Offeror Questions and Answers - General

Sequential Number	Req. for Cost Proposals Section or Pricing Table Number	"General" or "Offeror-Specific"	Offeror's Question and State Response
C-1	General	General	Will the State conduct face-to-face cost negotiations, as was done with the technical proposal? Response: The State reserves the right to negotiate (in writing) and conduct face-to-face discussions in the future.
C-2	General	General	Will the State request a cost BAFO? Response: The State reserves the right to request BAFOs. Offerors should propose their best prices in their initial Cost Proposal submissions.
C-3	General	General	Section 30.48.2 Retainage of the original RFP stated the following regarding operational retainages: "The State shall require payment retention (retainage) in an amount equal to ten (10) percent of each Operations Task CBU invoice item submitted for payment. Each month during the Operations Phase the State shall review the performance report card for performance during the preceding month. The State shall notify the Vendor of its determination relating to any retainage to be forfeited and shall include payment to the Vendor for any retainage due it in the next monthly invoice payment" Is 30.48.2 Retainage still applicable to the Cost Proposal? Response: RFP Section 30.48.2 was changed in the revised RFP published in December 2007 (and was renumbered as 30.45.2), and the text referred to in the question is no longer current. Retainage was never intended to be applied to the Cost Proposals. It is intended to apply to the payment of invoices during the Contract Term.
C-4		Offeror-	Offeror Specific question.

Sequential Number	Req. for Cost Proposals Section or Pricing Table Number	"General" or "Offeror-Specific"	Offeror's Question and State Response
		Specific	
C-5	Pricing Table E	General	Please identify where the State would like us to note the costs associated with the following aspect of Non-Title XIX / XXI items, since they fell into the General Area: --Database Conversions Response: The State will "ungrey" the General requirements area to allow Offerors to identify marginal costs associated with requirements having applicability across Non-Title XIX/XXI programs.
C-6	Pricing Table E	General	Please confirm that Benefit Plan Administration activities for Non-Title XIX / XXI should be included in the Reference section of this table. Response: Yes.
C-7	Pricing Table G	General	Offerors are required to determine rates and to determine percent mix of staff, as well as number of hours expected. As the State will be using this table in its evaluation, what method will the State use to evaluate this table? Response: The State will evaluate the proposed rates and "percent typical use" as part of its best value evaluation. See Question C-25 for further information.
C-8	Pricing Table H	General	Please provide the volume of FCBU and ECBU Pharmacy and Non-Pharmacy being experienced today by payer or by program. Response: DMH – See the updated Key Statistics in Update 18 to the Procurement Library. DMA – See "SFY 2008 DMA Paid Claim and CBU Statistics.xls" in Update 18 to the Procurement Library.

Sequential Number	Req. for Cost Proposals Section or Pricing Table Number	"General" or "Offeror-Specific"	Offeror's Question and State Response
			DPH – FCBU non-pharmacy – 164,000; FCBU pharmacy – 32,000 (SFY 2007 – 2008) NCHC – See "Updated Health Choice Claim-CBU Volumes.xls" in Update 18 to the Procurement Library.
C-9	Pricing Table H	General	Are the volumes by payer exclusive of denied claim transactions? Response: Yes.
C-10	Pricing Table H	General	How closely to the current FCBU and ECBU Pharmacy and Non-Pharmacy volumes are the numbers presented in Pricing Table H? Response: Currently, CBUs consist of paid and denied claims (for inpatient claims) and detail lines. The increase in anticipated FCBU's results from an increase in the way DMA claim details will be counted in the Replacement MMIS, rather than from an anticipated increase in the number of actual claims filed. In order to move to a HIPAA compliant hospital outpatient claim format in the Replacement MMIS, the average number of detail lines per hospital outpatient claim is anticipated to increase from an average of six lines today to 22 lines per claim.
C-11	Pricing Table H	General	Please provide the Non-Pharmacy FCBU, Non-Pharmacy ECBU, Total Non-Pharmacy CMU, and Pharmacy FCBU counts from Pricing Table H by individual payers so that the bidders can better understand how the totals were created. These are the particular numbers we are questioning and would like broken down by payer: SFY 10 - 11 July 1, 2010 - June 30, 2011 | 249,663,395 | 895,068 | 250,558,463 | 18,666,538 Response: The requested information can be found in Attachment Two of the Revised Cost RFP. Please note the State has reviewed and revised the Pricing Table H numbers in the "Replacement MMIS Revised Pricing Tables." In addition to updating the anticipated volumes based on **actual** SFY08 data, other adjustments were made.

