (EVS001).

Resend EVS request in 30 day intervals if name, SSN, DOB, or SEX remain unchanged in MEDS for a maximum of 3 times unless the application is denied or closed before the 3 requests have been sent.

2

Description: The name and DOB submitted by the state agency matches, but the sex code does not.

Action: MEDS generates Alert ID 400 UNABLE TO VALIDATE SSN. NAME & DOB MATCH, SEX DOESN'T. The eligibility worker should review documentation (case file, BENDEX, or SVE query) and correct any discrepancies in name, DOB, or sex code in MEDS.

3

Description - SSA could not validate the SSN due to a discrepancy in the name, DOB, and/or SSN.

Action: MEDS generates alert ID 401; Text = UNABLE TO VALIDATE SSN. NAME & SEX MATCH, DOB DOESNT. The eligibility worker needs to review documentation (case file, BENDEX, or SVE query) and determine if the MEDS DOB needs to be updated.

4

Description - SSA could not validate the SSN due to a discrepancy in the name, DOB, and/or SSN.



Action: MEDS generates Alert ID 402; Text = UNABLE TO VALIDATE SSN. NAME MATCHES, DOB/SEX DO NOT. The eligibility worker needs to review documentation (case file, BENDEX, or SVE query) and determine if the DOB or sex code needs to be updated in MEDS.

5

*

A

B

Description - SSA located a different SSN for this recipient than the one sent to SSA to be validated.

Action: MEDS generates Alert ID 403; Text = SSA LOCATED A DIFFERENT SSN FOR THIS RECIPIENT. The eligibility worker needs to review the SSA response and determine if the SSN in MEDS needs to be changed.

C

D

Description - SSA has located more than one potential SSN for this recipient, based on name and DOB or name only.

Action: MEDS generates Alert ID 404; Text = MORE THAN 1 POTENTIAL SSN MATCH FOUND FOR RECIP. The eligibility worker needs to review the potential matches and determine which SSN is the appropriate SSN for this recipient.

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

Demographics, SSN, codes indicating the status of the SSN verification.

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

N/A

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

An EVS request file is transmitted weekly (Friday) through DSS via C:D. Second and Third Requests are sent if the EVS validation code received is 1.

The EVS response is processed upon receipt.

Outputs

List all system / interface outputs -- e.g., names and contents of specific reports, data files, etc.

Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

The EVS Interface generates alerts, reports, and notices for information and action.

- A list of reports and alerts is available in the project repository.



- A notice is sent to the primary individual if SSA returns a verification code of 1. The notice is sent to the primary individual requesting they apply for an SSN or notify their eligibility worker if they have already obtained an SSN.

Record Layout

Attach sample layout if applicable.

File sent - EVS-VERIFY-REQUEST

Response received- EVS-SSA-RESPONSE

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

N/A

Governing Policies

Policies that govern use or other activity involving the system / interface.

1. SCDHHS has an agreement with SSA that provides for SSA to verify SSNs. Below are extracts from that agreement.

Section 1.A:

Purpose (5 U.S.C. § 552a(o)(1)(A))

The purpose of this agreement is to establish terms, conditions and safeguards under which the Social Security Administration (SSA) agrees to disclose information relating to the eligibility for, and payment of, Social Security benefits and/or Supplemental Security Income (SSI) and Special Veterans Benefits (SVB), including certain tax return information as authorized by 26 U.S.C. § 6103, to the Department of Health and Human Services, hereinafter referred to as the State Agency, for use in:

- Verifying income and eligibility factors for State-administered programs authorized by sections 453 and 1137 of the Social Security Act (the Act) (see Article II.E.1.);
- Verifying Social Security numbers (SSNs) of applicants for, and recipients of, benefits under such programs; and
- Defining safeguards against unauthorized use and re-disclosure of such information by the State Agency.

IV. Justification and Anticipated Results (5 U.S.C. § 552a(o)(1)(B))

Section A.3

The State Agency is required by law to require each applicant for, or recipient of, benefits under the 1137 programs listed in Article II.E. (Medicare Buy-In, Medicaid, Title XXI), to furnish his or her SSN or identifying information and to utilize such number or identifying information in the administration of the programs. SSA is required by law to verify the SSN of individuals applying for these State-administered benefit programs.

2. Social Security Act Sec. 1137. [42 U.S.C. 1320b–7] (a) In order to meet the requirements of this section, a State must have in effect an income and eligibility verification system which meets the requirements of subsection (d) and under which—
(3) the State shall require, as a condition of eligibility for benefits under any program listed in subsection (b), that each applicant for or recipient of benefits under that program furnish to the State his social security account number (or numbers, if he has more than one such number), and the State shall utilize such account numbers in the administration of that



program so as to enable the association of the records pertaining to the applicant or recipient with his account number;

Access Control Policies and Security

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

List data security levels, security requirements etc.

See Appendix L (Common Answers).

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

N/A

System / Interface Data Processing Standards

If a service level agreement (SLA) or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

EVS program series runs less than one hour.

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

24/7

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

Currently, EVS is the only automated way to obtain an SSN for persons that did not provide a SSN. An SSN is needed so that the agency can match Medicaid records with data from SSA, VA, Retirement, etc. to verify sources and amounts of income and identity, and to identify persons receiving Medicaid in more than one state.

Disaster Recovery

Attach any disaster recovery plans.

See Common Answers document.

Contract

Legal agreement status and document location.

The agreement with SSA covers the SVES, BENDEX, EVS, and SDX interfaces. The current agreement expires December 31, 2009. In the future, SSA plans to streamline the agreement process. With the process, SSA will have one Computer Matching and Privacy Protection Act (CMPPA) agreement per state, negotiated through the Governor's office. This agreement will need to be recertified after 18 months and then renewed after another 12 months. The individual agreements with the state agencies, referred to as the Master IEA (Information Exchange Agreement) once signed this year will be open ended with no expiration date unless changes are required.



Data Storage & System Attributes

What programming languages were used in creating the system / interface, or what **Commercial, off-the-shelf (COTS)** software was acquired?

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format / schema documentation if possible.

See Common Answers document; Cobol, JCL, SAS, IDMS-R

Transaction processing

Type (batch / real-time).

Batch

Data Quality Control

Describe quality control policies / procedures.

MEDS edits incoming and outgoing data.

Backup

Describe / attach backup procedures and policies.

See Common Answers document.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

There are very few requests and responses processed each week. Less than 100 per week.

Support

Support hours and response times. Who handles user support, and how? Explain escalation / levels, if applicable.

See Common Answers document.

Incident Management

Process / constraints by which incidents are handled.

See Common Answers document.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?

See Common Answers document.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

See Common Answers document.

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens? Include medium, etc.

N/A

Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

See Common Answers document.



Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

See Common Answers document.

Plans for the System / Interface

How long will the system / interface continue?

Indefinitely, or until EVS is replaced by another system that would provide verification of SSNs for newborns.

What upgrades and replacements are planned?

N/A

Legislative climate and other forces affecting system / interface?

N/A

Comments?

N/A



1.7. MEDS to MMIS Interface

There are two parts/interfaces, MEDS to MMIS and MMIS to MEDS. This document describes the MEDS to MMIS interface.

Owner Information

Name, phone, email, etc. of user and support contacts

See Common Answers document.

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

This interface is a nightly transfer (copy) of data from MEDS to MMIS. It includes Budget Group (Family), Member (Recipient), Medicaid Card, and Managed Care information.

Objectives

What are the goals of the system / interface? Why was it initiated?

To keep the MEDS and MMIS family and recipient data in sync.

To request Medicaid cards be produced.

To supply managed care information to MMIS.

Business Processes

What business processes require the interface?

See interfaces related to Business Processes document

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

None

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

MMIS

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, Connect:Direct etc.).

Mainframe flat files. Format/layout controlled by MMIS.

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

None. Files are created by MEDS subsystems and read by MMIS subsystems.

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

Any change to MEDS information that is also on the MMIS Family or Recipient records. The request for a Medicaid Card, either by the system for a new eligibility determination or by a worker for a replacement card.

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?



Family and Member Data. Documented in M:\MEDS\Production Documentation\Batch\MIS\MMIS-MEDS XREF.xls

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

N/A

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

MEDS family and recipient data that has changed.

Outputs

List all system / interface outputs -- e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

Files received by MMIS: namely, Family and recipient update file, Card file, Managed Care file.

Record Layout

Attach sample layout if applicable.

M:\MEDS\Production Documentation\Batch\MIS\MMIS-MEDS XREF.xls

MIS-FAM-RECORD

MIS-RCP-RECORD

Card File

MCO-MHN-ENROLLEE-RECORD

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

N/A

Governing Policies

Policies that govern use or other activity involving the system / interface.

N/A

Access Control Policies and Security

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

List data security levels, security requirements etc.



See Appendix L (Common Answers).

Access to files is controlled by RACF. Employees have direct READ-access only.

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

M:\MEDS\Production Documentation\Batch\MIS\

System / Interface Data Processing Standards

If a service level agreement (SLA) or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

Data once updated is sent to MMIS the same weeknight. Once over the weekend.

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

Weeknights and Sunday.

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

Important to keeping the MEDS and MMIS recipient data in sync.

Disaster Recovery

Attach any disaster recovery plans.

See Common Answers document

Contract

Legal agreement status and document location.

SCDHHS MEDS contract.

Data Storage & System Attributes

What programming languages were used in creating the system / interface, or what Commercial, off-the-shelf (COTS) software was acquired?

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format / schema documentation if possible.

See Common Answers document; Cobol, JCL, SAS, IDMS-R

Transaction processing

Type (batch / real-time).

Batch

Data Quality Control

Describe quality control policies / procedures.

N/A

Backup

Describe / attach backup procedures and policies.

See Common Answers document.



Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

Capacity: 280,000 per run.
10,000-20,000 per run.

Support

Support hours and response times. Who handles user support, and how? Explain escalation / levels, if applicable.

See Common Answers document

Incident Management

Process / constraints by which incidents are handled.

See Common Answers document.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?

See Common Answers document.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

See Common Answers document.

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens? Include medium, etc.

N/A

Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

See Common Answers document

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

See Common Answers document

Plans for the System / Interface

How long will the system / interface continue?

The interface will be required as long as separate systems are maintained for recipient data.

What upgrades and replacements are planned?

N/A

Legislative climate and other forces affecting system / interface?

N/A

Comments?

N/A



1.8. Medicare Modernization Act Interface

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

Medicare Modernization Act Interface (MMA)

Owner Information

Name, phone, email, etc. of user and support contacts

See Common Answers document.

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

The MMA of 2003 established the Medicare Prescription Drug Program, also known as Medicare Part D, making prescription drug coverage available to Medicare beneficiaries, effective January 1, 2006. The MMA transfers payment responsibility for the prescription drugs of dually eligible Medicaid and Medicare enrollees from Medicaid to Medicare. The MMA also established the Low-Income Subsidy (LIS) to assist individuals with low income and resources with payment of premiums, deductibles, and co-payments required under Part D.

MMA provides for a continued state contribution to the cost of providing drug benefits for full benefit dual eligibles through a monthly payment from the states to the Federal government. The Secretary determined a per capita amount for each state. In January, 2006, States began making monthly payments to the Federal government for each full benefit dual eligible in Part D. The state contribution is reduced each subsequent year by equal amounts to 75% of the calculated per capita amount in 2015 where it remains thereafter. The state contribution is also known as maintenance of effort or clawback.

The MMA interface is a monthly data exchange between states and CMS. States gather information on dual eligibles (full and partial) and potential full dual eligibles and sends to CMS. CMS identifies a full dual as a person having Medicare and full Medicaid benefits. A partial dual is one who is eligible for QMB only, SLMB or QI1. CMS identifies potential eligibles as persons who are not known to be full dual eligibles, but are Medicaid eligibles approaching an age or disability status that is likely to lead to a future determination of full dual eligibility. If CMS marches state's information to their records, it returns Medicare information related to the Medicare Part D prescription drug plan program, e.g. Medicare Part A, B, C, D, and LIS enrollment dates and the person's Part D plan contract number. This information is updated to the eligibility database and is used in the claims payment process. Online screens display the information received. BMSM staff uses the Medicare information provided by MMA to resolve Buy-In rejections.

Objectives

What are the goals of the system / interface? Why was it initiated?



The MMA interface is a monthly data exchange between South Carolina and CMS. The MMIS generates the file that contains everyone eligible for Medicaid and categories of assistance etc. This file is then sent to CMS. CMS uses this information for eligibility for low income programs. If CMS matches the state's information to the MBD, it returns Medicare information related to the Medicare Part D prescription drug plan program, e.g. Medicare Part A, B, C, D, and LIS enrollment dates and the person's Part D plan contract number. This information is updated to the eligibility database and is used in the claims payment process and by the Buy-In subsystem. Online screens display the information received. This is a good source of information that is used to update the MEDS.

Business Processes

What business processes require the interface?

See Interfaces related to Business Processes document

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

None

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

CMS

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, Connect:Direct etc.).

Mainframe flat file. Record format from MMA.

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

Connect:Direct.

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

Currently the file that is sent to CMS is created from MMIS. Initially only full and partial Medicare/Medicaid dual eligibles were sent. CMS expanded the process in August, 2006 to allow potential Medicare eligibles to be sent and to change the frequency that files may be sent and received.

For the output file:

MMIS first determines whether the recipient is covered by Medicare:

- yes, if they are SLMB-only
- yes, if their *buy-in* dates overlap with the reporting month

If determined covered by Medicare', the dual status code is set as follows:

01 = payment category 90

02 = QMB indicator is 'Q'

03 = assist-pay-cat 52



05 = assist-pay-cat 50

06 = assist-pay-cat 48

07 = assist-pay-cat 49

08 = anyone who doesn't fit the other categories 01-09

09 = payment category 42,43 (note: these categories are now obsolete)

Note: PCAT 92 is not sent. It is received through the COBC interface.

MMIS currently defines potential eligibles as:

Persons age 65 or older

Persons under age 65 with a qualifying category of 50 or 20.

Note: There is an outstanding system request to change the creation of the outgoing MMA file from MMIS to MEDS and to change the frequency from monthly to daily or weekly. There will also need to be changes in the way dual and potentials are identified. This outstanding request is scheduled to be implemented in September, 2009.

Upon receipt of the incoming file, both MMIS and MEDS have separate processes.

For MMIS, you will need to get this information from Jim Wood or Clemson.

For MEDS, the incoming file is:

- sorted prior to processing to remove duplicate records.
- Edited for valid data and transactions.
 - Alerts and reports are generated when invalid transactions, rejections, and other exceptional situations are received.
 - MEDS updates Medicare Parts A, B, C, D, and LIS data to the MEDS member record and
 - MEDS applies data to the MMA Master file.

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

Medicare data - Parts A, B, C, D, LIS, Medicaid data, Beneficiary Co-pay status, Institutional status, Prescription drug plans.

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

N/A

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

SCDHHS transmits a monthly file to CMS (see overview).

Outputs

List all system / interface outputs -- e.g., names and contents of specific reports, data files, etc. Include media and frequency.



Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

The MMA Interface generates alerts and reports for information and for necessary action. A list of reports is available in the project repository.

The following alerts are produced:

- Alert 308, MMA ERR CDE - NOT ENROLLED IN MEDICARE PART A OR B is generated if the basis for Part D subsidy denial = '1' or Medicare Part A/B finder code = '1' and the recipient is active in MEDS.
- Alert 309, DEATH REPORTED ON MMA. MEDICAID STILL ACTIVE is generated when the MMA DOD and the MEDS DOD are different or if the DOD matches and the member is still active on MEDS.
- Alert 310, MMA reports Z99. Verify Part A Buy In is generated if the current occurrence of Premium Payer = 'Z99' and the current occurrence of Part A coverage is a valid start date with an open end date, and the member is still eligible.
- Alert 311, MEDICARE TERMINATED FOR NONPAYMENT OF PREMIUMS. is generated if the member is still active in MEDS and the Part A/B Finder Code = 'T'. The text of this alert is being changed to: Medicare Ended, Refused, withdrew, or nonpay and will be generated if the member is still active in MEDS and:
The Part A entitlement status code = T or W and the Part B Entitlement status code is NULL or is not C, F, or S, or
The Part B entitlement status code = R, T, or W and the Part A Entitlement Status is NULL or is not C or S.
- There is an outstanding system request for a new alert, MMA REPORTS DIFFERENT NAME OR DOB to be generated when the recipient is Medicaid eligible (null end date) and the Part A and/or B start date is NULL and the Part A and/or B end date is NULL and the name and/or DOB does not match MEDS.

Record Layout

Attach sample layout if applicable.

MMA-INPUT-REC received from @MMA1100 defined in
MEDS.PROD.SOURCE(MMA2000).

MMA-INPUT-REC response file received from CMS defined in
MEDS.PROD.SOURCE(MMA2001).

File sent to MMA defined as WS-OUT-DETAIL-REC in
HHSMMIS.PROD.RSS.SOURCE(MMA1000).

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

N/A

Governing Policies

Policies that govern use or other activity involving the system / interface.



- The Medicare Modernization Act of 2003 established the Medicare Prescription Drug Program, also known as Medicare Part D, making prescription drug coverage available to Medicare beneficiaries, effective January 1, 2006.
- Section 1935(c) of the Social Security Act precludes subsequent Medicaid coverage of Part D-covered prescription drugs for these individuals and thus essentially requires that all such coverage for full benefit dual eligible individuals be provided under Medicare Part D. New section 1935(c)(1)(D) requires the Secretary to perform periodic data matches to identify the full-benefit dual eligibles for purposes of computing state contributions. States would make contributions only on behalf of individuals who would otherwise be eligible for prescription drug benefits under Medicaid and who have full benefits under a state Medicaid plan. States would not make contributions on behalf of individuals such as QMBs and SLMBs for whom the state would pay only Part B premiums and Medicare cost sharing on their behalf.

Access Control Policies and Security

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

List data security levels, security requirements etc.

See Appendix L (Common Answers).

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

N/A

System / Interface Data Processing Standards

If a service level agreement (SLA) or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

MMA job series runs approximately 2-3 hours.

Availability

When the system / interface must be available for use (e.g. 24X7, business hours, etc.)

24/7

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

States are required to submit verification of dual eligibles to CMS, which computes state contributions for the Medicare Part D prescription drug program. This information is shared with the Part D plans so that beneficiaries are charged the appropriate co-pay for their prescription drugs. The interface provides verification of Medicare numbers and dates of birth that can be used to resolve Buy-In rejections. The interface must be operational to share this data.



Disaster Recovery

Attach any disaster recovery plans.

See Common Answers document.

Contract

Legal agreement status and document location.

N/A

Data Storage & System Attributes

What programming languages were used in creating the system / interface, or what

Commercial, off-the-shelf (COTS) software was acquired?

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format / schema documentation if possible.

See Common Answers document; Cobol, JCL, SAS, IDMS-R

Transaction processing

Type (batch / real-time).

Batch

Data Quality Control

Describe quality control policies / procedures.

Program edits. MEDS edits incoming and outgoing data.

Backup

Describe / attach backup procedures and policies.

See Common Answers document.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

175,000 records total. 15,000 – 20,000 with new/changed information to be processed.

Support

Support hours and response times. Who handles user support, and how? Explain escalation / levels, if applicable.

See Common Answers document.

Incident Management

Process / constraints by which incidents are handled.

See Common Answers document.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?

See Common Answers document.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

See Common Answers document.



Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens? Include medium, etc.

N/A

Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

See Common Answers document.

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

See Common Answers document.

Plans for the System / Interface

How long will the system / interface continue?

N/A

What upgrades and replacements are planned?

N/A

Legislative climate and other forces affecting system / interface?

N/A

Comments?

N/A



1.9. SC State Retirement System (SCSRS) Interface

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

SC State Retirement System (SCSRS) Interface

Owner Information

Name, phone, email, etc. of user and support contacts

See Common Answers document

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

The SCSRS provides a monthly file of South Carolina residents who receive retirement benefits. SCDHHS receives this file from SCSRS through DSS via C:D. The information is updated to a master file and is available online for new applications or when an existing MEDS member becomes a new beneficiary of state retirement income. Receipt of or changes in the state retirement benefit are automatically updated to the Medicaid member record and can be used in eligibility determinations and reviews without an independent verification. Workers are alerted if the change requires a redetermination of eligibility. The redetermination process is not automated and requires manual calculations by a program area worker. For those clients who have state retirement benefits, the file provides documentation of benefit amounts as well as an indicator of other insurance coverage. Annually (May and June), the SCSRS is notified of persons receiving a state retirement benefit and reside in a nursing facility. A cost of living increase is not awarded to residents of nursing homes. For other categories, the eligibility data system automatically recalculates the countable income for budget groups containing persons that have received the annual cost of living increase in their state retirement benefit check.

Automated updates of information and re-budgets, when applicable, are planned to be included in the eligibility data system.

Objectives

What are the goals of the system / interface? Why was it initiated?

The exchange of information between SCSRS and SCDHHS was originally established as part of a Proviso to prevent nursing home residents from losing sponsored Nursing Home care as a result of receipt of a cost of living increase in SCSRS benefits. It has since been made an act of the South Carolina Code of Laws. See information under Overview.

Business Processes

What business processes require the interface?

See Interfaces related to Business Processes document

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.



Automated eligibility redeterminations when information from SCSRS affects a MEDS budget group.

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

Received from The South Carolina State Retirement System through DSS

Connect:Direct.

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, Connect:Direct etc.).

Mainframe flat file.

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

Connect:Direct.

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

A full file of South Carolina residents that receive S.C. State Retirement is received from SRS monthly.

When the monthly file is received, the SRS interface:

- Edits for valid data and transactions.
- Applies data to the SCSRS Master file.
- Updates retirement benefit data to the MEDS member's financial record.
- Alerts the eligibility worker if the information requires a redetermination.

SCDHHS also provides a monthly file to SCSRS that identifies beneficiaries who were previously Medicaid eligible in a Nursing home, but have either died or have been discharged from the nursing home.

Every May, SCDHHS provides a file to SCSRS that identifies Medicaid recipients that receive both South Carolina State Retirement and sponsored nursing home care.

Every June, SCDHHS provides another file that identifies any new Medicaid recipients that receive both South Carolina State Retirement and sponsored nursing home care that were not included in the May file. A cost of living increase in state retirement benefits is not awarded to these persons. For other categories, the eligibility data system automatically recalculates the countable income for budget groups containing persons that have received the annual cost of living increase in their State Retirement benefit check.

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

There are seven types of State Retirement income:

- State Retirement
- Regular Police Retirement
- General Assembly
- Police Insurance/annuity



- Police Accidental Death
- Judges/Solicitors Retirement
- Firemen Pre 1989

The SCSRS provides the benefit amount, the type, dental and health insurance indicators, lump sum indicator, and a long term care insurance indicator.

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

N/A

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

The SCSRS file is received monthly. The monthly file received in July provides the new state retirement benefit after the cost of living increases have been applied.

Outputs

List all system / interface outputs – e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

The SCSRS Interface generates alerts and reports for information and for necessary action. A list of reports is available in the project repository.

- SCSRS interface produces 2 alerts, Alerts 418 (SC ST RET UNEARNED INCOME INCREASED FOR NH RECIP) and 419 (SC ST RET UNEARNED INCOME DECREASED FOR NH RECIP) which are generated only when the monthly SCSRS file with the new cost of living increases is processed. These alerts notify workers of a change in income to a nursing home budget group. The worker should verify the change and determine if the increase or decrease was received in error. If it was received in error, contact the Department of Interfaces. If received correctly, the assigned worker will need to re-budget and/or re-determine recurring income for these budget groups manually and take any other appropriate action.

Note: There are outstanding changes requested for the SCSRS alerts.

