Offeror Questions and Answers

Sequential Number	Updated/New Requirement Number	Offeror's Question
S1	40.1.1.1	Will DHHS provide the NCHC Tables Manual(s) and edit/audit manual? Answer: Since Title XXI will operate similar to Title XIX, the Tables Manual for Title XIX will be in Update 16 of the Procurement Library for your reference.
S2	40.6.1.94	Please provide a sample of the Title XXI Tables Manual. Is this simply a report that shows valid values for Title XXI programs? Answer: See Question S1
S3	40.1.2.12	Regarding your letter of July 7, 2008, reference to the Current Operations and Capital Improvements Appropriations Act of 2008, and the introductory language in this cited RFP requirement, we note the Modify Appropriations Act of 2007, section 10.36.(e) contains revised requirements for provider performance bonds. Does DHHS intend to provide revisions to the RFP for provider enrollment and credentialing function? Answer: No revisions to the requirements for provider enrollment & credentialing functions will be made.
S4	40.1.2.12	Regarding your letter of July 7, 2008, reference to the Current Operations and Capital Improvements Appropriations Act of 2008, and the introductory language in this cited RFP requirement, we note the Modify Appropriations Act of 2007, section 10.40D.(a) contains reference to "all relevant Medicaid waivers." Will DHHS provide more detail regarding "all relevant Medicaid waivers?" Answer: Section 115 of the federal Social Security Act (SSA) authorizes the Secretary of the US Department of Health and Human Services to waive certain requirements of the federal Medicaid program under five-year demonstration projects. The Deficit Reduction Act (DRA) allows states the flexibility to develop benefit programs designed to meet more citizens' needs without constraints of comparability, state-wideness and other traditional Medicaid requirements. NCDHHS seeks to utilize the flexibility allowed by the DRA in combination with the waiver authority allowed under Titles XIX and XXI

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		of the SSA to expand access to affordable coverage, to promote prevention and patient responsibility, to encourage appropriate service utilization and to improve quality and care management in the delivery of health care services. Relevant Medicaid waivers include but are not limited to Community Alternatives Program (CAP) for Disabled Adults (CAP-DA), CAP for Persons with Mental Retardation or Developmental Disabilities (CAP-MR/DD), CAP for Children (CAP-C), CAP-Choice, Piedmont Cardinal Health Plan and Piedmont Innovations, Be Smart Medicaid Family Planning Waiver, and Money Follows the Person.
S5	40.1.2.19	Please provide information on the types and record counts of all NC Health Choice legacy data files to be converted. Answer: This information will be provided in Procurement Library Update 16.
S6	40.1.2.19	Is all the NCHC legacy data under control of the incumbent NCHC vendor? Answer: Blue Cross Blue Shield of North Carolina (BCBSNC) controls NCHC non-pharmacy data; Medco controls NCHC pharmacy data. Note that BCBSNC data will likely need to be converted from their legacy mainframe as well as the PowerMHS system. DHHS controls the eligibility data for NCHC.
S7	40.1.2.19	Regarding the conversion of legacy data for NC Health Choice, is it the State's intent to convert any TIFF images from the incumbent NCHC vendor's system? Answer: It is the State's intent to convert or migrate any images present in the incumbent NCHC vendors' systems.
S8	40.1.2.19	To allow bidders to scope the effort required to convert the North Carolina Health Choice (NCHC), including Kids' Care data, please provide the following information: • Is it required that the conversion include source data from both the BCBSNCand Medco systems? If so, what specific files (provider, recipient, claims, etc.) are to be converted?

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		Answer: Data must be converted from both BCBSNCand Medco systems. BCBSNC controls the NCHC non-pharmacy data; Medco controls the NCHC pharmacy data. • Is there a single owner of the recipient data, or will the data from both systems have to be merged to get a complete and accurate picture? • Is there a single owner of the provider data, or will the data from both systems have to be merged to get a complete and accurate picture? Answer: DHHS controls the eligibility data for NCHC. Additional recipient and provider data resides in the BCBSNC and Medco systems. • What is the amount of historical data to be converted? Answer: Ten years of claims data. Additional information will be in Update 16 of the Procurement Library (Health Choice Data Guide).
S9	40.1.2.19	Is Kids' Care data stored in a different application? Answer: Kids' Care will be implemented as a component of NCHC on July 1, 2009, provided federal funding is available. It will be implemented via State Health Plan/BCBSNC and transferred to the Replacement MMIS along with NCHC.
S10	40.1.2.19	Will the data for the CAP-MR/DD, CAP-C, and HCWD programs be present in the Legacy MMIS+? If not, please provide some background information on the location and size of the data. Answer: Yes. CAP-MR/DD and CAP-C are existing NCXIX programs. HCWD for individuals with income less than 200% of Federal poverty level (FPL) will be implemented in the Legacy MMIS+ in two phases beginning in April 2009.

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S11	40.2.1.124	Is this requirement limited to the NCHC program recipients? Answer: Yes.
S12	40.2.1.124	Are NCHC ID Cards produced for the family or for a family member? Answer: NCHC ID cards are produced for each eligible family member.
S13	40.2.1.124	Are NCHC recipient cards issued for each covered individual or one card for each group of members in a covered family unit? Answer: See Question S12
S14	40.2.1.124	How many NC Kid's Care ID Cards will be produced per month? Answer: Current legislation limits the annual number of Kids' Care Program participants to 15,000. Each recipient will receive an annual identification card and will receive a replacement card upon request.
S15	40.2.1.124	How many NCHC ID Cards are distributed per month? Answer: Recipient ID cards will be issued annually. Currently, the number of enrollees is approximately 122,000. The estimated annual turnover is 50% for a total of approximately 180,000 ever enrolled in a given year. The rate of growth is currently approximately 1% per month (NCHC only).
S16	40.2.1.124	What is the annual volume of original recipient identification cards, as of June 30, 2008? Answer: See Question S15
S17	40.2.1.124	To allow bidders to scope the printing of ID cards, please provide the following data: • How many cards are printed, and at what frequency • Who is responsible for printing these cards today Answer: See Questions S14 and S15 Blue Cross and Blue Shield of NC (BCBSNC) currently prints the NCHC ID