Sequential Number	Req. for Cost Proposals Section or Pricing Table Number	"General" or "Offeror-Specific"	Offeror's Question and State Response
C-12	Pricing Table H	General	Please explain the rationale of the inflationary factor in Pricing Table H from SFY to SFY. Response: See Attachment Two of the Revised Request for Cost Proposals.
C-13	Pricing Table H	General	Was the inflationary percentage based on historical average values over the past few years? If so, what were the actual historical average inflationary percentages by SFY? Response: Some of the growth rates were based on historical averages. For DMA: None of the growth rates were based directly on historical averages. For DMH: None of the growth rates were based directly on historical averages. For DPH: The growth rate was based on historical averages. The historical averages were: • SFY 04-05 to SFY 05-06 – 46% growth • SFY 05-06 to SFY 06-07 – 20.6% growth • SFY 06-07 to SFY 07-08 – 19% growth For NCHC: None of the growth rates were based directly on historical averages.
C-14	Pricing Table M	General	This table requires Offerors to complete recipient pricing for the following programs: North Carolina Health Choice, Kids Care, Ticket to Work/Health Coverage for Workers with Disabilities, and the Community Alternatives Program for Persons with Mental Retardation/Developmental Disabilities (CAP-MR/DD) and CAP Children's Program (CAP/C). Similar to Table F, please confirm this table is only for recipient services associated with the Supplement, since some of these services (such as recipient premiums) were requested in the base RFP.

Sequential Number	Req. for Cost Proposals Section or Pricing Table Number	"General" or "Offeror-Specific"	Offeror's Question and State Response
			Response: Offerors should include pricing in relation to all recipient management services uniquely applicable to the benefit programs identified above. While all of the *programs* requiring these services, at this time, were identified in Addenda 4 and 5 to the revised RFP, some of the *requirements* being satisfied were published in the base revised RFP. **(**Example: RFP 40.14.2.32) Note that recipient-related requirements from the base RFP that also apply to recipients other than the Supplement benefit programs should be priced as part of the Operations Phase – Fixed Price Due to Fixed Costs, rather than to Recipient Management (Example: RFP 40.2.2.1).
C-15	Pricing Table M	General	Please confirm that the State will use the same number of recipients served for each day within a month. If the State will not use the same number, how will the number of recipients served by day be derived? Response: The State interprets this question as asking how to invoice (RFP Section 30.40) rather than how to price (Pricing Table M). While a constant number of recipients throughout the month is currently the norm, the RFP was written to allow for mid-month enrollments and disenrollments. This will permit future flexibility without requiring a Contract amendment. The pricing of recipient management is based on daily volumes. During the Operations Phase, these volumes will be obtained from EIS for DMA benefit programs, and enrollments for DPH recipients will be submitted directly to the Fiscal Agent. NOTE: other sources may be needed to identify recipients for other benefit programs in the future.
C-16	Pricing Table M	General	What are the current volumes of recipients for these programs today? Response: Non-Premium Paying Recipients – 122,000 (NC Health Choice) Premium Paying Recipients – 130 (NC Health Choice – Classification Code L) Note that some of the programs proposed in the Supplements are not currently active.

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C-17	Pricing Table M	General	The State has acknowledged that, regardless of the number of recipients served or claims processed, certain fixed costs exist and generate fixed fees. The same holds true for the services requested because staff, systems, and processing cannot independently and immediately fluctuate by day with volumes. Will the State include a fixed fee for these services as well? Response: Yes, the State will separate pricing for recipient management by fixed and variable elements to address the Offeror's concern. The fixed element will be proposed and invoiced on a daily rate. The variable element will be proposed and invoiced on a per recipient per day basis based on the average recipient volume over the invoice period. The State will evaluate the fixed-to-variable cost ratio as part of its best value analysis.
C-18	Pricing Table Q	General	Should Offerors include the price for all other training classes besides those listed in Table Q, including content creation and delivery in the Operations Phase fixed fee? Response: Yes. The State assumes that content creation needed to address changes and improvements in operations will be included in the fixed price for Fiscal Agent operations in Pricing Table I. Content creation associated with Contract amendments that change the system or scope of work will be priced as part of that amendment. Does the State expect Offerors within the fixed fee to only deliver these training sessions for non-Offeror users, rather than an additional training curriculum? Or, does Requirement 40.1.2.81 quantify Operations Phase scope for Requirement 40.1.2.80? Response: The State expects that costs for training conducted during the Replacement Phase (required to prepare users for testing or for the Operations Phase) will be included in the DDI pricing in Table A. The State expects that the costs for training, other than the additional classes specifically identified in Pricing Table Q, will be included in Pricing Table I covering the fixed price for Fiscal Agent operations.

