

Alabama Medicaid Agency

Amendment 2 to ITB #10-X-2205737

1. If a Requirement from *Section 3 – Requirements* is modified by any Amendment to this ITB and is referenced in *Section 7 – Appendices, Appendix Q – AMMIS Enhancements*, the reference in Appendix Q shall be modified to reflect the said Amendment.
2. Requirement 3.03.117 is being modified due to the deletion of Requirement 3.03.123 in Amendment 1 # 25 as follows:

The Vendor shall provide an Alabama Medicaid Interactive Web Site which allows Recipients the option to report changes via the web. The recipient web application shall allow the recipient to print an Agency approved change form and provide a Vendor e-mail, a Vendor fax number and a Vendor mailing address for form submission. The Vendor shall update the AMAES application within one (1) day of receipt of the change from the web, fax, e-mail or mail. This applies to updates referenced in Requirements 3.03.077, 3.03.078, 3.03.119, and 3.03.122 ~~& 3.03.123~~.

3. Requirement 3.03.065 as revised in Amendment 1 #23 is being modified as follows:

The Vendor's Call Center shall process phone request on-line and real-time at the time of the call. The system updates shall occur within one day of the receipt of the request. The paper request will not require a paper response with the following exception:

The Vendor must respond in writing to any request for a specific Primary Medical Provider assignment which cannot be fulfilled.

The return response shall be mailed within two (2) days of receipt of the request.

4. Section 6.09.01.04 as revised in Amendment 1 #19 is being modified as follows:

Compensation for all approved pass-through expenses shall be paid based on documented costs. The following as specified in this ITB shall be allowable pass through expenses:

All postage expenses directly related to the operation of the Contract, including postal preparation fees for bulk and mass mailings,

Agency-approved printing of manuals, handbooks, and bulletins, as defined in *Section 3 – Requirements: 3.02.092, 3.02.093, 3.02.094, 3.02.095, 3.02.096, 3.02.097, and 3.02.098* (excluding enrollment packages), *3.02.099 - Provider*

Alabama Medicaid Agency

Amendment 2 to ITB #10-X-2205737

Requirements; 3.04.037, 3.04.038, 3.04.039, and 3.04.041 – Reference Requirements; 3.12.011 (PCCM Provider Referral Report), 3.12.012, 3.12.013, 3.12.014, 3.12.015, 3.12.016, 3.12.027, 3.12.028 and 3.12.039 - Managed Care Requirements; 3.13.008 – Medical Services Requirements.

Toll-free telecommunication lines, as defined in Section 3- Requirements: 3.01.010 (dial up toll free line) - General Requirements, 3.02.135- Provider Requirements; 3.06.002, 3.06.010, 3.06.049 - Claims Requirements; 3.03.098 - Recipient Requirements, 3.09.004 – Drug Utilization Review Requirements.

Plastic Medicaid identification cards, as defined in Section 3-Requirements: 3.03.014 (card stock, embossing, mailers and envelopes) – Recipient Requirements.

MMIS hardware and software, and any additional equipment, software upgrades and site licenses necessary to support Agency approved system enhancements. The Vendor shall obtain Agency approval prior to the purchase of any hardware, software, additional equipment, software upgrades or site licenses. This does not include any hardware and/or software required to meet requirements already specified within this ITB.

Vendor cost incurred in providing MMIS access to external entities at the request of the Agency such as data circuits or VPN access.

The Vendor shall submit to the Agency for approval, as part of the MMIS Implementation Plan, a plan for determining and documenting pass-through expenses. The Vendor shall make a reasonable effort to obtain the least costly alternative for all pass-through expenses. The Vendor shall take advantage of high volume printing and price comparison-shopping; automation-based rates and service provided by the United States Postal Service including zip+four, presorting, bar coding and bulk mailing.

