CONTRACT AMENDMENT NO. 16

Original Contract Number 14-64254

1. PARTIES

This Amendment to the above-referenced Original Contract (hereinafter called the "Contract") is entered into by and between DXC Technology Services LLC, 1775 Tysons Blvd., Tysons, VA 22102, (hereinafter called "Contractor"), and the STATE OF COLORADO, acting by and through the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203 (hereinafter called "Department" or "State.")

2. EFFECTIVE DATE AND ENFORCEABILITY

This Amendment shall not be effective or enforceable until it is approved and signed by the Colorado State Controller or designee (hereinafter called the "Effective Date.") The Department shall not be liable to pay or reimburse Contractor for any performance hereunder, including, but not limited to, costs or expenses incurred, or be bound by any provision hereof prior to the Effective Date.

3. FACTUAL RECITALS

The Parties entered into the Contract to develop and install the Colorado interChange and to provide services related to the Colorado interChange. The purpose of this Amendment is to update Section 7, PAYMENTS TO CONTRACTOR, modify Exhibit C, REQUIREMENTS, to add a Medical Assistance Provider Incentive Repository application, update Exhibit E, COMPENSATION AND QUALITY MAINTENANCE PAYMENTS, with payment information pertaining to the Medical Assistance Provider Incentive Repository (MAPIR) application, and update Exhibit F, TERMINOLOGY.

Payment under this Amendment does not include payment for MAPIR services associated with the liability incurred in violation of C.R.S § 24-30-202. The State Controller or an authorized delegate within the Central Contracts Unit may approve payment for MAPIR services that occurred prior to the execution of this Amendment pursuant to Colorado Fiscal Rule 3-1 § 8.4. If the State Controller or a delegate within the Central Contracts Unit approves a retroactive commitment voucher supporting the expenditure or obligation creating a Statutory Violation, then that approval shall constitute a valid commitment voucher that will support the payment of that obligation.

4. CONSIDERATION

The Parties acknowledge that the mutual promises and covenants contained herein and other good and valuable consideration are sufficient and adequate to support this Amendment.

5. LIMITS OF EFFECT

This Amendment is incorporated by reference into the Contract, and the Contract and all prior amendments thereto, if any, remain in full force and effect except as specifically modified herein.

6. MODIFICATIONS

The Contract and all prior amendments thereto, if any, are modified as follows:

A. Section 7, PAYMENTS TO CONTRACTOR, Subsection A., Maximum Amount, is hereby deleted in its entirety and replaced with the following:

A. Maximum Amount

The maximum amount payable under this Contract to Contractor by the State is shown in the following table, as determined by the State from available funds. Payments to Contractor are limited to the unpaid obligated balance of the Contract at the rates set forth in Exhibit E, Compensation and Quality Maintenance Payments. The maximum amount payable by the State to Contractor is:

State Fiscal Year	Amount
State Fiscal Year 2013-14	$9,201,096.00
State Fiscal Year 2014-15	$25,491,547.00
State Fiscal Year 2015-16	$25,851,971.00
State Fiscal Year 2016-17	$24,876,103.97
State Fiscal Year 2017-18	$36,497,277.54
State Fiscal Year 2018-19	$36,923,283.43
State Fiscal Year 2019-20	$27,363,796.15
State Fiscal Year 2020-21	$26,845,209.90
State Fiscal Year 2021-22	$9,980,589.33
State Fiscal Year 2022-23	$2,966,212.50
State Fiscal Year 2023-24	$1,041,245.50
Total for All State Fiscal Years	**$227,038,332.02**
Funding Changes in Contract Amendment 16 • Added $238,168.00 to State Fiscal Years 2018-2019 and 2019-2020 for MAPIR services. • Other funding changes made in this amendment were made to reconcile with Amendment 13 and forward.	

The State Fiscal Year amounts in the table in this section are based on State appropriations. Based on the timing of the invoicing and payment, the Contractor may receive amounts paid in a different State Fiscal Year than when the amounts were actually earned by the Contractor.

Any changes to the maximum amount payable under the Contract or Quality Maintenance Payments Specified in Exhibit E, shall require a formal written amendment, in accordance with State Fiscal Rules and State Controller Policies and Guidelines.

The Contractor shall work collaboratively with the Department throughout the activities of this amendment. The Contractor shall discuss issues, timelines, and prioritization of tasks with the Department and shall obtain the Department's approval on issue resolution or any changes. The Contractor shall discuss any changes to tasks or decisions that had already received approval and shall obtain the Department's approval on any changes.

B. Exhibit C, REQUIREMENTS, Section 96., MEDICAL ASSISTANCE PROVIDER INCENTIVE REPOSITORY, is hereby added as follows:

96. MEDICAL ASSISTANCE PROVIDER INCENTIVE REPOSITORY (MAPIR)

96.1. Reference Amendment 16-2019: MAPIR Services

96.1.1. Reference Amendment 16-2019: The Contractor shall assist the MAPIR Collaborative with the application design, development, and implementation of enhancements, system support, defect resolution, and technical solution services. Such technical solution services shall include the research, analysis, and recommendation of technical approaches to meet any CMS-defined or MAPIR Collaborative requirements.

96.1.1.1. Reference Amendment 16-2019: The Contractor shall provide, at a minimum, the following MAPIR services to the State:

96.1.1.1.1. Reference Amendment 16-2019: Maintain two (2) separate and distinct development systems, and deployment test environments for the two (2) latest core releases. In addition to the physical hardware and software for these environments, the Contractor shall support configuration management, system administration, and operational support (data backups and server maintenance).

96.1.1.1.1.1. Reference Amendment 16-2019: The Contractor shall maintain the functionality of the items listed in Section 96.1.1.1.1.

96.1.1.1.1.2. Reference Amendment 16-2019: The Contractor shall utilize the leveraged DXC Enterprise Labs (eLabs) environments for this effort. The servers under the management of the DXC eLabs are located in the United States and access to the test environments are restricted to the Core DXC MAPIR Team and the DXC eLabs system administrators.

96.1.1.1.2. Reference Amendment 16-2019: Work with the Pennsylvania DXC Project Team to support the State's User Acceptance Testing (UAT) of major MAPIR releases.

96.1.1.1.3. Reference Amendment 16-2019: Continue to provide support for the MAPIR SharePoint site for the State and Colorado's State DXC Project Teams for information sharing, documentation, submission of questions, presentations and technical data.

96.1.1.1.3.1. Reference Amendment 16-2019: MILESTONE: Update the SharePoint Enhancement List, including information pertaining to high-level estimates, project status, code delivery, code release numbering, anticipated release date, and other appropriate documentation.

96.1.1.1.4. Reference Amendment 16-2019: Support ongoing application design and development of the core MAPIR application; implementation of required changes resulting from software upgrades and communication protocols; modifications to interfaces between

MAPIR and the CMS Registration & Attestation System/National Level Repository; CMS or Office of National Coordinator (ONC); and defect resolution.