Sequential Number	Updated/New Requirement Number	Offeror's Question
		cards.
S18	40.2.1.124	What is the annual volume of replacement identification cards, as of June 30, 2008? Answer: This information is not available.
S19	40.2.1.124	What are the existing layout specifications of the NCHC recipient identification card? Answer: See page 3 of NC Health Choice Handbook at: http://www.dhhs.state.nc.us/dma/CHIP/NCHChandbook.pdf and in Update 16 of the Procurement Library.
S20	40.2.1.124	Are NCHC recipient identification cards required to be printed in languages other than English and Spanish? Answer: No, recipient cards are required to be printed in English only.
S21	40.2.1.125	Is this requirement limited to the NCHC program? Answer: Yes.
S22	40.2.1.125	Who is responsible for the content of the benefit booklet? Answer: The Fiscal Agent will write the content of the NCHC benefit booklets; DMA will have final approval of the content. Please see the CDRL data item description included with this Addendum.
S23	40.2.1.125	Please provide a sample of the Recipient Benefit Booklet in the Procurement Library. How often are the Recipient Benefit Booklets sent to recipients? Who provides the content and the printing of these booklets today? Please confirm that the benefit booklet is generic based on program and not specific to each individual participant. Answer: Currently there are three booklets: Emergency Respite Care,

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		Information for Children with Special Healthcare Needs and Their Families, and NCHC Handbook. Only the NCHC Handbook is provided upon enrollment; the others are available upon request by the family. The current Recipient Benefit Booklets will be in the Procurement Library Update 16. If multiple members of the same family are enrolled at the same time, then one booklet is sent to the family.
S24	40.2.1.125	What is the format and page length of the recipient benefit booklets? Answer: See Question S23
S25	40.2.1.125	Are the recipient benefit booklets black-and-white or multi-color? Answer: Recipient benefit booklets may be printed in black and white.
S26	40.2.1.125	How many NCHC benefit booklets are distributed per month? Answer: Currently, an estimated 11,000 booklets are distributed per month. There is no information available to determine how many of these are originals and how many are replacements.
S27	40.2.1.125	What is the annual volume of original recipient benefit booklets, as of June 30, 2008? Answer: See Question S26
S28	40.2.1.125	What is the annual volume of replacement recipient benefit booklets, as of June 30, 2008? Answer: This information is not available.
S29	40.2.2.10	As of June 30, 2008, what is the annual volume of recipient questions, related to claims payment, prior approval and any other issues not covered under 40.2.2.9, for response by the Fiscal Agent? Answer: Currently, the BCBSNC estimated annual recipient questions via telephone:

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		Benefit Verifications: 10,500 Claim Status: 8,500 ID Card Request: 5,600 General information: 6,000 There were only 450 written recipient inquires during the past year.
S30	40.2.2.10	As to the annual volume in the previous question, what portion of the questions and issues arrive via telephone, via paper, or other communication methods? Answer: Currently, the majority of recipient inquires are received via phone. Less than 1.5% are received via paper.
S31	40.2.2.10	Who will be responding to recipient eligibility questions? Answer: DMA Recipient Services will respond to recipient eligibility questions.
S32	40.2.2.10	What phone tree scripts are used to support NCHC recipient phone calls? Are there any special requirements/scripts for recipients to select from based on the type of services provided? Answer: The current vendor does not use scripts to support NCHC recipient phone calls.
S33	40.2.2.9	How many recipient phone calls are received per day? Per month? Answer: This information is not available.
S34	40.2.2.9	Please provide the daily, weekly, and monthly volumes of calls related to NCHC from the last three months. Does the State have any projected volumes based on historical references? Answer: No information is available on the current program; however, Offerors should assume there will be approximately 25 calls per day for premium paying recipients (for all programs). This assumes 17,000 premium payers.
S35	40.2.2.9	As of June 30, 2008, what is the annual volume of recipient questions, related to premium payment and cost sharing, for response by the Fiscal Agent?

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		Answer: This information is not available. Note: there are currently approximately 130 premium paying recipients, so the call volume is very low.
S36	40.2.2.9	As to the annual volume in the previous question, what portion of the questions and issues arrive via telephone, via paper, or other communication methods? Answer: This information is not available.
S37	40.3.1.8	Is the reference number issued to a provider as a result of an NCHC eligibility inquiry required to be submitted by the provider on a claim for the recipient? Answer: No
S38	40.3.1.8	How many eligibility verification inquiries are received per day? Per month? Answer: This information is not available.
S39	40.3.1.8	As of June 30, 2008, what is the annual volume of eligibility inquiries requested by providers via the incumbent's EVS? Answer: This information is not available.
S40	40.4.1.22	As of June 30, 2008, what are the annual volumes for the AVRS provider call flows contained in this requirement related to NCHC? Answer: Voice response is not used for NCHC today.
S41	40.4.1.24	In the last bulleted item, do "balances" refer to the current annual cost sharing balance of a recipient? Answer: Yes (i.e., premium balance, deductible balance)
S42	40.4.1.38	As of June 30, 2008, what are the annual volumes for the AVRS recipient call flows contained in this requirement related to NCHC? Answer: Voice response is not used for NCHC today.
S43	40.4.1.38	Please provide an estimate of the number of calls per day, week, and month that are typically received for these services.

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		Answer: Voice response is not used for NCHC today.
S44	40.4.1.39	Please provide an estimate of the number of recipients that access this information today, and the number anticipated to access it in the new system. Answer: This information is not available.
S45	40.6.1.23	What types of services are being provided which require an NCHC-specific service code? Answer: The term "NCHC specific service codes" has been removed from requirement 40.6.1.23. NCHC services in the Replacement MMIS will use HIPAA compliant standard codes sets as noted in 40.6.1.23 and 40.6.1.43.
S46	40.6.1.23	What is the format of the NCHC-specific service codes referenced in this section? Answer: See Question S45
S47	40.6.1.23	Will DHHS provide the list of NCHC-specific service codes? Answer: See Question S45
S48	40.6.1.23 40.6.1.43	Please provide examples of NCHC-specific service codes. Are these codes considered local service codes, rather than national service codes? If these codes are local codes, please comment on the use of these local codes as it relates to a HIPAA-compliant MMIS. Answer: See Question S45
S49	40.6.1.89	Are the NCHC services noted in this requirement the same codes noted in Requirements 40.6.1.23 and 40.6.1.43, or are they simply fees specific to NCHC services? Answer: See Question S45
S50	40.6.1.23	Are the "State-specified restrictions on conditions to be met for a claim to be paid" different for NCHC recipients than information previously provided by DHHS for DMA, DMH, DPH and ORHCC?