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			The training applies to all non-Vendor users, although the Vendor may include its personnel in these training sessions when space is available. Other Vendor training costs will be borne by the Vendor. Requirement 40.1.2.81 quantifies the Operations Phase training identified in 40.1.2.80.
C-19	5.4.1	General	The instructions to Pricing Table S state "After the initial 12-month effort, the State is expecting the Vendor to spread out the re-credentialing activities over a three-year period to avoid large peaks and valleys in the effort." How do these instructions match to the re-credentialing requirements in the RFP? For example, the Offeror may not have a choice but to have a large re-credentialing effort when medical doctors' licenses expire as most state licensing boards have specified months and years that the license is valid. Response: See the answer to Question C-52.
C-20	3 Basis of Estimates	General	We note the FCBU values on Pricing Table H are approximately 2.5 times higher than volumes previously provided by the State (July 2007). The addition of the Health Choice claims would not address these volume differences. Please provide additional information to support the dramatic increase in FCBUs from 2007's information. In order to provide a fair evaluation, will the State please provide the 2008 current FCBUs for DMA, DMH and DPH plus the addition of NCHC including Kids' Care, and growth due to Ticket to Work? Response: See the answers to Question C-8 and C-10.
C-21	Para 4. SFY vs CY	General	The Request for Cost Proposal (RCP) states that contractually binding invoicing shall be made by SFY based on quantities submitted in the Tables with this Cost Proposal. The RCP also requires Offerors to recalculate costs by Contract Year in a manner that we believe may dilute the visibility into fair pricing that the State will achieve from the SFY based cost displays. The State will only have to change the row or column labels on Tables G, L, N, P and T in order to have Offerors provide all costs by SFY which will

Sequential Number	Req. for Cost Proposals Section or Pricing Table Number	"General" or "Offeror-Specific"	Offeror's Question and State Response
			enable the State with the traceability and transparency to compare call costs on an SFY basis. Will the State please delete the requirement to submit costs by Contract Year and base its entire evaluation on SFY cost displays submitted by Offerors with instructions to Offerors to display costs by SFY even when work occurs in only part of the SFY? Response: The Request for Cost Proposal does not describe invoicing based on the quantities submitted in the Tables (other than for the limits on pricing validity). Invoiced prices are based on ***proposed*** rates and ***actual*** service quantities. The State does not concur that proposing "unit" prices by SFY and Contract prices by Contract year dilutes visibility. The State declines to make the requested changes.
C-22	Para 5. Pricing Table Preparation	General	Significant Decimal Places. Example calculations in the RCP use different numbers of significant places after decimals. This is logical because some numbers are very large and some are very small before being multiplied. To obtain complete visibility of calculations, will the State stipulate a specific number of significant decimal places to use for each Table so that Offerors present comparable costs? Response: The Offeror appears to be confusing "decimal places" with "significant digits" (also known as "significant figures"). For example, the number 0.000004 has six decimal places but only one significant digit. The State is concerned that increasing the number of significant digits could exceed the capabilities of Microsoft Excel (which is limited to 15 digits of precision) without providing any significant benefit. Additionally, the level of pricing granularity using six significant digits ***for coefficients*** seems reasonable. Prices and rates (not including the coefficients) shall be expressed to no greater precision than the nearest one cent ($0.01).
C-23	5.1.5	General	The instructions and the title for Pricing Table G use the term "All Inclusive" to modify Hourly Rates. This term was not found in the NCMMIS+ Glossary and Acronym List. Will the State define the term "all inclusive" in a manner that includes what costs are in the term and that also provides some examples of costs deemed to be outside of the "All Inclusive" term?

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			Response: "All-inclusive" means that the rate includes all overhead, profit, travel, per diem, etc. The State will not accept charges as a result of the Vendor's provision of labor other than those reflected in the all-inclusive rate.
C-24	5.2.4	General	Reports in the Procurement Library show amounts deducted by the incumbent fiscal agent from providers' payments, and discussions with providers inform us these are fees assessed on pharmacy claims on each financial cycle. In determining our variable pricing (and in view of RFP section 30.40.6) does the State intend to allow its fiscal agent to continue the current practice of retaining some portion of provider payments for use by the fiscal agent to reduce costs? Response: No.
C-25	Para 5. Pricing Table Preparation And Sec 60.2 of the original RFP	General	This section suggests that "discounts" or certain costs expressed in the Cost Proposal "…may be considered as part of best value". Additionally some text in the RCP differs from the evaluation criteria and methods defined in Sec 60.2 of the original RFP. Will the State update Sec 60.2 in this RCP with special emphasis on defining the State methodology for a best value evaluation (i.e., identification and categorization of elements, best value scoring including weighting of element scores, application of the best value score to the Technical and Cost Score values already defined in the RFP, etc.) Response: Section 60.2 was updated in Addendum 7 to 30-DHHS-1228-08-R; therefore the original text has been superseded. The State cannot practically identify every item that could contribute to the evaluation of best value because it does not know what the Offerors will propose. Offerors should refer to Section 2, Approach to Pricing; Section 3, Bases of Estimates; Section 4, State Fiscal Year Versus Contract Year; RFP Section 60; 09 NCAC 06; and NCGS 143-135.9 for general guidance. This list is not necessarily all-inclusive. The State declines to update RFP Section 60.2.