Record Layout

Attach sample layout if applicable.

N/A

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.



N/A

Governing Policies

Policies that govern use or other activity involving the system / interface.

Section 9-1-1870 of the Code of Laws of South Carolina: Beneficiaries receiving Medicaid (Title XIX) sponsored nursing home care; effect on benefits; exception. [SC ST SEC 9-1-1870]

Notwithstanding any other provision of law, except as provided below, retirees and beneficiaries under the State Retirement Systems receiving Medicaid (Title XIX) sponsored nursing home care as of June thirtieth of the prior fiscal year shall receive no increase in retirement benefits during the current fiscal year.

However, a retired employee affected by the above prohibition may receive the scheduled increase if he is discharged from the nursing home and does not require admission to a hospital or nursing home within six months. DHHS, DSS, and the State Retirement Systems must share the information needed to implement this section.

Access Control Policies and Security

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

List data security levels, security requirements etc.

See Appendix L (Common Answers).

SRS provides a full file of all South Carolina Retirement beneficiaries. Once the information is updated to the Master file, users may only access SRS information for SSNs found in MEDS (eligible or ineligible for Medicaid)

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

N/A

System / Interface Data Processing Standards

If a service level agreement (SLA) or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

Runs once per month, usually around the 20th.

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

Runs once per month, usually around the 20th.

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

Information received from SCSRS through the interface does not have to be independently verified. The ability to obtain verification of retirement income



within a short time frame expedites eligibility determinations and reviews.
Verification of receipt and the amount of the annual cost of living increases
provides the information MEDS needs to automatically re-budget increases in
retirement income. The inability to receive this information would cause
additional work for the eligibility worker.

Disaster Recovery

Attach any disaster recovery plans.

See Common Answers document.

Contract

Legal agreement status and document location.

N/A

Data Storage & System Attributes

What programming languages were used in creating the system / interface, or what

Commercial, off-the-shelf (COTS) software was acquired?

*What DBMS, file systems, etc., does the system use for storing transactional / operational
data?*

*Attach data formats or schemas or provide location of format / schema documentation if
possible.*

See Common Answers document; Cobol, JCL, SAS, IDMS-R

Transaction processing

Type (batch / real-time).

Batch

Data Quality Control

Describe quality control policies / procedures.

Built-in editing in processing programs.

Backup

Describe / attach backup procedures and policies.

See Common Answers document.

Load

*Any capacity minimums or maximums (such as concurrent connections, concurrent users,
etc.).*

117,000.

Support

*Support hours and response times. Who handles user support, and how? Explain
escalation / levels, if applicable.*

See Common Answers document.

Incident Management

Process / constraints by which incidents are handled.

See Common Answers document

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?



See Common Answers document

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

See Common Answers document.

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens? Include medium, etc.

N/A

Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

See Common Answers document.

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

See Common Answers document.

Plans for the System / Interface

How long will the system / interface continue?

As long as the interface continues to be mandated by the S.C. Code of Laws.

What upgrades and replacements are planned?

N/A

Legislative climate and other forces affecting system / interface?

N/A

Comments?

N/A



1.10. **State Data Exchange (SDX) Interface**

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

State Data Exchange (SDX) Interface

Owner Information

Name, phone, email, etc. of user and support contacts

See Common Answers document.

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

South Carolina is a 1634 State. The SDX receives SSI data from the SSA for establishing and maintaining Medicaid eligibility. When SSA notifies that an individual is SSI eligible, Medicaid eligibility is automatically established, if there is no current eligibility. If there is current eligibility, the Medicaid eligibility record is updated with the SDX data, if appropriate. When SSA notifies that an individual has lost their SSI, the system automatically updates the Medicaid eligibility record to reflect termination of eligibility. Most recipients losing their Medicaid due to the loss of their SSI benefit are given an additional 30 days to apply for benefits under another Medicaid coverage group before their eligibility is terminated. Updates are applied to MEDS based on the member's current SSI and Medicaid eligibility status and the Medicaid payment category.

The system reports, through online alerts, invalid and discrepant data, special transactions, non-process-able transactions or other conditions as defined. Reports are also generated for information as well as for exceptions. A Client Inquiry screen is available to display the SSI information received from SSA. The SDX transaction is also available online for resolution of discrepant data. SDX transactions are stored for 1 year.

Objectives

What are the goals of the system / interface? Why was it initiated?

The SDX receives SSI data from the SSA for the purpose of establishing and maintaining Medicaid eligibility.

Business Processes

What business processes require the interface?

See Interfaces related to Business Processes document

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

The system needs to be able to establish eligibility for persons where SSA determines SSI eligibility retroactively, but the beneficiary is not currently SSI eligible. Correction of existing problems with Medicaid eligibility being established and terminated accurately.



Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

Social Security Administration (SSA).

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, Connect:Direct etc.).

Mainframe flat file. Format comes from SSA.

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

Connect:Direct.

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

SSA provides certain information to communicate the SSI status of an individual.

Eligibility is established when (see below spreadsheet):

Medicaid Eligibility Code, Payment Status Code, SSI Gross Payable or Monthly Assistance Amount, Multicategory Indicator, Medicaid Test Indicator

A N/A N/A N/A N/A

B N/A N/A N/A N/A

C E01 or N01 N/A N/A

A, B, or F

G N/A N/A N/A N/A

Q N/A N/A N/A N/A

R M01 > \$0 N/A N/A

R M02 > \$0 N/A N/A

R N/A N/A

D, E, F, or G N/A

R E01 N/A N/A N/A

R E02 followed by C01 N/A N/A N/A

S M01 > \$0 N/A N/A

S M02 > \$0 N/A N/A

S N/A N/A

D, E, F, or G N/A

S E01 N/A N/A N/A

S E02 followed by C01 N/A N/A N/A

Y N/A N/A N/A N/A

Eligibility is terminated when (see below): Most terminations do not take place until 30 days have passed. There is a spreadsheet that identifies those that get the additional 30 days.

Medicaid Eligibility Code



Payment Status Code
SSI Gross Payable or Monthly Assistance Amount
Multicategory Indicator
Medicaid Test Indicator
C Not E01 or N01 N/A N/A
NOT A, B, or F
D N/A N/A N/A N/A
F N/A N/A N/A N/A
N N/A N/A N/A N/A
R N/A N/A
NOT D, E, F, or G N/A
R NOT M01, M02, or E01 N/A N/A N/A
R M01, M02 \$0 N/A N/A
S NOT M01, M02, or E01 N/A N/A N/A
S N/A N/A
NOT D, E, F, or G N/A
S M01, M02 \$0 N/A N/A
W N/A N/A N/A N/A

Note: Other factors such as the current Medicaid status, the BG composition, the payment category may affect the outcome. Clemson has various tables that are used to process the incoming SDX.

Upon receipt of the SDX containing the SSI cost of living increases, MEDS automatically recalculates the countable income for budget groups containing persons that have received the annual cost of living increase in their SSI benefit check.

Upon receipt of the 503 Leads and PICKLE files, MEDS produces a notice to the individual advising them to contact their local county office to apply for the Medicaid Pass-along category.

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

SSI payment status, SSI payment amount, SSI eligibility dates, Medicaid effective dates, living arrangement, demographics, other unearned income payment amounts.

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

N/A



Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

SSA transmits daily update files. There could be updates from A to Z that make up one update file and there could be from four to six update files per month followed by a monthly Treasury file. SSA uses a numbering system to help states know they have received all of the updates. Currently DSS does not send the SDX file to Clemson until they have received all of the daily updates (A to Z) that make up one update. SDX updates must be processed in the order they are received.

Daily files are created for all records where:

- a change has occurred in that record on a SDX related data element, including a denial decision, and/or
- a change of address, and/or
- a change in payment or eligibility amount
- Pending records are also included.\

A Treasury file contains records where payment is being made and it is not the same as the payment made the prior month.

SSA creates reconciliation files once each quarter in December, March, June, and September following production of the Treasury files created for that month. States' must request the Reconciliation files. Note: There is no MEDS process for the reconciliation files. There were plans to add this later.

The 503 Leads File identifies individuals who may be eligible for Medicaid continuation if the state disregarded the Title II COLA and subsequent COLA's.

The PICKLE (CSAVE) file also identifies individuals who may be eligible for Medicaid continuation if the state disregarded the Title II cost-of-living adjustment (COLA) and subsequent COLA's. This file is sent by CMS and includes persons from the last 3 years.

SCDHHS does not submit any SDX files to SSA.

Outputs

List all system / interface outputs -- e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

The SDX Interface generates alerts and reports for information and for necessary action.

- A list of reports and alerts is available in the project repository.



- SDX produces 2 notices, SDX002 and SDX008. SDX002 is generated when SDX reports an SSI termination and the payment status code is one that provides the recipient an additional 30 days of Medicaid. The notice advises the recipient that SSI has terminated and they have 30 days to apply for continued Medicaid under another program category. SDX008 is generated from SDX3000 when the annual COLA reports are processed.

Record Layout

Attach sample layout if applicable.

INPUT-SDX-RECORD – found in MEDS.PROD.Source(SDX1000)

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

N/A

Governing Policies

Policies that govern use or other activity involving the system / interface.

- Title XVI (Supplemental Security Income For The Aged, Blind, and Disabled) of the Social Security Act, as amended, established a national program, effective January 1, 1974, for the purpose of providing supplemental security income to individuals who have attained age 65 or are blind or disabled. The supplemental security income program replaces the financial assistance programs for the aged, blind, and disabled in the 50 States and the District of Columbia for which grants were made under the Social Security Act. Payments are financed from the general funds of the United States Treasury.
- Under section 1634 of the Social Security Act, SSA may enter into an agreement to make Medicaid eligibility determinations for a State providing the individual is SSI/State supplementary payment (SSP) eligible and meets all Medicaid eligibility factors (assigns rights, provides TPL information, and meets other requirements for Medicaid mandated by Federal law as specified in the agreement). In these States, an SSI application is also an application for Medicaid. In other States, an individual must file an application with the State/local Medicaid agency to be eligible for Medicaid even if he/she receives SSI/SSP.
- Section 503, Section 503 of Public Law (P.L.) 94-566 also known as the PICKLE amendment. This provision requires States to disregard a Title II COLA and subsequent COLA's when an individual or spouse would continue to be eligible for Federally administered benefits but for the title II COLA. Under the Pickle amendment, individuals who meet certain requirements are deemed to be receiving (SSI benefits for purposes of eligibility for Medicaid. Briefly, the Pickle amendment applies to an individual who:
 - Is entitled to an Old Age, Survivors, or Disability (OASDI) benefit under title II of the Act,
 - Was eligible for and receiving SSI benefits, or a State supplement, but became ineligible for those benefits after April 1977, and
 - Would still be eligible for the SSI benefit or State supplement if the total amount of title II COL increases paid after the last month (after April



1977) he or she was entitled to the title II benefit and received the SSI benefit was deducted from the current title II benefit.

If these requirements are met, the individual is deemed to be receiving SSI for purposes of eligibility for Medicaid. He or she does not actually receive an SSI benefit, but is considered to be categorically eligible for Medicaid.

Access Control Policies and Security

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

List data security levels, security requirements etc.

See Appendix L (Common Answers).

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

N/A

System / Interface Data Processing Standards

If a service level agreement (SLA) or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

SDX job series runs approximately 2 hours.

Availability

When the system / interface must be available for use (e.g., 24X7, business hours, etc.)

24/7

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

As of April, 2009 there are approximately 107,631 eligible PCAT 80 SSI recipients in South Carolina. No case records maintained for these persons as the eligibility is automatic and they are not assigned a SCDHHS eligibility worker. There must be some mechanism to receive the SSI data from SSA to maintain the current population as well as establishing Medicaid eligibility for new SSI eligibles and terminating eligibility when applicable in a timely manner. Delays in establishing eligibility could cause a hardship for the beneficiary in that they may not be able to receive medical services until they receive verification of Medicaid. The SDX interface must be operational to provide this service.

Disaster Recovery

Attach any disaster recovery plans.

See Common Answers document.

Contract

Legal agreement status and document location.

The agreement with SSA covers the SVES, BENDEX, EVS, and SDX interfaces. The



current agreement expires December 31, 2009. In the future, SSA plans to streamline the agreement process. With the process, SSA will have one CMPPA agreement per state, negotiated through the Governor's office. This agreement will need to be recertified after 18 months and then renewed after another 12 months. The individual agreements with the state agencies, referred to as the Master IEA once signed this year will be open ended with no expiration date unless changes are required.

Data Storage & System Attributes

What programming languages were used in creating the system / interface, or what

Commercial, off-the-shelf (COTS) software was acquired?

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format / schema documentation if possible.

See Common Answers document; Cobol, JCL, SAS, IDMS-R

Transaction processing

Type (batch / real-time).

Batch

Data Quality Control

Describe quality control policies / procedures.

Edits in SDX Programs.

Backup

Describe / attach backup procedures and policies.

See Common Answers document.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

15,000 – 25,000 weekly

Support

Support hours and response times. Who handles user support, and how? Explain escalation / levels, if applicable.

See Common Answers document.

Incident Management

Process / constraints by which incidents are handled.

See Common Answers document.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?

See Common Answers document.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

See Common Answers document.



Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens? Include medium, etc.

N/A

Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

See Common Answers document.

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

See Common Answers document.

Plans for the System / Interface

How long will the system / interface continue?

Indefinitely, or until such time as S.C. no longer has a 1634 agreement with SSA.

What upgrades and replacements are planned?

N/A

Legislative climate and other forces affecting system / interface?

N/A

Comments?

N/A



1.11. State Verification & Exchange System (SVES)

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

State Verification & Exchange System (SVES)

Owner Information

Name, phone, email, etc. of user and support contacts

See Common Answers document.

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

A data exchange of new and prospective Medicaid recipients that occurs nightly for the purpose of:

- the validation of social security numbers
- Verification of SSA benefits
- Verification of SSI benefits
- Verification of quarters of coverage
- Verification of prisoner status.

This file is transferred to DSS and merged with other SVES requests. DSS transmits to the SSA through C:D. The SSA processes this request file and sends back a response file with the information based on the request that was made.

The requests for SSN validation are generated automatically whenever a new or prospective Medicaid recipient is entered into MEDS or changes are made to specific personal information. Through online access with appropriate security authority, a user may manually request a SSA, an SSI inquiry, QC40 inquiry, and/or a prisoner inquiry. A QC40 inquiry is used to identify continued employment for 40 quarters); this describes the number of qualifying quarters of social security for the Medicaid recipient. A prisoner inquiry is used to determine if the recipient is in prison for the purpose of informing the worker so they can use it in the eligibility determination process. A SSA-SSI inquiry is for the identification of SSA and SSI benefits. There is only one file returned for SSN validation and SSA-SSI inquiry data.

Objectives

What are the goals of the system / interface? Why was it initiated?

The validation of new and prospective Medicaid recipients SSNs, identification of SSA benefits and SSI income, QC40 data, and prisoner information.

Business Processes

What business processes require the interface?

See Interfaces related to Business Processes document

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

Accurate processing



User friendly.
Implementation of SOLQ (State Online Query).

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

Social Security Administration

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, Connect:Direct etc.).

Propriety file format – controlled by the Social Security Administration from DSS

DSS controls file format from CU MEDS to DSS

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

Connect:Direct

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

Whenever a new or changed SSN is entered into the MEDS System. When a claim account number and personal identifying information change (name, social security number, date of birth, claim account number) is entered into the MEDS System. A manual request for an SSA, SSI, 40 quarters, or prisoner query is made using the online request screen.

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

Medicaid recipient identifying information.

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

N/A

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

SSN-SSA-SSI file, QC40 file, and prisoner file

@SVE3000 processes return response files and updates database table data for online access.



Outputs

List all system / interface outputs – e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

Medicaid recipient identifying information. (name, social security number, date of birth, claim account number). @MIS4000 process identifies additions and changes made to MEDS Member and related data to create files for the COM1000 process.

- @COM1000 process stores INF Valid Database Table rows that are used by EVS, IEV, and SVE to automatically (without worker intervention) create requests for SSA. @SVE2000 process creates the request file
@SVECNDNR sends request

Record Layout

Attach sample layout if applicable.

M:\MEDS\Production Documentation\General\SVE

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

Governing Policies

Policies that govern use or other activity involving the system / interface.

- Effective May 29, 1986, Section 2651 of the Deficit Reduction Act of 1984 (Pub. L. 98-369) amended the Social Security Act, the Food Stamp Act, and Internal Revenue Code. It requires State agencies that administer Food Stamps, Family Independence, Medicaid, etc. to develop an IEVS which meets certain statutory requirements. The major statutory changes reflected in the regulations provide state agencies with additional sources of useful information in verifying applicant and recipient reported circumstances and also ensure that appropriate privacy and procedural safeguards are applied in the use of the information.
- 42 CFR sections 435.940-435.960 provide regulations for the Income Eligibility Verification System.
- SSA developed SDX/BENDEX/SVES to implement Section 1137 of the Social Security Act which requires State agencies administering specific programs (TANF, Medicaid, Food Stamps, and Unemployment) to implement an income and eligibility verification system.
- SVES is covered by the same agreement with SSA as BENDEX, and SDX.

Access Control Policies and Security

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

See Appendix L (Common Answers).

Security and Confidentiality Procedures

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?



Data is protected by RACF. Secure file transfers using Connect:Direct.

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

M:\MEDS\Production Documentation\General\SVE

Contract and Service Level Information

If a service level agreement (SLA) or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

Sent overnight. Response within a day or two. Prisoners and QC40 can take longer

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

Once a night. Monday night through Thursday

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

Important to the operation of SC Medicaid

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

Affected by new applications or changes in personal identification

Support

Support hours and response times.

See Common Answers document.

Incident Management

Process / constraints by which incidents are handled.

See Common Answers document.

Disaster Recovery

Attach any disaster recovery plans.

See Common Answers document.

Contract

Legal agreement status and document location.

The agreement with SSA covers the SVES, BENDEX, EVS, and SDX interfaces. The current agreement expires December 31, 2009. In the future, SSA plans to streamline the agreement process. With the process, SSA will have one CMPPA agreement per state, negotiated through the Governor's office. This agreement will need to be recertified after 18 months and then renewed after another 12 months. The individual agreements with the state agencies, referred to as the Master IEA once signed this year will be open ended with no expiration date unless changes are required.



System / Interface Data Processing Standards

Data Storage

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format/schema documentation if possible.

See Common Answers document.

Transaction processing

Type (batch / real-time).

Batch and online

Capacity

Including peak intervals.

DSS does not want more than 25,000 at a time unless agreed upon first

Data Quality Control

Describe quality control policies / procedures.

Built-in Edits

Backup

Describe / attach backup procedures and policies.

See Common Answers document.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?

See Common Answers document.

Help Desk

Who handles user support, and how? Explain escalation / levels, if applicable.

See Common Answers document.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

See Common Answers document.

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens? Include medium, etc.

SVES manual M:\MEDS\Production Documentation\General\SVE

Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

See Common Answers document.



Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

See Common Answers document.

Plans for the System / Interface

How long will the system / interface continue?

Indefinitely. It is the only method available to receive QC 40 and prisoner information from SSA.

What upgrades and replacements are planned?

There are a number of outstanding requests for improvements to the SVES process. SOLQ is also needed to provide online real time access to SSA's data.

Legislative climate and other forces affecting system / interface?

N/A



1.12. *Paris Interface*

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

Paris Interface

Owner Information

Name, phone, email, etc. of user and support contacts

See Common Answers document.

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

The Public Assistance Reporting Information System was created to allow participating states to identify:

Persons that may be receiving benefits in multiple states (Interstate match)

Persons receiving VA benefits (VA match)

Persons receiving military pensions, etc. (Federal match)

Quarterly, SCDHHS sends Medicaid data for members of active and pending budget groups to the Defense Manpower Data Center (DMDC). The Office of Children and Family Services administers PARIS and contracts with DMDC to receive Medicaid data from participating states and data from the Veterans' Administration and the Department of Defense. DMDC matches the state data with the data received from other states, the Veterans' Administration and the Department of Defense and returns information to the states.

SCDHHS only requests matches with other states and VA at this time. There is not an agreement in place for SCDHHS to receive the Department of Defense matches. Currently, only the interstate match portion of PARIS is operational.

The COM components are used to combine and format the data from the ARS components to be used to generate a PARIS request file.

COM1500 combines the output files of ARS5020 and ARS5050 after they have been sorted by budget group number (BG_NUM_BUDGET_GROUP_ID from ARS5020 and BMJ_NUM_BUDGET_GROUP_ID from ARS5050).

COM1510 combines the output files of ARS5060 and ARS5080 after they have been sorted by household number (HMB_NUM_HOUSEHOLD_ID from ARS5060 and HH_NUM_HOUSEHOLD_ID from ARS5080). Please note that ARS5060 retrieves recipient information but also retrieves their current household from the HH_MBR_JUNCTION table.

COM1505 uses the output from COM1500 and reads each member number (BMJ_NUM_MEMBER_ID) to determine the database CALCKEY that will improve the performance of accessing MBR_ELIG_HISTORY rows in COM1530. COM1530 uses the output file from COM1505 after it has been sorted to retrieve the current row for each member from the member eligibility history table (MBR_ELIG_HISTORY). For every member who has current eligibility, their record will indicate that they are an applying member.



COM1520 uses the output files from COM1510 and COM1530 after they have been sorted by member number (MBR_NUM_MEMBER_ID from COM1510 and BMJ_NUM_MEMBER_ID from COM1530) and generates a combined output file for PAR to produce a request file. If the recipient is a member of both an active and a pending budget group, then the active record is used. If the recipient is a member of more than one active budget group, then only one of the active records is used. If the recipient is a member of more than one pending budget group, then only one of the pending records is used.

COM1550 uses the output file from COM1520 and removes the string of pound signs (#) from each record. ARS uses a string of pound signs to indicate null data instead of spaces.

Objectives

What are the goals of the system / interface? Why was it initiated?

PARIS is a voluntary Federal-State partnership which provides the fifty-one participating jurisdictions detailed information and data to assist them in maintaining program integrity and detecting/ deterring improper payments.

- **VA Interface:** PARIS identifies those persons receiving Department of Veterans Affairs (VA) compensation and pension payments and the benefit amounts. The information received will be available online. Changes in income will be updated to MEDS and workers will be alerted to redetermine eligibility when an individual begins receiving VA or there is a change in the VA amount. The February VA match reflects the Federal COLA increase.
- **Interstate Match:** PARIS identifies Medicaid applicants and recipients who are receiving or have received Medicaid, TANF, SNAP, SSI, General Assistance, Workers Compensation, or child care in more than one participating state for the same period. The information received is available online and workers are alerted to verify the whereabouts of the recipient during the overlapping period and terminate the Medicaid, if appropriate.
- **Federal:** Once a new agreement is signed, SCDHHS will request that DMDC also match South Carolina's Medicaid applicants, recipients, and ineligible members of active budget groups with the Department of Defense data to identify active and retired Federal civilian employees, and active and retired military matches. The information received will be available online and workers will be alerted to redetermine eligibility when an individual begins receiving civil service or a military pension or there is a change in the amount.

Business Processes

What business processes require the interface?

See Interfaces related to Business Processes document

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

Implementation of the VA and Federal matches.

Interface Summary



Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

- Defense Manpower Data Center
- Other participating states
- Veteran's Administration Department of Defense

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, Connect:Direct etc.).

- Flat mainframe file – MEDS.PAR1000B.DATA.SC
- PARIS has control over record layout

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

- Connect:Direct

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

- A quarterly file is sent based on a schedule set by ACF. It is usually run a week in advance to identify and correct any issues that might delay transmission and cause us to miss the deadline.
- Output files are due to be transmitted in February, May, August, November.
- The response file is received the following month in March, June, September, and December.