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		Answer: A comparison review of policies has not been completed. NCHC policies are found on the State Health Plan web site at http://www.shpnc.org/nchc-med-policies.html and through State Health Plan policy number AD0660 for Health Choice BCBSNC policies.
S51	40.6.1.23	Does the State intend to impose restrictions on the payment of a recipient's claim if the recipient's premiums are in arrears (overdue)? Answer: Yes. For NCHC recipients who share in the cost of care via premium payments, claims shall not be paid until the associated premiums have been received by the Fiscal Agent.
S52	40.6.1.43	Does DHHS intend to release the State-approved policies applicable to NCHC-specific services? Answer: State-approved policies applicable to NCHC-specific services can be found at http://www.shpnc.org/nchc-med-policies.html and through State Health Plan policy number AD0660 for Health Choice BCBSNC policies. Also, updates can be found in Session Law 2008-107.
S53	40.6.1.43	Does DHHS intend to release State-approved medical policy applicable to NCHC-specific services? Answer: Yes, see NC Health Choice medical policies at: http://www.shpnc.org/nchc-med-policies.html and State Health Plan policy number AD0660 for Health Choice BCBSNC policies.
S54	40.6.1.89	Please provide the Fee Schedule reports now in use for NCHC services? Answer: The codes for this requirement are the same as those codes noted in 40.6.1.23 and 40.6.1.43. Examples of the Fee Schedule reports for those codes can be found at http://www.dhhs.state.nc.us/dma/fee/fee.htm.
S55	40.6.1.95	This requirement seems to request the ability to receive both a procedure code and a revenue code on the same claim detail and conditionally price the claim with either a revenue code or procedure code. Please confirm this

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		interpretation. If this interpretation is accurate, please provide a business scenario in which this would occur. Answer: This requirement will be deleted; however, requirement 40.6.1.47 still applies.
S56	40.7.1.68	Please describe how this information is captured today. What is the format and frequency of this process? Answer: Currently, providers can call or fax information for pre-admission certifications. The reviewer will phone and send, in writing, questions and responses to the provider. The frequency is unavailable.
S57	40.7.1.69	Please provide detail on the current policy in effect today. How many prior approvals of this type are expected daily, weekly, and monthly? Answer: Current pre-admission and length-of-stay policy is provided on the State Health Plan web site at http://www.shpnc.org/nchc-med-policies.html, policy number AD0520. Currently, the estimated volumes are: • Daily 9 • Weekly 45 • Monthly 192
S58	40.7.2.50	How many of the pre-admission certifications are expected for the NCHC program on a daily, weekly, and monthly basis? Answer: See Question S57
S59	40.7.2.26	Please provide the State policy for RetroDUR activities? Answer: The Outpatient Pharmacy Services Policy can be found at: http://www.dhhs.state.nc.us/dma/pharmacy/9pharmacy.pdf, Attachment E (Drug Use Review Program)

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S60	40.7.2.30	Does the State prefer the RetroDUR data analysis activities to use the incumbent's legacy claims data, or the NC DHHS DRIVE warehouse? Answer: The State prefers RetroDUR data analysis activities to use the incumbent's legacy claims data.
S61	40.7.2.44	Which "other DMA initiatives" provide the therapeutic criteria for the Fiscal Agent's DUR activities? Other DMA initiatives may include but are not limited to Prospective DUR criteria, Prior Authorization Program criteria (http://www.ncmedicaidpbm.com), Mental Health Management Program, or any clinical policy that impacts total services provided to allow for internal consistency of the criteria and standards with other programs (e.g., Medicare criteria/DMA criteria).
S62	40.7.2.48	What are the requirements for an expedited review of an appealed prior approval denial or claim denial? Answer: For services wherein the Fiscal Agent is responsible for evaluation and determination of prior approval adjudication (see RFP 40.7.2.13), the Fiscal Agent will review additional documentation that may be submitted to determine if an appeal is appropriate and can be expedited. The Fiscal Agent shall also carry out other duties associated with the appeal process as described in RFP 40.7.2.11.
S63	40.7.2.48	What are the annual volumes as of June 30, 2008, for expedited reviews of appealed prior approval denials and claim denials? Answer: This information is unavailable.
S64	40.7.2.48	What level of staff skill or credential is required per State policy to conduct expedited reviews of appealed prior approval denials and of claim denials? Answer: Expedited reviews during the appeal process for NCHC services will follow Title XIX appeal processes. Prior Approval staff reviewers who render decisions on prior approval services specialize in specific areas (see RFP 40.7.2.13) and are usually RN/LPNs licensed in the state of North Carolina. A

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		physician licensed in the state of North Carolina also participates in this process (see RFP 40.7.2.11).
S65	40.7.2.49	What are the requirements for retrospective reviews of services provided without the required prior approval? Answer: Current information on retrospective reviews can be found in the NC Health Choice Handbook, 2006, page 21 (will be included in Update 16 of the Procurement Library). Information concerning retrospective reviews of services already delivered when there is a change in eligibility can be found in State Health Plan Policy AD0230, NC Health Choice Behavioral Health Services for Children with Special Health Care Needs, located on the State Health Plan web site at http://www.shpnc.org/nchc-med-policies.html. The same staff that performed the initial prior approval reviews would participate in retrospective reviews.
S66	40.7.2.49	What are the annual volumes as of June 30, 2008, for retrospective reviews of services performed without required prior approvals? Answer: Currently, these are not tracked separately from the State Health Plan. The current estimated NCHC volume is 650 per year.
S67	40.7.2.49	What level of staff skill or credential is required per State policy to conduct retrospective reviews of services performed without required prior approvals? Answer: See Question S65
S68	40.7.2.50	Who is currently performing the pre-admission certifications and length-of-stay reviews for the NCHC population? Answer: BCBSNC currently performs the pre-admission certifications and length-of-stay reviews for the NCHC population.
S69	40.7.2.50	Is this activity performed at facilities throughout the State or in a centralized location? Answer: Reviews are performed in a centralized location.

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S70	40.7.2.50	How many staff members currently perform these activities? What qualifications do these staff members carry? Are there specific certifications that apply to this staff? Answer: About 1.25 FTEs currently perform admissions/pre-certifications: • Intake Specialist (non-licensed) 0.5 FTE • Nurse (LPN/RN) 0.5 • MD 0.25 Most diagnoses are auto-approved for admission. A few diagnoses are reviewed based on Milliman Care Guidelines. If the Intake Specialists are unable to find an Optimal Recovery Guideline, they refer the case to the Nurse. Procedures that are potentially investigational, experimental or cosmetic are reviewed under NCHC medical policies and may be referred to a physician for review. Another 1.25 FTEs review requests for certification of outpatient services.
S71	SOO S.1.1	What are the State criteria or protocols does the State use to make pre-admission certification for inpatient hospitalization services? Answer: See Question S70
S72	SOO S.1.1	Are there specific education or license requirements for the staff performing pre-admission certification related to NCHC? Answer: See Question S70
S73	40.7.2.50	How are the criteria for making these certification and length-of-stay determinations developed? Answer: Currently, BCBSNC licenses Milliman Care Guidelines.