Sequential Number	Req. for Cost Proposals Section or Pricing Table Number	"General" or "Offeror-Specific"	Offeror's Question and State Response
C-26	Table A, Replacement Ph Milestone Payments	General	For visibility of calculations, will the State add columns with instructions for Offerors to identify the SFY in which the payment will be invoiced? Response: The State declines to make the requested change.
C-27	3 Basis of Estimates	General	Workload Quantities. Workload quantities provided in the RFP and the RCP vary greatly from what is found in the State Procurement Library. To obtain visibility of the basis of estimate and a fair comparison will the State provide a specific list of workload quantities, in addition to those in the RCP, for the following work: Response: The State does not have projected quantities for the information requested. Offerors may need to use their experience to derive estimated future quantities. The required workload quantities may be influenced by each Offeror's specific proposed solutions. The State has listed **historical estimates** below to assist the Offerors. The volume of all documents that require imaging For DMA, approximately 5.4 million paper documents were processed in SFY 07-08. For DMH, approximately 430 paper documents were processed in SFY 07-08. For DPH, approximately 270,000 paper documents were processed in SFY 07-08. For NCHC, approximately 93,000 paper documents were processed in SFY 07-08. Pended claims for the last calendar year The State does not have this information for DMA or NCHC. For DPH, there were 12,430 for SFY 2007-2008. For DMH there were 244,886 for SFY 2007-2008. DMH pended claims currently do not require manual intervention. All claims, not CBUs, submitted by line of business delineated by electronic submission

Sequential Number	Req. for Cost Proposals Section or Pricing Table Number	"General" or "Offeror-Specific"	Offeror's Question and State Response
			and paper submission For DMA, this information is provided in "SFY 2008 DMA Paid Claim and CBU Statistics.xls" in Update 18 to the Procurement Library. For DMH, refer to the DMH Key Statistics in Update 18 to the Procurement Library. For DPH, 98,000, all paper submissions For NCHC, 1,772,416 electronic, 93,285 paper claims
C-28	3 Basis of Estimates	General	Paper Claims Submission Rates. Paper Claim submission rates are a major driver of resource requirements for Tables J and K. Paper volumes are needed to provide a realistic bid. To obtain a fair comparison of Offerors bids, specifically for mailroom and claims staff, will the State please consider stipulating the paper claim submission rates that is expected in contract year 3 (the approximate time the successful Offeror will be begin operations of the Replacement MMIS)? It is in the best interest of the State to instruct the Offerors the volumes to use for paper and electronic submission as these two variables greatly influence the number of staff that the Offeror will propose. For example, with the present variances staff could double in the mailroom and the claims keying/resolution staff. Response: The State declines to stipulate the paper claim submission rate. Historical estimates are provided below. For DMA, the average monthly paper claim volume has decreased as shown: 2004 – 12% of total claim volume; 2005 – 8% of total claim volume; 2006 – 8% of total claim volume; 2007 – 7% of total claim volume;

Sequential Number	Req. for Cost Proposals Section or Pricing Table Number	"General" or "Offeror-Specific"	Offeror's Question and State Response
			2008 – 6% of total claim volume. For DMH, 100% of claims are submitted electronically. Approximately 30-40 adjustments per month are submitted on paper. For DPH, 100% of claims are submitted on paper. DPH cannot currently accept electronic claims.
C-29	Table G. Replacement Ph Additional Functionality Pool	General	Because of the many methods Offerors can use to develop an average labor hour price list by labor category in an uncapped pool environment as defined by Table G (e.g., extended work weeks for exempt employees, use of labor from other cost centers within a company or subs, etc,) a listing of average hourly rates by labor category will not provide the State with visibility into the amount of work this labor pool will be able to generate. To provide visibility of calculations leading to a fair cost comparison, will the State provide an annual SFY funding cap for this Table as the State has provided with Table O? Response: As stated in RFP Section 10.5, "Offerors shall propose a pool of software modification labor for use during DDI based on their historical experience." Thus, the Replacement Phase Additional Functionality Pool is capped. Offerors define the caps. The rates proposed by the Offerors are binding for the State Fiscal Years identified. Offerors should list all reasonable labor categories that are likely to participate in the types of modifications expected. Per RFP Section 30.40.1.1, Contract amendments using this Pool may be cost-based or price-based. In either situation, the rates proposed will be used to define the cost or price of the amendment unless the Parties agree otherwise. The State declines to provide an annual funding cap as requested.
C-30	Table G	General	Table G is designated as a Table that will be evaluated. However, no explanation is given regarding how that evaluation will be made. Will the State please explain how they will evaluate the contents of this table? Response: See Questions C-7 and C-25.

