

**BID ADDENDUM**

**May 2, 2008**



**State of North Carolina  
Department of Health & Human Services  
Office of Procurement & Contract Services**

**FAILURE TO RETURN THIS BID ADDENDUM  
IN ACCORDANCE WITH INSTRUCTIONS MAY  
SUBJECT YOUR BID TO REJECTION**

**BID NUMBER:** RFP 30-DHHS-1228-08-R

**SERVICE:** "NC Replacement Medicaid  
Management Information System"

**ADDENDUM NUMBER:** 3

Questions and Answers on Updated Requirements

**PURCHASER:** Susan W. Lewis

**USING AGENCY:** NC DHHS

**OPENING/TIME:** N/A.

**INSTRUCTIONS:**

1. Two (2) properly executed copies of this Addendum shall be included with your Proposal.
2. This Addendum contains changes in specifications.
3. Acknowledgement of receipt of letter titled "North Carolina Replacement MMIS Updated Requirements," dated April 18, 2008 which shall be considered part of this Addendum \_\_\_\_\_(initials)
4. Acknowledgement of receipt of letter titled "North Carolina Replacement MMIS Updated Requirements," dated May 1, 2008 which shall be considered part of this Addendum \_\_\_\_\_(initials)
5. Execute Addendum:

Bidder: \_\_\_\_\_

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name and Title (Typed or Printed): \_\_\_\_\_

## Questions and Answers on Updated Requirements

Sequential Number	Updated/New Requirement Number	Offeror’s Question
1	40.1.1.107	<p>Please elaborate on automate date specific rules and provide an example.</p> <p><i>The rules engine should be automated. Each rule should have an effective and end date and should, if applicable, create application events that could result in workflow activities. Example: Edit 0205, effective date 1/1/2007 – Providers may bill procedure codes used to indicate that anesthesia is complicated by an emergency (CPT code 99140). When edit fails, deny, suspend and send to workflow queue.</i></p>
2	40.1.1.109	<p>Please provide examples for media events and application events.</p> <p><i>An event is a communication mechanism between the rules engine and the workflow manager.</i></p> <p><i>Example of Media Event: Additional documentation is required to complete processing of a claim, prior approval, etc. A media event is initiated to produce a letter to the provider.</i></p> <p><i>Example of Application Event: Edit or audit fails. This creates an event with a disposition such as suspend, manually price, etc.</i></p>
3	40.1.2.109	<p>Please clarify what users are being referenced here. What is the format of the batch?</p> <p><i>Batch formats will be determined during DDI.</i></p>
4	40.2.1.40	<p>What are the allowable notification options that will satisfy this requirement?</p> <p><i>Automated notifications are required. The purpose of automated notifications is to trigger any process related to retro eligibility. In this instance, the term “business area” includes the system or subsystem capabilities that perform automated processing.</i></p>
5	40.2.1.40	<p>Will the State provide actual experience (volumes) for the retroactive enrollment/disenrollment described in this requirement?</p> <p><i>For DMH, over the past nine months, an average of 655 claims per month was reprocessed due to retroactive enrollments into Medicaid.</i></p> <p><i>For DMA, approximately 25 recipients per year are enrolled into a managed care organization, requiring retro processing.</i></p> <p><i>For DPH, over the past year, approximately 100 recipients were retroactively enrolled in Medicaid resulting in the reprocessing of 450 claims.</i></p> <p><i>Given the current manual processes, it is possible that an automated system might identify higher volumes.</i></p>

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6	40.5.1.78	<p>What is meant by placing a provider on review for incentives?  <i>This requirement will be updated for clarity.</i></p>
7	40.6.1.45	<p>Please clarify the State’s meaning of “Reference Modifier Information” as used in this requirement.  <i>“Reference Modifier Information” refers to elements that describe a modifier such as type of modifier, effective date, end date, provider type/specialty, audits or edits, or percentage (if pricing modifier). It also refers to which modifiers can be used with specific procedure codes and which modifiers can be used with other modifiers.</i></p>
8	40.6.1.45	<p>What is the expected update mechanism (manual, automated) to be used for maintaining applicable edit and audit numbers for a procedure code modifier?  <i>Automated</i></p>
9	40.7.1.65	<p>If an existing date range is updated for a specific billing provider, for example, is the requirement to recalculate all historical prior approvals to determine if the maximum has been reached. If so, would existing “approved” prior approvals then be updated to “denied” if the maximum dollars has already been reached?  <i>The limit of dollars should be based on claims that are processing, not on prior approvals. The purpose of this requirement is to be able to limit the dollar amount of claims that can be paid for the specified provider. There should be no tie to a prior approval unless that is the mechanism that is being used to enforce this limitation.</i></p>
10	40.7.1.66	<p>If an existing date range is updated for a specific recipient, for example, is the requirement to recalculate all historical prior approvals to determine if the maximum has been reached. If so, would existing “approved” prior approvals then be updated to “denied” if the maximum dollars has already been reached?  <i>The limit of dollars should be based on claims that are processing, not on prior approvals. The purpose of this requirement is to be able to limit the dollar amount of claims that can be paid for the specified client. There should be no tie to a prior approval unless that is the mechanism that is being used to enforce this limitation.</i></p>
11	40.7.1.66	<p>Would an outstanding balance from an expired date range need to be added to the balance for the new date range.  <i>No, date ranges should be independent of each other.</i></p>
12	40.7.1.67	<p>Will you please explain the status: “re-enter”?  <i>Instead of denying, the claim detail will route to the next possible benefit plan if one exists. If one does not exist for that claim detail, then it would deny.</i></p>