96.1.1.1.4.1. Reference Amendment 16-2019: The Contractor shall be responsible for analyzing the impact of changes to the core MAPIR application, designing the solution, modifying the core MAPIR application, testing the modifications, and packaging the changes for delivery to the State.

96.1.1.1.5. Reference Amendment 16-2019: Apply and test enhancements, design changes, and configuration modifications in the core MAPIR test environments prior to deployment to the State, consistent with all such Contractor activities on behalf of Collaborative Members.

96.1.1.1.5.1. Reference Amendment 16-2019: Such testing may include testing with the National Level Repository (NLR), Office of National Coordinator (ONC), and preparing documentation for CMS approval. All testing and communication with CMS shall have prior approval from the MAPIR Steering Committee or the Change Management Committee.

96.1.1.1.6. Reference Amendment 16-2019: Perform application software updates issued on a schedule approved first by the MAPIR Change Management Committee, followed by the MAPIR Steering Committee.

96.1.1.1.7. Reference Amendment 16-2019: Develop a project plan schedule for each software update that contains at least the following:

96.1.1.1.7.1. Reference Amendment 16-2019: Timelines that include producing the Business Design Document (BDD).

96.1.1.1.7.2. Reference Amendment 16-2019: Date(s) for a walk through of the BDD within five (5) Business Days after publishing the BDD, UAT, and core code delivery to the State DXC Project Team.

96.1.1.1.7.2.1. Reference Amendment 16-2019: The project plan shall be reviewed at each Change Management Committee meeting and each MAPIR Steering Committee meeting.

96.1.1.1.8. Reference Amendment 16-2019: Make available, with majority approval from the MAPIR Steering Committee, any releases available to State DXC Project-Teams for deployment to the state-specific environments through the existing secure FTP server process.

96.1.1.1.8.1. Reference Amendment 16-2019: The bi-weekly MAPIR Steering Committee meetings shall be used to update the State of upcoming releases. A standing agenda item will exist to review application release schedules.

96.1.1.1.9. Reference Amendment 16-2019: Work with the State and Colorado's State DXC Project Teams to minimize the number of different MAPIR versions, releases and patches in production.

96.2. **Reference Amendment 16-2019: Technical Support**

96.2.1. Reference Amendment 16-2019: The Contractor shall provide technical support services to the State in support of the MAPIR application. The available resources shall include at least the following:

96.2.1.1. Reference Amendment 16-2019: Direct phone lines to the State DXC Project Team specific to the state of Colorado.

96.2.1.1.1. Reference Amendment 16-2019: MILESTONE: Establish the direct phone lines to the State DXC Project Team specific to the State of Colorado.

96.2.1.2. Reference Amendment 16-2019: A read-only Knowledge Base maintained on the Core MAPIR Team's SharePoint site, accessible by the State DXC Project Teams and the State.

96.2.1.2.1. Reference Amendment 16-2019: Solutions to common configuration issues and questions shall be indexed by subsystem and capability. The Knowledge Base also provides additional documentation specific to resolution of certain issues.

96.2.1.3. Reference Amendment 16-2019: A repository of deployment/production issues documented on the Core MAPIR Team's SharePoint site, accessible by the State DXC Project Teams and the State.

96.2.1.3.1. Reference Amendment 16-2019: The State and Colorado's DXC Project Teams shall have the ability to search this listing to determine if the issue has arisen elsewhere and has been addressed. If the issue has not been identified, State DXC Project Team members shall have the ability to create a new issue in this listing that shall initiate the Core DXC MAPIR Defect/Change Management Process specified in Exhibit I.

96.2.1.4. Reference Amendment 16-2019: A standing weekly meeting between the DXC Core MAPIR Team and Colorado's State DXC Project Team to share knowledge and collectively address questions and issues.

96.2.1.4.1. Reference Amendment 16-2019: This meeting shall facilitate communication between the Core DXC MAPIR Team and the State DXC Project Teams, and amongst the various account team members. MAPIR specific issues that are reported at the meetings shall be shared with the MAPIR Collaborative as part of the MAPIR Steering Committee agenda.

96.2.1.5. Reference Amendment 16-2019: A set of escalation procedures to address any issues that the State encounters in its use of the MAPIR application.

96.2.1.5.1. Reference Amendment 16-2019: Issues that arise with the State's use of the Core MAPIR application will first be addressed with the Colorado State DXC Project Team at the account level.

96.2.1.5.2. Reference Amendment 16-2019: If an issue is encountered in Colorado's instance of MAPIR, the first step is for the Colorado State DXC Project Team to log the issue in the MAPIR SharePoint deployment/production issues list so that the DXC Account team staff and the DXC Core MAPIR Team can work together to determine if the issue is specific to the State's installation of MAPIR.

96.2.1.5.3. Reference Amendment 16-2019: If the issue is specific to the State's installation of MAPIR, then the DXC Project Team will need to work through the existing support agreements between the State and the DXC account team.

96.2.1.5.4. Reference Amendment 16-2019: If the issue is related to the core MAPIR product, an issue will be upgraded to a defect. The defect will be presented at the next regularly scheduled CMC meeting as documented in the addendum to this SOW.

96.2.2. Reference Amendment 16-2019: The Colorado State DXC Team shall address and resolve environment-specific issues for the State.

96.2.2.1. Reference Amendment 16-2019: Environment-specific issues are identified as those aspects of the MAPIR product that are unique to Colorado's installation and are not part of the baseline functionality provided by the DXC Core MAPIR Team. These issues include those that pertain to a state's security, performance, encryption, hardware, communication, and storage attributes for MAPIR.

96.2.3. Reference Amendment 16-2019: The Contractor shall update the State regarding any new versions, releases, or patches to the MAPIR application, and any subsequent work or deliverables stemming therefrom.

96.2.4. Reference Amendment 16-2019: The Contractor shall provide performance support services to the State. Performance support includes, but is not limited to, issues related to servers, the network, the database, or the MAPIR application itself.

96.2.5. Reference Amendment 16-2019: The Contractor shall make recommendations to the State on third-party or open-source software necessary or desirable to be acquired to support the MAPIR application.

96.2.5.1. Reference Amendment 16-2019: MILESTONE: Third-party or open-source software recommendations to support the MAPIR application.

96.3. **Reference Amendment 16-2019: Project Management Support**

96.3.1. Reference Amendment 16-2019: The Contractor shall maintain project management documentation and tools used to support the design, development and implementation of core MAPIR requirements, including, but limited to, project schedules for each release and version, risk logs, issue logs, defect logs and communication plans/matrixes.

96.3.2. Reference Amendment 16-2019: The Contractor shall provide high-level estimates to the State upon CMC review of proposed changes to the MAPIR application.