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		NCHC clinical policies can be found at http://statehealthplan.state.nc.us/nchc-med-policies.html Milliman Care Guidelines are reviewed annually by a BCBSNC Physician Advisory Group. Clinical policies are based on NCHC benefits, NC Statutes & BCBSNC medical policies. New policies and revisions are reviewed and approved by a UM Committee and the Medical Director for the State Health Plan, and presented to the State Health Plan Board of Trustees for final approval.
S74	40.7.2.50	Please provide the defined criteria for making this determination. Answer: See Question S73
S75	40.7.2.50	Does the State anticipate a turnaround time for adjudication of these pre-admission certifications? Answer: Yes. The turnaround time will be defined during DDI.
S76	40.8.1.203	What are the specific reports, report formats, and production frequencies for the scheduled reports for recipient and provider profiling? Answer: Each quarter the vendor shall be responsible for ad hoc reports, provider report cards, and recipient / provider profilings as requested by the DUR Board upon approval by the State. The development of the criteria for each specific report is at the discretion of the DUR Board and varies quarter to quarter. The vendor shall have the capability to support and assist the Board in the criteria development. The report format is defined at the DUR Board meeting. Samples of some potential report types will be provided in Update 16 of the Procurement Library.
S77	40.8.1.203	What are the format and production frequency of provider report cards? Answer: The frequency of the provider report cards shall be quarterly. The format will be determined at the quarterly DUR Board meeting upon approval

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		by the State.
S78	40.8.1.25	What are the situations outlined in State policy when service limitations would be overridden for NCHC Special Needs Plan-eligible recipients? Answer: If a claim is denied for a service that exceeds service limitations or is ordinarily not covered under core benefits of the HCHC Program and meets Medicaid medical necessity criteria, the claim can be paid if the recipient qualifies for the NCHC Special Needs Plan. RFP requirements 40.8.1.25 and 40.8.2.45 will be revised.
S79	40.8.1.25	What are the annual volumes, as of June 30, 2008, for overrides of service limitations? Answer: This is not tracked, but currently, the estimated volume is 500.
S80	40.8.1.384	What are acceptable formats for recipient-submitted claims to be presented to the Offeror for payment? Answer: Recipient-submitted claim forms will be designed during DDI and will be similar to current forms. Examples of current recipient claim forms are available on the State Employees' Health Plan at: http://www.shpnc.org/indemnity-plan-forms.html
S81	40.8.1.385	Is the recipient-submitted claim on a proprietary claim form? Answer: Yes. Also see question S80
S82	40.8.1.384	Will the Offeror be responsible for assisting the recipient with completing out-of-pocket claims for submission for reimbursement? Answer: Yes
S83	40.8.1.384	How many recipient-submitted claims are processed for payment per month? Answer: The incumbent NCHC vendor processes approximately five recipient-submitted claims each week, or about 22 each month.
S84	40.8.1.385	How many claims are expected weekly for NCHC?

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		Answer: BCBSNC currently processes about five recipient-submitted claims weekly.
S85	40.8.1.384	What out of pocket expenses are eligible for reimbursement for NCHC recipients? Answer: As defined by the benefit plan, these are expenses for eligible goods and services for which the recipient paid the provider directly.
S86	40.8.1.384	What are the situations outlined in State policy when NCHC recipients may file claims for out of pocket expenses? Answer: See Question S85
S87	40.8.1.384	Please define the process by which a recipient would notify the fiscal agent regarding out of pocket claim expenses and what notification and documentation standards are required for this processing. Answer: The recipient would submit a claim form and attached itemized bill from the provider to the Fiscal Agent. (Current processes for recipient reimbursement are found in the NCHC Handbook on the NCHC Website.) (See Question S80)
S88	40.8.1.384	What are the filing requirements, including claim format and method of submission, for out of pocket expenses of NCHC recipients? Answer: Claims filed by recipients must include the appropriate information furnished by the service provider (including, but not limited to, signature, service description and diagnosis) and proof that the service was already paid by the member. Claims filed by providers for reimbursement to recipients must indicate that the charges have been paid to the provider. Please see the NC Health Choice Handbook for additional information. Also, see questions S80 and S85
S89	40.8.1.384	What are the annual volumes, as of June 30, 2008, of reimbursement requests

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		for recipient out of pocket expenses? Answer: See Question S83
S90	40.8.1.384	Please define the specific types of "out of pocket" claims expenses that are reimbursed. Answer: See Question S85
S91	40.8.1.385	Will the recipient-submitted claims be required to meet the same edit and audit criteria as provider-submitted claims? Answer: Yes
S92	40.8.1.385	Please define what editing criteria must be performed on the recipient-submitted claims. Answer: Editing requirements for recipient-submitted claims are the same as for provider-submitted claims. See Question S91
S93	40.8.1.384	Please define the editing and review requirements for processing the requests for reimbursement of out of pocket claims expenses. Answer: See Question S91
S94	40.8.1.385	Please describe how a recipient would submit a claim for payment. Answer: See Questions S80 and S85
S95	40.8.1.385	How are NCHC claims processed today? Answer: BCBSNC processes recipient-submitted NCHC claims.
S96	40.8.1.385	Will Remittance Advices be required for recipient-submitted claims? Answer: Remittance Advices will not be required for recipient-submitted claims. NCHC recipients will receive explanation of benefits (EOB) reports for all claims, whether the claims have been filed by providers or by recipients
S97	40.8.1.385	Of the total annual volumes for NCHC-recipient filed claims, what percentage

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		or volume are represented by CMS-1500, UB-04, ADA, NCDMA Pharmacy claim, or other claim formats? Answer: The current contractor does not use these forms for recipient-submitted claims. Of recipient-filed claims received annually: • 31% are Dental (84 claims), and • 69% are Professional (186 claims). Also, see Question S80
S98	40.8.1.385	What are the State's requirements for a NCHC recipient to document a recipient-submitted claim? Answer: See Question S87
S99	40.8.1.385	What format "Explanation of Benefits" is required for processing of claims submitted by NCHC recipients? Answer: The format for the NCHC recipient EOB will be similar to that of the Explanation of Benefits for the State Employees Health Plan. Update 16 to the Procurement Library will include a copy of this EOB.
S100	40.8.1.385	Please provide some examples of business scenarios that would be covered by this requirement. Who would be the payee on this type of claim, the provider of services or the recipient? Answer: For recipient-submitted claims, payment could be made to the recipient or the provider, based on information submitted on the claim form. For examples, refer to the NCHC Handbook.
S101	40.8.1.386	What are the State's specific policies for the application of service limitations across multiple health care programs and benefit plans? Answer: The State's specific policies for application of service limitations across multiple health care programs and benefit plans rules will be

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		communicated during DDI.
S102	40.8.1.386	Please provide documentation on the current policy for claims processing for the NCHC program. Answer: See Question S101
S103	40.8.2.59	Please provide examples of actual DUR Programs Project Status Reports produced during 2008? Answer: The DUR Programs' Project Status Reports will be determined during DDI.
S104	40.12.1.3	For each program that has drug and pharmacy coverage, does the State require the vendor to administer both technically and operationally a state supplemental drug rebate program? Answer: The State is not requiring the vendor to administer, either technically or operationally, a Medicaid supplemental drug rebate program. The Fiscal Agent shall support drug rebate activities for other non-Medicaid State programs.
S105	40.12.1.14	How many months or years of State drug rebate data are to be stored? Answer: Storage requirements are the same as stated in RFP requirements 40.12.1.18.
S106	40.12.1.20	What are the State policies for conversion of units paid per claim to State units billed, and State units billed to units paid per claim? Answer: The State's unit conversion and units billed policies shall follow NC Medicaid's Drug Rebate Program.