[RxSureScript transaction fees incurred in providing MMIS Requirements 3.04.119 through 3.04.139. This does not include any maintenance fees charged by RxSureScript to the Vendor.](#)

5. Section 6.01.16 – Subcontracts is being modified as follows:

The Vendor may subcontract for any services necessary to the completion and maintenance of this contract and to the performance of its duties under this

Alabama Medicaid Agency

Amendment 2 to ITB #10-X-2205737

contract with advance written approval by the Agency of both the subcontracted function and the subcontractor. ~~Subcontractors include those whose services shall be purchased or software licensed by the Vendor, and any business partnerships between the Vendor and others.~~ Subcontractors shall demonstrate the capability to perform the function to be subcontracted at a level equal or superior to that of the Vendor. All subcontracts shall be in writing, with the subcontractor functions and duties clearly identified, and shall require the subcontractor to comply with all applicable provisions of this ITB. The Vendor shall at all times remain responsible for the performance by any subcontractors approved by the Agency. The Vendor's performance bond and Vendor's indemnification of the State and responsibility for damages shall apply whether performance or nonperformance was by the Vendor or one of its subcontractors. The Agency shall not release the Vendor from any claims or defaults of this contract which are predicated upon any action or inaction or default by any subcontractor of the Vendor, even if such subcontractor was approved by the Agency as provided above. The Vendor shall give the Agency notice in writing by certified or registered mail of any action or suit filed against it by any subcontractor and prompt notice of any claim made against the Vendor by any subcontractor or vendor, which in the opinion of the Vendor may result in litigation related in any way to this contract with the State of Alabama.

6. Section 6.04.03 – Worker's Compensation is being modified as follows:

The Vendor must take out and maintain during the initial term of these contracts and any renewal thereof, worker's compensation insurance for all of its employees working as part of this Contract; and, in the event any work is subcontracted, the Vendor must require any subcontractor similarly to provide worker's compensation insurance for all the latter's employees working as a part of this Contract as required by law.

7. Section 6.04.04 – Other Insurance is being modified as follows:

The Vendor must obtain, pay for and keep in force the following minimum insurance coverage and shall furnish a certificate to the Agency evidencing that such insurance is in effect:

- Comprehensive general liability policy with endorsement to insure contractual liability, personal injury, personal and advertising liability waiving right of subrogation against the State,

Alabama Medicaid Agency

Amendment 2 to ITB #10-X-2205737

- Liability insurance against bodily injury or death of any one person in any one accident in the amount of five hundred thousand dollars (\$500,000) and in the amount of one million dollars (\$1,000,000) for the injury or death of more than one person in any accident; and
- Insurance against liability for property damages in the amount of one hundred thousand dollars (\$100,000).

It ~~shall be the responsibility of~~ is advisable for the Vendor to require any subcontractor to secure the same insurance coverage as prescribed herein for the Vendor because, as stated in Section 6.01.16, Vendor is responsible for any action, inaction or damages caused by a subcontractor, and to furnish to the Agency a certificate or certificates evidencing that such insurance is in effect. Evidence of insurability under these provisions shall be directed to the Agency. In addition, the Vendor must indemnify and save the State harmless from any liability arising out of the Vendor's or any subcontractor's ~~untimely~~ failure in securing adequate insurance coverage as prescribed herein. All such coverage shall remain in full force and effect during the initial term of these contracts and any renewal thereof.

8. Section 7 – Appendices , Appendix A – Glossary of Terms, the definition of Subcontractor is being modified as follows:

Any and all corporations, partnerships, agents, and/or individuals retained by the Vendor (with prior written approval from the State) to perform services under this ITB, regardless of the amount, duration, or scope of the services provided and regardless of whether identified in the Vendor's proposal in response to this ITB or subsequently retained during the contract term. This definition does not include entities that only provide commercial off the shelf software and technical support of such software. Examples of these types of entities are Microsoft, Feith, BusinessObjects, Oracle, etc.