96.3.2.1. Reference Amendment 16-2019: The CMC shall create a Scope Document detailing any proposed changes, including, but not limited to, the following:

96.3.2.1.1. Reference Amendment 16-2019: A summary of changes and their background.

96.3.2.1.2. Reference Amendment 16-2019: Requirements for the core MAPIR User Interface to meet those changes.

96.3.2.1.3. Reference Amendment 16-2019: MAPIR Administrative Tool changes.

96.3.2.1.4. Reference Amendment 16-2019: MAPIR Reports changes.

96.3.2.2. Reference Amendment 16-2019: The CMC shall deliver the completed Scope Document to the Contractor for review.

96.3.2.3. Reference Amendment 16-2019: The Contractor shall provide an initial high-level estimate to the State, including hours necessary to implement the proposed changes.

96.3.2.3.1. Reference Amendment 16-2019: The high-level estimate shall include a list of known application impacts and assumptions made at the time of Contractor's initial analysis.

96.3.2.3.2. Reference Amendment 16-2019: Estimate levels shall be categorized as follows:

96.3.2.3.2.1. Reference Amendment 16-2019: Level 1: 0-99 hours

96.3.2.3.2.2. Reference Amendment 16-2019: Level 2: 100-299 hours

96.3.2.3.2.3. Reference Amendment 16-2019: Level 3: 300-749 hours

96.3.2.3.2.4. Reference Amendment 16-2019: Level 4: 750-1200 hours

96.3.2.3.2.5. Reference Amendment 16-2019: Level 5: 1201 and above.

96.3.2.3.2.5.1. Reference Amendment 16-2019: Estimates beginning at this level use a 400-hour range (e.g. 1401 – 1800).

96.3.2.3.3. Reference Amendment 16-2019: MILESTONE: Review Scope Document provided by CMC and provide high-level estimate of hours

96.3.2.3.4. Reference Amendment 16-2019: MILESTONE: Revise high-level estimates as necessary

C. Exhibit E, COMPENSATION AND QUALITY MAINTENANCE PAYMENTS, Section 1.1.14, MEDICAL ASSISTANCE PROVIDER INCENTIVE REPOSITORY, is hereby added as follows:

1.1.14. Reference Amendment 16-2019: The Contractor shall be paid for work described under Contract Amendment No. 14 by submitting an invoice on a quarterly basis for the State's equally divided cost pursuant to the State's membership in the MAPIR Collaborative.

1.1.14.1. Reference Amendment 16-2019: The fee associated with MAPIR design, development, and implementation of enhancements shall be divided equally between all participating MAPIR Collaborative states.

1.1.14.1.1. Reference Amendment 16-2019: If additional states join the MAPIR Collaborative, the Contractor shall adjust the quarterly payment by dividing the total amount by that total number of participating states starting with the next full quarter.

1.1.14.2. Reference Amendment 16-2019: A tiered payment schedule for the number of participating MAPIR Collaborative states is as follows:

Services Provided	Time Period	Payment Date	Quarterly Price with 14 Members	Quarterly Price with 13 Members	Quarterly Price with 12 Members	Quarterly Price with 11 Members	Quarterly Price with 10 Members	Quarterly Price with 9 Members	Quarterly Price with 8 Members
MAPIR: Design, Development and Implementation Support	Oct 2018 – Dec 2018	Dec-18	$58,051	$62,517	$67,727	$73,884	$81,272	$90,302	$101,590
MAPIR: Design, Development and Implementation Support	Jan 2019 – Mar 2019	Mar-19	$58,051	$62,517	$67,727	$73,884	$81,272	$90,302	$101,590
MAPIR: Design, Development and Implementation Support	Apr 2019 – June 2019	Jun-19	$58,051	$62,517	$67,727	$73,884	$81,272	$90,302	$101,590
MAPIR: Design, Development and Implementation Support	Jul 2019 – Sep 2019	Sep-19	$58,051	$62,517	$67,727	$73,884	$81,272	$90,302	$101,590

MAPIR: Design, Development and Implementation Support	Oct 2019 – Dec 2019	Dec-19	$58,051	$62,517	$67,727	$73,884	$81,272	$90,302	$101,590
MAPIR: Design, Development and Implementation Support	Jan 2020 – Mar 2020	Mar-20	$58,051	$62,517	$67,727	$73,884	$81,272	$90,302	$101,590
MAPIR: Design, Development and Implementation Support	Apr 2020 – Jun 2020	Jun-20	$58,051	$62,517	$67,727	$73,884	$81,272	$90,302	$101,590
MAPIR: Design, Development and Implementation Support	Jul 2020 – Sep 2020	Sep-20	$58,051	$62,517	$67,727	$73,884	$81,272	$90,302	$101,590
TOTAL FOR 24 MONTHS PER STATE			$464,412	$500,135	$541,813	$591,069	$650,176	$722,418	$812,720

1.1.14.2. Reference Amendment 16-2019: The Department may withhold up to 25% of each of its own quarterly payments unless and until the Contractor completes the milestones listed throughout Section 96.

D. Exhibit F, TERMINOLOGY, is hereby deleted in its entirety and replaced with Exhibit F-1, TERMINOLOGY, attached hereto and incorporated by reference into the Contract. All references within the Contract to Exhibit F shall be deemed to reference Exhibit F-1.

7. START DATE

This Amendment shall take effect on its Effective Date.

8. ORDER OF PRECEDENCE

Except for the Special Provisions and the HIPAA Business Associates Addendum, in the event of any conflict, inconsistency, variance, or contradiction between the provisions of this Amendment and any of the provisions of the Contract, the provisions of this Amendment shall in all respects supersede, govern, and control. The most recent version of the Special Provisions incorporated into the Contract or any amendment shall always control other provisions in the Contract or any amendments.

9. AVAILABLE FUNDS

Financial obligations of the state payable after the current fiscal year are contingent upon funds for that purpose being appropriated, budgeted, or otherwise made available to the Department by the federal government, state government and/or grantor.

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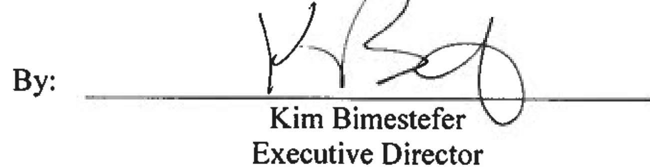
THE PARTIES HERETO HAVE EXECUTED THIS AMENDMENT

Persons signing for Contractor hereby swear and affirm that they are authorized to act on Contractor's behalf and acknowledge that the State is relying on their representations to that effect.