Sequential Number	Req. for Cost Proposals Section or Pricing Table Number	"General" or "Offeror-Specific"	Offeror's Question and State Response
C-31	Table O	General	Will the State change the column headings on this form from "FY XX – YY" format to a "SFY XX – YY" format? Response: Yes.
C-32	5.2.4	General	If the fees in the previous question [Question C-24] will continue, please provide the incumbent's total collection for the State fiscal Year ended June 30, 2008. Supporting this amount, please include the number of claims and the per claim fee(s) used for the offsets. Response: N/A. See Question C-24.
C-33	Table P	General	To provide better visibility and fair comparison of offers, will the State change the first column from "Operations Contract Years" to "State Fiscal Years" with actual SFY dates included? Response: The State declines to make the requested change.
C-34	5.2.10	General	In reference to requirement 40.1.2.86, will the State specify the uniform class size of these instructor-based training workshops? Response: No, the State will not *specify* a *uniform* class size. The 70 instructor-based training workshops conducted annually across the state should accommodate up to 250 attendees per workshop.
C-35	Replacement MMIS Pricing Table H, Operations Phase - Anticipated Volume	General	Will DHHS provide a breakdown of the projected non-pharmacy and pharmacy CBUs by media type (CBUs projected to be submitted as paper claims and those projected to be submitted by electronic media) and claim type (professional, institutional, dental) for non-pharmacy claims? Response: See the answers to Questions C-8 and C-27, and Question S143 of Addendum 5 to the revised RFP (for NC Health Choice).
C-36	3	General	The State provided a report titled "IPRS Mental Health Paid and Denied Claims," that contained information for twelve months ended December 2006. Will the State please

Sequential Number	Req. for Cost Proposals Section or Pricing Table Number	"General" or "Offeror-Specific"	Offeror's Question and State Response
	Basis of Estimates		provide updated claim counts for the State fiscal year ended June 30, 2008? Additionally, we request that the report titled "Key Statistics for DMH" be updated to reflect volumes for the State Fiscal Year Ended June 30, 2008. Response: These two updated reports have been place in the procurement library under Update Volume 18.
C-37	3 Basis of Estimates	General	To support the State's objective of fair pricing, will the State please provide historical volume information for the State fiscal year ended June 30, 2008, on the following activities: 1. Number of file maintenance updates performed by the fiscal agent. Response: DMH = 11 file maintenances in SFY 07/08. DPH = 10 file maintenances in SFY 07/08. DMA – The State will make available copies of the SFY 07/08 numbered memos for the Offerors' review. These numbered memos represent instructions to the current Fiscal Agent. Each Offeror should review these numbered memos/instructions to determine what would constitute a file maintenance activity within the Offeror's proposed Solution. 2. Number of medical policies reviewed and/or developed by the fiscal agent. Response: DMH, DPH and DMA – The Fiscal Agent does not develop medical policies and does not typically review medical policies. 3. Number of edits and audits updated per State memoranda. Response: DMH = 7 edits and audits updates in SFY 07/08. DPH = Currently N/A (not handled via State memoranda) DMA – 93 edits 272 audits.

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			4. Number of edits and audits analyzed for correct coding. Response: DMH = 0 DPH = Currently N/A DMA – 93 edits, 272 audits. 5. Number of claims suspended to Medical Review, by type of issue. Response: DMH = 0 DPH = Currently N/A (not handled by suspending claims) This information is not available for DMA. 6. Number of claims suspended for "Level 1" reviews Response: DMH, DPH = Currently N/A This information is not available for DMA. 7. Number of bite-wing dental x-rays received. Response: DMH, DPH = Currently N/A. DMA – The State does not have specific counts of dental x-rays received. DMA requires two sets of dental x-rays and a set of impressions to accompany each orthodontic prior approval request; In SFY 2006-2007, Medicaid received 11,504 orthodontic PA requests. Approximately 75% of non-orthodontic dental prior approval requests are accompanied by x-rays; in SYF 2006-2007, Medicaid received 85,740 non-orthodontic dental PA requests. 8. Number of other x-rays received Response: DMH, DPH = Currently N/A. DMA - The State does not have specific requirements for submission/review of

Sequential Number	Req. for Cost Proposals Section or Pricing Table Number	"General" or "Offeror-Specific"	Offeror's Question and State Response
			other x-rays and does not have specific counts of other x-rays received. 9. Number of dental impressions received Response: DMH, DPH = Currently N/A. DMA – See item #7. 10. Number of dental consultant reviews by type of issue Response: DMH, DPH = Currently N/A. DMA – The State does not have specific counts of dental consultant reviews by type of issue. 11. Number of PA requests for DPH. Response: DPH = 36,000 (DPH PAs are considered authorizations for a type of service that can be submitted.) 12. Number of Pharmacy PA requests, by type of media and by type of request. Response: DMH = Currently N/A DPH = This information is not available by media type. DMA – For calendar year 2007, DMA received 35,762 Pharmacy PA requests. Of those: • 73% were received by fax; • 27% were received by telephone; • Less than 1% received by email, US mail, and voice mail. 13. Number of adjustments to claims due to TPL recoveries Response: DMH = Currently N/A