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

- Medicaid recipient data (Active and Pending budget groups)
- See data layout.

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

- N/A

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

- 3 files from PARIS: (1) interstate match – data matching between states. (2) Federal Match and (3) Veteran Match
- (2) and (3) have not been implemented



Outputs

List all system / interface outputs – e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

JCL @PAR500 executes ARS jobs to pull data from database (pg 4) (this JCL job gathers the data) and @PAR1000 (this JCL job actually creates the file)

The ARS components are used to gather all MEDS recipients, their household, budget group and eligibility data for PAR processing.

ARS5020 retrieves all current budget group information from the budget group table (BG_BUDGET_GROUP) and the budget group period table (BG_BGT_PERIOD).

ARS5050 retrieves all current budget group member information from the budget group member table (BG_MBR_JUNCTION).

ARS5060 retrieves all current member information from the member table (MBR_MEMBER) and the member period table (MBR_MEMBER_PERIOD).

ARS5080 retrieves all current household information from the household table (HH_HOUSEHOLD).

The ARS programs are not used for receiving the PAR file responses.

List of reports is attached.

The following alerts are generated.

Alert 412 - Recipient receives Medicaid in more than two states

Alert 413 - Invalid or non-processable transaction for SSN

Alert 414 - Recipient receives benefits in another state

Record Layout

Attach sample layout if applicable.

PARIS defined file format –PAR.INTRSTAT.MATCH

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

PARIS proprietary file formats, Connect:Direct

Governing Policies

Policies that govern use or other activity involving the system / interface.

SCDHHS has signed separate agreements to participate in the Interstate and VA matches

- **Interstate Match:** Sections 402 and 1137 of the Social Security Act, 42 U.S.C. 602 and 42 U.S.C. 1320b-7.
- **VA Match:** Each SPAA match is expected to comply with pertinent requirements under the Privacy Act, 5 U.S.C. 552a, as amended, and with the regulations promulgated hereunder, including computer matching portions of a revised ((OMB) Circular No. A-130, 65 FR 77677, December 12, 2000) and this agreement. The legal authority for this match is section 402(a) (6) of the Social Security Act, 42 USC 602(a) (6). Both SPAAs and VA agree to comply



with the requirements of the Federal Information Security Management Act of 2002 (FISMA), 44 U.S.C. § 3541 et seq.; related OMB circulars and memoranda, such as Circular A-130, Management of Federal Information Resources (Nov. 28, 2000), and Memorandum M-06-16, Protection of Sensitive Agency Information (June 23, 2006); National Institute of Standards and Technology (NIST) directives; and the Federal Acquisition Regulations. These laws, directives, and regulations include requirements for safeguarding Federal information systems and personally identifiable information (PII) used in Federal agency business processes, as well as related reporting requirements. Both agencies recognize and will implement, if mandated, the laws, regulations, NIST standards, and OMB directives including subsequent publications to the effective date relating to the subject of this agreement. Information systems used to store, access, process, or transmit records matched and information produced by the match will employ security controls consistent with those recommended by the U.S. Department of Commerce, National Institute of Standards and Technology (NIST), or will utilize a comparable risk management program. NIST-recommended security controls are described in NIST Special Publication 800-53 Revision 1, "Recommended Security Controls for Federal Information Systems.I1."

- **Federal Match:** Each SPAA match is expected to comply with the Privacy Act of 1974, as amended, 5 U.S.C. § 552a; the Office of Management and Budget (OMB) Guidelines (54 FR 25818, June 19, 1989) interpreting the provisions of the Privacy Act pertaining to computer matching; and the computer matching portions of Appendix I to OMB Circular No. A-130 as amended at 61 Fed. Reg. 6428, February 20, 1996. The legal authority for this match is section 402(a) (6) of the Social Security Act, 42 USC 602(a) (6). Information systems used to store, access, process, or transmit records matched and information produced by the match will employ security controls consistent with those recommended by the U.S. Department of Commerce, National Institute of Standards and Technology (NIST), or will utilize a comparable risk management program. NIST-recommended security controls are described in NIST Special Publication 800-53 Revision 1, "Recommended Security Controls for Federal Information Systems.I1"

Access Control Policies and Security

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

See Appendix L (Common Answers).

Security and Confidentiality Procedures

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

Protected by RACF as is all mainframe data.

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

M:\MEDS\Production Documentation\Batch find path

The file layout of the data PAR1000 sends to DMDC can be located at



PAR10F01_Redesign (M:\Meds\Maint\SR03155-PAR\File_Layouts\Phase One\PAR10F01_Redesign.doc).

Contract and Service Level Information

If a service level agreement (SLA) or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

File sent quarterly. PARIS has one month to return interstate data match. Usually back within a week.

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

Once a quarter

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

Not vital, but important to fiscal oversight and management of SC Medicaid.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

900,000 recipients – all data is sent

5,000 to 8,000 recipients in interstate match file

Support

Support hours and response times.

See Common Answers document

Incident Management

Process / constraints by which incidents are handled.

See Common Answers document.

Disaster Recovery

Attach any disaster recovery plans.

See Common Answers document.

Contract

Legal agreement status and document location.

The agreement for the Interstate Match is open ended.

The VA agreement is currently in the process of recertification. Once signed, it will be in effect through January 5, 2011. It must then be recertified for an additional 12 months.

The agreement for the Federal match cannot be signed until the agency determines that the agency's security controls are consistent with those recommended by the U.S. Department of Commerce, NIST. NIST-recommended security controls are described in NIST Special Publication 800-53 Revision 1, "Recommended Security Controls for Federal Information Systems.11".



System / Interface Data Processing Standards

Data Storage

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format/schema documentation if possible.

See Common Answers document; MEDS tables: MEDS.PAR.DATA.FROM.SC, interstate match response table, and in general all MEDS tables

Transaction processing

Type (batch / real-time).

Batch

Capacity

Including peak intervals.

900,000 recipients each time (all eligible SC Medicaid members are included in the file sent to PARIS)

Data Quality Control

Describe quality control policies / procedures.

MEDS edits incoming and outgoing data.

Backup

Describe / attach backup procedures and policies.

See Common Answers document.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?

See Common Answers document.

Help Desk

Who handles user support, and how? Explain escalation / levels, if applicable.

See Common Answers document.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

See Common Answers document.

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens? Include medium, etc.

N/A

Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

Interact with PARIS, alert CU of all pertinent changes



Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

See Common Answers document.

Plans for the System / Interface

How long will the system / interface continue?

Indefinitely or as long as Management considers it to be an effective cost savings interface.

What upgrades and replacements are planned?

Other 2 response files. Implementation of the VA and Federal interfaces.

Legislative climate and other forces affecting system / interface?

N/A

South Carolina

Department of Health and Human Services



Appendix L-O: Technical Components Self-Assessment Report for the Medicaid Information Technology Architecture State Self-Assessment



November 2009



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Appendix L: PC Applications

Record layouts, file layouts, jobs, files, reports, and other supplementary materials related to these interfaces are stored in the MITA project repository.

1.1. Accounts Receivable Log (ARL) System

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

Accounts Receivable Log (ARL) System

Owner Information

Name, phone, email, etc. of user and support contacts

See Common Answers document.

SCDHHS Bureau of Fiscal Affairs (Division of Accounting Operations):

Lynette Wilson – (803) 898-2916 – wilsonl@scdhhs.gov

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

All receivables that have been identified by SCDHHS (i.e. the Accounts Receivable Department) are entered into the ARL. Once in the ARL, the receivable is assigned a receivable number (RC #). This number is then keyed into GAFRS for official tracking with Comptroller General's Office.

Weekly revenue detail reports are submitted to the TPL and Program Integrity program areas at SCDHHS for recovery tracking purpose. Program Integrity utilizes that information to track and reconcile Medicaid overpayment debts that have been submitted from their area.

Objectives

What are the goals of the system / interface? Why was it initiated?

The objective of this system is to capture and track all SCDHHS receivables.

Business Processes

What business processes require the interface?

See Interfaces/PC Applications related to Business Processes document.

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

There is an AR module in GAFRS that the program area doesn't use for various reasons (primarily -it doesn't work effectively for their needs). Many potential interfaces between the Cash Receipts Log (CRL)/ARL and GAFRS have been looked at in the past; because of the age of GAFRS, no suitable solution has been found. the program area would like if some of the information from CRL/ARL was able to interface into GAFRS so that they wouldn't have to key it in manually. Fiscal Affairs is in the process of implementing a new agency wide accounting system to replace GAFRS called SAP, and the AR program area doesn't know how the new system will affect the CRL/ARL.



Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

The ARL interfaces with the CRL, another system in the AR area. All checks that are received by the Accounts Receivable's program area are entered into this system. If the check that is entered into the CRL is a receivable, the payment amount automatically feeds into the ARL -- essentially letting the ARL know that the check has been received (this is done via the RC#) and to reduce the receivable amount in the ARL. All receipts are then manually keyed in GAFRS as deposits.

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, Connect:Direct etc.).

N/A

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

During data entry of check receivables in the CRL the ARALOG.DBF and ARAACT.DBF database files from the ARL system are accessed by CRL system so that credits or debits on balances can be updated in real-time.

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

Any time the AR program area has a receivable come in (e.g. check in the mail, Medicaid funds debit etc.), the receivable is entered into the ARL system.

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

Receivables information.

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

N/A

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

Receivable information that is used for tracking and reconciliation purposes (GAFRS).

Outputs

List all system / interface outputs – e.g., names and contents of specific reports, data files, etc. Include media and frequency.



Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

Reports are run out of the ARL (detailing how many checks were received, and from what sources etc.).

Record Layout

Attach sample layout if applicable.

N/A

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

N/A

Governing Policies

Policies that govern use or other activity involving the system / interface.

See Common Answers document.

Access Control Policies and Security

*Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)
What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?*

List data security levels, security requirements etc.

The ARL uses network group access level security.

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

N/A

System / Interface Data Processing Standards

If a service level agreement (SLA) or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

N/A

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

Standard business hours.

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

This system is very critical to the AR program area's operations. This system tracks all of the receivables that are received by SCDHHS and stores them on a server. The receivable information is available for query once in the system (i.e. AR staff can access the archived checks for research etc.).



Disaster Recovery

Attach any disaster recovery plans.

See Common Answers document.

Contract

Legal agreement status and document location.

N/A

Data Storage & System Attributes

*What programming languages were used in creating the system / interface, or what **Commercial, off-the-shelf (COTS)** software was acquired?*

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format / schema documentation if possible.

The ARL is an older Clipper 5.2 application with an XBase database (Clipper DBFs with NTX indexes). The application is distributed over the network (Novell).

Transaction processing

Type (batch / real-time).

Real-time

Data Quality Control

Describe quality control policies / procedures.

N/A

Backup

Describe / attach backup procedures and policies.

See Common Answers document.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

There is no known capacity – as many users as the server can handle. This has never been an issue for the program area.

Support

Support hours and response times. Who handles user support, and how? Explain escalation / levels, if applicable.

See Common Answers document.

Incident Management

Process / constraints by which incidents are handled.

See Common Answers document.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?

See Common Answers document.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?



See Common Answers document.

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens? Include medium, etc.

N/A

Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

N/A

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

N/A

Plans for the System / Interface

How long will the system / interface continue?

This system is essential to the operations of the AR program area. With the transition to SAP, there must be a solution that would perform the same functions as the ARL system, or the program area would continue using this subsystem.

What upgrades and replacements are planned?

Legislative climate and other forces affecting system / interface?



1.2. Approach System

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

Approach System

Owner Information

Name, phone, email, etc. of user and support contacts

See Common Answers document.

SCDHHS Bureau of Fiscal Affairs (Division of Financial Systems):

Jametta Wilson – (803) 898-2951 – wilsonj@scdhhs.gov

Milton German – (803) 898-1051 – german@scdhhs.gov

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

The Approach System is a "Lotus" tool that functions as a database similar to Microsoft Access. The system is housed in the Bureau of Information Technology (BITS). It is located on the network under a specific user directory; however it is not distributed over the network for multiple users. The application resides on a particular machine.

Objectives

What are the goals of the system / interface? Why was it initiated?

The objective of this application is to convert all of the grants information contained in GAFRS into a "subaccounts" format that the Payment Management System (PMS) can process (subaccounts are just grants that have been coupled together). A Department of Reporting worker signs on to the network, he/she then populates the Approach application with grants information from the GAFRS report in order to generate documents used in requesting funds via the PMS. The Approach application has prebuilt algorithms that calculate all of the information that is keyed in by the worker.

Business Processes

What business processes require the interface?

See Interfaces/PC Applications related to Business Processes document.

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

The program area would like the functionality this application provides to be automated in the new SCDHHS accounting system (SAP) – or it could be included in the future MMIS. The application is only used as a fix for putting the grants information into a "subaccounts" format for processing by the PMS.

Interface Summary



Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

N/A

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, C:D etc.).

N/A

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

N/A

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

N/A

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

N/A

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

N/A

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

Grants information from the GAFRS report are used to populate the Approach application. The figures taken off of the GAFRS report is the input to this application. See the Overview section.

Outputs

List all system / interface outputs – e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

There are no reports.

The application calculates grants information is such a way to put them in a “subaccounts” format that the PMS can process.

Record Layout

Attach sample layout if applicable.

N/A



Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

N/A

Governing Policies

Policies that govern use or other activity involving the system / interface.

See Common Answers document

Access Control Policies and Security

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

List data security levels, security requirements etc.

Access control for the Approach System is limited to one Department of Reporting worker. Once the designated worker signs on to the network, he/she has access to populate the Approach application with information from the GAFRS report in order to obtain the summary documents used in requesting funds via the Payment Management System.

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

N/A

System / Interface Data Processing Standards

If a SLA or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

N/A

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

Standard business hours.

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

This Approach application is really redundant – if GAFRS could convert grants to the required “subaccounts” format required for the PMS (Federal Reserve system), the application would not be needed. This application is just used as a “middleman” tool to get the grant numbers in the right format for the PMS.

Disaster Recovery

Attach any disaster recovery plans.

See Common Answers document.

Contract

Legal agreement status and document location.



N/A

Data Storage & System Attributes

*What programming languages were used in creating the system / interface, or what **Commercial, off-the-shelf (COTS)** software was acquired?*

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format / schema documentation if possible.

COTS software.

Transaction processing

Type (batch / real-time).

Real-time

Data Quality Control

Describe quality control policies / procedures.

N/A

Backup

Describe / attach backup procedures and policies.

See Common Answers document.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

There is no known capacity – as many users as the server can handle. This has never been an issue for the program area.

Support

Support hours and response times. Who handles user support, and how? Explain escalation / levels, if applicable.

See Common Answers document.

Incident Management

Process / constraints by which incidents are handled.

See Common Answers document.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?

See Common Answers document.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

See Common Answers document.

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens?

Include medium, etc.

N/A



Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

N/A

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

N/A

Plans for the System / Interface

How long will the system / interface continue?

The program area hopes that SAP will eliminate the need for this application.

What upgrades and replacements are planned?

Legislative climate and other forces affecting system / interface?



1.3. Cash Receipt Log (CRL) System

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

Cash Receipt Log (CRL) System

Owner Information

Name, phone, email, etc. of user and support contacts

See Common Answers document.

SCDHHS Bureau of Fiscal Affairs (Division of Accounting Operations):

Lynette Wilson – (803) 898-2916 – wilsonl@scdhhs.gov

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

All checks that are received by the AR program area are entered into the CRL. The CRL assigns a receipt # and captures the check number, payer, date, provider number (if applicable), etc. All of these entries can be searched at a later date if research has to be done on a specific check.

Once a month, SCDHHS sends a floppy disk to MCCC so that they may key the aforementioned receivable checks (RC12's) into the MMIS to capture checks that have been submitted for 1099 reporting. SCDHHS sends a Data Transmission Form and MCCC acknowledges receipt by sending the form and the disk back to us (This is a paper report).

Weekly revenue detail reports are submitted to the TPL and PI program areas at SCDHHS for recovery tracking purpose. Program Integrity utilizes that information to track and reconcile Medicaid overpayment debts that have been submitted from their area.

Objectives

What are the goals of the system / interface? Why was it initiated?

The objective of this system is to capture all the information for checks that come in to the AR program area at SCDHHS. If the check is a receivable, it is automatically submitted to the ARL. The check information is stored in the system and available to be searched in the future.

Business Processes

What business processes require the interface?

See Interfaces/PC Applications related to Business Processes document.

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

There is an AR module in GAFRS that the program area doesn't use for various reasons (primarily -it doesn't work effectively for their needs). Many potential interfaces between the CRL/ARL and GAFRS have been looked at in the past; because of the age of GAFRS, no suitable



solution has been found. Of course the program area would like if some of the information from CRL/ARL was able to interface into GAFRS so that they wouldn't have to key it in manually. Fiscal Affairs is in the process of implementing a new agency wide accounting system to replace GAFRS called SAP, and the AR program area doesn't know how the new system will affect the CRL/ARL.

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

The CRL interfaces with the ARL in the AR program area. If the check that is entered into the CRL is a receivable, the payment amount automatically feeds into the ARL – to notify the ARL know that the check has been received (this is done via the RC#) and to reduce the receivable amount in the ARL. All receipts are then manually keyed in GAFRS as deposits.

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, Connect:Direct etc.).

N/A

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

During data entry of check receivables in the CRL the ARALOG.DBF and ARAACT.DBF database files from the ARL system are accessed by CRL system so that credits or debits on balances can be updated in real-time.

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

All check that are received by the AR Department (whether they are a receivable or not) are entered into the CRL. If a check that is entered into the CRL is a receivable, it is automatically transferred to the ARL.

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

N/A

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

N/A

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?



All check information (check #, payer, date, provider # etc.) contained on checks that are received by the AR program area are the only input.

Outputs

List all system / interface outputs – e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

Reports are run out of the CRL (detailing how many checks were received, and from what sources etc.).

Record Layout

Attach sample layout if applicable.

N/A

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

N/A

Governing Policies

Policies that govern use or other activity involving the system / interface.

See Common Answers document

Access Control Policies and Security

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

List data security levels, security requirements etc.

Access to the system is controlled in part by group rights administration on the SCDHHS network. Within the CRL system, there are 6 levels of user access: 00 - None; 10 - Read Only (CR Log entries); 30 - Update(CR Log entries); 50 - Payer Table(CR Log entries & Payer Table); 70 - All Tables (Access all tables except User Profiles); and 90 - Supervisor (Access all Tables & Utilities).

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

N/A

System / Interface Data Processing Standards

If a service level agreement (SLA) or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

N/A



Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

Standard business hours.

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

This system is critical to the AR program area's operations. This system tracks all of the checks that are received and stores them on a server. The check receivable information is available for query once in the system (i.e. AR staff can access the archived checks for research etc.).

Disaster Recovery

Attach any disaster recovery plans.

See Common Answers document.

Contract

Legal agreement status and document location.

N/A

Data Storage & System Attributes

What programming languages were used in creating the system / interface, or what Commercial, off-the-shelf (COTS) software was acquired?

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format / schema documentation if possible.

CRL is an old Clarion 5.X application with a TPS database (TopSpeed).

Transaction processing

Type (batch / real-time).

Real-time

Data Quality Control

Describe quality control policies / procedures.

N/A

Backup

Describe / attach backup procedures and policies.

See Common Answers document.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

There is no known capacity – as many users as the server can handle. This has never been an issue for the program area.

Support

Support hours and response times. Who handles user support, and how? Explain escalation / levels, if applicable.

See Common Answers document.

Incident Management

Process / constraints by which incidents are handled.

See Common Answers document.



Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?

See Common Answers document.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

See Common Answers document.

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens?

Include medium, etc.

N/A

Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

N/A

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

N/A

Plans for the System / Interface

How long will the system / interface continue?

This system is essential to the operations of the AR program area. With the transition to SAP, there must be a solution that would perform the same functions as the CRL system, or the program area would continue using this subsystem.

What upgrades and replacements are planned?

Legislative climate and other forces affecting system / interface?



1.4. Check Cancellation System

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

Check Cancellation System

Owner Information

Name, phone, email, etc. of user and support contacts

See Common Answers document.

SCDHHS Bureau of Fiscal Affairs:

Anita Risher – (803) 898-1065 – risher@scdhhs.gov

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

The Check Cancellation System is used to track the deletion and cancellation of checks paid to Medicaid providers (e.g. a provider didn't cash the check within the required period of time etc.). The system tracks reissued checks to Medicaid providers. Information entered into the Check Cancellation System for deletions and cancellations is transferred to Clemson's mainframe via FTP under a Time Sharing Option (TSO). Clemson uses this information to generate a tape or file to send to the bank to have these items removed from the bank's master file. Cancellation information is also sent to MCCS to process RC18 adjustments that are keyed into MMIS to reduce the provider's 1099.

Objectives

What are the goals of the system / interface? Why was it initiated?

The objective if this system is to track the deletion and cancellation of checks paid to Medicaid providers.

Business Processes

What business processes require the interface?

See Interfaces/PC Applications related to Business Processes document.

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

Additional edits on Check number and Provider ID/NPI numbers.

A way to make corrections to RC18 adjustments if necessary.

RC18 adjustments are generated when the program area cancels checks. RC18 adjustments reduce providers 1099s. Currently there is no edit that will prevent a check number from being canceled twice. This means a provider's 1099 could be reduced twice. Currently, there is no other adjustment RC that could be used to make a correction if this occurred.



Also because most providers have a legacy number and NPI number, there are times when a provider is paid under the legacy number and the check is canceled under the NPI number in error. This will also cause a problem with the 1099.

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

N/A

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, Connect:Direct etc.).

N/A

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

N/A

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

When a check that has been paid to Medicaid providers is deleted or canceled.

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

See Overview Section.

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

N/A

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

See Overview section.

Outputs

List all system / interface outputs – e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

No reports are generated from this system. Also see Overview section.

Record Layout

Attach sample layout if applicable.



N/A

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

N/A

Governing Policies

Policies that govern use or other activity involving the system / interface.

See Common Answers document.

Access Control Policies and Security

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

List data security levels, security requirements etc.

Access to this system is controlled by Group rights administration on our network. The system does have a logon but there are no roles within the system. All users have access to all functions in the system.

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

N/A

System / Interface Data Processing Standards

If a service level agreement (SLA) or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

N/A

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

During standard business hours.

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

This system is critical to the business process.

Disaster Recovery

Attach any disaster recovery plans.

See Common Answers document.

Contract

Legal agreement status and document location.

N/A



Data Storage & System Attributes

*What programming languages were used in creating the system / interface, or what **Commercial, off-the-shelf (COTS)** software was acquired?*

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format / schema documentation if possible.

This system was developed using Microsoft Visual Basic v6.X with a Microsoft Access Database.

The system is distributed over the network as a multiuser application.

Transaction processing

Type (batch / real-time).

Real-time

Data Quality Control

Describe quality control policies / procedures.

N/A

Backup

Describe / attach backup procedures and policies.

See Common Answers document.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

There is no known capacity – as many users as the server can handle. This has never been an issue for the program area.

Support

Support hours and response times. Who handles user support, and how? Explain escalation / levels, if applicable.

See Common Answers document.

Incident Management

Process / constraints by which incidents are handled.

See Common Answers document.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?

See Common Answers document.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

See Common Answers document.

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens?

Include medium, etc.

N/A



Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

N/A

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

N/A

Plans for the System / Interface

How long will the system / interface continue?

N/A

What upgrades and replacements are planned?

N/A

Legislative climate and other forces affecting system / interface?

N/A



1.5. AdminDays System

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

AdminDays

Owner Information

Name, phone, email, etc. of user and support contacts

See Common Answers document.