CONTRACTOR:	STATE OF COLORADO: Jared S. Polis, Governor
By: Signature of Authorized Officer	By:  Kim Bimestefer, Executive Director, Department of Health Care Policy and Financing
Date: 6/14/2019	Date: 6·27-19
CAROL PANGBORN Printed Name of Authorized Officer	**LEGAL REVIEW:** Phil Weiser, Attorney General
ACCOUNT EXECUTIVE Printed Title of Authorized Officer	By: ____ Date: ____

ALL CONTRACTS REQUIRE APPROVAL BY THE STATE CONTROLLER

CRS §24-30-202 requires the State Controller to approve all State Contracts. This Contract is not valid until signed and dated below by the State Controller or delegate. Contractor is not authorized to begin performance until such time. If Contractor begins performing prior thereto, the State of Colorado is not obligated to pay Contractor for such performance or for any goods and/or services provided hereunder.

STATE CONTROLLER:

Robert Jaros, CPA, MBA, JD

By:
Department of Health Care Policy and Financing

Date: 6/28/19

EXHIBIT F-1, TERMINOLOGY

1. TERMINOLOGY

1.1. The following list is provided to assist the reader in understanding terminology, acronyms and abbreviations used throughout this Contract.

1.1.1. ACA Provider Screening Rules – The rules implemented and published in 42 CFR Parts 405, 424, 447 et al.

1.1.2. Affordable Care Act (ACA) – The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, enacted March 23, 2010, and the Health Care and Education Reconciliation Act of 2010 enacted March 30, 2010.

1.1.3. Accountable Care Collaborative (ACC) – The Colorado Medicaid program, established to improve clients' health care and reduce costs, that is administered by the Department through contracted regional vendors.

1.1.4. Address Confidentiality Program (ACP) – The Colorado Address Confidentiality Program described in C.R.S. §24-30-2101.

1.1.5. Americans With Disabilities Act (ADA) – The Americans With Disabilities Act of 1990, 42 U.S.C. §12101 *et. seq.*

1.1.6. Adjusted Claim – A submitted Claim that has been processed with a resulting status of either paid or denied.

1.1.7. All Patient Refined Diagnosis Related Groups (APR/DRG) – An expanded DRG that adds two sets of subclasses to each base APR/DRG.

1.1.8. American Recovery and Reinvestment Act (ARRA) – The American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5.

1.1.9. Authorization – The official approval for action taken for, or on behalf of, a Medicaid client. The Authorization only valid if the client is eligible on the date or dates of service for the applicable Claim.

1.1.10. Average Length of Stay (ALOS) – The arithmetic mean length of stay experienced by a patient in the inpatient hospital setting within a chosen DRG.

1.1.11. Benefits Utilization System (BUS) – The Department's Case Management system for Home and Community Based Long Term Care clients and Nursing Facilities. Business Analyst – An individual responsible for requirements gathering and problem definition staff for Configuration and Customization activities.

1.1.12. Business Intelligence and Data Management (BIDM) – The contractor and system that will replace the Department's current Medicaid decision support system, Data Warehouse, and Statewide Data Analytics Contractor.

1.1.13. Business Process Reengineering (BPR) – The activities associated with optimizing the MMIS related business processes.

1.1.14. Capitation – A payment arrangement for health care service providers that pays the provider a set amount for each enrolled person assigned to them, per period of time, whether or not that person seeks care.

1.1.15. Case Management (CM) – The facilitation of treatment plans to ensure the appropriate services are provided to Clients.

1.1.16. Category of Service (COS) – Broad types of medical services for which federal reimbursement is allowed under the Medicaid Act.

1.1.17. Centers for Medicare and Medicaid Services (CMS) – An agency of the United States Department of Health and Human Services that provides federal oversight of the Medicaid program.

1.1.18. Change Management or Change Management Process – A process that facilitates the organized planning, development, and execution of modifications and Enhancements to the Core MMIS and Supporting Services so that changes to the System are introduced in a controlled and coordinated manner, and the possibility that unnecessary changes will be introduced to a system without proper planning is reduced.

1.1.19. Change Request – A document detailing the addition or modification to the functionality of the MMIS.

1.1.20. Child Health Plan *Plus (CHP+)* – Public health insurance for children and pregnant women who earn too much to qualify for Medicaid, but cannot afford private health insurance.

1.1.21. Claim – A bill for services that is appropriate for the provider type and type of service(s), whether submitted as a paper claim or electronically, and identified by a unique claim control number. A single claim is defined as a billing comprised of a single beneficiary with the same Date of Service (or range of dates for service), submitted by a single billing provider which may include one or more service(s) or document(s).

1.1.22. Clean Claim – A Claim that complies with the following definitions:

1.1.22.1. A Claim that does not contain any Defect requiring the Contractor to investigate or develop prior to adjudication.

1.1.22.2. A Claim that has no Defect, impropriety or special circumstance, including incomplete documentation that delays timely payment.

1.1.22.3. A Claim that can be processed without obtaining additional information from the provider of the service or from a third party.

1.1.22.4. A Clean Claim does not include a Claim from a provider who is under investigation for Fraud or abuse, or a Claim under review for medical necessity.

1.1.23. Client – Any individual eligible for or enrolled in a public health insurance program administered by the Department such as the Colorado Medicaid program, Colorado's CHP+ program, the Colorado Indigent Care Program or other program as determined by the Department.

1.1.24. Client Healthcare Portal – The secured Web site that is used by Clients to review their Medicaid related health information.

1.1.25. Client Service Plan – A plan of service for clients under one of the HCBS waiver programs within the Colorado Medical Assistance program.

1.1.26. Code on Dental Procedures and Nomenclature (CDT) – The HIPAA standard code set to achieve uniformity, consistency and specificity in accurately reporting dental treatment and process dental claims.

1.1.27. Colorado Benefits Management System (CBMS) – The State of Colorado's single integrated system for determining eligibility and calculating benefits for the State's major welfare programs, including Medicaid.

1.1.28. Colorado Financial Reporting System (COFRS) – The financial system that maintains the official accounting records for the State of Colorado government.

1.1.28.1. As of the Effective Date, the State is working on replacing COFRS with a new financial reporting system commonly referred to as the Colorado Operations Resource Engine (CORE), which is intended to be operational as of July 1, 2014. For the purposes of this contract, all references to COFRS shall be deemed to reference CORE once the CORE system is operational.

1.1.29. Colorado Health Benefits Exchange (COHBE) – A marketplace for Coloradans to shop for and purchase health insurance based on quality and price.

1.1.30. Colorado Registry and Attestation – Colorado's State Level Registry that supports HITECH and is making available incentive payments to eligible Medicaid providers that adopt and successfully demonstrate Meaningful Use of a certified Electronic Health Records technology

1.1.31. Commercial Off-The-Shelf (COTS) – A product that is sold in substantial quantities in the commercial marketplace that does not require additional software or hardware development or Customization for general use.

1.1.32. Computer-Based Training (CBT) – A type of education in which the individual learns by executing special training programs on a computer.

1.1.33. Configurable/Configuration – Modification of System functionality, which does not require development changes to the software and can be modified by non-technical (e.g., non-programmer or developer) staff.

1.1.34. Continuity of Care Document (CCD) – A document, created as a joint effort by Health Level Seven International and the American Society for Testing and Materials, to allow physicians to send electronic medical information to other providers without loss of meaning and enabling improvement of patient care.