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S107	40.12.1.3	What are the source, format, media, and frequency of the State drug rebate data file? Answer: The source/format/media of the State drug rebate data file will be determined during DDI. The frequency shall model the CMS National Drug Rebate Program.
S108	40.14.1.96–106 40.14.2.72–80	Please provide documentation regarding the overall financial operations and policy for the NCHC premium payment program. Answer: This information is not available.
S109	40.14.1.97	Please provide further documentation on the range of premiums. How they are calculated? What is the policy for application of the sliding scale? Answer: Premiums will be established by DHHS in accordance with the authority and within the parameters authorized by the General Assembly. They are expected to vary by program and within each program by individual and/or family based on income level. The Replacement MMIS will apply the premium amounts based on eligibility and income information received in the nightly EIS update.
S110	40.14.1.97	How and from what entity will the fiscal agent be provided the data related to the sliding scale? How often does it change? Answer: The Fiscal Agent will receive information on premium amounts from the State. Premium amounts may change based on State and/or Federal mandates.
S111	40.14.1.100	What is the State policy for determining the due dates of recipient premiums? Answer: Currently, bills are issued on the 15th of the month, with payment due by the first of the following month.
S112	40.14.1.56	What is the State policy for the timing of the issuance of recipient premium invoices?

Sequential Number	Updated/New Requirement Number	Offeror's Question
		Answer: See Question S111
S113	40.14.1.101	What are the State policies, including formats and required language for letters, for issuance of notices of non-payment and cancellation notices? Answer: Formats for recipient notices will be determined during DDI. All oral and written recipient communications must be in compliance with the DHHS Title VI Language Access Policy, "Title VI of the Civil Rights Act of 1964; Policy on the Prohibition Against National Origin Discrimination as it Affects Persons with Limited English Proficiency."
S114	40.14.1.102	What are the situations where the State would require unpaid refunds to be aged? Answer: When a recipient is due a refund (due to overpayment, change in eligibility, etc.) the Fiscal Agent is responsible for issuing the refund. The aging portion of this requirement has been removed.
S115	40.14.1.103	Please define the performance criteria for "near real time" for this interface. Answer: RFP Requirement 40.14.1.103 will be updated.
S116	40.14.1.104	What are the current criteria for determination of payment for dependent coverage for NCHC? Answer: Criteria are defined in GS-108A-70.20 as updated by Session Law 2008-107, Section 10.13.(f).
S117	40.14.1.104	What are the State-defined criteria to trigger the payment of dependent coverage under a private insurance plan for a NCHC recipient? Answer: The MMIS will receive specific benefit plan information as part of the eligibility file update from the Eligibility Information System (EIS).
S118	40.14.1.104	What funding source, bank account, and payment method is required for the payment of premiums for NCHC recipients who are eligible to be covered

Sequential Number	Updated/New Requirement Number	Offeror's Question
		under private insurance? Answer: Banking and cash control requirements for the NCHC program, including payment of premiums, will be identical to those of other programs. Please refer to Requirement #s 40.14.2.58 through 40.14.2.67. Specifically, the Fiscal Agent will issue premium payments from their bank account. As "presentments" are made on their account, the Fiscal Agent will be able to transfer funds from a State account to cover the presentments. The payment method would be at the discretion of the Fiscal Agent (i.e., check or EFT).
S119	40.14.1.105	Please provide more detail on this requirement. Does this require reducing the individual claim reimbursement amount to the provider by the patient obligation and also deducting any premium payment money collected directly from the recipients from the total program reimbursement expenditure before seeking FFP match for the remainder? Answer: Yes. Refer to 42CFR 447.59
S120	40.14.1.106	What are the situations where the Fiscal Agent would need to perform an actuarial determination of premiums for State health programs, as these premium amounts appear to be part of the State statute for NCHC? Answer: RFP Requirement 40.14.1.106 will be deleted.
S121	40.14.1.106	Will the vendor be required to provide actuarial support and premium-setting services? What is the anticipated frequency for actuarial determination of premiums? Answer: RFP Requirement 40.14.1.106 will be deleted.
S122	40.14.1.106	Please define to which of the State's healthcare programs this will be applicable. Answer: RFP Requirement 40.14.1.106 will be deleted.
S123	40.14.1.55	What are the situations requiring refunds or adjustments of premium

Sequential Number	Updated/New Requirement Number	Offeror's Question
		payments? Answer: The business rules defining these policies will be communicated during DDI.
S124	40.14.1.55	What are the State policies applicable to handling of recipient premiums, including refunds? Answer: There are no unique State policies for recipient premiums. The handling of recipient premiums and refunds follows the same State policies documented in the DHHS Cash Management Plan, located in the Procurement Library.
S125	40.14.1.59	What is the State policy for determining total annual aggregate family cost sharing, for children who move between NCHC and NCXIX? Answer: Refer to NC Session Law 2008-107
S126	40.14.2.33	What is the State policy for refunding and adjusting recipient premiums? Answer: The business rules defining these policies will be communicated during DDI.
S127	40.14.2.77	What is the annual volume, as of June 30, 2008, of the instances of payments of NCHC premiums by cash (paper currency) payments? Answer: The current Contractor does not accept cash.
S128	40.14.2.79	Does the NC DHHS or the NC DOI require any financial reporting on a Statutory Basis in addition to the GAAP basis financial requirements? If so, please provide the State requirements for such reporting? Answer: No
S129	40.14.2.79	What specific financial statements and expenditure reports are required? Please provide examples and reporting instructions. Answer: Specifics to the type of reports will be addressed during DDI. There

Sequential Number	Updated/New Requirement Number	Offeror's Question
		are; however, examples of reports such as NCAS/Budget expenditure reporting, expenditure reporting by LOB, Financial control reporting, Financial Participation reporting, and A/R reporting. Refer to the DSD (Chapter 18 Financial) contained in Update 1 of the Procurement Library for further examples.
S130	40.14.2.79	Do the reporting requirements include any impacts on MMIS reporting systems such as MSIS, MARs or other reports (e.g., CMS-64)? Answer: Yes. Impacts on MSIS quarterly reporting identifying Title XXI (SCHIP) recipient data and corresponding paid claim data. Impact on MARS reporting of utilization and expenditures for benefit plan. Impact on CMS-64 expenditure reporting for additional Title XXI (SCHIP) FFP data.
S131	40.14.2.80	Who is responsible for the credit card transaction service fee? If the bidder is responsible, please provide the anticipated average premium payment so bidders can scope the administration fee for those payments. Answer: The State will bear the cost. Each Offeror must identify its solution to credit card transaction processing in its Supplement–including whether or not it will use the State's service or another commercial service. If selected to submit a Cost Proposal, an Offeror must clearly identify the costs associated with transaction fees.
S132	40.14.2.80	What is the anticipated adoption rate of recipients using credit cards and debit cards to pay their premiums? Answer: The estimated population of recipients paying premiums at the Operational Start Date is 17,000. The number of recipients that will be using credit and debit cards to pay premiums is unknown.
S133	SOO S.1.1	Please provide a copy of the Medicare 646 waiver application for Offerors to review. Answer: North Carolina's Medicare 646 waiver application has not yet been approved by CMS and is not available for review.