Sequential Number	Req. for Cost Proposals Section or Pricing Table Number	"General" or "Offeror-Specific"	Offeror's Question and State Response
			DPH = 1675 DMA – 3200 14. Number of medical reviews or PA reviews for DMH claims. Response: The LMEs do their own medical and PA reviews. 15. Number of claims adjustments not related to TPL recoveries. DMH had 432 paper adjustments for SFY2007-2008. Electronic adjustment counts are included in the claim counts. DPH = 52 Response: DMA – information is available on the Performance Reports in the Procurement Library. 16. Number of RTD (turnaround documents). Response: DMH = Currently N/A. DPH = Currently N/A. (NOTE: DPH manually reviews documents for accuracy and returns them to the originator prior to entry into the system.) This information is not available for DMA.
C-38	3 Basis of Estimates	General	The State has instructed us to use values in the incumbent's Performance Reports (see Key Statistics for DMA). The Procurement Library contains a file titled "EDS Performance Reports Reference and Process." We note that someone, perhaps a State reviewer or contract monitor, has added review comments to a number of worksheets casting some doubt on the accuracy and completeness of numbers being reported. This Offeror does not have access to Report to Web, so the numbers being reported cannot be verified. The R2W reports provided in the Procurement Library only display the first page of system reports – all successive pages, including those pages

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			with totals, are not viewable by this Offeror. Follows are samples of some of the reviewer's comments: "Total Transaction value does not equal the sum of the column in any of the columns. Where does the "Total Voice Calls In" value come from?" "Are the reports used for this the same as the PVS Summary reports –" "Please check the totals of the first two columns." "Should the total 'calls in' less the "calls answered" equal the "calls Abandon"? "Please further explain the "Total Refunds received >90 days" I don't see where this number comes from." "The Prior month Ending inventory is not the same value as the current months beginning Inventory - Although the Ending Inventory breakdown does equal the Beginning inventory." "I would like to sit through the production of this report. I wasn't able to follow the process, and I couldn't come up with the same values. I'm sure I'm missing something." "The report HMDRV00N dated 10/24/2006 and the report in the October Performance report does not totally match - " "Are the rows that are hidden significant to the rows that are shown on the report?" "I am not sure what is reported on the spreadsheet. Please make this report more specific." "Shouldn't the calls answered plus the calls abandoned equal the Total calls In?"

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			Will the State please advise if the information contained in this report is correct and contains the required data needed by the Offeror for staffing confirmation and to provide the State a fair basis in our price evaluation. Response: The State inadvertently included a table being used to train an individual new to the job, and the comments are not pertinent to the actual data. Offerors should disregard this document.
C-39	3 Basis of Estimates	General	To support the State's objective of fair pricing, will the State please provide information on the following: 1. Incumbent desk procedures appear to suggest work supporting Program Integrity. What specific functions are required for the replacement MMIS operations, and what are the incumbent annual volumes at June 30, 2008 for these support activities? 2. Incumbent desk procedures appear to suggest the dental consultant is tasked to discuss certain issues with providers. Please provide information on what issues are referred to the dental consultant for discussions with providers. Response: The information requested relates to the submission of Technical Proposals. The State declines to answer this question.
C-40	3 Basis of Estimates	General	Will the State please provide the volume of special batches, with corresponding claim counts that are submitted by month and a total for calendar year? Special batches of claims as discussed in RFP 40.8.1.196 are claims authorized by DHHS on behalf of a provider. For calendar year 2007, DMA forwarded one special batch containing 7,066 electronic Medicaid claims to the Fiscal Agent for processing. Thus far in calendar year 2008, DMA has forwarded one special batch containing 3,585

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			electronic Medicaid claims to the Fiscal Agent for processing. DMH and DPH do not currently process special batches.
C-41	3 Basis of Estimates	General	Table M, will the State please define those components to be considered in this table? We understand the definition of recipient management in RFP section 10.12.3, and in the RCP; however, in order for the State to receive FFP (where applicable) and to assist the State in forward looking budgeting, we would not want to overlook any component of this price. Response: This question should have been addressed as part of the Technical Proposal solicitation (including the Supplement). Offerors should price their service components as they were proposed.
C-42		Offeror-Specific	Offeror-Specific question.
C-43	3 Basis of Estimates	General	Will the State please provide the translation or conversion factor used, by claim form type, between the incumbent's claims report that appears to be by document level and the pricing sheets that are provided in the CBU level? Response: Please refer to "SFY 2008 DMA Paid Claim and CBU Statistics.xls" in Procurement Library Update 18.
C-44	3 Basis of Estimates	General	Will both Offerors be instructed to provide the basis for estimate using the CBU level? The incumbent would have a distinct advantage in staffing at claim level vs. CBU level based on their knowledge of the current North Carolina volumes. Response: Given that the variable pricing model for claims is based off of CBUs, the State expects that Offerors will relate the BOE to CBUs in some reasonable fashion. Note that the Request for Cost Proposals requires operations BOEs to address the derivation of labor quantities, labor productivity, and material/non-labor costs.