1.1.35. Coordination of Benefits (COB) – A provision establishing an order in which health care plans pay their claims, and permitting secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.

1.1.36. Copayment – The Client's financial responsibility for a service, procedure or Prescription assigned by the Department.

1.1.37. Core DXC MAPIR Team – The DXC team that is responsible for the design, development, implementation, and support of the core MAPIR application. Coordinates the deployment and assists in resolving deployment issues with each collaborative State DXC Project Team.

1.1.38. Core MMIS – See "Medicaid Management Information System"

1.1.39. Current Procedural Terminology (CPT) – A code set maintained by the American Medical Association through the CPT Editorial Panel.

1.1.40. Customer Relationship Management (CRM) – A software or system used the Contractor to organize, automate and synchronize customer service and technical support.

1.1.41. Customization – Any modification, alteration or extension to software requiring changes to the existing source code for such software to achieve new or modified functionality and that requires dedicated technical staff (e.g., a programmer or developer).

1.1.42. Dashboard – A subset of information delivery that includes the ability to publish formal, web-based reports with intuitive displays of information. It has an easy to read, often single page, real-time User Interface, showing a graphical presentation of the current status and historical trends of an organization's Key Performance Indicators to enable instantaneous and informed decisions to be made at a glance.

1.1.43. Data Dictionary – A centralized repository of information about data such as meaning, valid values, relationships to other data, origin, usage and format.

1.1.44. Data Warehouse (DW) – A database used for reporting and analysis.

1.1.45. Date of Service (DOS) – The calendar date on which a specific medical service is performed.

1.1.46. Defect – An error, flaw, mistake, failure or fault in a computer program or system that produces an incorrect or unexpected result that differs from an agreed-to Specification, or causes the computer program or system to behave in unintended ways that differ from an agreed-to Specification.

1.1.47. Design, Development and Implementation (DDI) – The portion of the Work required to identify, design, develop and implement technical and business services.

1.1.48. Diagnosis Related Group (DRG) – A system that classifies hospital cases.

1.1.49. Dispute Process – The process described in the Contract for the Contractor and the Department to follow to resolve all debates or disagreements between the Department and Contractor.

1.1.50. Drill-Down – Functionality that allows a user to move from summary information to detailed data by focusing on a specific criteria.

1.1.51. Drug Utilization Review (DUR) – A program designed to measure and assess the proper use of outpatient drugs in the Medicaid program.

1.1.52. Durable Medical Equipment (DME) – Medical equipment used in the home to aid in a better quality of living

1.1.53. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) – Federal Medicaid requirement that the State's Medicaid agency cover services, products or procedures, for Medicaid recipients under 21 years of age, if the service is medically necessary health care to correct or improve a Defect, physical or mental illness, or a condition identified through a screening examination.

1.1.54. Electronic Data Interchange (EDI) – The structured transmission of data between organizations by electronic means, which is used to transfer electronic documents or business data from one computer system to another computer system.

1.1.55. Electronic Document Management System (EDMS) – Software that manages documents for electronic publishing.

1.1.56. Electronic Funds Transfer (EFT) – An electronic transfer of money, also known as direct deposit.

1.1.57. Electronic Health Records (EHR) – A systematic collection of electronic health information about individual patients or populations.

1.1.58. Electronic Medical Record (EMR) – A computerized medical record created in an organization that delivers care, such as a hospital or physician's office.

1.1.59. Eligibility Verification System (EVS) – A real time, online system that provides timely and accurate information regarding a recipient's eligibility for services.

1.1.60. Eligible Hospital (EH) – Hospitals eligible to meet the system capability requirements of the Meaningful Use incentive program, as defined in 42 CFR Parts 412, 413, 422, and 495.

1.1.61. Eligible Professional (EP) – Professionals eligible to meet the system capability requirements of the Meaningful Use incentive program, as defined in 42 CFR Parts 412, 413, 422, and 495.

1.1.62. Encounter – A claim submitted by a Managed Care Entity for reporting purposes only.

1.1.63. Encounter Data – Data collected to track use of provider services by managed care health plan enrollees.

1.1.64. Enhanced Ambulatory Patient Groups (EAPG) – A system to classify and calculate reimbursement for outpatient services.

1.1.65. Enhancement – Functional changes or performance improvements that require Configuration or Customization to the System and follow the Change Management Process described in the Change Management Plan.

1.1.66. Enterprise Application Integration (EAI) – The collection of technologies and services that enable integration of systems and applications across the enterprise.

1.1.67. Enrolled Provider (EP) – A provider whose enrollment status is active and has billed a claim within the past twelve (12) calendar months.

1.1.68. Episodes of Care – A health problem, from its first Encounter with a health care provider through the completion of the last Encounter related to the problem, typically encompassing the patient's reason for the Encounter, the diagnosis code and the resulting therapeutic intervention.

1.1.69. Excluded Party List System (EPLS) – Part of the federal System for Award Management, the EPLS is an electronic, web-based system that identifies those parties excluded from receiving Federal contracts, certain subcontracts, and certain types of Federal financial and nonfinancial assistance and benefits.

1.1.70. Explanation of Benefits (EOB) – A statement sent by a health insurance company to covered individuals explaining what medical treatment and/or services were paid for on their behalf.

1.1.71. Explanation of Medical Benefits (EOMB) – See "Explanation of Benefits".

1.1.72. Extract, Transform and Load (ETL) – A database and data warehousing process used to extract data from outside sources, transform it to fit operational needs, and load it into the end target.

1.1.73. Family Support Services Program (FSSP) – A program to assist families with costs beyond those normally experienced by other families, to avoid or delay costly out of home placements and reduce stress.

1.1.74. Federal Financial Participation (FFP) – Federal matching funds for State expenditures relating to assistance payments for certain social services, and State medical and medical insurance expenditures.

1.1.75. Fee-For-Service (FFS) – A payment model where services are unbundled and paid for separately.

1.1.76. Fiscal Agent (FA) – An entity that acts on behalf of the State Medicaid agency in respect to claims processing, Provider Enrollment and relations, utilization review, and other functions.

1.1.77. Fiscal Agent Operations (FAO) – All contractual activities and responsibilities associated with the Fiscal Agent.

1.1.78. Fiscal Year (FY) – A period used for calculating annual financial statements in businesses and other organizations.

1.1.79. Fraud – An intentional deception or misrepresentation that could result in the payment of an unauthorized benefit.

1.1.80. Full Time Equivalent (FTE) – A unit of measure that equates to the workload of an individual who works a full time schedule, regardless of the actual number of individuals who perform that work or the actual number of hours worked by those individuals.

1.1.81. Health Benefit Plan (HBP) – A health care plan provided by the Department that includes a standard set of services, such as hospital and outpatient care, mental health, prevention, well-child care and maternity care.