SCDHHS Bureau of Health Services:

Mary Thomas – (803) 898-2812 – rogers@scdhhs.gov

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

The Medicaid Administrative Days database program is used for logging administrative day's claims. Providers send their hardcopy administrative day's claims to the Department of Health and Human Services (SCDHHS). Hospital Services processes these claims. The administrative day's rate is used to calculate what this period of time costs; then the provider files a claim to receive payment for services during that period. These claims are for the period of time in which a Medicaid beneficiary has already been discharged and is awaiting a nursing home bed. The administrative day's rate changes yearly and the new rates are entered into the program area's (Hospital Services) database. Once the claims are entered into the database, the database program multiplies the number of days and the administrative rate at the time service was rendered. After entering all administrative days claims, a credit adjustment is done for each hospital (provider). When they have been signed, the credit adjustment is forwarded to MCCS for payment. Upon request, a report can be printed (by the database program) to show the patients and providers that participate or have participated in the program. The program area also uses decision support tools for other reporting functions.

Objectives

What are the goals of the system / interface? Why was it initiated?

The AdminDays database program was created because there was nothing in the current MMIS that could manage these claims. Hospital Services was responsible for the manual calculations that needed to be done before AdminDays was created. A System Worksheet (SW) has been submitted internally to BITS to request these claims be processed through the system (MMIS) as with other claims.

Business Processes

What business processes require the interface?

See Interfaces/PC Applications related to Business Processes document.



Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

The Hospital Services program area has submitted a System worksheet (internal SCDHHS systems request document) to request these claims be processed through MMIS as with other claims. If this could be done, AdminDays wouldn't be necessary and providers' would be able to submit claims to the MCCS claims processing for direct interaction with the MMIS.

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

Providers send their hardcopy administrative day's claims to SCDHHS. Another interface is the credit adjustment that is forwarded to MCCS for payment. This is a manual process that consists of a hardcopy list of the adjustment credits sent via courier to MCCS. MCCS uses the list to credit the appropriate providers, so that they receive payment for the services rendered.

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, Connect:Direct etc.).

Manual Process – a courier from MCCS comes to the Hospital Services program area to get the credit adjustment information. MCCS processes this adjustment and the provider is then paid.

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

N/A

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

Hospital Services processes these claims. Monthly, an MCCS courier picks up credit adjustment information for MCCS processing and provider payment

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

Credit adjustment data that is used by MCCS for the payment of administrative day's claims.

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

Input Characteristics: MCCS receives the credit adjustment data and processes it – the provider is then paid.

Output Characteristics: Hospital Services sends credit adjustment data via courier.

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.



If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

Administrative day's claims are the only form received as an input. Providers send these claims directly to SCDHHS. Hospital Services processes these claims. The claims data is entered directly into the AdminDays database program.

Outputs

List all system / interface outputs – e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

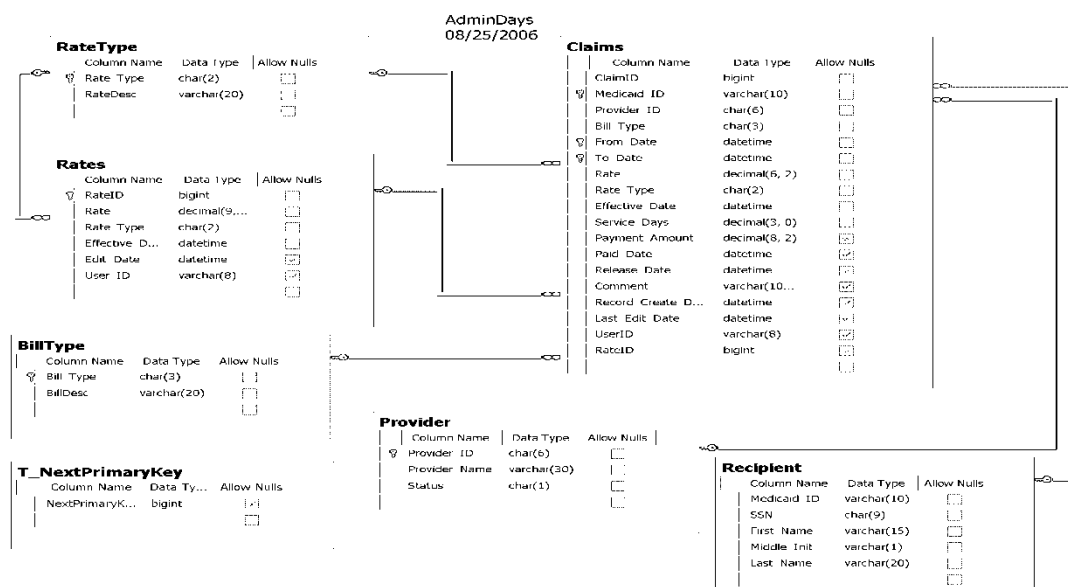
By request, the AdminDays program prints reports to show the patients and providers that participate or have participated in the program. The program area also uses decision support tools for other reporting functions.

The amount and other info is sent to MCCS for creation of the credit adjustment.

Record Layout

Attach sample layout if applicable.

The following is a current version (as of 1/1/2009) of the AdminDays database layout.



1-1

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

Attached:

These procedures are outlined within the Division of PC Software and Application Management's Software Development Life Cycle (SDLC).

Chapter 7 – Support Phase.



Governing Policies

Policies that govern use or other activity involving the system / interface.

See Common Answers document.

Security

List data security levels, security requirements etc.

System access is controlled at the network level (Novell). If rights to the system are granted then the user has access to all functions.

Access Control Policies

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

System access is controlled at the network level (Novell). If rights to the system are granted then the user has access to all functions.

Security and Confidentiality Procedures

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

Data on the system is stored on a secure Microsoft SQL Server. See agency HIPAA Policies and procedures.

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

N/A

Contract and Service Level Information

If a service level agreement (SLA) or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

N/A

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

Standard business hours.

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

The system is vital to this program area's operations. Additional resources would be required to return to manual processing.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

As much as the server can handle; capacity has never been an issue for this system.

Support

Support hours and response times.

See Common Answers document.



Incident Management

Process / constraints by which incidents are handled.

See Common Answers document.

Disaster Recovery

Attach any disaster recovery plans.

See Common Answers document.

Contract

Legal agreement status and document location.

N/A

System / Interface Data Processing Standards

Data Storage

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format/schema documentation if possible.

Clarion 6.3 with MS SQL 2k5 database.

Transaction processing

Type (batch / real-time).

N/A

Capacity

Including peak intervals.

As much as the server can handle; capacity has never been an issue for this system.

Data Quality Control

Describe quality control policies / procedures.

N/A

Backup

Describe / attach backup procedures and policies.

See Common Answers document

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

As much as the server can handle; capacity has never been an issue for this system.

Support

Support hours and response times.

See Common Answers document.

Incident Management

Process / constraints by which incidents are handled.

See Common Answers document.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?



See Common Answers document.

Help Desk

Who handles user support, and how? Explain escalation / levels, if applicable.

Staff first contact SCDHHS Help Desk if there is an incident with the AdminDays database program (support hours listed above). If the Help Desk cannot manage the incident, they determine if the incident should be turned over to Network Services, or Application Development Support – and then hand the issue over to one of them. Historically, most issues encountered have been connection, or access issues.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

N/A

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens? Include medium, etc.

N/A

Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

N/A

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

N/A

Plans for the System / Interface

How long will the system / interface continue?

N/A

What upgrades and replacements are planned?

N/A

Legislative climate and other forces affecting system / interface?

N/A



1.6. Appeals and Hearings System

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

Appeals and Hearings Tracking System

Owner Information

Name, phone, email, etc. of user and support contacts

See Common Answers Document.

SCDHHS Bureau of Administrative Services (Division of Appeals and Hearings):

Vastine Crouch – (803) 898-2600 – crouch@scdhhs.gov

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

This database system is used for tracking appeal case information. Information including the name of the person appealing, date received, hearing officer, and case number etc. are all recorded in this database. The system also tracks information for the cases as they progress from a new case to closure. However tracking of correspondence between all parties is not tracked in this system (see wish list below). This is not a user friendly system.

Objectives

What are the goals of the system / interface? Why was it initiated?

Originally, appeal tracking was done manually in a three-ring binder. This was not an efficient method for locating records quickly. An excel spreadsheet was developed to track data instead. Appeals tracking is now managed by a database on a SQL Server 2000 and VB.NET platform.

Business Processes

What business processes require the interface?

See Interfaces/PC Applications related to Business Processes document.

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

There is a wish to track the final outcome of an appeal (see Output section). BITS has worked with the program area to tweak the Appeals and Hearings Tracking System as necessary. Currently, the administrative assistant is the only extensive user of the system. Overall, the system is very cumbersome and unintuitive. The program area would like to modify, create, or purchase a new tracking system that is user friendly for the whole area's use.

The Case Management Sheet (see interfaces below) is passed between the admin and hearing office for the hearing officer to choose correspondence he or she would like sent to various parties involved in the appeal process. When a hearing officer chooses the type of correspondence, the correspondence is not tracked in the system. The program area uses



ApplicationXtender to scan and image any responses received. The original hard copy response is filed in the program area. Having a system track the sending and receipt of correspondence would be a useful and valuable improvement to the appeals process.

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

The program area uses a Case Management Sheet (CM Sheet , Microsoft Word file) to aid the Hearing Officers with correspondence. The CM Sheet is sent to the Hearing Officer via email – the document has drop down boxes that let the Hearing Officer select the kind of correspondence he or she would like the appeals program area to send. Once the Hearing Officer has completed the CM Sheet, he or she will then emails it back to the appeals program area. The program area then generates the letters (which are already predefined in the Appeals and Hearings Tracking System) and sends them to the appropriate recipients. The system currently does not track this correspondence (see wish list above). While this is not directly an interface to the system, it is a significant part of the process.

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, Connect:Direct etc.).

N/A

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

N/A

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

The system is used when an appeal will be granted (some appeals are not granted because the issue being disputed clearly has no merit. In this case the information is not even entered into the system).

After a hearing officer has made a decision on an appeal case, the Appeals and Hearings Tracking System is updated to reflect the change in status. This triggers the CM Sheet document to be sent to the hearing officer by the program area admin.

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

See Triggers above.

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

N/A



Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

For Medicaid beneficiary or applicant appeals, the assigned eligibility case worker submits the forms to the division. The case workers have a SCDHHS Form 3260 that contains required information for the appeal. The case worker forwards the form along with a narrative (explaining why the worker closed the case, denied the case, etc.). Identifying information (name, address, contact person, phone, etc.) is taken right from the form and entered directly into the Appeals and Hearings Tracking System. In other appeal situations (i.e. providers, contractors), identifying information is pulled from the correspondence.

Outputs

List all system / interface outputs – e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

The Appeals and Hearings Tracking System has the ability to run various reports (e.g. what cases were closed over a period of time, a specific hearing officer's caseload etc.), however, the program area rarely uses reporting functions of the system. The program area's main focus is keeping the cases moving and tracking this movement. The outcome of an appeal isn't tracked, other than if a case was dismissed or a decision was rendered. If a decision is rendered, the program area doesn't track whether the decision was enforced by the agency.

Record Layout

Attach sample layout if applicable.

Normal database table layout.

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

See MITA project repository and SDLC

Governing Policies

Policies that govern use or other activity involving the system / interface.

See Common Answers document.

Security

List data security levels, security requirements etc.

System access is controlled at the network level (Novell). If rights to the system are granted then the user has access to all functions.

Access Control Policies

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

Everyone has the same user access level.



Security and Confidentiality Procedures

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

System access is controlled at the network level (Novell). If rights to the system are granted then the user has access to all functions.

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

N/A

Contract and Service Level Information

If a service level agreement (SLA) or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

N/A

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

Standard business hours.

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

The system is very important for tracking purposes (and history of appeals decisions etc.).

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

As much as the network / server can handle; capacity has never been an issue for this system.

Support

Support hours and response times.

See Common Answers Document.

Incident Management

Process / constraints by which incidents are handled.

See Common Answers Document.

Disaster Recovery

Attach any disaster recovery plans.

See Common Answers Document.

Contract

Legal agreement status and document location.

N/A

System / Interface Data Processing Standards

Data Storage

What DBMS, file systems, etc., does the system use for storing transactional / operational data?



Attach data formats or schemas or provide location of format/schema documentation if possible.

SQL

Transaction processing

Type (batch / real-time).

N/A

Capacity

Including peak intervals.

None at all – has less than 10 users. Capacity has never been an issue with this system.

Data Quality Control

Describe quality control policies / procedures.

N/A

Backup

Describe / attach backup procedures and policies.

See Common Answers Document.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

As much as the network / server can handle; capacity has never been an issue for this system.

Support

Support hours and response times.

See Common Answers Document.

Incident Management

Process / constraints by which incidents are handled.

See Common Answers Document.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?

See Common Answers Document.

Help Desk

Who handles user support, and how? Explain escalation / levels, if applicable.

Staff first contact the SCDHHS Help Desk if there is an incident with this system (support hours listed above). The Help Desk then determines if they will assist the staff or assign resolution to Network Services, or Application Development Support., most issues encountered have been connection, or access issues.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

Typically the program area Admin will contact Neal Sessions or Harvey Brown (in Application Development Support) directly with requests for any system modifications. Together, they coordinate the scheduling of any such adjustments.



Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens? Include medium, etc.

N/A

Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

N/A

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

N/A

Plans for the System / Interface

How long will the system / interface continue?

N/A

What upgrades and replacements are planned?

N/A

Legislative climate and other forces affecting system / interface?

N/A



1.7. ApplicationXtender

Project / System / Interface Summary

Name of Project / System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

ApplicationXtender / Document Imaging System

Owner Information

Name, phone, email, etc. of user and support contacts

See Common Answers Document.

SCDHHS Bureau of Eligibility Processing:

Tamara Douglas – (803) 898-3006 – douglas@scdhhs.gov

SCDHHS Bureau of Care Management and Medical Support Services:

Terri Fridy – (803) 898-2887 – fridy@scdhhs.gov

SCDHHS Bureau of Eligibility Policy and Oversight:

Paula Milhouse – (803) 898-2635 – milhousp@scdhhs.gov

SCDHHS Bureau of Fiscal Affairs:

Angela West-Barnett – (803) 898-2953 – west@scdhhs.gov

Lynette Wilson – (803) 898-2916 – wilsonl@scdhhs.gov

SCDHHS Bureau of Administrative Services:

Vastine Crouch – (803) 898-2661 – crouch@scdhhs.gov

Overview

Briefly describe the project, system, or interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

The ApplicationXtender System is a document imaging solution for scanning and archiving documents throughout the agency. A transmittal letter (produced by Scan Log) along with the documents needing archival is sent to Harvey Brown and his staff, who then scan the documents into the system. Once archived, documents can be retrieved from this system for review. Documents are retained indefinitely unless a purge is requested.

The following describes how each of the six business areas identified as stakeholders use ApplicationXtender:

Central Eligibility Processing: ApplicationXtender is used to digitally archive case files.

Beneficiary & User Services, Program Support: ApplicationXtender is used to digitally archive enrollment / disenrollment / transfers for Medicaid Managed Care beneficiaries.

Policy / Planning, Eligibility / Policy Oversight: ApplicationXtender is used to digitally archive case files.

TPL, Fiscal Affairs: ApplicationXtender is used to digitally archive checks (cash receivables), case files and correspondence.

Accounting Operations, Fiscal Affairs: ApplicationXtender is used to digitally archive checks (cash receivables state recovery, or casualty recovery) .



Division of Appeals & Hearings: ApplicationXtender is used to digitally archive hearing files (old order decisions).

Note: The Application-Xtender system is a COTS scalable to the environment system. Licensing is concurrent and users are named within the system. For detailed hardware requirements contact vendor EMC or check their website

<http://www.emc.com/products/family/documentum-applicationxtender-family.htm>

Objectives

What are the goals of the project, system or interface? Why was it initiated?

The goal of this system is to provide various program areas across the agency with a system that digitally archives important documents – that can then be easily retrieved at a future date via ApplicationXtender.

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

Another PC Application called Scan Log is used to enter desired search criteria for Application-Xtender. Scan Log is not integrated with the ApplicationXtender. It only produces a Batch inventory coversheet. The Scan Log is also used to track the status of batches being processed by the scanning unit (BITS). A worker enters search criteria for the document that they wish to image (social security #, birthday etc. The worker can choose any search criteria they wish) that will be used to search for archived documents in Application-Xtender in the future. Scan Log then produces a transmittal letter that contains all of the desired search criteria that will be used. This transmittal letter along with document that needs to be archived is then sent to Harvey Brown and his staff. They scan the document and enter the desired search criteria into Application-Xtender. Now the program area staff can launch Application-Xtender on their computer and use the search criteria they originally supplied Harvey Brown to view their archived documents. This manual process that is required to get the documents archived could be more efficient etc. However, the Application-Xtender system itself is satisfactory.

Exchange Format

Data structure of data exchange. Attach description if needed. .

Format (XML, custom, X12, etc.)

N/A

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

N/A

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

See Overview section.



Information Entities

What kinds of information, in whole or in part, are exchanged (person, claims, etc.)?

Documents that various program areas wish to archive. This allows the program area to view the archived document in the future if required.

Business Processes

What business processes require the interface?

See MMIS – MEDS – PC Applications Related to BPs Document.

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics

N/A

Inputs

List all project / system / interface inputs -- e.g., form names, files, etc. Include media and frequency. Attach samples if applicable.

Outputs

List all project / system / interface outputs – e.g., names and contents of specific reports, data files, etc. Include media and frequency. Attach samples if applicable.

Any archived document that a specific program area wishes to view via **Application-Xtender**.

Record Layout

Attach sample layout if applicable.

N/A

Governance and Security

Applicable Standards

Standards to which the interface adheres (if not listed elsewhere)

N/A

Governing Policies

Policies that govern use or other activity involving the interface.

See Common Answers Document.

Security

Data security levels, security requirements, access control policies, etc.

Security within ApplicationXtender is configured based on user profiles, group profiles, and certain types of document level security. (e.g. Scanning projects are divided into applications on the ApplicationXtender server, groups are granted access only to certain applications, users within groups are granted certain rights within that application.

Access Control

Describe access control rules for accessing the system (roles, responsibilities, accesses, etc.)

See Common Answers Document.



The system/application is distributed over the network. Users have a logon (combination of user's identification and password) that allows them entry to the system/application. Access to the system/application is requested using the OAC Request Form.

Confidentiality

N/A

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

N/A

Contract and Service Level Information

If a service level agreement (SLA) or contract with SLA information exists, please attach the SLA information. Otherwise, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

N/A

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

N/A

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

N/A

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.)

There are approximately 100+ users of the system.

Support

Support hours and response times.

N/A

Incident Management

Process / constraints by which incidents are handled

N/A

Disaster Recovery

Attach any disaster recovery plans

See Common Answers Document.

Business Continuity

Attach any business continuity plans

N/A

Contract

Legal agreement status and document location.

N/A



Data Processing Standards

Roles and Responsibilities of Data Access

Provide table/matrix showing data access according to user role/functional job title down to the row and column level, if applicable.

N/A

Information Processed

What kinds of information does the system process and how (people, claims, etc.)?

Various documents that are in need or archival.

Data Stores

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format/schema documentation if possible.

Transaction processing

The system currently resides on a Windows 2003 server, running EMC ApplicationXtender with related EMC DisXtender technology, and is connected to our Production SQL 2k5 Server (contains auditing info, an index data, etc).

Type (batch/real-time), capacity, etc.

Batch

Capacity

Including peak intervals

There is a significant delay for many of the program areas from the time in which a batch (the documents needing archival, and the transmittal letter) is ready for archival, and when the documents become available in ApplicationXtender. The staff in BITS has many documents to image, that some batches aren't processed for months.

The current configuration of our system allows 45 concurrent connections. The number of documents are limited only by the amount of space. For more general technical information contact the vendor EMC or check their website

<http://www.emc.com/products/family/documentum-applicationxtender-family.htm>.

Data Quality Control

Describe quality control policies/procedures.

N/A

Backup

Describe/attach backup procedures and policies

See Common Answers Document.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.)

There is a significant delay for many of the program areas from the time in which a batch (the documents needing archival, and the transmittal letter) is ready for archival, and when the documents become available in ApplicationXtender. Due to the level of demand, some batches aren't processed for months.

Support

Support hours and response times.



See Common Answers Document.

Incident Management

Process / constraints by which incidents are handled

See Common Answers Document.

Contract

Legal agreement status and document location.

N/A

Other Project Features

Attach diagrams and supplementary materials as needed.

Data Center

Where is the system housed? (City and state, owner, etc.)

See Common Answers Document.

Help Desk

Who handles user support, and how? Explain escalation/levels, if applicable.

BITS: Harvey Brown – (803) 898-2768 – brownha@scdhhs.gov

System Modification and Change Control

How are project/system changes requested, carried out, and documented?

See Common Answers Document.

Application Development and Testing Procedures

N/A

Security and Confidentiality Procedures

What precautions ensure PHI, proprietary information, and other information is kept secure?

N/A

Contingency Plan

N/A

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens?

Include medium, etc.

N/A

Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A

Project Roles and Responsibilities

SCDHHS Responsibilities

N/A

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

N/A



Performance Standards

#/Function/Accuracy Requirement/Timeliness Requirement/Liquidated Damage (LD) Incentive (I)

N/A

Plans for the Project / System / Interface

How long will the project / system / interface continue?

Until the future Medicaid Enterprise provides a more effective / efficient solution.

What upgrades and replacements are planned?

N/A

Legislative climate and other forces affecting project?

N/A



1.8. Beneficiary Users System (BUS)

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

BUS Beneficiary Users System (aka MCIS)

Owner Information

Name, phone, email, etc. of user and support contacts

See Common Answers document.

SCDHHS Bureau of Care Management and Medical Support Services; Division of Care Management; Department of Managed Care Enrollment:

Terri Fridy – (803) 898-2887 – fridy@scdhhs.gov

Melissa Glover – (803) 898-4442 – glovermd@scdhhs.gov

Beverly Ashford – (803) 898-2835 – ashfordb@scdhhs.gov

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

This system tracks the receipt of Managed Care Plan Enrollment / Disenrollment / Change Form (SCDHHS Form 280-2) from members. Authorized users enter the members' family number, name, address, notes, and other identifying information. Authorized users read notes and track forms / correspondence to check the status of a members' request.

Objectives

What are the goals of the system / interface? Why was it initiated?

The Managed Care Enrollment staff developed this system quite a few years ago with the help of Harvey Brown. It was designed to track managed care enrollment, disenrollment, transfers, etc. The system was initially used just for HMO and PEP reports and no longer supports that function. The system previously held HMO enrollments for 17 days, but now all reports are available on D:D. The system is used to log hostile phone callers, complaints, and tracking "over the 90 day" disenrollment forms (primary use). Only hostile/complaint phone calls are tracked (caller and how complaint was resolved). The Beneficiary Call Center has read-only access to the system; if a caller is referring to a complaint/conversation they had with a Managed Care Enrollment worker, the Call Center worker can look at notes etc. contained in the BUS.

Business Processes

What business processes require the interface?

See MMIS - MEDS - PC Applications Related to BPs document.

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

See MMIS - MEDS - PC Applications Related to BPs document.



Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

N/A

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, Connect:Direct etc.).

N/A

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

N/A

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

Hostile/complain phone calls. “Over the 90 day” disenrollment forms. See Overview section for more details.

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

See Overview section.

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

N/A

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

Manual data entry of notes related to hostile/complains phone calls. Also manual data of dates related to the “over the 90 day” disenrollment forms.