9. Section 4.04.09.02 Quality Assurance is being modified as follows:

In this section, the Bidder shall fully describe their approach to quality assurance (QA) and quality management for all aspects of the Operations Phase of the contract. The Quality Assurance/Quality Management Plan should be included in this section. This Plan~~The Bidder~~ shall include ~~in this response~~ the proposed quality assurance approach for manual functions and system interfaces and performance

Alabama Medicaid Agency

Amendment 2 to ITB #10-X-2205737

monitoring tools for electronic claims processing functions, customer relations, and automated file inquiry features. The Bidder Plan shall:

10. Section 4.04.10.01 Corporate Information is being modified as follows:

In this section, the Bidder shall:

1. Include a description of the Bidder's corporation and each subcontractor's firm (if the total annual value of the subcontract is greater than two hundred thousand dollars (\$200,000)any). This discussion shall describe the structure, information system's background and resources (both equipment and personnel). Details shall include:

11. Requirement 3.03.114 is being modified as follows:

The Vendor shall accept changes in date of birth that are not related to cases on unborn/newborn – reporting reports of birth of baby from parents, hospitals, or providers by phone or fax and update the AMAES system.

12. Requirement 3.03.122 is being modified as follows:

The Alabama Medicaid Interactive Web Site shall allow the recipient to submit an Agency approved change request on-line real-time. The change request shall allow the recipient to change the following information:

- Address
- Home Phone with Area Code
- Cell Phone
- E-mail Address
- Marital Status
- Sponsor Address
- Family Changes,
- Income Changes,
- Expense Changes,
- ~~-Insurance Changes,~~
- Report of Death,
- Ability to close a Medicaid Account or withdraw an Application, and

Alabama Medicaid Agency

Amendment 2 to ITB #10-X-2205737

- A free text area to enter other change information with an effective date for the change.

The Vendor shall receive the information entered on the web and make the changes in the AMAES application within one (1) day of receipt.

13. Requirement 3.01.007 is being modified as follows:

The MMIS shall allow forward/backward movement in multiple screen displays for screens in Provider, Prior Authorization, Claims and Recipient subsystems. All search result screens in the above identified subsystems must provide the capability to view the details associated with any specific search results and to return from the search results detail back to the original search results screen.

14. Requirement 3.01.112 is being deleted which read:

The Vendor shall produce summary reports of payouts and recoupments for reporting and analysis.

1. The Vendor shall maintain a separate file cabinet in a report repository such as COLD to allow the individual transaction to be displayed. This shall be like Remittance Advices (RAs) presently are in a separate file cabinet to allow individual provider numbers to be displayed.
2. The Vendor shall utilize Agency approved reason codes.
3. The Vendor shall ensure when these transactions are keyed, a tracking number (case number) is generated. This number shall be the index number in COLD to display the individual transaction.

15. Requirement 3.02.039 is being modified as follows:

The Vendor shall during enrollment, perform duplicate checks on tax ID, SSN, and license number, ~~and name~~. The Vendor shall ensure all provider numbers are linked together and cross-referenced to all inactive or old provider numbers and identify the

Alabama Medicaid Agency

Amendment 2 to ITB #10-X-2205737

current active NPI for that entity. The Vendor shall override duplicates when necessary.

16. Requirement 3.03.002 is being deleted which read:

The Vendor shall link nursing home provider information to the recipient so that changes to the name and address on the nursing home provider file are updated in the recipient's information.

17. Requirement 3.11.017 is being deleted which read:

The Vendor shall link nursing home provider information to the recipient so that changes to the name and address on the nursing home provider file are updated in the recipient's information.

18. Requirement 3.03.014 is being modified as follows:

The Vendor shall produce new and replacement plastic magnetic stripe identification cards and mail them to the recipient. The magnetic stripe shall contain the recipient ~~name and~~ ID number. There shall be a number on the card to define the number of times the card has been issued. The original card shall start with 00 and it shall increment by one (1) for each additional card issued. New or replacement cards shall be produced within forty-eight (48) hours of the request and mailed to the recipient within three (3) days of receipt of the request. There is an average of 23,000 new and replacement cards produced a month. The Vendor shall issue replacement cards in accordance with current Agency policy.