1.1.82. Health Care Common Procedure Coding System (HCPCS) – A standardized coding system used to describe the items and services provided in health care, comprised of three levels.

1.1.83. Health Information Exchange (HIE) – A system that that provides the capability to electronically move clinical information among disparate health care information systems while maintaining the meaning of the information being exchanged.

1.1.84. Health Information Technology for Economic and Clinical Health Act (HITECH) - The Health Information Technology for Economic and Clinical Health Act provisions of ARRA.

1.1.85. Health Insurance Buy-In (HIBI) – A program that pays the Medicaid client's portion of commercial health insurance premiums when it would be cost-effective for Medicaid to do so.

1.1.86. Health Insurance Portability and Accountability Act (HIPAA) – The Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191.

1.1.87. Health Maintenance Organization (HMO) – See Managed Care Organization.

1.1.88. Healthcare Effectiveness Data and Information Set (HEDIS) – A tool to measure performance on important dimensions of care and service, produced by the National Committee for Quality Assurance.

1.1.89. Healthcare Portal – This term includes both the Client Healthcare Portal and the Provider Healthcare Portal.

1.1.90. Home and Community Based Services (HCBS) – The federal designation for the waiver for alternatives to institutionalization waiver programs under section 1915(c), administered by the Department.

1.1.91. Implementation Contract Stages – All of the following stages within this Contract:

1.1.91.1. BPR Contract Stage.

1.1.91.2. Implementation Contract Stage I.

1.1.91.3. Implementation Contract Stage II.

1.1.91.4. Implementation Contract Stage III.

1.1.92. Independent Verification and Validation (IV&V) - Processes and products to ensure adherence to Contract requirements and sound engineering practices to meet the Department's objectives.

1.1.93. Interactive Voice Response (IVR) – A technology that allows a computer to interact with humans through the use of voice and Dual-tone multi-frequency tones input via keypad.

1.1.94. Intermediate Care Facilities for Persons with Intellectual Disabilities (ICF/ID) – A disability benefit that is offered through Medicaid funding for institutions, consisting of four (4) or more beds, for individuals with mental retardation or developmental disabilities.

1.1.95. International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9) – The 9th revision to the International Classification of Diseases promulgated by the World Health Organization.

1.1.96. International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10) – The 10th revision to the International Classification of Diseases promulgated by the World Health Organization.

1.1.97. Interoperability – The ability to exchange and use information from multiple machines from multiple different entities.

1.1.98. Key Personnel – The position or positions that are specifically designated as such in this Contract.

1.1.99. Labor Category – A grouping of similar skills, knowledge, ability, experience and education specific to the labor to be provided.

1.1.100. Learning Management System (LMS) – A software application that allows for the administration, documentation, tracking, delivery, and reporting of online training or education programs.

1.1.101. Legacy System – The Department's existing MMIS and supporting systems as of the Effective Date.

1.1.102. Level of Care (LOC) – The intensity of medical care being provided by a physician or health care facility.

1.1.103. List of Excluded Individuals & Entities (LEIE) – The list maintained by the federal Office of the Inspector General that provides information to the health care industry, patients and the public regarding individuals and entities currently excluded from participation in Medicare, Medicaid and all other Federal health care programs.

1.1.104. Long-Term Care (LTC) – A variety of services that help meet both the medical and non-medical needs of people with a chronic illness or disability who cannot care for themselves for long periods of time.

1.1.105. Long-Term Services and Supports (LTSS) – A Medicaid program allowing for the coverage of LTC services, such as Institutional Care and Home and Community Based Long Term Services and Supports.

1.1.106. Maintenance – Routine activities required to sustain normal operations of the Fiscal Agent Operations and the System, including COTS utilized by the Contractor under this Contract and the upkeep of servers and software patches. These activities are not considered Enhancements and do not require a formal Change Management Process to complete.

1.1.107. Managed Care Entity (MCE) – An entity that supports the administration of a variety of different managed care service delivery models, including PPO agreements, PHP agreements, vendor

contracting arrangements, ACO, Intermediary Service Organizations, utilization-controlled Fee-For-Service arrangements, PIHP, PAHP, MCO and PCCM.

1.1.108. Managed Care Organization (MCO) – A health care system that assumes both the financial risk associated with providing comprehensive medical services and the responsibility for health care delivery in a particular geographic area to MCO members, in return for a fixed, prepaid fee. Formerly referred to as an HMO.

1.1.109. MAPIR Collaborative – Representatives from each of the states that have chosen to participate in the collaborative, not including DXC staff.

1.1.110. MAPIR Collaborative Change Management Committee (CMC) - The group of individuals responsible for reviewing MAPIR enhancement requests, defects, and makes recommendations for prioritization and scheduling in MAPIR release schedules. Recommendations are brought to the MAPIR Steering Committee for final approval and prioritization.

1.1.111. MAPIR Collaborative Subject Area Focus Work Groups – Comprised of Comprised of state staff members from the MAPIR Collaborative. Subject area focus work groups are formed on an as needed basis and take the lead in analyzing business requirements for a specific topic or function for the core MAPIR application.

1.1.112. MAPIR Steering Committee – The group of individuals responsible for making high-level decisions regarding the design and development of the core MAPIR application. The committee consists of a representative from each state that agreed to share the core MAPIR application development costs. Pennsylvania leads the Steering Committee, sets the agenda, brings open issues to the meeting and records all decisions related to the MAPIR implementation. In the event Pennsylvania can no longer lead the collaborative the remaining members of the MAPIR Collaborative will nominate and elect a lead state to replace Pennsylvania.

1.1.113. Meaningful Use (MU) – A qualification to receive federal funding for health information technology, specifically, the use of Electronic Health Records.

1.1.114. Medicaid – The Medical assistance program authorized under Title XIX of the Social Security Act.

1.1.115. Medicaid Enterprise – The organizing logic for business processes and information technology infrastructure reflecting the integration and standardization requirements of the Colorado Medical Assistance program's operating model, which includes the MMIS.

1.1.116. Medicaid Enterprise Certification Toolkit (MECT) – A tool created by CMS to assist states in all phases of the MMIS life cycle.

1.1.117. Medical Assistance Provider Incentive Repository (MAPIR) – Open sourced software developed and maintained by DXC.

1.1.118. Medical Service Questionnaire (MSQ) – A letter sent to Clients, based on Claims payment, to allow the Client to verify that they received the services billed to the Department.

1.1.119. Medicare – A health insurance program for the aged and disabled under Title XVIII of the Social Security Act.

1.1.120. Medicare Buy-In – A procedure whereby the Department pays a monthly premium to the Social Security Administration on behalf of eligible medical assistance clients, enrolling them in the Medicare Part B program.

1.1.121. Medicare Exclusion Database (MED) – The CMS repository and distributor of all the Office of the Inspector General Sanction data that is updated monthly.