Outputs

List all system / interface outputs – e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

N/A

Record Layout

Attach sample layout if applicable.



N/A

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

Governing Policies

Policies that govern use or other activity involving the system / interface.

See Common Answers document.

Access Control Policies and Security

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

List data security levels, security requirements etc.

See Common Answers document.

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

N/A

System / Interface Data Processing Standards

If a service level agreement (SLA) or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

N/A

Response Time

Within what timeframe must the system / interface respond?

Instantly

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

During SCDHHS standard business hours.

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

The program area relies on this system to track member requests and enter notes.

The system is useful, but not critical for tracking “over the 90 day” disenrollment forms.

Disaster Recovery

Attach any disaster recovery plans.

See Common Answers document.

Contract

Legal agreement status and document location.

N/A



Data Storage & System Attributes

*What programming languages were used in creating the system / interface, or what **Commercial, off-the-shelf (COTS)** software was acquired?*

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format / schema documentation if possible.

Network: Netware server; Programming language: Clarion 6.X (TPS Database files).

Transaction processing

Type (batch / real-time).

Real-time

Data Quality Control

Describe quality control policies / procedures.

N/A

Backup

Describe / attach backup procedures and policies.

See Common Answers document.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

N/A

Support

Support hours and response times. Who handles user support, and how? Explain escalation / levels, if applicable.

See Common Answers document.

Incident Management

Process / constraints by which incidents are handled.

See Common Answers document.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where is the system / interface housed?

See Common Answers document.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

See Common Answers document.

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens?

Include medium, etc.

N/A

Continuous Business Process Improvement

Is a methodology in place? Explain.



N/A

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

N/A

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

N/A

Plans for the System / Interface

How long will the system / interface continue?

N/A

What upgrades and replacements are planned?

N/A

Legislative climate and other forces affecting system / interface?

N/A

Comments?

N/A



1.9. Community Long Term Care – Case Management System (CLTC CMS)

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

Community Long Term Care - Case Management System (CLTC CMS)

Owner Information

Name, phone, email, etc. of user and support contacts

See Common Answers document

Bureau of LTC and Behavioral Health Services (Division of CLTC Waiver Management:

Roy Smith - (803)898-2590 – smithroy@scdhhs.gov

Feaster - (803)898-2532 - Feaster@scdhhs.gov

Technical contacts:

Neal Sessions - (803) 898-2762 or 2787 - SESSIONS@scdhhs.gov

Rick Kelley - (830) 898-2773 or 2787 - KELLEYR@scdhhs.gov

Harvey Brown – (803) 898-2768 – brownha@scdhhs.gov

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

Agency staff use the Case Management System (CMS, a Microsoft Access application) for the day-to-day management of three Medicaid waivers (Elderly/Disabled, HIV/AIDS, and Ventilator Dependent). CMS databases are maintained daily by the state's 13 CLTC regional offices, with updates to the central database occurring nightly.

CMS contains assessment information and service plans for the Medicaid home and community-based services waivers listed above. The service plan includes the reasons a person may need long-term care services (the "problems"), the preferred result for the person (the "goals"), and the means to reach the goals (the "intervention"). Case managers enter the service plans and assessment information into the CMS. The CMS is also used to support quality management through its report-generation function (e.g. reports on timeliness of assessment, reassessments, care plan development, tracking missed provider visits, identifying participants at risk in the event of an emergency or natural disaster etc.).

Objectives

What are the goals of the system / interface? Why was it initiated?

SCDHHS created CMS in 1991 to help its case managers administer several long-term care programs. By 2002, CMS databases were maintained daily by the state's 13 regional offices, with updates to the central database occurring nightly (see Data Storage below).



Business Processes

What business processes require the interface?

See Interfaces/PC Applications related to Business Processes document.

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

The current system is undergoing an update. A major improvement currently being implemented is the creation of a single database accessible via the internet. This will allow the 13 regional CLTC offices to have real time access to the same database. Currently each area office's database is uploaded to the central server at the Columbia SCDHHS data warehouse.

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

TBA – CareCall etc.

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, Connect:Direct etc.).

The data is sent to SCDHHS' central office as zipped Microsoft Access databases. The CMS timer program, that transfers the files to the central office, runs daily in each area office at 12:30 PM.

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

TBA

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

TBA

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

CLTC client data, CMS codes data (validation data used in data entry), Provider data, and updates to queue positions for clients on statewide waiting list.

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

N/A

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?



The case managers are issued laptops by BITS. The case manager goes out to the beneficiary and completes a full assessment, documenting the “problems”, “goals”, and “intervention” (see overview above). This documentation is then uploaded to a server at the CLTC regional office (see overview above). There is a timer program that sends the updated MS Access file to the SCDHHS central server at 12:30 PM.

Outputs

List all system / interface outputs – e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

At 4:45 AM each morning a DTS job is executed at GovConnect to retrieve the current data from the SQL Server CMS database to transfer CareCall data to First Data Government Solutions.

Reports:

A list of frequently generated reports has been attached:

Reports are generated with Crystal software. Some are hard coded into Visual Basic.

Record Layout

Attach sample layout if applicable.

N/A

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

Refer to the SDLC

Governing Policies

Policies that govern use or other activity involving the system / interface.

See Common Answers document.

Security

List data security levels, security requirements etc.

Three security levels:

- 1.) 99 & 100 - All Access.
- 2.) 90 - Delete and Edit Formal Supports
- 3.) NULL - general access (data entry)

For the case managers that use laptops out in the field, all laptops have LDD (or Lost Data Destruction software) installed. This software does rules based encryption on the hard drive of the laptop (for more detailed information on LDD contact the HELPDESK).

Access Control Policies

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

See above.



Security and Confidentiality Procedures

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

See above.

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

N/A

Contract and Service Level Information

If a service level agreement (SLA) or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

N/A

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

Local CLTC area office systems are required to be available for user access during normal business hours (7:30a – 5:30p M-F). The Columbia central data warehouse is available for user access (reporting) during normal business hours and weekends (weekend up time is flexible based on maintenance schedules).

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

The CMS is a vital part of CLTC' operations. This system is relied upon to deliver the assessment and service plan information required to proceed

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

Because of the manner in which the system is distributed and written, load is not a factor.

Support

Support hours and response times.

See Common Answers document.

Incident Management

Process / constraints by which incidents are handled.

See Common Answers document.

Disaster Recovery

Attach any disaster recovery plans.

See Common Answers document.

Contract

Legal agreement status and document location.

N/A



System / Interface Data Processing Standards

Data Storage

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format/schema documentation if possible.

CMS resides on servers (OS is Netware 6.5) in 13 CLTC regional office locations (13 separate servers) with a central data warehouse located in Columbia. The databases for CMS are in MS Access 97 in the area offices. The Data Warehouse, located on the Mezzanine of Jefferson Square Plaza, is on the SCDHHS production Microsoft SQL Server 2k5 (OS is MS Server 2k3).

Transaction processing

Type (batch / real-time).

Batch

Capacity

Including peak intervals.

None

Data Quality Control

Describe quality control policies / procedures.

N/A

Backup

Describe / attach backup procedures and policies.

See Common Answers document.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

N/A

Support

Support hours and response times.

See Common Answers document.

Incident Management

Process / constraints by which incidents are handled.

See Common Answers document.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?

See Common Answers document.

Help Desk

Who handles user support, and how? Explain escalation / levels, if applicable.



CLTC staff first goes to the SCDHHS Help Desk if there is an incident with the CLTC CMS(support hours listed above). The Help Desk then determines if they will manage the incident or if Network Services or Application Development Support will. Historically, most issues encountered have been connection, or access issues.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

Typically the program area Admin will contact Neal Sessions or Harvey Brown (in Application Development Support) directly with requests for any modifications to the system. Together, they coordinate the scheduling of any such adjustments.

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens? Include medium, etc.

N/A

Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

N/A

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

N/A

Plans for the System / Interface

How long will the system / interface continue?

This system is vital to CLTC operations. This system would need to interface with the future MMIS, or be incorporated in such a way that the current functionality is maintained.

What upgrades and replacements are planned?

N/A

Legislative climate and other forces affecting system / interface?

N/A



1.10. **Constituent Services System**

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

Constituent Services Tracking System

Owner Information

Name, phone, email, etc. of user and support contacts

See Common Answers document.

SCDHHS Bureau of Eligibility Policy and Oversight (Division of Constituent Services):

Jennifer Lynch – (803) 898-2635 – lynchjen@scdhhs.gov

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

This database system tracks constituent (e.g. other agencies, legislators etc.) cases (issues) received via direct call, agency email box, legislative referrals, etc. Constituent Services staff uses the system to track the progress and keep record of issues they are handling. The tracker allows this area to quickly find information on individuals within the agency they have assigned to a constituent case in the past (the system keeps record of all past entries). They also use the tracker to log letters that go out under Agency Director or the Deputy Director of Medicaid Eligibility and Beneficiary Services. The tracker is used for ad-hoc reports as well to determine which cases are pending and who in the agency is responsible for handling the case.

Objectives

What are the goals of the system / interface? Why was it initiated?

Track constituent cases (issues).

Business Processes

What business processes require the interface?

See Interfaces/PC Applications related to Business Processes document.

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

No wish list items for this system.

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

N/A

Exchange Format

Data structure of data exchange. Attach description if needed.



Format (XML, custom, X12, Connect:Direct etc.).

N/A

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

N/A

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

See Overview.

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

See Overview.

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

N/A

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

The issues that will be tracked are inputs for the system.

Outputs

List all system / interface outputs – e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

Ad-hoc reports.

Record Layout

Attach sample layout if applicable.

N/A

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

See the SDLC, Chapter 7 – Support Phase.

Governing Policies

Policies that govern use or other activity involving the system / interface.

See Common Answers document.

Access Control Policies and Security

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)



What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

List data security levels, security requirements etc.

Username and password.

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

N/A

System / Interface Data Processing Standards

If a service level agreement (SLA) or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

The system responds immediately.

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

Standard business hours: 7:30am – 5:30pm, Monday – Friday.

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

This system is critical for recording and tracking current and past issues.

Disaster Recovery

Attach any disaster recovery plans.

See Common Answers document.

Contract

Legal agreement status and document location.

N/A

Data Storage & System Attributes

*What programming languages were used in creating the system / interface, or what **Commercial, off-the-shelf (COTS)** software was acquired?*

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format / schema documentation if possible.

Netware server with MS SQL Server 2k (OS is MS Server 2k).

Transaction processing

Type (batch / real-time).

Real-time

Data Quality Control

Describe quality control policies / procedures.

N/A



Backup

Describe / attach backup procedures and policies.

See Common Answers document.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

There is no known capacity – as many users as the server can handle.

Support

Support hours and response times. Who handles user support, and how? Explain escalation / levels, if applicable.

See Common Answers document.

Incident Management

Process / constraints by which incidents are handled.

See Common Answers document.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?

See Common Answers document.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

See Common Answers document.

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens? Include medium, etc.

N/A

Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

N/A

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

N/A

Plans for the System / Interface

How long will the system / interface continue?

N/A

What upgrades and replacements are planned?



N/A

Legislative climate and other forces affecting system / interface?

N/A

Comments?

N/A



1.11. Contract Log System

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

Contract Log System

Owner Information

Name, phone, email, etc. of user and support contacts

See Common Answers document

Division of Contracts: Ernestine Staley – (803) 898-2642 – staley@scdhhs.gov

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

The Contract Log System is used to:

- Assign contract numbers by provider type.
- Add/change a provider record.
- Delete a provider record.
- Change a status records.
- Amend a provider record.
- Browse contracts.
- Track review process (i.e. to - from dates).
- Reports include the Renewal list of contracts by Bureau, All Bureaus, and Procurement Specialist.
- Provider the Sole Source/MMO contract.
- HIPAA Report.
- Administrative Cost Sharing Report.

Objectives

What are the goals of the system / interface? Why was it initiated?

The objective of this system is to track and report on contracts with providers held by the agency.

Business Processes

What business processes require the interface?

See Interfaces/PC Applications related to Business Process document.

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

The program area would like to be able to include Medicaid/ NPI numbers in the system.

Changes may be made regarding how the Contract Log System will be used when SCEIS is implemented in November 2009.



Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

N/A

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, Connect:Direct etc.).

N/A

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

N/A

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

Business triggers include:

- New contract number.
- Amendment to the contracts.
- Extension to the contracts.
- Renewal of contracts.
- Termination of Contracts.

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

See Overview section.

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

N/A

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

No forms – just assignment of a new contract number and contract information into the system.

Outputs

List all system / interface outputs – e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable. If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

Report Menu:



- Contract Standard Log Report
- Contract Numbering Assignment Report
- Contract Tracking Report
- My Contract Tracking Report
- All Contracts by Procurement Specialist
- All Contracts by Bureau
- Annual Contract Renewal Reports
- My Bureau
- All Bureaus
- Procurement Specialist
- All Procurement Specialists
- Provider Listing
- Bureau Listing
- Service Code Listing
- Category Code Listing
- Status Code Listing
- User Listing
- Report Previewer
- MMO Contracts
- Contracts that Include HIPAA
- Sole Source Contracts
- Emergency Procurement

Record Layout

Attach sample layout if applicable.

N/A

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

N/A

Governing Policies

Policies that govern use or other activity involving the system / interface.

See Common answers document.

Access Control Policies and Security

*Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)
What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?*

List data security levels, security requirements etc.

See Common Answers document.



Access to the system is controlled in part by Group rights administration over the SCDHHS network. Within the Contract Log System, there are 7 levels of user access that are controlled by username and password: 99 - Procurement Manager (access to all reports, utilities, procurement tables, as well as user table); 95 - Procurement Specialist (access to all reports, procurement data entry, and validation tables); 79 - Procurement Assistant (procurement basic data entry); 75 - Technical Support; 69 - Fiscal (Fiscal basic data entry); 59 - Bureau (Read Only for assigned bureau); 00 - No Access.

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

N/A

System / Interface Data Processing Standards

If a service level agreement (SLA) or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

The system responds immediately.

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

7:30am – 5:30pm, Monday – Friday.

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

This system is very important to the contractor management business areas.

Disaster Recovery

Attach any disaster recovery plans.

See Common Answers document.

Contract

Legal agreement status and document location.

N/A

Data Storage & System Attributes

*What programming languages were used in creating the system / interface, or what **Commercial, off-the-shelf (COTS)** software was acquired?*

What DBMS, file systems, etc., does the system use for storing transactional / operational data? Attach data formats or schemas or provide location of format / schema documentation if possible.

The Contract Log System is an old Clarion 5.X application with a TPS database (TopSpeed). It is a multiuser system accessible over our central office Local Area Network (LAN).

Transaction processing

Type (batch / real-time).

Real-time



Data Quality Control

Describe quality control policies / procedures.

N/A

Backup

Describe / attach backup procedures and policies.

See Common Answers document.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

There is no known capacity – as many users as the server can handle.

Support

Support hours and response times. Who handles user support, and how? Explain escalation / levels, if applicable.

See Common Answers document.

Incident Management

Process / constraints by which incidents are handled.

See Common Answers document

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?

See Common Answers document.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

See Common Answers document

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens? Include medium, etc.

N/A

Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

N/A

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

N/A



Plans for the System / Interface

How long will the system / interface continue?

N/A

What upgrades and replacements are planned?

N/A

Legislative climate and other forces affecting system / interface?

N/A

Comments?

N/A



1.12. Dental Prior Authorization System (DPA System)

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

Dental Prior Authorization System (DPAS)

Owner Information

Name, phone, email, etc. of user and support contacts

See Common Answers document

SCDHHS Bureau of Care Management and Medical Support Services; Division of Preventative and Ancillary Health Services; Department of Dental Services:

Shirley W Carrington – (803) 898-2568 – carrings@scdhhs.gov

Benita F Jacobs – (803) 898-2655 – jacobsbf@scdhhs.gov

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

The DPAS submits and tracks approved prior authorization (PA) requests as they are processed, and serves as a beneficiary treatment history resource. PAs that have been denied are kept in the Dental program area filing cabinet (these are not tracked by the DPAS).

Process for using the DPAS system:

- a. When the Dental program area receives a PA request, the request is either approved or denied. Approved PA information (provider number, recipient number etc.) is entered into the system and a PA number is assigned.
- b. In cases of determination of medical necessity for non covered services or frequency issues, the request (with documentation attached) is then forwarded to the program area's dental consultant for his/her determination of approval or denial of the request. The consultant may also assign an allowable reimbursement rate to the services.
- c. Services that are standard frequency issues (e.g. multiple periodic Panorex films taken for treatment of broken mandible outside the once every 3 years limit) and have documentation attached, are entered, approved and returned (mailed) to the provider.
- d. The provider submits a claim with the PA number listed on the claim form and a copy of the approved request for PA. They will list the procedure code "D9999" on the claim, which causes the claim to suspend to the program area for manual pricing (507 edit).
- e. The program area enters the reimbursement pricing amount and returns the suspended claim to MCCS for processing.

In the Dental Services program, there are dental procedures that are non-covered services or limited in frequency. For beneficiaries under the age of 21, some non-covered services and/or services outside the frequency limits may be identified as medically necessary during an Early,



Preventive Screening, Diagnosis and Treatment (EPSDT) appointment. SCDHHS is then required to provide that service to the beneficiary, and this process requires a PA request.

Objectives

What are the goals of the system / interface? Why was it initiated?

In the Dental Services program, there are dental procedures that are non-covered services or that may be limited in frequency. For beneficiaries under the age of 21, some non-covered services and/or services outside the frequency limits may be identified as medically necessary during an EPSDT appointment, which require PA.

The DPAS system generates PA number and tracks approved PA requests as they are processed. The system contains a beneficiary's treatment history and provider's PA usage. The DPAS retains information and providers accessible to PA requests.

Business Processes

What business processes require the interface?

See Interfaces/PC Applications related to Business Processes document.

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

Improvements for DPAS:

The Dental Program would like for the DPA to be interfaced or integrated with the MMIS. Processing requests for Prior Authorization is a tedious and time consuming job that needs to be streamlined and more automated. The program area would like to eliminate the need for the claim to circulate so many times between provider and the program area while utilizing a licensed dentist consultant in the approval process.

NOTE: Also see "What upgrades and replacements are planned?" near the bottom of this document.

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

N/A

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, Connect:Direct etc.).

N/A

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

N/A

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface



When a PA request is approved, this triggers a worker to key the information into the DPAS system, which generate a PA number for use in claims submission.

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

N/A

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

N/A

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

See overview.

Outputs

List all system / interface outputs – e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

Ad-hoc reports.

Record Layout

Attach sample layout if applicable.

N/A

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

N/A

Governing Policies

Policies that govern use or other activity involving the system / interface.

See Common Answers Document.

Security

List data security levels, security requirements etc.

Security is set at the network level (Novell). The system is accessed through Novell Application Launcher on the workers desktop.

Access Control Policies

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

N/A



Security and Confidentiality Procedures

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

Security is set at the network level (Novell). The system is accessed through Novell Application Launcher on the workers desktop.

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

N/A

Contract and Service Level Information

If a service level agreement (SLA) or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

N/A

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

During standard business hours.

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

This is a manual and inefficient process. The system provides an electronic record of approved Pas and generates PA numbers. However, staff could complete PA requests without the system.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

N/A

Support

Support hours and response times.

7:30am – 5:30pm, Monday – Friday.

The program area calls the Help Desk, which refers the issue to Richard Twohey.

Incident Management

Process / constraints by which incidents are handled.

See Common Answers document.

Disaster Recovery

Attach any disaster recovery plans.

See Common Answers document.

Contract

Legal agreement status and document location.

N/A



System / Interface Data Processing Standards

Data Storage

*What DBMS, file systems, etc., does the system use for storing transactional / operational data?
Attach data formats or schemas or provide location of format/schema documentation if possible.*

Front End: Clarion

Back End: MSSQL

Windows based.

Transaction processing

Type (batch / real-time).

N/A

Capacity

Including peak intervals.

There is no known capacity – as many users as the server can handle. This has never been an issue for the program area.

Data Quality Control

Describe quality control policies / procedures.

N/A

Backup

Describe / attach backup procedures and policies.

See Common Answers document.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

There is no known capacity – as many users as the server can handle. This has never been an issue for the program area.

Support

Support hours and response times.

See Common Answers document.

The program area calls the Help Desk, which refers the issue to Richard Twohey.

Incident Management

Process / constraints by which incidents are handled.

See Common Answers document.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?

See Common Answers document.

Help Desk

Who handles user support, and how? Explain escalation / levels, if applicable.

The program area calls the Help Desk, which refers the issue to Richard Twohey.



System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

No problems have been reported though the system is not efficient.

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens?

Include medium, etc.

N/A

Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

N/A

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

N/A

Plans for the System / Interface

How long will the system / interface continue?

SCDHHS has awarded a contract with an Administrative Services Organization (ASO) to administer the processing and adjudication of dental claims including the PA process.

What upgrades and replacements are planned?

See above.

Legislative climate and other forces affecting system / interface?

See above.



1.13. Durable Medical Equipment (DME)

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

Durable Medical Equipment (DME) Tracking System

Owner Information

Name, phone, email, etc. of user and support contacts

See Common Answers document

SCDHHS Bureau of Health Services (Division of Pharmacy and DME Services):

Zanipha Mohamed – (803) 898-2879 – Mohamed@scdhhs.gov

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

This in-house database application houses all approved DME PA requests. This application tracks the usage of DME and supplies. Denials of PA requests are sent to the provider and recipient, and hard copy records are maintained. No denied PA requests are housed in the system. The program area would like to redesign the system to increase its functionality and inherent value. The application is used daily to research past PA requests as a safeguard against duplicate requests for DME. The application is also used to manually place new information online for this program area's research.

Objectives

What are the goals of the system / interface? Why was it initiated?

The objectives of this system are to track approved PA requests for DME that has been provided to a recipient of Medicaid to protect against provider fraud. The information stored in this tracking system is used by the program area for research.

Business Processes

What business processes require the interface?

See Interfaces/PC Applications related to Business Processes document.

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

Currently, PAs are filled out by hand and then keyed into the DME Tracking System. Copies are made of the hand-filled PA forms and mailed to MCCA for use during claims processing. The program area would like for the PA forms to be available online for completion and then automatically loaded into a database. MCCA should have access to this database, eliminating the need for hard copies. They would also like the ability to email the electronically stored PAs as attachments to the requesting providers .

Interface Summary



Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

N/A

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, Connect:Direct etc.).

N/A

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

N/A

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

N/A

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

N/A

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

N/A

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

PA data that is manually keyed; the data is stored by PA number.

Outputs

List all system / interface outputs – e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

No outputs: There is no reporting component.

Record Layout

Attach sample layout if applicable.

N/A

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.



N/A

Governing Policies

Policies that govern use or other activity involving the system / interface.

See Common Answers document.

Security

List data security levels, security requirements etc.

N/A

Access Control Policies

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

N/A

Security and Confidentiality Procedures

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

N/A

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

N/A

Contract and Service Level Information

If a service level agreement (SLA) or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

N/A

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

N/A

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

N/A

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

N/A

Support

Support hours and response times.

See Common Answers document.

Incident Management

Process / constraints by which incidents are handled.

See Common Answers document.



Disaster Recovery

Attach any disaster recovery plans.

See Common Answers document.

Contract

Legal agreement status and document location.

N/A

System / Interface Data Processing Standards

Data Storage

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format/schema documentation if possible.

N/A

Transaction processing

Type (batch / real-time).

N/A

Capacity

Including peak intervals.

N/A

Data Quality Control

Describe quality control policies / procedures.

N/A

Backup

Describe / attach backup procedures and policies.