19. Requirement 3.03.020 is being modified as follows:

The Vendor shall maintain an on-line real-time panel that allows the Agency to search ~~and/or update~~ recipient data, including but not limited to partial eligibility, full eligibility, recipients with no eligibility (head of household/payees only), denied cases, pending cases, restriction/lock-in data, LTC data, financial application data and patient liability information with effective dates.

20. Requirement 3.03.033 is being modified as follows:

Alabama Medicaid Agency

Amendment 2 to ITB #10-X-2205737

The Vendor shall maintain a process to move a recipient's claims history from one Medicaid number to another number as designated by the Agency. The Vendor shall maintain panels that allow selected Agency personnel to move claims from one Medicaid number to another using an on-line ~~real-time~~ panel. Changes entered in that panel shall be made to the master file no later than 8:00 A.M. the next day. There shall also be a batch process that will be available to move large quantities of claims for recipients.

21. Requirement 3.03.036 is being modified as follows:

The Vendor shall identify potential duplicate recipient records during update processing and in special batch processing. The vendor shall produce a report ~~daily~~ weekly by 7:00 AM and the report shall be stored in COLD.

22. Requirement 3.03.038 is being modified as follows:

The Vendor shall create Medicaid eligibility extracts for Medicare according to the CMS schedule. The file shall be transmitted or uploaded to Medicare per their specifications. The extracts shall include Medicaid recipients with current eligibility or recipients whose eligibility has been terminated within the past twenty-four (24) ~~twelve~~ months and recipients with current Medicare coverage. The extract shall include all recipients with Medicare Part A, Part B and Part B-DMERC. The data in the extract shall contain the data required by Medicare and be in the format defined by Medicare.

23. Requirement 3.04.061 is being modified as follows:

The Vendor shall provide capability to support provider-specific reimbursement, including at least sixty (60) date-specific pricing indicators, using these data elements: provider ID, payment location, specialty code, procedure code and modifier, encounter fees, rate ~~type of service~~, and rates.

24. Requirement 3.04.070 is being modified as follows:

The Vendor shall provide weekly ~~pre-processing~~ drug reports to the Agency through COLD and hard-copy no later than the first day of each week unless otherwise specified by the Agency. Pre-processing rReports include, but are not limited to:

Alabama Medicaid Agency

Amendment 2 to ITB #10-X-2205737

- Added drugs
- Changed drugs
- Price updates
- PDL updates
- Drugs added to Part D classification
- Any error reports.

25. Requirement 3.04.071 is being modified as follows:

The Vendor shall notify the Pharmacy Services staff when ~~pre-processing~~ reports are available.

26. Requirement 3.04.096 is being modified as follows:

The Vendor shall produce and submit to the Medicaid Pharmacy Program, in formats approved by Medicaid, weekly or monthly ~~pre-processing~~ reports based on data provided by the data warehouse. The Vendor shall deliver weekly hard copy ~~pre-processing~~ drug reports to the Agency no later than the first day of each week or unless otherwise specified by Medicaid. The Vendor shall provide additional reports necessary to maintain the drug file upon Agency request.

27. Requirement 3.05.035 is being deleted which read:

The Vendor shall generate approval and denial notices to the Agency within two (2) days of decision or within the timeframe specified by the Agency for pharmacy PAs. The notice shall be generated using variable parameters (e.g. specific name or address, or to send notices to more than one (1) provider).

The notices shall include but not be limited to, procedure codes and modifiers (including descriptions), denial reason, and appeal rights and procedures, Electronic requests shall receive real-time electronic responses.

28. Requirement 3.03.088 is being modified as follows:

The Vendor shall have ~~an~~the AVRS selection ~~for~~as Automated Claims Status and Verification of Coverage.