1.1.122. Medicaid Information Technology Architecture (MITA) – A national initiative, overseen by CMS, that is intended to foster integrated business and IT transformation across the Medicaid Enterprise to improve the administration of the Medicaid program.

1.1.123. Medicaid Management Information System (MMIS) - A collection of services and automated claims processing that fulfills, at a minimum, the federal requirements specified in Part 11 of the State Medicaid Manual (CMS Publication 45), program directives and memos, policy statements, and the like that serve as the basis for CMS certification and is compliant with HIPAA requirements, as modified.

1.1.124. Transformed Medicaid Statistical Information System (T-MSIS) – The mandatory system for States to submit raw eligibility and claims data to CMS.

1.1.125. Milestone – A significant point, event or achievement that reflects progress toward completion of a process, phase or project.

1.1.126. National Correct Coding Initiative (NCCI) – A set of coding methodologies required under the ACA.

1.1.127. National Council for Prescription Drug Programs (NCPDP) – An entity that creates and promotes standards for the transfer of data to and from the pharmacy services sector of the health care industry.

1.1.128. National Drug Code (NDC) - An eleven-digit code assigned to each drug.

1.1.129. National Level Repository (NLR) – A system which tracks and stores information on providers' Meaningful Use of EHR, allowing CMS to determine appropriate HITECH incentive payments for Medicare and Medicaid programs.

1.1.130. National Medicaid EDI HIPAA Workgroup (NMEH) – A CMS sponsored workgroup for state collaboration in response to the original HIPAA mandates.

1.1.131. National Plan and Provider Enumeration System (NPPES) - The system that uniquely identifies a health care provider and assigns it an NPI.

1.1.132. National Provider Identifier (NPI) - A unique 10-digit identification number issued to health care providers in the United States by CMS.

1.1.133. National Uniform Billing Committee (NUBC) - A committee comprised of major national provider and payer organizations in order to develop a single billing form and standard data sets that could be used nationwide by institutional providers and payers for handling diagnosis codes within health care claims.

1.1.134. Non-Emergent Medicaid Transportation (NEMT) - transportation services for Clients to routine and urgent medical appointments.

1.1.135. Nursing Facility – A facility that provides Nursing Facility Services as those are defined in 42 CFR 440, Subpart A.

1.1.136. Office of the Inspector General (OIG) – An agency of the United States Department of Health and Human Services that protects against Fraud, waste and abuse by improving the efficiency of the Medicare and Medicaid programs.

1.1.137. Office of the National Coordinator (ONC) - An agency of the United States Department of Health and Human Services that is charged with coordination of nationwide efforts to implement and use the most advanced health information technology and the electronic exchange of health information.

1.1.138. Omnibus Budget Reconciliation Act (OBRA) – The Omnibus Budget Reconciliation Act of 1990, Pub. L. No. Pub.L. 101–508 that defines Medicaid drug coverage requirements and drug rebate rules.

1.1.139. Online Analytical Processing (OLAP) - Tools that enable users to interactively analyze multidimensional queries and resulting data from multiple perspectives.

1.1.140. Open Source Software - Software that incorporates or has embedded in it any source, object or other software code subject to an "open source", "copyleft" or other similar type of license terms (including, without limitation, any GNU General Public License, Library General Public License, Lesser General Public License, Mozilla License, Berkeley Software Distribution License, Open Source Initiative License, MIT license, Apache license, and the like).

1.1.141. Operational Start Date – The date on which the Department authorizes the Contractor to begin fulfilling its operations and Maintenance obligations under the Contract.

1.1.142. Optical Character Recognition (OCR) - The mechanical or electronic conversion of scanned images of handwritten, typewritten or printed text into machine-encoded text for the purpose of electronically searching, storing more compactly, on-line display, and text mining.

1.1.143. Payment Error Rate Measurement (PERM) - A program to measure improper payments in Medicaid and CHP+ and produces error rates for each program.

1.1.144. Pennsylvania Department of Human Services (PADHS) – Serves as the lead state of the MAPIR Collaborative and as such, provides DXC with final direction and formal approvals based on concurrence from the Collaborative.

1.1.145. Per Member Per Month (PMPM) - A standard unit of measure for Capitation payments that payers provide to Providers.

1.1.146. Personal Health Record (PHR) - Related health data and care information maintained by the patient which may include patient-reported outcome data, lab results, data from devices such as wireless electronic weighing scales, or collected passively from a smartphone.

1.1.147. Pharmacy Benefit Management System (PBMS) - The point-of-sale claims processing system for pharmacy benefits.

1.1.148. Post-Eligibility Treatment of Income (PETI) - A program for Nursing Facilities to provide services that are not a Medicaid benefit if they are medically necessary and the Client has a patient payment amount.

1.1.149. Pre-Admission Screening and Resident Review (PASRR) - A federally required review to help ensure that individuals are not inappropriately placed in nursing homes for long term care.

1.1.150. Predictive Modeling - The process by which a model is created or chosen to try to best predict the probability of an outcome to assist with forecasting and trend analysis.

1.1.151. Preferred Drug List (PDL) - A formal published list of specific Prescription drug products by brand and generic name that may be reimbursed without a PA.

1.1.152. Prescription - A written, faxed or oral order, as required by the Board of Pharmacy, from a practitioner that a certain drug, medical supply, device or service is medically necessary.

1.1.153. Primary Care Medical Provider (PCMP) - Health care providers that typically act as the principal point of consultation for patients within a health care system and coordinate other specialists that the patient may need. PCPs enrolled in the ACC are PCMPs.

1.1.154. Primary Care Provider (PCP) – A Provider that provides both the first contact for a person with an undiagnosed health concern as well as continuing care of varied medical conditions, not limited by cause, organ system, or diagnosis.

1.1.155. Prior Authorization (PA) - A requirement mandating that a provider must obtain approval to perform a service or prescribe a specific medication prior to performing the service or prescribing the medication, and is the record of the approved PAR.

1.1.156. Prior Authorization Request (PAR) - A request submitted to a health plan for review, accompanied by the necessary supporting clinical documentation for a service or medication, prior to performing the service or prescribing the medication.

1.1.157. Problem - A Defect, operational issue or situation regarded as unwelcome or harmful and needing to be dealt with and overcome.

1.1.158. Production Environment - The System hardware and software environment designated to the final stage in the release process, which serves the end-users.

1.1.159. Program Integrity (PI) – Activities completed by the Department or other entities concerning monitoring the utilization habits and patterns of both members and providers of the Colorado Medical Assistance Program to create a culture where there are consistent incentives to provide better health outcomes within a context that avoids over- or underutilization of services.

1.1.160. Program of All-Inclusive Care for the Elderly (PACE) - Comprehensive health services for individuals age 55 and over who are categorized as "nursing home eligible" by the Department.

1.1.161. Protected Health Information (PHI) - Individually identifiable health information or health information with data items that reasonably could be expected to allow individual identification.