See Common Answers document. \

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

N/A

Support

Support hours and response times.

See Common Answers document.

Incident Management

Process / constraints by which incidents are handled.

See Common Answers document.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?

See Common Answers document.

Help Desk

Who handles user support, and how? Explain escalation / levels, if applicable.



Staff first contact the SCDHHS Help Desk for assistance. The Help Desk determines if they will resolve the incident or send the request to Network Services or Application Development Support. Historically, most issues encountered have been connection or access issues.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

N/A

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens? Include medium, etc.

N/A

Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

N/A

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

N/A

Plans for the System / Interface

How long will the system / interface continue?

N/A

What upgrades and replacements are planned?

N/A

Legislative climate and other forces affecting system / interface?

N/A



1.14. Estate Recovery System

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

Estate Recovery (ER) System (including the interface with the Estate Recovery Import System which DHEC maintains)

Owner Information

Name, phone, email, etc. of user and support contacts

SCDHHS Bureau of Fiscal Affairs; Division of Accountability and Collections; Department of Estate Recovery:

Melinda Clark – (803) 898-2862 – clarkmj@scdhhs.gov

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

The ER System is a database that tracks estate recovery cases and related information. The ER System has three primary functions: case management, diary, and reports.

The case management function of the Estate Recovery System tracks the returned questionnaire information – and open a case if there is sufficient enough assets (\$10,000 or greater) to pursue a claim. The diary function tracks critical time reminders and deadlines.

An Estate Recovery Questionnaire is sent to the family or personal representative of all recipients who died that were either in a nursing home or receiving CLTC services. The letter that is sent out with the questionnaire is generated out of the ER System.

Review case files for all pertinent information and ensure that all information has been posted accurately to the Estate Recovery database. The following is a list of the pertinent information:

Case Number

Personal Representative(s) Information (name and address)

Attorney Information (name and address)

Date of Death

Date Notice to Creditor's first ran in the newspaper

Claim Amount

This information can come from several sources; the Estate Questionnaire, the Probate Inquiry, notes in the log from a telephone conversation with a family member, an attorney, or responsible party.



Note: The Estate Recovery database receives its data from MMIS differently than other TPL functions at SCDHHS. BMSM has a data interface with BITS to provide data for the ER database to be operational. BMSM runs jobs to take data off of the MMIS mainframe.

Objectives

What are the goals of the system / interface? Why was it initiated?

Tracking Estate Recovery cases is the primary objective. See Overview.

Business Processes

What business processes require the interface?

See Interfaces/PC Applications related to Business Process document.

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

No wish list items for this system.

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

DHEC –Estate Recovery receives the daily deaths from DHEC through a secure FTP transfer and stores this data in a temporary database. This data is matched against the MMIS, and matches are sent to the ER Import Database (see below). Data from the temporary ER Import Database will be entered into the primary ER database if it becomes a case.

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, Connect:Direct etc.).

The data files are fixed length text file.

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

Data is encrypted and transmitted from DHEC to SCDHHS via C:D.

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

Below is a list of these events that would prompt Estate Recovery to use the ER database:

REFERRAL SOURCES

*Nursing Homes (181 Form) – This form is sent from claims processing when a Medicaid recipient is terminated from Medicaid.

Estate Recovery Import System (DHEC) – Estate Recovery does not receive the hard copy report any longer. Each day their IT department receives the daily deaths from DHEC through a secure FTP transfer. The data is stored in a temporary database. This data is matched against the MMIS system and matches are sent to the ER Import Database (see Interfaces above).

*Income Trust – When the Division of Eligibility terminates a recipient's income trust due to death, the Division forwards a copy of this letter (via e-mail) to the department head in Estate Recovery. In addition to being a referral, the letter is used to potentially reduce the amount of



monies recovered by Estate Recovery. However, effective in 2005, the policy changed and there shouldn't be remaining funds in the income trust. The trusts have been established to utilize all the funds in the account each month. However, there are rare occasions where the funds were not spent as established. The Eligibility Department will not request the funds to be repaid.

However, based on the type of account (joint, sole) and the balance remaining in the account it may become part of the recipient's estate and therefore subject to Estate Recovery

Family Member – contacts received by the family either by phone or letter.

Attorney – contacts received by the attorney probating the estate or real estate closing attorney.

*MMIS – (recipient subsystem) – On a monthly basis, BMSM provides a report that lists recipients over the age of 55 who had a date of death entered into the recipient record.

Casualty Department –forward leads to the ER department that are obtained from accident questionnaires or notices.

Health Department –forward leads to the ER department from canceled policies.

*Community Long Term Care (CLTC) – leads are forwarded from case managers when they close recipient's files due to death.

Provider – any provider that is aware of a recipient's death may forward information to the ER department. *(Have not received any of these types of referrals)*

*SCDHHS – (238 Form) – when an eligibility case worker receives a notice of death and closes out the recipient's file, he completes this form and forwards it to the ER department with any supporting documentation.

*Hospital – the UB-04 claim form contains a data element for the hospital to enter the date of death. Computer form is generated and sent to the Estate Recovery Department.

Personal Representative – This is the individual that has been appointed by the Probate Court to administer the recipient's estate.

Probate Court -This is the court in SC who is responsible for the administration of estates for all South Carolina residents.

Hospice – this report is sent from the department of Community Long Term Care when a recipient has been discharged from Hospice.

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

See Overview, and Interfaces sections.

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

N/A

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.



If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

See Interfaces. The ER questionnaire is entered manually into the ER database.

Outputs

List all system / interface outputs – e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

See project repository for a screenshot of available reports.

Record Layout

Attach sample layout if applicable.

N/A

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

Attached:

See SDLC, Chapter 7 – Support Phase.

Governing Policies

Policies that govern use or other activity involving the system / interface.

See Common Answers document.

Access Control Policies and Security

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

List data security levels, security requirements etc.

See Common Answers document.

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

N/A

System / Interface Data Processing Standards

If a service level agreement (SLA) or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

The system responds immediately.

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

Standard business hours: 7:30am – 5:30pm, Monday – Friday.



Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

This system is very important to case management and ER reporting.

Disaster Recovery

Attach any disaster recovery plans.

See Common Answers document.

Contract

Legal agreement status and document location.

N/A

Data Storage & System Attributes

*What programming languages were used in creating the system / interface, or what **Commercial, off-the-shelf (COTS)** software was acquired?*

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format / schema documentation if possible.

Netware server

Database: MS Access 97 (estaterc)

Transaction processing

Type (batch / real-time).

Real-time

Data Quality Control

Describe quality control policies / procedures.

N/A

Backup

Describe / attach backup procedures and policies.

See Common Answers document.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

There is no known capacity – as many users as the server can handle.

Support

Support hours and response times. Who handles user support, and how? Explain escalation / levels, if applicable.

See Common Answers document.

Incident Management

Process / constraints by which incidents are handled.

See Common Answers document.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?



See Common Answers document.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

See Common Answers document.

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens?

Include medium, etc.

N/A

Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

N/A

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

N/A

Plans for the System / Interface

How long will the system / interface continue?

N/A

What upgrades and replacements are planned?

N/A

Legislative climate and other forces affecting system / interface?

N/A

Comments?

N/A



1.15. Executive Log System

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

Executive Tracking Log System

Owner Information

Name, phone, email, etc. of user and support contacts

See Common Answers document

Office of the Director

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

The Executive Log System tracks mail sent to the Director's Office. Sources for this mail include: the Governor's office, other State Agencies, CMS, beneficiaries, etc. After mail is stamped in, it is logged to the appropriate Deputy, and their assistant will send it to the appropriate functional business area. No documents are imaged as this is a simple tracking system.

Any correspondence that requires a response is logged into the system with a suspense date. Turnaround time is five business days for legislative or Governor's office correspondence, seven for regular correspondence, and ten for FOIA requests.

Information entered into the system includes: entry date, last update, user name, log number, fiscal year, correspondence date, subject, category, category description, referred to, date referred, response time, due date, logged to and date cleared (also there is an entry for if it needs the Director's signature).

Objectives

What are the goals of the system / interface? Why was it initiated?

Track the flow and assign an owner to all correspondence received within the Director's Office.

Business Processes

What business processes require the interface?

See Interfaces/PC Applications related to Business Process document.

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

The Director's Office would like for the system to not close out the log for the communication. Currently, once the log is closed, the original log cannot be edited.

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.



N/A

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, Connect:Direct etc.).

N/A

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

N/A

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

Mail that is received.

Generation of reports for the Deputies' assistants.

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

See Overview section.

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

N/A

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

No forms – just a simple tracking system.

Outputs

List all system / interface outputs – e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

The Director's Office generates reports weekly for the Deputies' assistants to track the status of logs. The documents are not imaged.

Record Layout

Attach sample layout if applicable.

N/A

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

N/A



Governing Policies

Policies that govern use or other activity involving the system / interface.

See Common answers document.

Access Control Policies and Security

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

List data security levels, security requirements etc.

See Common Answers document.

Username and password.

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

N/A

System / Interface Data Processing Standards

If a service level agreement (SLA) or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

The system responds immediately.

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

7:30am – 5:30pm, Monday – Friday.

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

Non-critical

Disaster Recovery

Attach any disaster recovery plans.

See Common Answers document.

Contract

Legal agreement status and document location.

N/A

Data Storage & System Attributes

*What programming languages were used in creating the system / interface, or what **Commercial, off-the-shelf (COTS)** software was acquired?*

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format / schema documentation if possible.

Programming language: Clarion 6.X

Database platform: MS SQL 2k (ExecutiveMail_Tracking).

Network: Netware Server.



Transaction processing

Type (batch / real-time).

Real-time

Data Quality Control

Describe quality control policies / procedures.

N/A

Backup

Describe / attach backup procedures and policies.

See Common Answers document.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

There is no known capacity – as many users as the server can handle.

Support

Support hours and response times. Who handles user support, and how? Explain escalation / levels, if applicable.

See Common Answers document.

Incident Management

Process / constraints by which incidents are handled.

See Common Answers document

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?

See Common Answers document.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

See Common Answers document

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens?

Include medium, etc.

N/A

Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

N/A

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.



N/A

Plans for the System / Interface

How long will the system / interface continue?

N/A

What upgrades and replacements are planned?

N/A

Legislative climate and other forces affecting system / interface?

N/A

Comments?

N/A



1.16. Government Accounting and Financial Reporting System (GAFRS)

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

Government Accounting and Financial Reporting System (GAFRS)

Owner Information

Name, phone, email, etc. of user and support contacts

South Carolina Budget and Control Board

Technical contact(s):

Rod Davis (SCDHHS) - 898-2787

Billy Crout (DSIT) - 737-4630

SCDHHS program area contact(s):

Virginia Shealy (SCDHHS) - (803) 898-4592 – shealyv@scdhhs.gov

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

GAFRS is the accounting system used by SCDHHS and other state agencies. The system is physically housed at the Budget and Control Board and is maintained by their Chief Information Officer (CIO). The Bureau of Fiscal Affairs is responsible for using GAFRS to track all financial transactions at SCDHHS. All physical funds reside at the South Carolina Treasurer's Office). SCDHHS receives the Chart of Accounts from the Comptroller General's Office with the annual appropriations by Mini Code (Budget Unit Code as they are known in Fiscal Affairs). The Medicaid Finance and Accounting Operations departments prepare an AFI file and send it to the Financial Systems department for loading appropriations into GAFRS (the Agency accounting system). Appropriations are loaded into GAFRS by Mini Code, Fund and Expenditure Object codes 1100 and 1201.

Based on the approved funding levels, allotments are developed for each Bureau/Division. The information is entered into EXCEL spreadsheets and must be approved by executive staff. When allotments are approved by executive staff, Accounting Operations prepares an AFI file to send to Financial Systems for loading into GAFRS. This is both a manual and electronic process handled through EXCEL, ACCESS, FTP and GAFRS. Allotments are loaded for Other Operating and Salary by Index, PCA and Expenditure Object.

After Appropriations and Allotments are loaded into GAFRS, beginning cash balances for state 1001 funds are loaded into the Grants by taking the total amounts allocated by Mini Code and allocating it to each Grant based on the previous year's expenditures. Borrowing limits for



Federal funds are loaded into GAFRS. This is both a manual and electronic process handled through EXCEL, ACCESS, FTP and GAFRS.

SCDHHS has a contractors that receives refund payments from insurance companies, providers, and pharmaceutical companies. These contractors deposit these monies into a Lock Box account at Wachovia Bank. The State Treasurer's Office sweeps that account daily and posts these funds to J02 (SCDHHS). Nightly, the Comptroller General's office sweeps the State Treasurer's Office for SCDHHS transactions. A Revenue Interface is conducted (based on specific criteria established for the interface) to post funds into GAFRS. The following morning, the batch is available in GAFRS for Financial Systems staff to release, activate, and post.

Funding can be moved between grants, appropriations, and allotments in several ways. Funds from a grant can be moved between grants. Appropriations can be moved between Mini Codes. Allotments can be moved between the program areas. Fiscal Affairs staff monitors this using GAFRS reports or error messages. After GAFRS processes the weekly MMIS data, the staff reviews the reports and alerts to ensure there is sufficient money appropriated to each fund to fund the week's MMIS payments. Staff make manual "journal entries" in GAFRS to adjust the source of funds, if necessary.

GAFRS flags any errors it finds and provides a description of what happened. A Fiscal Affairs worker makes a manual adjustment (e.g. journal entry) in GAFRS to correct the error. Supervisors will sometimes address the error, or they will email the appropriate division making them aware of the issue requiring action. Supervisors have the ability to monitor every user that is logged into GAFRS; this allows them to ensure that the Fiscal Affairs workers are performing their assigned tasks (e.g. clearing up any errors that GAFRS flagged).

Reports are generated monthly from GAFRS and MMIS and are used to reconcile the two systems. Any errors identified are cleared up as quickly as possible. The Fiscal Affairs accounting operation are heavily monitored with reports generated from GAFRS. All financial reports are generated in GAFRS. They are created Daily, Weekly, Monthly, Quarterly, Annually, and on an ad-hoc basis and are available for viewing electronically in D:D. The primary reports used for monitoring cash, appropriations, allotments, etc., are as follows:

DAFR9424 - Appropriation Summary Status Report; DAFR9427 - Program Structure Appropriation Summary Status Report; DAFR 9428 - GAFRS Financial Data Summary Analysis Report; DAFR 9053 - Allotment Detail by Selected Expend Object & BUC Report; DAFR 9213 - Summary Pre-Encumbrance/Encumbrance Status Report;

Objectives

What are the goals of the system / interface? Why was it initiated?

The objective of GAFRS is to provide an efficient and effective way to track all SCDHHS financial transactions.



Business Processes

What business processes require the interface?

See Interfaces/PC Applications related to Business Processes document.

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

GAFRS will be retired and replaced with SAP in the near future (scheduled for the end of 2009).

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

See attached legacy interfaces for overview, description, and business triggers.

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, Connect:Direct etc.).

N/A

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

N/A

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

See attached legacy interfaces for overview, description, and business triggers.

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

See attached legacy interfaces for overview, description, and business triggers.

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

N/A

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

See attached legacy interfaces for overview, description, and business triggers.

Outputs

List all system / interface outputs – e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?



GAFRS has various reporting capabilities. The primary reports used for monitoring cash, appropriations, allotments, etc., are as follows:

DAFR9424 - Appropriation Summary Status Report; DAFR9427 - Program Structure Appropriation Summary Status Report; DAFR 9428 - GAFRS Financial Data Summary Analysis Report; DAFR 9053 - Allotment Detail by Selected Expend Object & BUC Report; DAFR 9213 - Summary Pre-Encumbrance/Encumbrance Status Report;

These reports are all available to Fiscal Affairs staff electronically via Document Direct. Additional reports can be generated by some of the interfaces – see legacy interfaces listed in the project repository for a description of those reports.

Record Layout

Attach sample layout if applicable.

N/A

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

N/A

Governing Policies

Policies that govern use or other activity involving the system / interface.

N/A

Security

List data security levels, security requirements etc.

There are 2 security levels; Administrator, and User. An Administrator has full access, while a User only has access to certain transaction codes that are related to the job he/she is performing for Fiscal Affairs. A transaction code is used when any task is performed.

Access Control Policies

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

Refer to Security section. Access is restricted by transaction codes.

Security and Confidentiality Procedures

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

See security levels above.

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

See attached legacy interfaces for overview, description, and business triggers.

Response Time

Within what timeframe must the system / interface respond?

N/A

**Availability**

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

Standard business hours.

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

The system is critical to the financial operations of SCDHHS. If the system were unavailable, claims could still be paid, but there would be no record (outside of the MMIS) of these service transactions. GAFRS also keeps record of all of the administrative transactions made by the agency, and there would be no way to monitor this (outside of the specific program areas records of the transactions). The system also keeps track of the appropriations, allocations, and grants – it would be very difficult to monitor all of these funding sources (e.g. what has been spent, and how much is left) without this financial system.

Disaster Recovery

Attach any disaster recovery plans.

DSIT has a disaster recovery contract with SunGard. Recovery from tape to like-hardware at the SunGard facility is the method of disaster recovery used. There is a written plan for recovery maintained by the CIO.

In addition to nightly backups, there are also "GAFRS" batch-cycle files kept offsite.

Contract

Legal agreement status and document location.

N/A

System / Interface Data Processing Standards**Data Storage**

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format/schema documentation if possible.

The DBMS is IDMS. Data files are stored on disk, and on tape. Files are sequential and perhaps some VSAM. Applications are responsible for running the batch cycles.

Transaction processing

Type (batch / real-time).

N/A

Capacity

Including peak intervals.

N/A

Data Quality Control

Describe quality control policies / procedures.

N/A

Backup

Describe / attach backup procedures and policies.



Daily, files are incrementally backed up to onsite Virtual Tape System (VTS) only. There are batch cycles for the system; they are the responsibility of Applications.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

There are no limitations to the number of users that connect to the DB. Connectivity can be established via TN3270 emulators. Users must have RACF authority.

Support

Support hours and response times.

See Common Answers

Incident Management

Process / constraints by which incidents are handled.

Fiscal Affairs staff are the first line of support. Otherwise, the CIO helpdesk at the South Carolina budget and control board manages a helpdesk for handling issues like password resets, printers reset, etc. Most issues can be resolved in a few minutes up to one business day. For programming changes, Fiscal Affairs staff works with the CIO come to an agreed upon timeline.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?

GAFRS is located at the Budget and Control Board. The Budget and Control Board has multiple offices. The physical location of the GAFRS system is the Broad River Road facility. Much of the technical staff for GAFRS is located at SCEIS (which is a part of the Budget and Control Board); this facility is on Browning Road.

Help Desk

Who handles user support, and how? Explain escalation / levels, if applicable.

Fiscal Affairs staff are the first line of support. Otherwise, the CIO helpdesk at the South Carolina budget and control board manages a helpdesk for handling issues like password resets, printers reset, etc. Most issues can be resolved in a few minutes up to one business day. For programming changes, Fiscal Affairs staff works with the CIO come to an agreed upon timeline.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

For programming changes, the Fiscal Affairs program area works with the CIO come to an agreed upon timeline. Billy Crout and Danny Stokes are the support staff that handle most system issues.

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens? Include medium, etc.

N/A

Continuous Business Process Improvement

Is a methodology in place? Explain.



N/A

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

N/A

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

N/A

Plans for the System / Interface

How long will the system / interface continue?

GAFRS will be retired and replaced with SAP, which is scheduled for the end of 2009.

What upgrades and replacements are planned?

SAP

Legislative climate and other forces affecting system / interface?

N/A



1.17. Hospital Services System

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

Hospital Services Tracking System

Owner Information

Name, phone, email, etc. of user and support contacts

See Common Answers document

SCDHHS Bureau of Health Services (Division of Hospitals):

Zenovia Vaughn – (803) 898-2665 – vaughnz@scdhhs.gov

Edith Moore Faulkenberry – faulkenb@scdhhs.gov

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

SCDHHS contracts with a Quality Improvement Organization (QIO) contractor for reviews of prior/pre-authorizations and support documentation for services rendered by physicians. The remaining hospital services go through agency-internal review by the hospital services registered nurse and medical director. They review requests for unlisted drugs and services and for codes not covered under contract with the contractor. Unlisted codes require authorization and manual pricing. Unlisted codes suspend to the program area for this review.

This system tracks suspended claims (1500 and UB-04) that come in for internal review.

The system was created to more effectively respond to hospitals', and physicians' inquiries on the status of a suspended claim/ECF. This tracking system is located in the Hospital Services program area's office at SCDHHS. As mailed claims/ECFs are received from MCCS (contractor), they are date stamped and then forwarded to Hospital Services for keying into the tracking system. The claims/ECFs that are accepted are then sent back to MCCS for processing. Once the claim is worked(rejected, accepted, additional information is requested, etc.), the system is updated to reflect that action. Only Hospital Services staff performs these reviews and enter data into the tracking system. Physicians' Services staff has read-only access; they have read-only access because 90% of the claims/ECFs being reviewed by Hospital Services are for doctors who often want to know the status of their claims/ECFs. The remaining 10% of inquires come from hospitals' independent of the physician inquiring about a claim/ECFs.

Objectives

What are the goals of the system / interface? Why was it initiated?



The objectives of this system are to track hospitals', and physicians' claims for the Hospital Services, and Physician Services program areas. Additionally, the system determines how timely suspended claims are reviewed by the nurse reviewer.

Business Processes

What business processes require the interface?

See Interfaces/PC Applications related to Business Processes document.

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

N/A

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

N/A

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, Connect:Direct etc.).

N/A

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

N/A

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

Suspended claims coming in for internal review (see Overview).

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

Suspended claims coming into Hospital Services for review (see Overview).

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

N/A

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

Hospital and physician claims tracking data, claims action. Inputs are keyed manually.



Outputs

List all system / interface outputs – e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

No outputs: There is no reporting component.

Record Layout

Attach sample layout if applicable.

N/A

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

N/A

Governing Policies

Policies that govern use or other activity involving the system / interface.

See Common Answers document.

Security

List data security levels, security requirements etc.

N/A

Access Control Policies

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

N/A

Security and Confidentiality Procedures

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

N/A

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

N/A

Contract and Service Level Information

If a service level agreement (SLA) or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

N/A

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

N/A



Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

This system is critical to the operations of Hospital Services. Without it, the staff must manually track the progress of suspended claims awaiting internal-agency review.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

N/A

Support

Support hours and response times.

See Common Answers document.

Incident Management

Process / constraints by which incidents are handled.

See Common Answers document.

Disaster Recovery

Attach any disaster recovery plans.

See Common Answers document.

Contract

Legal agreement status and document location.

N/A

System / Interface Data Processing Standards

Data Storage

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format/schema documentation if possible.

N/A

Transaction processing

Type (batch / real-time).

N/A

Capacity

Including peak intervals.

N/A

Data Quality Control

Describe quality control policies / procedures.

N/A

Backup

Describe / attach backup procedures and policies.

See Common Answers document.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

N/A



Support

Support hours and response times.

See Common Answers document.

Incident Management

Process / constraints by which incidents are handled.

See Common Answers document.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?

See Common Answers document.

Help Desk

Who handles user support, and how? Explain escalation / levels, if applicable.

Staff contact the SCDHHS help desk for assistance. The help desk determines if they, Network Services, or Application Development Support will resolve the issue.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

N/A

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens? Include medium, etc.

N/A

Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

N/A

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

N/A

Plans for the System / Interface

How long will the system / interface continue?

N/A

What upgrades and replacements are planned?

N/A

Legislative climate and other forces affecting system / interface?