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S134	SOO S.1.1	What are the specific requirements to be established by the Medicare 646 waiver? Please describe the Offeror's role in the Medicare 646 waiver. Answer: The Offeror's role in the Medicare 646 Waiver is to fulfill the Managed Care requirements in Section 40.9 of the RFP, including the quarterly utilization reports as described in RFP requirement 40.9.1.30.
S135	SOO S.1.1	Please define the meaning of the phrase "more complex, family-oriented eligibility definitions" as used in this section. Please provide definitions or examples of this complexity as it related to financial transactions. Answer: This requirement was intended to apply to aggregate cost sharing thresholds. The SOO will be updated to clarify this requirement.
S136	SOO S.1.2	What are the membership projections for each fiscal year for the new Kid's Care expansion? Answer: Current legislation limits the annual number of Kids' Care Program participants to 15,000.
S137	SOO S.1.2	Please define in detail or provide the "managed care policies and procedures" referenced in this section. Answer: Managed Care policies and procedures are defined in the DSD located in Update 1 to the Procurement Library.
S138	SOO S.2	With the inclusion of the Retrospective Drug Utilization Review (DUR) functions and requirements, will DHHS also update the Appendix 40, Attachment G, Consolidated List of Reports to include those reports required for these new requirements? Answer: Most reports will be ad hoc based on the needs identified by the DUR Board. Typically, approximately a half dozen reports are produced each quarter–to include provider profiling, recipient profiling and provider report cards. Samples of some potential report types will be included in Update 16 to the Procurement Library.

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S139	SOO S.2	With the inclusion of the Retrospective Drug Utilization Review (DUR) functions and requirements, will DHHS update the Appendix 40, Attachment H, Replacement MMIS External Interfaces? Answer: A data extract will be required from the Legacy MMIS+ and will be defined during DDI.
S140	SOO S.1.1	Please confirm that our understanding of premiums and enrollment fees is correct. Based upon a family's county-determined poverty level, an enrollment fee for North Carolina Health Choice for Children may be applied. The 'new' benefit plans (Ticket to Work, NC Kid's Care and CAP-MR/DD) have no enrollment fee but the enrollee pays a monthly premium. The only time an enrollment fee and a monthly premium apply under the 'new' plan is when the enrollee is no longer eligible due to income changes and applies for continuation of coverage. Is our understanding correct? Answer: NCHC enrollees may have an enrollment fee. NCGS §108-A-54.1, (Effective July 1, 2008) Medicaid buy-in for workers with disabilities, indicates individuals who participate in Health Coverage for Workers with Disabilities (HCWD), aka Ticket to Work, with countable income more than 200% of Federal Poverty Guidelines (FPG) may have an annual enrollment fee in addition to a monthly premium. The cost-sharing requirements for CAP-MR/DD and CAP Children's programs have not been defined.
S141	Addendum Statement of Objectives, S.1.1 Overview	Section S.1.1 Overview of the Addendum Statement of Objectives states that the Replacement MMIS shall "have the capability to fully implement the administration of NC Health Choice, NC Kids' Care, Ticket to Work, Families Pay Part of the Cost of Services under the CAP-MR/DD, CAP Children's Program, and all relevant Medicaid waivers and the Medicare 646 waiver as it applies to Medicaid eligibles." However, there are no specific application processing requirements related to the following programs: • Medicaid Community Alternatives Program for Persons with Mental Retardation or Developmental Disabilities (CAP-MR/DD) and Medicaid

Sequential Number	Updated/New Requirement Number	Offeror's Question
		Community Alternatives Program for Children (CAP-C) where families pay part of the cost of services Answer: o The CAP-MR/DD and CAP-C Programs are existing NCXIX programs; information on these programs may be found on the DMA Website (http://www.dhhs.state.nc.us/dma/ o NC Session Law 2008-107 requires DHHS to develop and implement recipient cost-sharing for these programs where families pay part of the cost of services by means of premiums, co-payments and/or deductibles. o Currently there are approximately 11,000 recipients in the CAP-MR/DD and CAP-C programs; however, only those with annual family income in excess of 200% of FPL are anticipated to be required to pay a premium. o There is no premium payment capability in the Legacy MMIS+. o Cost-sharing requirements will be based on information received in the Eligibility Information System (EIS) nightly update. • Health Coverage for Workers with Disabilities (HCWD), a Medicaid program under Ticket to Work–Work Incentives Improvement Act (TWWIIA) Answer: o Information on the HCWD Program may be found on the DMA Website (http://www.dhhs.state.nc.us/dma) and in the Procurement Library. DMA will implement the program for individuals under 200% of the Federal Poverty Level (FPL) in two phases beginning in April 2009. Individuals with income over 200% of FPL may purchase HCWD coverage by paying a monthly premium.

Sequential Number	Updated/New Requirement Number	Offeror's Question
		o Information on the anticipated number of program participants may be found in the Procurement Library. o The Legacy MMIS+ will support the initial phases of HCWD. There is no premium payment capability in the Legacy MMIS+, so coverage for individuals over 200 % of FPL will not begin until start-up of the Replacement MMIS. o Cost-sharing requirements will be based on information received in the Eligibility Information System (EIS) nightly update. Please provide the following information regarding each program: • An overview of the program • Number of program participants • Current application supporting the program • Unique requirements for the program Please confirm how the State intends to distribute this information. For example, will it be in the form of an additional RFP addendum with requirements specific to these programs, or will additional data be added to the Procurement Library? Answered above (within this question).
S142	40.1.2.19	Is a data conversion required for the following programs? If so, please provide additional details regarding the source of the data and the amount of data that must be included in the conversion. • Medicaid Community Alternatives Program for Persons with Mental Retardation or Developmental Disabilities (CAP-MR/DD) and Medicaid Community Alternatives Program for Children (CAP-C) where families pay part of the cost of services • Health Coverage for Workers with Disabilities (HCWD), a Medicaid program under Ticket to Work–Work Incentives Improvement Act