1.1.162. Provider – An individual or entity furnishing medical, mental health, dental or pharmacy services.

1.1.163. Provider Enrollment - A completed capture and verification of provider demographic, licensure, disclosure information, and an executed provider participation agreement, including a Provider Revalidation.

1.1.164. Provider Enrollment Tool – The product of the Implementation Stage I Contract Stage that will allow providers to be enrolled, re-enrolled and validated through an automated, Web-based application.

1.1.165. Provider Healthcare Portal – The secured Web site that is used to submit and retrieve Provider transactions and/or reports, and includes the Provider Enrollment Tool.

1.1.166. Provider Preventable Conditions (PPC) – All conditions that are Health Care-Acquired Conditions and Other Provider-Preventable Conditions as defined in the final rule for Medicaid Program; Payment Adjustment for Provider-Preventable Conditions Including Health Care-Acquired Conditions 42 CFR Parts 434, 438, and 447.

1.1.167. Provider Revalidation - A completed evaluation verifying that a provider meets Federal and State conditions for participation in accordance with the ACA Provider Screening Rule.

1.1.168. Provider Screening - An evaluation that verifies that a provider meets the legal requirements in order to be reimbursed for services provided under the Medicaid or CHP+, without limitations.

1.1.169. Quality Assurance (QA) - The planned and systematic activities implemented in a quality system so that quality requirements for a product or service will be fulfilled.

1.1.170. Qualified Medicare Beneficiaries (QMB) – A program that covers Medicare cost sharing requirements for certain low-income Medicare beneficiaries

1.1.171. Recovery Audit Contractor (RAC) – A contractor selected by the Department to identify and recover improper payments paid to health care providers.

1.1.172. Regional Care Collaborative Organization (RCCO) – A contractor, selected by the Department for each of the seven ACC regions, to help Providers communicate with Clients and with other Providers, so Clients receive coordinated care as part of the ACC.

1.1.173. Requirements Traceability Matrix (RTM) - A document that compares any two baseline documents that require a many-to-many relationship to determine the completeness of the relationship.

1.1.174. Sanction - Penalty for noncompliance with laws, rules, and policies regarding Medicaid, which may include withholding payment from a provider or terminating Medicaid enrollment.

1.1.175. Scorecard - A management tool used to compare actual results to business targets or goals.

1.1.176. Service Oriented Architecture (SOA) - Software architecture comprised of interoperable, discoverable and potentially reusable services.

1.1.177. Service Plan Spending Limit (SPSL) - A spending plan that includes service limits, such as caps and unit limits, included in a Client's service plan established by the Client's case manager.

1.1.178. Single Sign-On (SSO) - An access control feature of Software applications that allows a user to log in once and gain access to all associated applications, without being prompted to log in for each.

1.1.179. Software - A set of programs, procedures, algorithms and its documentation concerned with the operation of a data processing system.

1.1.180. Specification - A detailed, exact statement of particulars such as a statement prescribing materials, dimensions and quality of work.

1.1.181. Star Schema – A schema that typically consists of one or more fact tables that reference one or more dimension tables.

1.1.182. State DXC Project Team – The individual DXC state account project team that is contracted to work with each MAPIR collaborative state to implement, operate, support, upgrade and maintain each state's MAPIR system. The State DXC Project Team works in conjunction with the Core DXC MAPIR Team to integrate and configure the core MAPIR application at the state level and perform custom work requested by the state.

1.1.183. State Fiscal Year (SFY) - The twelve (12) month period beginning on July 1st of a year and ending on June 30th of the following year.

1.1.184. State Level Registry (SLR) - A system which tracks and stores information on providers' Meaningful Use of EHR at the state level and provides the necessary information for the state to pay an EHR incentive payment.

1.1.185. State Self-Assessment (SS-A) - A structured method used to document a state's current Medicaid business enterprise by aligning a state's business areas to the MITA business areas and business processes.

1.1.186. Statement on Standards for Attestation Engagements No. 16 (SSAE-16) - The authoritative guidance for reporting on service organizations promulgated by the American Institute of Certified Public Accountants.

1.1.187. Support Intensity Scale (SIS) - a tool used by some of the HCBS waiver programs to evaluate the severity of the Client's condition.

1.1.188. Supported Living Services (SLS) – A program to provide a variety of services, such as personal care or homemaking needs, employment or other day type services, helping a Client accessing his or her community, help with decision-making, assistive technology, home modification, professional therapies, transportation and twenty-four hour emergency assistance.

1.1.189. Surveillance and Utilization Review Subsystem (SURS) – A subsystem that allows Medicaid programs to identify program policy inconsistencies and potential Fraud or provider abuse by identifying aberrant billing patterns.

1.1.190. System – The collection of technical and/or automated functions within the Core MMIS and Supporting Services.

1.1.191. Systems Integrator - An enterprise that specializes in implementing, planning, coordinating, scheduling, testing, improving and maintaining computing operation.

1.1.192. Systems Development Life Cycle (SDLC) - A process of creating or altering information systems, and the models and methodologies that are used to develop these systems. The methodologies form the framework for planning and controlling the creation of an information system.

1.1.193. Technology Stack - A Technology Stack comprises the layers of components or services that are used to provide a software solution or application.

1.1.194. Third Party Liability (TPL) – The liability of an entity that is, or may be, liable to pay all or part of the medical cost of care for a Medicaid client.

1.1.195. TRAILS - The system used by the Colorado Department of Human Services to track foster care clients.

1.1.196. Transaction Control Number (TCN) - The unique claim identifier used by the Legacy System.

1.1.197. Transmittal - An official document from the Department authorizing the Contractor to perform a specific function that is considered within the Contractor's Scope-of-Work during the Contract, but a Transmittal may not be used for any changes that require an SDLC or follow the Change Management Process.

1.1.198. UAT Environment – The System hardware and software environment designated for UAT, in which the Department may perform tests prior to the System or modifications to the System being made available in the Production Environment.

1.1.199. Uniform Long Term Care 100.2 (ULTC 100.2) - the current client needs assessment tool form, as of the Effective Date, used to evaluate whether long term care is appropriate for any given client or potential client.

1.1.200. User Acceptance Testing (UAT) - The process to obtain confirmation that a system meets mutually agreed-upon requirements prior to the Department's acceptance of the System or changes to the System.

1.1.201. User Interface (UI) – The interface between the Colorado interChange and users.

1.1.202. Utilization Management (UM) - The evaluation of the appropriateness, medical need and efficiency of health care services procedures and facilities according to established criteria or guidelines and under the provisions of an applicable health benefits plan.

1.1.203. Warm Hand-Off - A call center technique that ensures that if a caller must be transferred, they are passed from one person to another person without being placed on hold or speaking to an automated system.

1.1.204. Web Portal - A secure Internet website that contains forms and other information specific to the system and provides the Medical Assistance program enterprise a consistent look and feel for the various applications.

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