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13	40.8.1.138	<p>Is the requirement relating specifically to paper remittance production when referring to “report a system-configurable number of failed edits per detail line” or are there other reports this capability would be required for?</p> <p><i>This requirement relates to both paper RAs and online responses with the intent to display as many failed edits as specified by the State.</i></p>
14	40.8.1.222	<p>Will the State require that the fields and format on a paper remittance differ from program to program or will the format and fields display remain standard across programs?</p> <p><i>RAs will remain standard across programs.</i></p>
15	40.8.1.222	<p>Please confirm that control totals are equivalents of the budget totals.</p> <p><i>No, control totals are not equivalent to the budget totals. Control totals are used to reconcile the input transactions (counts and amounts) and output transactions of a checkwrite.</i></p>
16	40.8.1.382	<p>Please provide us with an example of where the General Assembly mandates tracking for LMEs of “\$0 paid claims” for a service</p> <p><i>The General Assembly has given the LMEs the ability to receive their DMH/DD/SA State dollars in a series of 1/12th payments outside of IPRS. This is called Single Stream Funding. However, the LMEs are still required to submit claims to IPRS to justify earnings for these funds. These claims are edited and processed the same as a claim that is paid using Federal funds. However, the paid amount for these claims is set to \$0 as the funding has been received outside of IPRS. The Division believes that there are other situations on the horizon that will require the system to function in a similar manner.</i></p>
17	40.8.1.382	<p>When you speak of “\$0 paid claims” are you referring to a process similar to “encounter claims” or “blind billing” that would be tracked in a managed care environment?</p> <p><i>The claims would have to be submitted and treated as normal professional claims as there may be funds available to pay them. If, however, there are no funds available, instead of just receiving an ‘out of budget’ denial, a claim would need to be tracked and handled in such a way that future claims would be able to edit and audit against it.</i></p>
18	40.8.1.383	<p>As an example, claim 1 is eligible for two (2) programs. Based on hierarchy, the system processes using Program A first and denies for several different Claims edits. The system tries to re-process using Program B and pays. Do we need to save the edits codes the resulted in Program A not paying on history? If so, how many codes would the State like to see?</p> <p><i>For DMH, there are no edits that would allow a claim detail to route</i></p>

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		<i>to a subsequent benefit plan if the claim detail failed them with the first benefit plan. If an audit is failed, that audit should be tracked with the benefit plan to which the audit applied. One audit code per benefit plan would be sufficient.</i>
19	40.8.1.383	<p>As an example, claim 1 is eligible for two (2) programs. Based on hierarchy, the system processes using Program A first and pays thru claim adjudication. However, during financial processing it finds that funding is not available and checks for funding using program B. In this situation should that claim be re-adjudicated using Program B since the pricing rules and editing could be different for program B? Should we maintain historical information detailing that funding was not available for program A?</p> <p><i>Yes, the claim should be re-adjudicated using Program B. Yes, we should maintain historical information detailing that funding was not available for program A. This can be as simple as associating the denial code with the benefit plan.</i></p>
20	BAFO	<p>We request the State increase the total pages that may be added to our page limited proposal sections at BAFO from a total of 50 to 100 pages. We believe the new page breaks we will be generating from making the clarifications the State has requested may require more than 50 new pages.</p> <p><i>The State declines to increase the number of additional pages.</i></p>
21	BAFO	<p>Because we believe that some graphics are more easily interpreted when viewed in color we request the State allow the Technical Volume BAFO to be delivered in either color or B&amp;W.</p> <p><i>The letter requesting BAFOs will address this and will provide flexibility to the Offeror in terms of using color, black and white, or both.</i></p>
22	BAFO	<p>We request the State move the work start date from 16 September as stated in the RFP to 30 October as recently forecasted to the NC State Legislature. We understand the actual date may change; however the later date reduces risk for the State and early announcement of that date will permit us to respond more accurately to State Negotiation Package comments.</p> <p><i>As identified in a letter dated April 30, 2008, the State is adjusting the expected contract award date to October 29, 2008.</i></p>
23	40.1.1.120	<p>Please provide a business example of how the State sees this requirement being used.</p> <p><i>See Procurement Library II/Business Rules (All LOBs)/MMIS(DMA)/PR File Clean-up Bus Rules.</i></p>
24	40.8.1.223	<p>Please confirm that the voucher statements are checks or RAs.</p> <p><i>Vouchers are check stubs.</i></p>

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24	SOO Matrix, section 10.5 (nine requirements)	<p>These requirements relate to the Cost Proposal. Our understanding is that we are not permitted to discuss costing in the Technical Proposal. Please provide some direction on how to respond to these requirements.</p> <p><i>In the “Vendor will meet the requirement or objective (Y/N)” column, Offerors should respond whether they intend to meet each requirement. In the “Proposal Page Reference(s)” column, enter “Cost Proposal” for those requirements that will be met in that portion of the Offeror’s Proposal.</i></p>