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C-45	3 Basis of Estimates	General	The incumbent-prepared Performance Report for March 2007, delivered in the Procurement Library II, Update 2, appears to contain incorrect volume information. The three columns titled "# Details Processed" report the exact same values as found on the prior month report (February 2007). Will the State please request accurate information for the March 2007 reporting period and have it added to the State Procurement Library? Response: Claim detail information for the March 2007 Performance Report has been updated and a revised version of the report will be included in Update 18 to the Procurement Library.
C-46	3 Basis of Estimates	General	This bidder has no access to Report to Web, and requires additional information on incumbent volume and activities. The State has been providing some incumbent Performance Reports for the DMA MMIS contract. In the Procurement Library II, the most recent submissions were – Update 8 (incumbent's reports for the months of December 2007 and January 2008), Update 9 (incumbent's Corrected December 2007 report), and Update 11 (incumbent's report for March 2008). Will the State please provide the Performance Reports for the 2008 months of February, April, May, June and July? This will assist the Offeror in finalizing its price and allow the State a fair evaluation of said price. Response: The Performance Report for February, 2008 will be provided in Update 18 to the Procurement Library. The report for March, 2008, was provided in Procurement Library Update 11. Reports for the months of April, May, June and July, 2008, were provided in Update 17.
C-47	3 Basis of Estimates	General	Procurement Library II, Update 16 provided report with OMMISS' logo for Health Choice claims. This report appears to be reporting only whole number of claims. To determine the FCBUs attributable to NCHC, we request the number of claim detail lines (total and paid) for services that are not inpatient hospital or long term care services.

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			Response: See "Updated Health Choice Claim-CBU Volumes.xls" in Update 18 to the Procurement Library.
C-48	3 Basis of Estimates	General	RFP section 30.40.2.1 indicates FCBUs for Medicare crossover claims are to be the claim detail lines for paid services. However, the incumbent Performance Reports found in the Procurement Library have the values for crossover claims' "# Details Processed" blacked out on all reports. Will the State please provide the missing information on paid and total detail lines, at a minimum, for the SFY 2008? Response: No detail line information is available for inpatient crossovers or outpatient crossovers because the Legacy MMIS+ does not process these claim types at detail level.
C-49	3 Basis of Estimates	General	One category of FCBUs described in RFP section 30.40.2.1 is for Medicare crossover claims. We understand that FCBUs for crossovers are counted at the paid line detail level. Please confirm that Inpatient Medicare crossovers are counted at the detail line level and not at the whole claim (single ICN) level. Response: Medicare crossover claims as defined in the fourth bullet for Non-Pharmacy FCBU information refers to Medicare outpatient crossover claims which will be counted at the detail level. Inpatient Medicare crossovers are included with all other inpatient hospital service claims in the first bullet and will continue to be counted at the whole claim (single ICN) level.
C-50	30.7 Tax	General	Reference text: "State agencies may have additional exemptions or exclusions for Federal or State taxes. Evidence of such additional exemptions or exclusions may be provided to the Vendor by agencies, as applicable, during the Term of the Contract." Will the State provide the Vendor with State and local tax exemption (i.e. property taxes) and, therefore, the vendor would exclude such taxes from the bid cost?

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			Response: Offerors should not expect any tax exemptions or exclusions when determining prices in their Cost Proposals.
C-51	5.4.1	General	In regard to Pricing Table S, will the State please provide the counts by provider types to support the estimated volumes shown in the tables? This information is needed for the Basis of estimates calculations. Response: See "Number of Providers by Type.xls" in Update 18 to the Procurement Library.
C-52	5.4.1	General	Pricing Table S shows 38,000 initial Credentialing and Verification activities (for the first 12-month from contract start. In the Anticipated Volume section, for SFY 08 – 09, volumes are shown of 33,500 for Verify and 21,000 for Credential or Recredential, summing to 54,500. The accompanying note informs us these 54,500 units are to begin only after completion of the initial Credentialing and Verification. Since the initial 38,000 are to be performed in the first 12-month period, and the State would like a staggered approach over a three-year re-credential period, what will be included in the additional count of 54,500 (the 33,500 plus 21,000 in the shaded cells) for SFY 08 – 09? Response: The State's assumptions behind the chart are as follows: There are approximately 65,000 active providers, with about 49,000 unduplicated providers. - Approximately 11,000 of the 49,000 unduplicated providers will not need to be included in the initial credentialing and verification activities because they will have been credentialed in the 12 months prior to Contract award, or because their provider type is excluded from credentialing and verification, or because they have ceased to participate in the programs. - Approximately 38,000 of the 49,000 unduplicated providers will be credentialed

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			by the Vendor in the first 12 months of the Contract - Approximately 33,500 of the 49,000 unduplicated providers have licenses, certification or endorsements that expire on a regular basis (typically annually), and will need to be source verified by the Vendor. o Approximately 7,000 are providers licensed by DHSR; licenses expire on December 31 of each year. o Approximately 3,000 are dentists; licenses expire on January 1 of each year. o Approximately 1,500 are psychologists and psychological associates; licenses expire on October 1 of odd or even years. o Approximately 1,600 are pharmacies; licenses expire on December 31 of each year. o Of the remaining providers, most are staggered throughout the year. - Approximately 5,800 new providers will be enrolled by the Vendor during the first 12 months of the Contract, and approximately 1400 currently enrolled providers are expected to be enrolled by the Vendor in additional benefit programs - Some providers (e.g., government) do not go through the credentialing process - After the first 12-month credentialing period, the Vendor will begin a "steady state" approach to verification and credentialing. Verification will be done when licenses are within 30 days of expiration and up to 60 days after expiration date. The State will work with the Vendor to spread re-credentialing activities out over a three year rotation to smooth out the workload. The activity quantities shown in Table S reflect that smoothing. **The Vendor will not be required to "catch up" on all services in the shaded region on Table S but will assume normal scheduling of credentialing and verification after completion of the**