Sequential Number	Updated/New Requirement Number	Offeror's Question
		(TWWIIA) Answer: The data for these programs will exist in the Legacy MMIS+ and must be converted in accordance with existing requirements.
S143	SOO S.1.1	What are the current annual volumes, as of June 30, 2008, of the claims received for NCHC, by type of claim, and by electronic/paper formats? Answer: This information is provided in Procurement Library Update 16. Currently the contractor receives approximately 83% of professional claims electronically and 95% institutional claims electronically.
S144	SOO S.1.1	Of the total annual claims received as of June 30, 2008, what percentage denied? Answer: This information is provided in Procurement Library Update 16.
S145	SOO S.1.1	What are the current annual volumes, as of June 30, 2008, for Prior Approval requests received for NCHC, by type of PA, and by electronic/phone/paper formats? Answer: Note: These data include only BCBSNC claims. Vision care-eyeglasses, phone, 3,000 Dental, hearing services, fax, 150 DME, prosthetics, fax, 150 Home Health, private duty nursing, fax, 200 Procedures, fax, 100 Medications, fax, 100 Inpatient, phone/fax/electronic, 500
S146	SOO S.1.1	Are x-ray films received for NCHC recipients? Answer: Rarely. Generally, X-ray films are not reviewed by BCBSNC.

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S147	SOO S.1.1	What are the current annual volumes, as of June 30, 2008, for claim adjustments requests received for NCHC, by type of claim? Answer: This information is provided in Procurement Library Update 16.
S148	SOO S.1.1	What are the current annual volumes, as of June 30, 2008, for provider refunds received for NCHC? Answer: This information is not available.
S149	SOO S.1.1	What are the current annual volumes, as of June 30, 2008, for claim adjustments and refunds received related to Third Party recoveries related to NCHC recipients? Answer: This information is not available.
S150	SOO S.1.1	Is the Fiscal Agent required to use a drug formulary for NCHC recipients? Answer: Yes
S151	SOO S.1.1	What are the current annual volumes, as of June 30, 2008, for written inquiries received related to NCHC recipients, in total and by type of inquiry? Answer: From 7/1/07 to 6/30/08 BCBSNC received 2,015 written inquiries. Of these, 1,600 were submitted by providers and the rest by custodial parents or other sources. The top types of inquiries were verification of benefits, claim status, eligibility, and general information.
S152	SOO S.1.1	Is the Fiscal Agent required to produce the SCHIP Annual Report Template – FFY 2005? Answer: No. CMS produces the report template. The State is responsible for completing the report using data provided by the Fiscal Agent.
S153	SOO S.1.1	What number of checkwrite cycles are to be performed for the NCHC claims? Answer: As with any other benefit plan, the number of NCHC checkwrites are

Sequential Number	Updated/New Requirement Number	Offeror's Question
		benefit plan driven and will be determined during the Requirements phase of the project. Currently, there are 52 NCHC checkwrite cycles per year; and the State anticipates continuing this practice.
S154	SOO S.1.1	Are the NCHC claims payments to be reported on NCHC remittance advices, or combined with other DHHS claims? Answer: NCHC claim payments and other NCHC financial transactions impacting provider payment are to be uniquely identifiable on remittance advices and not combined indistinguishably with other DHHS claims payment activity.
S155	SOO S.1.1	What is the layout specification and reporting frequency for Explanation of Benefits produced and mailed to NCHC recipients (or heads of households)? Answer: Currently, the contractor uses the same layout as the State Health Plan's Indemnity EOB. The EOBs are mailed once a week.
S156	SOO S.1.1	Please provide samples of the current mailings to NCHC recipients? Answer: See Question S19. The current EOB will be included in Procurement Library Update 16.
S157	SOO S.1.1	What is the State policy, applicable to the Fiscal Agent, for the transfer of NCHC recipients to and from regular Medicaid benefit plans? Answer: The Fiscal Agent will receive the eligibility data for NCHC and Medicaid in the regular update from the State's eligibility system and must enroll recipients in the applicable benefit plan, apply business rules and pay claims accordingly.
S158	SOO S.1.1	Does the State intend our proposal to include any responsibilities for prior authorization of mental health-related functions now performed by Value Options? Answer: No

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S159	SOO S.1.1	What pricing rules used for NCHC are different than those used by Medicaid benefit plans? Answer: Statutory requirements in Session Law 2008-107, Section 10.13 (f), 108A-70.21(b1) currently state: "Payments-Prescriptions drug providers shall accept as payment in full, for outpatient prescriptions filled, amounts allowable for prescription drugs under Medicaid. For all other providers, services provided to children enrolled in the Program shall be provided at rates equivalent to one hundred percent (100%) of Medicaid rates, less any copayments assessed to enrollees under this Part." Currently, BCBSNC approximates Medicaid rates when providing reimbursement for institutional services. Pricing in the replacement MMIS for NCHC must comply with the statutory requirement.
S160	40.6.1.95	Please provide documentation on the existing pricing methodology and policy for the NCHC program. Answer: See Question S159
S161	SOO S.1.1	Does NCHC use the same enrolled and credentialed provider network that will exist for Medicaid? Answer: For the Replacement MMIS Contract, a provider will be able to choose to participate in NCHC without necessarily enrolling in Medicaid. All providers will use the same guidelines to enroll into the programs. At the time of enrollment, providers will select the programs/benefit plans for which they will provide services.
S162	Addendum Statement of Objectives, S.1.1 Overview	Are there any intended changes to the managed care program anticipated to support the services allowed to the NCHC members, or does the State intend to reimburse those additional services on a fee-for-service basis? Answer: There are no intended changes to the Managed Care Program.

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S163	SOO S.1.1	Does the State intend to revise Appendix 40, Attachment G, Consolidated List of Reports, to include work related to NCHC? Answer: This information is not currently available. The State anticipates needing approximately 25 reports which will be finalized during DDI.
S164	SOO S.1.1	Will the call center be required to take/receive payment over the telephone using credit card information? Answer: The SOO encourages Offerors to propose collection and refunding methodologies that are flexible and cost-effective. The State will evaluate each Offeror's solution based on its ability to provide a range of methodologies while still being cost-effective and not being overly burdensome on the population being served.
S165	SOO S.1.1	For recipient related calls, are there any special language requirements for this population? Answer: All oral and written recipient communications must be in compliance with the DHHS Title VI Language Access Policy, "Title VI of the Civil Rights Act of 1964; Policy on the Prohibition Against National Origin Discrimination as it Affects Persons with Limited English Proficiency."
S166	SOO S.1.1	What are the hours of operations (time that the call center will be open), i.e. 8:00AM to 5:00 PM EST. Answer: There are no unique call center hours of operations for the new programs. Offerors shall follow the existing RFP requirements in this area.
S167	SOO S.1.1	Is there call history information as to the number of calls related to premium payments? Answer: This information is not available.
S168	Other	State legislation requires that the cost of each program be developed separately. Acceptable methods for meeting this State requirement can range from the general (i.e., allocating total costs based on claims loads), to the very