N/A



1.18. Integrated Personal Care – Case Management System (IPC CMS)

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

IPC-CMS (Integrated Personal Care – Case Management System)

Owner Information

Name, phone, email, etc. of user and support contacts

See Common Answers document

SCDHHS Bureau of Long Term Care and Behavioral Health Services (Division of Community and Facility Services)

Cathy Lowe – (803) 898-2590 – lowech@scdhhs.gov

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

Staff enter OSS recipients (on Medicaid and gets SS or SSI) assessments completed by IPC nurses into this database. If the resident meets requirements the system issues an Authorization for services that is attached to billing documents (TAD – Turn-Around Document). The system tracks residents in the IPC program.

Below is a description of IPC:

OSS or The Optional State Supplement program pays Community residential care facilities (CRCF's) X dollars per month for Medicaid eligible recipients. This money is a supplement to the residents SS or SSI for room and board.

The amount of the supplement is set by state government via the SC legislative budgetary process.

The amount does not match what CRCF's actually charge for their rooms. IPC was created to increase the amount paid to the CRCF's with matching federal funds. To meet the Federal Government requirements the state can pay facilities for "personal care" (e.g. bathing).

Not all residents require personal care so SCDHHS RNs complete an assessment to determine if the resident requires personal care.

Because SCDHHS gets matching federal funds the CRCF has to apply, be approved, and sign a contract with SCDHHS to be an IPC or "Integrated Personal Care" provider.



If a facility is an IPC provider and has a resident that meets the following conditions the nurse that works at the facility and only that nurse can make the referral.

1. The resident must be receiving an OSS payment. (On Medicaid and gets SS or SSI)
2. The resident must need help with personal care.
3. The resident must consent to an assessment by the SCDHHS nurse to determine eligibility.

The RN will enter the assessment criteria described above into the IPC-CMS. Once the SCDHHS RN determines that the facility is providing personal care and other criteria is met, SCDHHS authorizes the payment of 16.00/day to the facility to provide that care. The form is called an Authorization Service Provision Form or "Authorization" for short.

Monthly-The facility "bills" or "requests payment" for the OSS residents on the TAD. So when they have a resident that qualifies for the EXTRA 16.00/day they simply fill in an extra column on that TAD and attach the Authorization form to request payment. They only attach the "Authorization" form the first month the resident is determined eligible. After that the payment will continue as long as the resident continues to live in the facility and receives personal care. The TAD is mailed by the facility to MCCS (claims processing contractor). MCCS directly deposits the payment into the facilities bank account.

Objectives

What are the goals of the system / interface? Why was it initiated?

The system holds the assessment information performed on residents. The system generates an authorization for service if the resident qualifies. The system tracks the IPC program residents.

Business Processes

What business processes require the interface?

See Interfaces Related to BPs Document.

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

No wish list items for this system.

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

N/A

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, Connect:Direct etc.).

N/A

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

N/A



Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

Assessment of a resident by a SCDHHS nurse. Tracking IPC program residents.

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

Assessment data and authorizations. See the Overview section.

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

N/A

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

Assessment data. See Overview section.

Outputs

List all system / interface outputs – e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

Authorizations – see Overview section. Ad-hoc reports are also generated from the system.

Record Layout

Attach sample layout if applicable.

N/A

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

Attached:

See SDLC, Chapter 7 – Support Phase.

Governing Policies

Policies that govern use or other activity involving the system / interface.

See Common Answers document

Access Control Policies and Security

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

List data security levels, security requirements etc.

Simple username and password are used for access control.



Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

N/A

System / Interface Data Processing Standards

If a service level agreement (SLA) or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

The system responds immediately.

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

Standard business hours: 7:30am – 5:30pm, Monday – Friday.

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

This system is critical to IPC department processes as it monitors and tracks IPC program residents and generates authorization forms.

Disaster Recovery

Attach any disaster recovery plans.

See Common Answers document.

Contract

Legal agreement status and document location.

N/A

Data Storage & System Attributes

*What programming languages were used in creating the system / interface, or what **Commercial, off-the-shelf (COTS)** software was acquired?*

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format / schema documentation if possible.

Database platform: SQL; Programming: VB.Net; System: server based, delivered over network.

Transaction processing

Type (batch / real-time).

Real-time

Data Quality Control

Describe quality control policies / procedures.

N/A

Backup

Describe / attach backup procedures and policies.

See Common Answers document.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).



There is no known capacity – as many users as the server can handle.

Support

Support hours and response times. Who handles user support, and how? Explain escalation / levels, if applicable.

See Common Answers document

Incident Management

Process / constraints by which incidents are handled.

See Common Answers document.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?

See Common Answers document.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

See Common Answers document.

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens? Include medium, etc.

N/A

Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

N/A

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

N/A

Plans for the System / Interface

How long will the system / interface continue?

N/A

What upgrades and replacements are planned?

N/A

Legislative climate and other forces affecting system / interface?

N/A

Comments?

N/A



1.19. Medicaid Disability System

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

Medicaid Disability Tracking System

Owner Information

Name, phone, email, etc. of user and support contacts

See Common Answers document

SCDHHS Bureau of Eligibility Policy & Oversight; Division of Constituent and Beneficiary Services;
Department of Disability Determinations:

Valerie Hollis – (803) 898-3103 – hollisv@scdhhs.gov

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

The Department of Disability Determinations receives 2 types of hardcopy applications (an initial application, and a review application). The initial application is for when an applicant first applies. The information manually keyed into the system for the hardcopy initial application is the applicant data (name, address, SSN), application date, county, eligibility worker, date received, application category and a brief description of the alleged disability. If an applicant becomes a beneficiary (disabled and meet eligibility), they are assigned a medical review date (usually within 3-7 years). The medical review is completed to assess if the medical condition has improved. Information in the system is updated based on the review application.

Objectives

What are the goals of the system / interface? Why was it initiated?

Track Medicaid disability applications from receipt to acceptance or denial into the program.

Business Processes

What business processes require the interface?

See Interfaces/PC Applications related to Business Process document.

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

The Department would like minor improvements and the ability to run reports/queries.

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

N/A



Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, Connect:Direct etc.).

N/A

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

N/A

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

The primary trigger for the use of the system is receipt of an application. If an attribute changes, it is a trigger to use the system.

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

See Overview section.

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

N/A

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

No forms – just a simple tracking system. The inputs are the data that is keyed into the system off of the hardcopy applications (initial and review if applicable).

Outputs

List all system / interface outputs – e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

The data must be viewed on the screen; this system does not have reporting/querying capabilities (see Wish List section).

Attach sample layout if applicable.

N/A

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

N/A

Governing Policies

Policies that govern use or other activity involving the system / interface.



See Common answers document.

Access Control Policies and Security

*Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)
What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?*

List data security levels, security requirements etc.

See Common Answers document.

Username and password is the primary access control mechanism.

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

N/A

System / Interface Data Processing Standards

If a service level agreement (SLA) or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

The system responds immediately.

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

Standard business hours: 7:30am – 5:30pm, Monday – Friday.

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

Non-critical

Disaster Recovery

Attach any disaster recovery plans.

See Common Answers document.

Contract

Legal agreement status and document location.

N/A

Data Storage & System Attributes

*What programming languages were used in creating the system / interface, or what **Commercial, off-the-shelf (COTS)** software was acquired?*

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format / schema documentation if possible.

Programming language: Clarion 6.X

Network: Netware Server.

Transaction processing

Type (batch / real-time).

Real-time



Data Quality Control

Describe quality control policies / procedures.

N/A

Backup

Describe / attach backup procedures and policies.

See Common Answers document.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

There is no known capacity – as many users as the server can handle.

Support

Support hours and response times. Who handles user support, and how? Explain escalation / levels, if applicable.

See Common Answers document.

Incident Management

Process / constraints by which incidents are handled.

See Common Answers document

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?

See Common Answers document.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

See Common Answers document

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens? Include medium, etc.

N/A

Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

N/A

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

N/A



Plans for the System / Interface

How long will the system / interface continue?

N/A

What upgrades and replacements are planned?

N/A

Legislative climate and other forces affecting system / interface?

N/A

Comments?

N/A



1.20. Partners for Health System (PFH)

Project / System / Interface Summary

Name of Project / System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

Partners for Health Tracking System/Central Eligibility Tracking System (PFH system).

Owner Information

Name, phone, email, etc. of user and support contacts

See Common Answers document.

SCDHHS Bureau of Eligibility Processing (Division of Central Eligibility Processing, CEP):

Betsy Fuller – 8038982515 – FULLER@scdhhs.gov

Overview

Briefly describe the project, system, or interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

CEP uses this system in partnership with MEDS.

The PFH system is an automated logbook that tracks the status of Medicaid applications. The system also prints letters based on application events (e.g. enrollment acceptance or denial).

Data in the tracking system is arranged in the form of record entries. Each record entry in the system contains detailed information related to the Medicaid application and its status. These records include information such as payee name, address, household members, application type, pay category, date and time of events, effective dates, termination date, etc.

CEP receives hundreds of pieces of mail each day include Medicaid applications, reviews, and information requested by a caseworker. The mail is: opened, time stamped, copied, hard copy filed, and then manually keyed into the PFH System and sent to the appropriate caseworker.

The tracking system is used when mail is received and when a caseworker takes action. The system prints letters requesting additional information from clients. This system has no interaction with MEDS. The system is useful for tracking the progress of cases and updating clients on the status of their application.

Objectives

What are the goals of the project, system or interface? Why was it initiated?

The goal is to track the movement of applications. A secondary goal is/was to produce letters to beneficiaries, local eligibility offices, or others that were not being produced in MMIS and MEDS.

The PFH system allows supervisors to monitor staff and ensure they are taking the required actions necessary to process the required amount of work each day.



The system was originally initiated to track applications that were generated under the Partners for Healthy Children Project. The program was later expanded and modified to track applications for all applications in Central Eligibility.

Once an application is approved, and the relevant information that is contained in the PFH system needs to be reflected in MEDS, it is transferred manually.

Interface Summary

Wish List

Central Eligibility staff sees the PFH system as a critical and useful tool and would like for its functionality to be incorporated into the new MMIS/MEDS.

Interface Overview

Briefly describe the interface, mention agencies involved, systems involved, data exchange information, etc.

There is no interface. This is a LAN based system.

Purpose

Why does the interface exist? What objectives does it help to achieve?

N/A

Exchange Format

Data structure of data exchange. Attach description if needed. .

Format (XML, custom, X12, etc.)

N/A

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SNA, etc.).

N/A

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

Receipt of mail (Medicaid applications, reviews, additional requested documentation etc.).

Phone calls requesting status of Medicaid application.

Changes to record information (i.e. change of address, change of termination dates etc.).

Information Entities

What kinds of information, in whole or in part, is exchanged (person, claims, etc.)?

N/A

Business Processes

What business processes require the interface?

Refer to Interfaces Related to BPs.

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

N/A



Inputs

List all system inputs -- e.g., form names, files, etc. Include media and frequency. Attach samples if applicable.

Inputs for this system come from the physical applications, reviews, and requested documentation from the beneficiary / potential beneficiary.

Documentation may be received using forms available to the eligibility worker contained in the following link: <http://medsweb.scdhhs.gov/formslisting.htm>

Outputs

List all systems outputs – e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

All Reports are on demand.

Analysis of Application Sources Report; DHEC Cases Returned Report; Event Reports (COU, DOU, and HOU); and TEFRA Detail Report.

User Activity Log Reports (By Event Date or Entry Date, detail data on events logged by users);

TEFRA Activity Log (detail event data related to TEFRA plus logging user).

Acceptance / denial letters can and often are produced out of this system.

Record Layout

Attach sample layout if applicable.

Attached

Governance and Security

Applicable Standards

Standards to which the interface adheres (if not listed elsewhere)

Refer to the SDLC

Governing Policies

Policies that govern use or other activity involving the interface.

N.A.

Security and Access Control

Data security levels, security requirements, access control policies, etc. Describe access control rules for accessing the system (roles, responsibilities, accesses etc. Provide table/matrix showing data access according to user role/functional job title down to the row and column level, if applicable.)

There is group level security in Novell E-directory which controls access to the directory and the application information – it delivers the application to the users that have access to them based on their credentials when signing into Novell.

This is a legacy system – there are access control rules and security built directly into the user interface. There is a User ID Table that assigns roles, responsibilities, permissions etc. Only a system administrator with security level 99 can edit the User ID Table.

Security Level 99 = System Administration (Access to all tables, reports, and utilities)

Security Level 98 = Supervisor (Access to all reports plus add, edit, delete all tables to include validation tables and user profiles)



Security Level 97 = Data Entry Operator Plus (Access to All Reports plus data entry and update access to primary system data – Payee data, Application data, Event data)

Security Level 96 = Data Entry Operator (Data entry access to primary system data)

Security Level 50 = Read Only Access (View Payee, Applications, and Event Data only)

Security Level 00 = No Access (User is disabled)

Confidentiality

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

The system is in the SCDHHS Local Area Network (LAN), so it isn't exposed to the internet. At the network layer, Novell is used to limit exposure to the program. Once a user signs into the system – they are assigned a security level that ensures only the correct staff can view PHI.

Supervisors that have access to PHI ensure that their computers aren't facing public areas.

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

NA (there is a record layout and the SDLC document etc. attached with this document).

Contract and Service Level Information

If a service level agreement (SLA) or contract with SLA information exists, please attach the SLA information. Otherwise, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

The response time for this system is immediate. If a new report is requested by the program area, it is resolved and available within 48 hours.

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

Available 24X7. Support is available during regular business hours. Maintenance that requires the system to be unavailable is completed in the early morning, or on weekends. If immediate action is required during business hours, the program area director is notified.

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

Critical for tracking mail and the status of applications.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.)

The only capacity restriction is what the network can handle.

Support

Support hours and response times.

See Common Answers document.

Incident Management

Process by which incidents are handled.

See Common Answers document.



Disaster Recovery

Attach any disaster recovery plans

See Common Answers document.

Business Continuity

Attach any business continuity plans

NA

Contract

Legal agreement status and document location.

NA

Data Processing Standards

Information Processed

What kinds of information does the system process and how (people, claims, etc.)?

The system tracks detailed information about applications and its status in the process.

Data Stores

What DBMS, file systems, etc., does the system use for storing transactional/operational data?

Attach data formats or schemas or provide location of format/schema documentation if possible.

The data is currently stored in a local TopSpeed database files on our agency LAN.

Transaction processing

Type (batch/real-time), capacity, concurrent users etc.

Processing is in real-time with no restriction on the number of concurrent users.

Capacity

Including peak intervals

The capacity is based on based on bandwidth and has an adequate amount available.

Data Quality Control

Describe quality control policies/procedures.

Refer to the SDLC.

Backup

Describe/Attach backup procedures and policies

Refer to the SDLC.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.)

The capacity is based on based on bandwidth and has an adequate amount available.

Support

Support hours and response times.

See Common Answers document.

Incident Management

Process by which incidents are handled.

See Common Answers document.



Other Project / System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where is the system housed? (City and state, owner, etc.)

Columbia, South Carolina, SC SCDHHS

System Modification and Change Control

How are project/system changes requested, carried out, and documented?

Changes to the system are requested using OAC Request forms. See the SDLC document.

Application Development and Testing Procedures

See the SDLC document.

Security and Confidentiality Procedures

What precautions ensure PHI, proprietary information, and other information is kept secure?

These procedures are outlined within the BITS and HIPAA policies. This is a standalone system.

Contingency Plan

NA

Documentation (User/System)

What kind of technical documentation has been produced? Are there any user manuals or help screens?

Include medium, etc.

Technical documentation is located on the BITS Wiki. A user manual is available.

Continuous Business Process Improvement

Is a methodology in place? Explain.

The functionality of this tracking system will most likely be incorporated into the future MMIS.

Project Roles and Responsibilities

SCDHHS Responsibilities

NA

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

NA

Plans for the Project / System / Interface

How long will the project / System / Interface continue?

NA

What upgrades and replacements are planned?

incorporation into the future MMIS.

Legislative climate and other forces affecting project?

NA



1.21. Program Integrity Case Management System (PI CMS)

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

Program Integrity – Case Management System (PI CMS)

Owner Information

Name, phone, email, etc. of user and support contacts

See Common Answers document

SCDHHS Bureau of Compliance and Performance Review (Division of Program Integrity):

Kathleen Snider – (803) 898-8876 – sniderk@scdhhs.gov, Larry Overbaugh – (803) 898-2901 – overbaugh@scdhhs.gov

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

This is a proprietary Microsoft Access application that manages PI cases. The system tracks basic information about the case, including the case source, open and closure dates, the reviewer and department conducting the review, provider type under review, type of allegation, outcome of the case (including sanctions), and the amount of the overpayment identified and recouped.

Objectives

What are the goals of the system / interface? Why was it initiated?

The objectives are to manage all important information related to program integrity's cases.

Business Processes

What business processes require the interface?

See Interfaces/PC Applications related to business processes document.

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

The PI Division would like to have a web based system with security roles and responsibilities.

They would like to see it incorporated into the new system.

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

N/A

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, Connect:Direct etc.).



N/A

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

N/A

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

When a case is opened, input forms are used to enter case data into the CMS. Any new information requires an update to the CMS.

Whenever leads come to the Fraud Abuse Hotline, the system is used

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

N/A

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

N/A

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.

Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

Note: Screenshots are available in the project repository.

Data is keyed directly into forms in the PI CMS. The Medicaid Complaint Form and Case Form are two commonly used forms. The Medicaid Complaint Form is used when tips come into the Fraud Abuse Hotline. The Medicaid Complaint Form is used once a case file is open.

Outputs

List all system / interface outputs – e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

Note: Screenshots are available in the project repository.

Many reports are generated to track open cases, and do research etc.

Only the PI uses this system. When a case is initiated, a case number and the amount a provider owes input for the system. The outstanding balance report shows outstanding balances, and the collection data range report is used to look specific periods in which a provider owes money.

Record Layout

Attach sample layout if applicable.

N/A



Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

N/A

Governing Policies

Policies that govern use or other activity involving the system / interface.

See Common Answers document.

Security

List data security levels, security requirements etc.

Security is not set at the network level (Novell) but rather directly from within Microsoft Access.

The security levels are as follows:

Full permission, Full Case Data, Full Data Users, Reports Users, Forms Users, and Read-Only

Access Control Policies

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

N/A

Security and Confidentiality Procedures

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

The system has security roles and is only available for division use. Supervisors have full access.

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

N/A

Contract and Service Level Information

If a service level agreement (SLA) or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

N/A

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

Standard business hours.

Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

The system is critical to operations. Without it, new cases would be tracked manually.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

N/A

Support

Support hours and response times.



See Common Answers document. Larry Overbaugh provides the majority of system support.

Incident Management

Process / constraints by which incidents are handled.

See Common Answers document.

Disaster Recovery

Attach any disaster recovery plans.

See Common Answers Document

Contract

Legal agreement status and document location.

N/A

System / Interface Data Processing Standards

Data Storage

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format/schema documentation if possible.

Microsoft Access.

Transaction processing

Type (batch / real-time).

N/A

Capacity

Including peak intervals.

N/A

Data Quality Control

Describe quality control policies / procedures.

N/A

Backup

Describe / attach backup procedures and policies.

See Common Answers document.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

N/A

Support

Support hours and response times.

See Common Answers document. Larry Overbaugh provides the majority of system support.

Incident Management

Process / constraints by which incidents are handled.

See Common Answers document.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.



Data Center

Where are the system / interface housed?

The master file is in the SCDHHS data center (the network room, Mezzanine, Jefferson Square).

Help Desk

Who handles user support, and how? Explain escalation / levels, if applicable.

See Common Answers document. Larry Overbaugh provides the majority of system support.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

N/A

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens?

Include medium, etc.

N/A

Continuous Business Process Improvement

Is a methodology in place? Explain.

N/A

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

N/A

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

N/A

Plans for the System / Interface

How long will the system / interface continue?

N/A

What upgrades and replacements are planned?

N/A

Legislative climate and other forces affecting system / interface?

N/A



1.22. Third Party Liability – Casualty System (TPL Casualty)

Project / System / Interface Summary

Name of System / Interface

Detail whether you are describing a project, system or interface before answering the following questions.

TPL Casualty System

Owner Information

Name, phone, email, etc. of user and support contacts

See Common Answers document

Division of Accountability and Collections; Department of Casualty:

Angela West-Barnett – (803) 898-2953 – west@scdhhs.gov

Overview

Briefly describe the system / interface. What does it involve? Who does it serve? What agency divisions and other entities are involved? What's the status?

The MMIS automatically generates accident questionnaires when certain trauma-related codes appear on claim forms. Clemson prints and sends the questionnaires to SCDHHS for mailing to beneficiaries. The beneficiaries mail the completed questionnaires to the TPL Division at SCDHHS, which handles casualty-related recovery efforts. When questionnaires are returned, the response is posted in the tracking file of the TPL subsystem to stop subsequent letters from being mailed. The MMIS has recovery level indicators on the procedure code file that determines whether 1, 2, or 3 questionnaires will be sent.

The system tracks events, generates letters, and reports related to accident claims received by the agency's TPL department. The system also tracks case information related to the beneficiary, such as Medicaid number, address, other insurance coverage, etc.

The attorney's info (if applicable) may have been provided by the beneficiary on the questionnaire. The TPL Division sends the attorney the itemization form if it is determined that there are enough accident-related claims to warrant establishing a case.

A questionnaire is not always generated for all of the potential casualty recovery cases. Many attorneys already have the Medicaid itemization form on file. Because many questionnaires are not returned, most cases result from attorney itemization requests. They will fill it out and sent it to TPL; they sometimes do this without ever having received a questionnaire.

The attorney sends the TPL Department the itemization form with case information for the accident.



The TPL department conducts research to find out if any claims were paid by Medicaid related to the accident. If Medicaid did pay claims related to the accident and other insurance is available to pay the claim, the TPL department recoup these funds from the insurance company.

Objectives

What are the goals of the system / interface? Why was it initiated?

The objective is to track casualty TPL cases. The system houses information received from the returned questionnaires and attorney itemization forms.

Business Processes

What business processes require the interface?

See Interfaces/PC Applications related to business processes document.

Wish List

List any improvements, upgrades etc. to the system that you would like to see in the future.

N/A

Interface Summary

Interfaces (Internal & External)

List all interfaces, including external users and external hardware and software – e.g., nightly file transfer from another state agency. Include media and frequency.

N/A

Exchange Format

Data structure of data exchange. Attach description if needed.

Format (XML, custom, X12, Connect:Direct etc.).

N/A

Exchange Protocol

What protocols are used in communicating through the interface (FTP, HTTP, SN/A, etc.).

N/A

Triggers

Events, business cycles, technology events, etc., that cause an endpoint to use the interface

A returned questionnaire or an itemization form is sent to the agency.

Information Processed

What kinds of information, in whole or in part, are exchanged (claims, etc.)?

The system tracks events, generates letters, and reports related to accident claims. The system tracks beneficiary case data including Medicaid number, address, other insurance coverage, etc.

Endpoints

The interface endpoints are the information systems that are exchanging data through the interface and the characteristics. For each endpoint, give the system name, characteristics beyond format and protocol. For example, if System A calls a method on a web service provided by System B, mention that it is a web service method call and the method call inputs, outputs, and return value characteristics.

N/A

Inputs

List all system / interface inputs -- e.g., form names, files, etc. Include media and frequency.



Attach samples if applicable.

If input is a form, are these documents imaged, indexed, stored, and accessed electronically?

A returned questionnaire or an itemization form is sent to the agency.

Outputs

List all system / interface outputs – e.g., names and contents of specific reports, data files, etc. Include media and frequency.

Attach samples if applicable.

If output is a report, are these documents imaged, indexed, stored, and accessed electronically?