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			initial credentialing and verification effort. For example, if an Offeror plans to use the entire 12 months to complete the initial credentialing and verification activities, then the only "Ongoing Credentialing" and "Ongoing Verification" activities during Replacement Phase Year 1 would be those associated with new provider enrollment ("EC") or existing providers enrolling in new programs ("EV"). Upon completion of the initial credentialing and verification, the Offeror would assume ongoing credentialing and ongoing verification at the ***rate*** of 35175 per year for verification (averaging about 2930 per month) and 17150 per year for credentialing (averaging about 1430 per month). The Offeror would ***not*** be required to complete the quantities of 35175 and 17150 by the end of SFY 09-10. For clarity, the State has eliminated from Pricing Table S the anticipated verification ("V") and credentialing ("C") quantities for SFY08-09 under the assumption that there is no requirement to complete the initial credentialing and verification activities substantially prior to the 12-month point in the Contract. - The State has updated the service quantities in Table S.
C-53	5.2.1 Methodology and MS Excel worksheet for Replacement MMIS Pricing Tables J	General	In order to provide the State with the best possible value, we have differing interpretations of how to populate Pricing Table J. Also in some scenarios a limitation of six digits for a coefficient A negative value, the resultant price is negative. Will the State please provide a complete one year example for Pricing Table J? Response: See the answer to question 22. An example for SFY 10-11 would be: Coefficient A = -1×10^{-9} Coefficient B = 0.01 Average Daily Price at Anticipated Volume = $6393.38 Upper Limit of Valid CBU Average Daily Volume – 225% Note that the above numbers are notional, and are not intended to represent expected values.

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C-54	5.2.1 Methodology and MS Excel worksheet for Replacement MMIS Pricing Tables K	General	In order to provide the State with the best possible value, we have differing interpretations of how to populate Pricing Table K. Will the State please provide a complete one year example for Pricing Table K with a negative coefficient A value and a positive coefficient B value? Response: See the answer to question 22. Example for SFY 10 - 11: Coefficient A = -1×10^{-9} Coefficient B = 0.01 Average Daily Price at Anticipated Volume = $508.80 Upper Limit of Valid CBU Average Daily Volume – 400% Note that the above numbers are notional, and are not intended to represent expected values.
C-55	3 Basis of Estimates	General	The State provided a series of reports titled "Key Statistics for DPH," containing some monthly and some annual volumes. One page displayed POMCS counts for Fiscal Years 2002 through 2006. Several cells were marked "unknown." Will the State please provide updated values for the State fiscal year ended June 30, 2008, for DPH. Response: The State was unable to identify "unknown" cells relating to the information being requested. Questions C-8 and C-13 provide information related to the Offeror's question.
C-56	3 Basis of Estimates	General	In Procurement Library II, volume 16, the State published counts of Health Choice processed claims. In the workbook "Health Choice Claim Volumes", using the worksheet "Total Claims by Type of Claim" one may derive the sum of total claims for the twelve months ended May 2008 of 1,875,870 claims. However, the adjacent worksheet "Percentage of Denied Claims" reports total claims for the same 12 months ended May 2008 as only 1,783,043. In order to provide a fair evaluation, the Offerors

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			would need claims by type to isolate pharmacy claims, but also need percent paid to determine the FCBUs. Will the State be able to provide corrected worksheet(s), or indicate which total is correct? If the Claims by Type worksheet are correct, will the State please provide a percent paid for Pharmacy and Non-pharmacy claims? Response: The claim count total on the "Total Claims by Type of Claim" tab is slightly higher than the claim count on the "Total Claims by Month" tab because an NCHC claim can have multiple reporting group codes. The State has updated the "Percentage of Denied Claims" tab to be in agreement with the "Total Claims by Type of Claims" tab by including major group codes in both tabs. The updated spreadsheet (now named "Updated Health Choice Claim-CBU Volumes.xls") is included in Update 18 to the Procurement Library.
C-57	5.2.1 Methodology and MS Excel worksheet for Replacement MMIS Pricing Tables M	General	In order to provide the State with the best possible value, we have differing interpretations of how to populate Pricing Table M. Will the State please provide a complete one year example for Pricing Table M with a negative coefficient A value and a positive coefficient B value? Response: Note that recipient management pricing is being modified to incorporate a fixed/variable model; therefore any answer would automatically be out of date. Note that the State corrected errors to the "Average Daily Price at Anticipated Volume ($)" columns. The original pricing tables divided by the number of days in a year. This was incorrect. The new pricing tables have corrected this error. Offerors should double check their calculations to ensure accuracy.