Sequential Number	Updated/New Requirement Number	Offeror's Question
		specific (i.e., allocating actual core and unique hardware/software costs to each benefit plan). To enable Offerors to meet State objectives for levels of traceability and transparency, will the State provide a level of detail in its functional requirements that permits Offerors to provide a comparable level of detail it their ultimate price bids for the benefit programs in Amendment 4 and will such a costing requirement be added to all other programs described in final RFP? Answer: The State plans to require Offerors to identify the ***marginal*** costs of adding the new requirements at the granularity listed in the Act (e.g., NC Health Choice, Ticket to Work, etc.). The individual RFP requirements will be marked in such a fashion that Offerors will be able to identify the appropriate Act requirements to which each belongs (similar to the identification of non-Medicaid requirements in the RFP). As this approach is not yet complete, ***this information is subject to change.***
S169	Other	Will the State define all minimum operational capability levels and specific dates required for all early and full capability implementation milestones mandated in the legislation but not defined in Addendum 4? Answer: None of the dates listed in the Act affect the Targeted Operational Start Date or any other time for implementation of capabilities in the Replacement MMIS. All programs and benefits identified in Section 10.9(a) must be fully implemented on the Operational Start Date, as proposed by the Offeror. Note that the updated RetroDUR requirements are separate from those specified in the Act. The RetroDUR early operations capability must be implemented as soon as practical after contract award.
S170	Addendum Statement of Objectives, S.1.1 Overview	Please clarify the implementation timing for the programs identified in the amendment. Is the State's intent to integrate and implement these programs at the same time as the original four programs, or on a staged delivery after the initial Replacement MMIS implementation? Answer: See Question S169
S171	SOO S.1.1	As the new RFP Addendum Section S.1 references the Current Operations

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		and Capital Improvements Appropriations Act of 2008, are the requirements stated within the Act that pertain to this project, e.g. start Dates, benefits, medical policies, etc., also included by reference as a part of the RFP Addendum? Answer: See Question S169 Although the new RFP Addendum (which is part of the Replacement MMIS Contract) refers by name to the Current Operations and Capital Improvements Appropriations Act of 2008 (the "Act") and includes requirements intended to comply with the Act, from a technical legal perspective no portion of the Act itself is "incorporated by reference" into the Replacement MMIS Contract. Like any other applicable "Law" within the definition set forth in RFP Section 30.31, the Act bears on each party's performance under the Replacement MMIS Contract, but the Act's verbatim text becomes a part of the Contract only to the extent it may be reproduced verbatim in the Replacement MMIS Contract.
S172	SOO S.1.1	The Current Operations and Capital Improvements Appropriations Act of 2008, Section 10.13(l) establishes July 1, 2010 as a date for the transition of claims processing among other duties to DHHS. Please advise how a bidder is to consider this fixed date in the preparation of it Replacement MMIS IMS. Answer: This date does not apply to the Replacement MMIS Contract.
S173	Other	State legislation mandates operational start dates that are not cited in Addendum 4. This Addendum does, however, require bidders to comply with State legislation, which may change over time and may not be physically achievable when integrated into the Master Schedule leading to completion of a CMS certifiable solution. In light of the variables just described, will the State clarify which operational dates Offerors shall base their bids on? Answer: The legislation does not address the Operational Start Date. DHHS plans to meet the dates in the Act using other solutions than the Replacement MMIS.
S174	July 7 Addendum 4 Letter, page 2, IMS changes	The update required to our IMS management level views to add the new capabilities cited in Addendum 4 can only be accomplished with substantial changes to lower level task linkages, resource allocations, etc. In order to

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		provide a clear, meaningful revised IMS within the schedule allowed by the State, can the Offerors change their IMS in the manner that they believe are most efficient in meeting State objectives as long as bidders clearly display and explain the differences between the Technical Proposal BAFO IMS and the new IMS provided in response to Addendum 4? Answer: Yes. Offerors may describe any changes to the planned development order/staged delivery in their IMP. Please note that for the sake of practicality, the entire IMS must be delivered in an Offeror's Supplement, not just changes to the IMS.
S175	July 7 Addendum 4 Letter, page 2, paragraph 3	Our Addendum 4 response requires that we respond to 102 new and modified requirements and tailor our response to incorporate three new benefit programs and DUR modifications. Given the magnitude of change will the State please increase the number of pages allocated to Section D to 75 for DDI and 30 for Operations? Answer: The number of pages allocated to Section D will be changed to: • *50 for Overview for System Solution and Solution for Design, Development and Installation* • *30 for Proposed Solution for Operations*
S176	July 7 Addendum 4 Letter, page 2, paragraph 3	Will the State please clarify how the Offeror should reference current technical proposal text in our response? In our supplement are we to reprint relevant sections from the proposal followed by the new text, show the current text with "track changes" activated, include a "pointer" reference to existing text by page and paragraph number or use some other method to meet the requirement? Answer: The State is expecting the "pointer" methodology. If for clarity an Offeror feels it needs to reproduce large sections of text or diagrams from its Technical BAFO, this is acceptable, even if some changes are interspersed in this reproduced content. In this case, the Supplement must clearly identify what content is being replaced from the Technical BAFO. At a later date, the State will require the Supplement and any subsequent BAFOs to be incorporated into a single revised and restated Technical Proposal.
S177	July 7 Addendum 4 Letter, page 2,	Will the State please provide an example of the format/layout that will meet your expectations.

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	paragraph 3	Answer: Offerors may use formats similar to those previously used in their Technical Proposals. The following example should help clarify an acceptable approach. Assume that the proposed text is in response to an Addendum to an RFP for designing and building a house: *The driveway for the home will be made out of tumbled red brick to give an aged appearance. This driveway will lead to a detached garage with a 500 sq. ft. home office above. This office will be "heated" space and will include full plumbing to support a half bathroom.* *On p. T-14, change, "The house will have a gabled roof consistent with a Midwestern farmhouse style," to, "The house, garage, and guesthouse will have low-pitched hipped roofs consistent with the Prairie style."* *The guesthouse will be a story-and-a-half and consist of a sitting room, a kitchenette, a full bath, and a loft bedroom. The front porch of the guesthouse will open directly to the pool.* It is also acceptable to the State for an Offeror to use change bars to highlight changed content in large sections of reproduced text.
S178	July 7 Addendum 4 Letter, page 2, paragraph 3	Please define "inline" as used to define our submission. Answer: This means to include changes to existing Technical BAFO text in a context-appropriate location in the Supplement rather than segregating changes to the BAFO text in one or more separate tables.