Ad-hoc reports are generated from this system and support case tracking.

Record Layout

Attach sample layout if applicable.

N/A

Governance and Security

Applicable Standards

Standards to which the system / interface adheres.

Refer to the SDLC document.

Governing Policies

Policies that govern use or other activity involving the system / interface.

See Common Answers document.

Access Control Policies and Security

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

List data security levels, security requirements etc.

See Common Answers document.

This SQL application is distributed to the TPL Casualty area over the network. Simple password and username are used to control access to the system. There are no data security levels.

Documentation

Types (technical, administrator, etc.) and where the documentation can be found.

System / Interface Data Processing Standards

If a service level agreement (SLA) or contract with SLA information exists, please attach the SLA information. If no documentation is available, or there is no SLA / contract, please fill out the following:

Response Time

Within what timeframe must the system / interface respond?

N/A

Availability

When the system / interface must be available for use (for example, 24X7, business hours, etc.)

N/A



Criticality

How critical is the system / interface to business functions? How critical to the mission of the agency is the business function and the system?

This system aids in tracking cases but is not critical.

Disaster Recovery

Attach any disaster recovery plans.

See Common Answers document.

Contract

Legal agreement status and document location.

N/A

Data Storage & System Attributes

*What programming languages were used in creating the system / interface, or what **Commercial, off-the-shelf (COTS)** software was acquired?*

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Attach data formats or schemas or provide location of format / schema documentation if possible.

Netware server, MS Visual Basic v6, MS Access 97 (Cas)

Transaction processing

Type (batch / real-time).

Real-time

Data Quality Control

Describe quality control policies / procedures.

N/A

Backup

Describe / attach backup procedures and policies.

See Common Answers document.

Load

Any capacity minimums or maximums (such as concurrent connections, concurrent users, etc.).

Because of the manner in which the system is distributed and written, load is not a factor.

Support

Support hours and response times. Who handles user support, and how? Explain escalation / levels, if applicable.

See Common Answers document.

Incident Management

Process / constraints by which incidents are handled.

See Common Answers document.

Additional System / Interface Features

Attach diagrams and supplementary materials as needed.

Data Center

Where are the system / interface housed?



See Common Answers document.

System Modification and Change Control

How are systems / interfaces changes requested, carried out, and documented?

Interface changes are requested via the RFC process.

Documentation (User / System)

What kind of technical documentation has been produced? Are there any user manuals or help screens?

Include medium, etc.

Continuous Business Process Improvement

Is a methodology in place? Explain.

System / Interface Roles and Responsibilities

SCDHHS Responsibilities

Contractor Responsibilities

If applicable, explain role of contractor and list major responsibilities.

Plans for the System / Interface

How long will the system / interface continue?

What upgrades and replacements are planned?

Legislative climate and other forces affecting system / interface?

Comments?



Appendix M: Common Answers

MMIS Interfaces: Common Answers

Owner Information:

Name, phone, email, etc. of user and support contacts.

Clemson Medicaid Services MMIS Interface (MMIS and MEDS contractor).

SCDHHS Bureau of Medicaid Systems Management (BMSM).

Access Control Policies and Security:

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)

What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

List data security levels, security requirements etc.

- RACF and Connect:Direct.
- RACF (Resource Access Control Facility) is the security system that protects all mainframe resources at Clemson.
- C:D requires a username and password to sign-on to the online system. You must have RACF access to use C:D for transmission of files.
- HIPAA Privacy Policies.

Disaster Recovery:

Attach any disaster recovery plans.

Clemson University has Disaster Recovery Plans for locations in South Carolina: the Information Technology Center in Anderson, Eagle's Landing (Medicaid Services) in Seneca and Poole Computing Center on the University's campus in Clemson. Data is housed at the ITC and also at Poole Center for backup purposes. Certain critical systems operate redundantly at ITC and Poole. Plans are underway for an out of state redundant location. Disaster Recovery Plans are reviewed and updated.

Backup:

Describe / attach backup procedures and policies.

Both MMIS and MEDS have a Backup and Recovery Strategy that ensures production data to be safe. The database is backed up before running certain production jobs that update the database and can be restored as necessary. Jobs can be restarted at appropriate stopping points. The database can be 'rolled back' to a previous time period.

Multiple backups of data are kept for a duration determined by SCDHHS and Clemson staff. Programs, online dialogs, scripts, etc are backed-up daily during incremental backups. These are partial backups of changed entities. Full system backups are conducted weekly

Support:

Support hours and response times. Who handles user support, and how? Explain escalation / levels, if applicable.



MARCI (Medicaid Applications Response Center Interface) and TigerTracks are used by the Medicaid Services team at Clemson to provide on-call support.

MS Help Desk and GroupLink – are used by the Medicaid Systems Help Desk at SCDHHS. Issues are submitted by MMIS and MEDS users via email and escalated to the Department Head. If there is problem with the data, BMSM is contacted to resolve the problem. Clemson resolves technical issues.

CCIT (Clemson Computing and IT) Operations monitors mainframe jobs.

Incident Management:

Process / constraints by which incidents are handled.

Incident Management and Request for Services for the Medicaid Contract with Clemson University are processed through MARCI.

SCDHHS contacts MARCI via phone or email. Incidents/Requests are logged into Clemson University's "Tiger Tracks" tracking system where they are sent to appropriate areas for resolution. The responding areas can be from the Medicaid Operational team, Technical Support team, Clemson's Network Operations Center and others depending on the request.

Data Center:

Where are the system / interface housed?

The data center is located at Clemson Information Technology Center (ITC) and backup is at the Poole location.

System Modification and Change Control:

How are systems / interfaces changes requested, carried out, and documented?

System Modifications/Request for Services is sent to Clemson University via MARCI where they are entered into "Tiger Tracks" tracking system. Clemson follows a formal plan for new work and system modifications. The plan covers project initialization, planning, execution, production support and closing. These plans are available for review by a request to MARCI.

Change Control: The MEDS system at Clemson University uses Serena Software's ChangeMan product to control changes to Production systems. The MMIS uses an in-house method and plans to use a software product for this purpose.

SCDHHS Responsibilities:

If applicable, explain role of SCDHHS and list major responsibilities.

Submit RFCs to Clemson University.

Contractor Responsibilities:

If applicable, explain role of contractor and list major responsibilities.

Clemson University implements changes and is responsible for executing the interface.

Data Storage & System Attributes:

*What programming languages were used in creating the system / interface, or what **Commercial, off-the-shelf (COTS)** software was acquired?*

What DBMS, file systems, etc., does the system use for storing transactional / operational data?



Attach data formats or schemas or provide location of format / schema documentation if possible.

Mainframe

*What programming languages were used in creating the system / interface, or what **Commercial, off-the-shelf (COTS)** software was acquired?*

COBOL, SAS, Syncsort

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

For MMIS data is extracted from or stored to an IDMS Network database. Extract files are sequential files.

For MEDS data is extracted from or stored to an IDMS Relational database. Extract files are sequential files.

Attach data formats or schemas or provide location of format / schema documentation if possible.

This information is available through the Clemson Medicaid Services DBA group.

EDI X12 Output Files

*What programming languages were used in creating the system / interface, or what **Commercial, off-the-shelf (COTS)** software was acquired?*

COBOL or SAS may be used on the mainframe to create a file which is then sent to the HIPAA Translator system. A combination of Sybase products are used to create the X12 transaction files.

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Data may be pulled from the Sybase Repository, a relational database. The HIPAA Translator system also uses Microsoft SQL Server relational databases. Data from the mainframe may be extracted from sequential files, an IDMS network database, or a combination.

Attach data formats or schemas or provide location of format / schema documentation if possible.

Available through the Clemson Medicaid Services DBA group.

MEVS

*What programming languages were used in creating the system / interface, or what **Commercial, off-the-shelf (COTS)** software was acquired?*

C++, PERL

What DBMS, file systems, etc., does the system use for storing transactional / operational data?

Sybase relational database.

Attach data formats or schemas or provide location of format / schema documentation if possible.

Available from the Clemson Medicaid Services DBA group.



MEDS Interfaces: Common Answers

Owner Information:

Name, phone, email, etc. of user and support contacts.

Clemson Medicaid Services MEDS Interfaces and BMSM.

Access Control Policies and Security:

*Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)
What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?*

List data security levels, security requirements etc.

- RACF (Resource Access Control Facility) is the security system that protects all mainframe resources at Clemson. Anything from who can view or edit a dataset to who can logon to specific systems at Clemson is secured this way.
- Connect:Direct requires a username and password to sign-on to the online system. Additionally, to utilize Connect:Direct for transmission of files, you must have RACF access.
- HIPAA Privacy Policies.

Disaster Recovery:

Attach any disaster recovery plans.

Clemson University has Disaster Recovery Plans for locations in South Carolina: the ITC in Anderson, Eagle's Landing (Medicaid Services) in Seneca and Poole Computing Center on the University's campus in Clemson. Data is housed at the ITC and at Poole Center for backup purposes. Certain critical systems operate redundantly at ITC and Poole. Plans are underway for an out of state redundant location. Disaster Recovery Plans are reviewed and updated.

Backup:

Describe / attach backup procedures and policies.

Both MMIS and MEDS have a Backup and Recovery Strategy that ensures production data to be safe from system outages, program errors and so forth. The database is backed up before running certain production jobs that update the database and can be restored as necessary. Jobs can be restarted at appropriate stopping points. The database can be 'rolled back' to a previous time period.

Multiple backups of data are kept for a duration determined by SCDHHS and Clemson staff. Programs, online dialogs, scripts, etc are backed-up daily during incremental backups. These are partial backups of changed entities. Full system backups are conducted weekly.

Support:

Support hours and response times. Who handles user support, and how? Explain escalation / levels, if applicable.

Support: 24/7 by Clemson.

MARCI and TigerTracks are used for Clemson.

MS Help Desk and GroupLink – are used by the Medicaid Systems Help Desk at SCDHHS. Issues are submitted by MMIS and MEDS users via email and escalated to the Department Head.



Incident Management:

Process / constraints by which incidents are handled.

Incident Management and Request for Services for the Medicaid Contract with Clemson University are processed through MARCI.

SCDHHS contacts MARCI via phone or email. Incidents/Requests are logged into Clemson University's "Tiger Tracks" tracking system where they are sent to appropriate areas for resolution. The responding areas can be from the Medicaid Operational team, Technical Support team, Clemson's Network Operations Center and others depending on request.

Data Center:

Where are the system / interface housed?

ITC and backup at Clemson and Poole Computing Center on the University's campus in Clemson.

System Modification and Change Control:

How are systems / interfaces changes requested, carried out, and documented?

System Modifications/Requests for Services are sent to Clemson University via MARCI (on call center) where they are entered into "Tiger Tracks" tracking system. Clemson follows a formal plan for new work and system modifications. The plan covers project initialization, planning, execution, production support and closing. These plans are available for review by a request to MARCI.

Change Control:

The MEDS system at Clemson University uses Serena Software's ChangeMan product to control changes to Production systems. The MMIS uses an in-house method and plans to use a software product for this purpose.

SCDHHS Responsibilities:

If applicable, explain role of SCDHHS and list major responsibilities.

Request for changes.

Contractor Responsibilities:

If applicable, explain role of contractor and list major responsibilities.

Implement changes and to execute interface.

Data Storage & System Attributes:

What programming languages were used in creating the system/interface, or what Commercial, off-the-shelf (COTS) software was required? What DBMS, file systems, etc., does the system use for storing transactional/operational data? Attach data formats or schemas or provide location of format/schema documentation if possible.

MEDS databases and tables (master, beneficiary and audit tables where applicable).



PC Applications

Owner Information:

Name, phone, email, etc. of user and support contacts

BITS - Division of PC Software and Application Management.

Harvey Brown – (803) 898-2768 – brownha@scdhhs.gov

Neal Sessions - (803) 898-2762 or 2787 - SESSIONS@scdhhs.gov

Rick Kelley - (830) 898-2773 or 2787 - KELLEYR@scdhhs.gov

Harvey Brown – (803) 898-2768 – brownha@scdhhs.gov

Governing Policies:

Policies that govern use or other activity involving the system / interface

See the SDLC document located in the project repository.

Disaster Recovery:

Attach any disaster recovery plans.

There is no formalized DR Plan document; it is currently under development. If a disaster were to occur, recovery is planned in 3 phases according to business needs:

(1) MMIS and MEDS: these are the biggest and most important systems. Both of these mainframe systems are operated by Clemson University who will provide system recovery (for more information, contact MMIS - Jim Wood (803) 898-4629, or MEDS - Michael Jones 803-898-2987). The recovery priority is to reestablish connectivity to these systems and work both with Clemson (who are installing new software to facilitate emergency access outside the SCDHHS portal) and with the State Department of IT who provide state networking - for more information, contact Algie McCoy (803) 898-2575.

(2) The CLTC CMS is the most important server-based system. Centered at the State Office data center, it is distributed to 13 field office servers for local upload/download to case workers' laptops for field work. (For disaster processing, laptops replace field office servers.) For more information, contact Roy Smith (803) 898-2590 or Harvey Brown (803) 898-2768.

(3). All other server-based systems will be restored from backups to replacement (purchased) equipment - all server configurations and specifications are documented on the BITS Wiki which is offloaded regularly for offline DR reference. The priority and RTO of these systems is being established in the Risk Assessment project currently in progress (an initial criticality listing has been drafted but is not ready for release).

Backup:

Describe / attach backup procedures and policies.

SCDHHS runs incremental backups nightly and full backups weekly for all data (including this system). The agency is in the process of negotiating an agreement to hold backup tapes in a safe at the Attorney General's Office. All backups are currently stored in a fireproof safe in the network room at the SCDHHS State Office.

Access Control Policies and Security:

Describe access control rules for accessing the system / interface (roles, responsibilities, accesses, etc.)



What precautions ensure PHI, proprietary information, and other information is kept confidential and secure?

List data security levels, security requirements etc.

Accessed is controlled via the OAC request form. The system/application is distributed over the network. A logon and password is required for entry into the system.

Support:

Support hours and response times. Who handles user support, and how? Explain escalation / levels, if applicable.

SCDHHS standard business hours: 7:30am – 5:30pm, Monday – Friday.

Incident Management:

Process / constraints by which incidents are handled.

Staff first contact the help desk. The help desk, Division of network Services, or the Division of Application Development Support will resolve the issue.

Data Center:

Where is the system/interface housed?

State Office data center (the SCDHHS network room, Mezzanine, Jefferson Square Building).

System Modification and Change Control:

How are systems / interfaces changes requested, carried out, and documented?

OAC request form (paper form); The Help Desk is within BITS.



Appendix N: MMIS Interfaces, MEDS Interfaces & PC Applications Related to Business Processes

Template type	Name	Related BP
MMIS	1099 Process	PG Manage 1099s
MMIS	Affiliated Computer Services (ACS)	OM Manage TPL Recovery, OM Prepare COB
MMIS	First Data Voice Services—Care Call	CM Establish Case, CM Manage Case, OM Authorize Service
MMIS	CCME	N/A
MMIS	MSIS	N/A
MMIS	South Carolina COC	N/A
MMIS	HealthPort	SC NEW Enter Claim
MMIS	BMSM Data Match	ME Inquire Member Eligibility,
MMIS	South Carolina DDSN	N/A
MMIS	DHEC –BCCP	N/A
MMIS	South Carolina DMH	N/A
MMIS	South Carolina DOE	N/A
MMIS	South Carolina DSS	N/A
MMIS	Wachovia—(EFT)	OM Prepare Provider EFT-Check
MMIS	First Health	OM Authorize Service
MMIS	GAFRS	PG Perform Accounting Functions, PG Draw and Report FFP, PG Manage FFP for MMIS, PG Manage FFP for Services, PG Manage FMAP, Formulate Budget, Manage State Funds, Generate Financial and Program Analysis Report
MMIS	HIPAA Mailbox	OM Inquire Payment Status, SC NEW Enter Claim
MMIS	First Data Government Solutions—IVRS	ME Inquire Member Eligibility ; OM Inquire Payment Status
MMIS	MCOs	SC NEW Enter Claim
MMIS	Maximus	ME Enroll Member, ME Disenroll Member
MMIS	MCCS	PM Enroll Provider, PM Disenroll Provider, PM Manage Provider Communication, PM Inquire Provider Information, PM Manage Provider Information, PM Perform Provider Outreach, NEW Enter Claim, NEW Perform Adjustment, NEW Manage ECFs, OM Apply Attachment, OM Authorize Service, OM Edit Claim-Encounter, OM Price Claim-Value Encounter, OM Prepare Premium EFT-Check, OM Prepare Provider EFT-Check, Prepare Remittance Advice-Encounter Report, OM Manage Estate Recovery, OM Inquire Payment Status, PG Perform Accounting



Template type	Name	Related BP
		Functions, PG Maintain Benefits-Reference Information
MMIS	MMIS to MEDS	ME Determine Eligibility, ME Disenroll Member, ME Enroll Member, ME Manage Member Information
MMIS	MEVS	ME Inquire Member Eligibility
MMIS	MHN	N/A
MMIS	Milliman	PG Manage Rate Setting
MMIS	South Carolina B&CB ORS	PG Manage Program Information
MMIS	Medicaid Part D GAPS Coverage	N/A
MMIS	First Health –Pharmacy POS	OM Authorize Service
MMIS	Qualis Health—QIO	N/A
MMIS	SCAN: Medicaid Eligibility Module	N/A
MMIS	SCSD&B	N/A
MMIS	SSA through DSS—SSA8019	OM Manage TPL Recovery
MMIS	Thomson Reuters MMIS/MEDS Interface	PI Identify Candidate Case; PG Manage Program Information; PG Monitor Performance and Business Activity
MMIS	Transportation Brokers	OM Prepare Capitation Premium Payment OM Prepare Premium EFT-Check
MMIS	TRICARE DEERS Data Match	OM Manage TPL Recovery
MMIS	USC— IFSA and HEDIS Measures	N/A
MMIS	South Carolina Medicaid Web-Based Claims Submission Tool	SC New Enter Claim, SC New Perform Adjustment, OM Inquire Payment Status
MEDS	BENDEX	ME Determine Eligibility
MEDS	Buy-In Interface	OM Prepare Medicare Premium Payment
MEDS	COB	ME Manage Member Information
MEDS	DSS Data Sharing	N/A
MEDS	ESC Interface	ME Determine Eligibility
MEDS	EVS	ME Determine Eligibility
MEDS	MEDS to MMIS	ME Manage Member Information
MEDS	MMA Interface	ME Determine Eligibility
MEDS	SCSRS Interface	ME Determine Eligibility
MEDS	SDX Interface	ME Determine Eligibility; ME Disenroll Member
MEDS	SVES	ME Determine Eligibility
MEDS	Paris Interface	ME Manage Member Information, ME Disenroll Member
PC App	ARL System	PG Perform Accounting Functions
PC App	Approach System	PG Perform Accounting Functions
PC App	CRL System	PG Perform Accounting Functions



Template type	Name	Related BP
PC App	Check Cancellation System	PG Perform Accounting Functions
PC App	AdminDays System	N/A
PC App	Appeals and Hearing System	ME Manage Member Grievance and Appeal; PM Manage Provider Grievance and Appeal; CO Support Contractor Grievance and Appeal
PC App	ApplicationXtender	ME Manage Member Grievance and Appeal; PM Manage Provider Grievance and Appeal; CO Support Contractor Grievance and Appeal
PC App	BUS	ME Manage Member Information; ME Disenroll Member, ME Enroll Member
PC App	CLTC CMS	CM Establish/Manage Case
PC App	Constituent Services System	ME Manage Member Grievance and Appeal
PC App	Contract Log System	Contract Management business area
PC App	DPA System	OM Authorize Service
PC App	DME	OM Authorize Service
PC App	Estate Recovery System	OM Manage Estate Recovery
PC App	Executive Log System	CO Inquire Contractor Information
PC App	GAFRS	PG Perform Accounting Functions, PG Draw and Report FFP, PG Manage FFP for MMIS, PG Manage FFP for Services, PG Manage FMAP, Formulate Budget, Manage State Funds, Generate Financial and Program Analysis Report
PC App	Hospital Services System	OM Authorize Service
PC App	IPC CMS	N/A
PC App	Medicaid Disability System	N/A
PC App	PFH	ME Manage Applicant and Member Communication, ME Inquire Member Eligibility, ME Manage Member Information, ME Determine Eligibility
PC App	PI CMS	PI Manage Case PI Identify Candidate Case
PC App	TPL Casualty	OM Manage TPL Recovery



Appendix O: OAC Systems Request Form

<h1 style="margin: 0;">OAC Systems Request Form</h1> <h2 style="margin: 0;">Department of Health and Human Services</h2> <p style="margin: 0; font-size: small;">(To be used for New Hire, Change, or Termination of user access, Hardware/Software installation and/or problem notification)</p>																								
Current Date:		Requested Completion/Start Date:																						
Employee Name:		Bureau:																						
Employee phone #/ext:		Department:																						
Employee Street/Office:		Network ID:																						
Employee Location/City:		SSN (Required for MMIS/MEDS):																						
New Agency Staff: System(s) Access:	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">Needs Telephone</td> <td style="width: 25%;">Needs PC</td> <td style="width: 25%;">PC Available</td> <td style="width: 25%;"></td> </tr> <tr> <td>OAC</td> <td>MMIS/ADSO*</td> <td>Clemson TSO</td> <td></td> </tr> <tr> <td>MEDS*</td> <td>GAFRS</td> <td>CAPS</td> <td></td> </tr> <tr> <td colspan="4">Department Application / Other</td> </tr> <tr> <td colspan="4"><i>(Identify Request, below, in "Other Changes, Installations, Problems or Special Instructions")</i></td> </tr> </table>				Needs Telephone	Needs PC	PC Available		OAC	MMIS/ADSO*	Clemson TSO		MEDS*	GAFRS	CAPS		Department Application / Other				<i>(Identify Request, below, in "Other Changes, Installations, Problems or Special Instructions")</i>			
Needs Telephone	Needs PC	PC Available																						
OAC	MMIS/ADSO*	Clemson TSO																						
MEDS*	GAFRS	CAPS																						
Department Application / Other																								
<i>(Identify Request, below, in "Other Changes, Installations, Problems or Special Instructions")</i>																								
Agency Staff ID:		Current User ID:		Name Change To:																				
		Deactivate ID <i>(no files destroyed)</i>		Files Transferred to User ID:																				
		<i>(supervisor's signature required below)</i>		<i>(Bureau Chief's Signature Required Below)</i>																				
		Delete ID <i>(files deleted or transferred)</i> <i>(Bureau Chief's Signature Required Below)</i>																						
MEDS Information		MEDS Location Code		County Code																				
Access Level Desired:	Inquiry Only		County Worker																					
	Hospital Worker		Supervisor Clerical/Admin																					
*Additional County Access:																								
<i>(* If additional access is needed for other counties, please list the counties.)</i>																								
Supervisor Name:		and MEDS User ID:																						
(Print)																								
Non-Agency Staff	Add User to Portal	Reactivate ID	Deactivate ID	Current User ID:																				
System(s) Access:	Department Application Access / Other																							
	<i>(Identify Request, below, in "Other Changes, Installations, Problems or Special Instructions")</i>																							



Add to Email Group(s):		Add to File Access Group(s):	
Add to Portal Application(s)/Community(s):			
<p>Other Changes, Installations, Problems, Special Instructions or Justification for access level requested:</p> <p style="text-align: right;">Application/Reports (Deployment/Installation) Instructions Attached</p>			
Required Signature:		Phone #	Date:
OAC Staff Used Only:	Date Received:	OAC System Request Number:	
Assigned To:	Complete	Date Complete:	
Ticket #:			

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