Alabama Medicaid Agency

Amendment 2 to ITB #10-X-2205737

Recipients shall be able to call twenty-one (21) hours per day, seven (7) days per week, to hear the status of a claim or to verify Medicaid coverage via the Automated Voice Response System. The caller shall be prompted to enter key information such as the recipient number using a touch-tone phone to retrieve the information from the system. Routine maintenance shall be scheduled between 2AM and 5AM daily.

The Vendor shall implement a redundant automatic voice response system (AVRS). This Vendor shall provide two (2) AVRS systems which shall provide redundancy and support the current Provider AVRS and the new Recipient Call Center AVRS. Each AVRS shall operate concurrently, sharing the load. Should one of the two systems fail, the other shall support both the Provider AVRS and the Recipient Call Center system until service can be restored.

29. Requirement 3.03.089 is being modified as follows:

The Vendor shall have ~~an~~the AVRS selection ~~for2-as~~ Application Requests.

Recipients and potential applicants shall be able to call twenty-four (24) hours per day, seven (7) days per week, to request an application for a Medicaid program. By making touch-tone responses to the telephone system prompts, callers shall be directed to one of four voice mail boxes where they shall be able to leave their name, address, city, state, and zip code. Recipient Call Center staff members shall collect the information from these mailboxes and send the applications to the requesting party.

30. Requirement 3.03.090 is being modified as follows:

The Vendor shall have ~~the-an~~ AVRS selection ~~for3-as~~ Frequently Asked Questions.

Recipients and potential applicants shall be able to call twenty-four (24) hours per day, seven (7) days per week, to hear responses to Frequently Asked Questions (FAQ). By making touch tone responses to the telephone system prompts, callers shall be able to navigate through the FAQ menu to hear information provided by the Medicaid Agency to the recipient community.

31. Requirement 3.03.091 is being modified as follows:

Alabama Medicaid Agency

Amendment 2 to ITB #10-X-2205737

The Vendor shall have ~~an~~the AVRS selection ~~for4-as~~ Report Fraud Recording

Recipients who choose this menu option shall hear a recording directing them to immediately call the Medicaid Fraud Hot-Line number at 1-866-452-4930.

32. Requirement 3.03.092 is being modified as follows:

The Vendor shall have ~~the-an~~ AVRS selection ~~for5-as~~ Recipient Inquiry Unit

The majority of calls to the Recipient Inquiry Unit currently are related to the Patient 1st program. The calls received shall include replacement ID card requests, temporary ID card requests, program application requests, and eligibility file error correction requests. SOBRA workers may contact the RCC to request the replacement of recipient Medicaid card requests via mail, phone, or fax.

33. Requirement 3.03.093 is being modified as follows:

The Vendor shall have ~~thean~~ AVRS selection ~~for6-as~~ Customer Service Unit.

The Customer Service Unit shall answer a wide variety of questions. Call Center Representatives shall verify and update multiple data elements on the Recipient Eligibility Master File. They shall answer eligibility, policy, benefit, and claim status questions. In addition, they will perform the initial intake process for the Agency's NET unit. Basic information shall be obtained regarding the callers' transportation request and the request will be electronically routed to the Agency NET Unit for follow-up.

34. Requirement 3.03.094 is being modified as follows:

The Vendor shall have ~~an~~the AVRS selection ~~for7-as~~ Long Term Care (LTC) Unit.

The Vendor staff in the Long Term Care unit shall be thoroughly familiar with LTC policies and procedures. They shall be trained and prepared to answer in-depth eligibility and policy questions.

35. Requirement 3.03.095 is being modified as follows:

Alabama Medicaid Agency

Amendment 2 to ITB #10-X-2205737

The Vendor shall have ~~an~~the AVRS selection ~~for~~as E-Mail or Fax directly to Recipient Call Center.

A single e-mail address shall be provided to allow recipients to send their question or request directly to the call center. Call center representatives shall be assigned to monitor the inbox and respond to the recipient using secure email methods if PHI is included in the text of the message. Recipients may also fax a question or request to the call center. Call center representatives shall be able to fax a response to the sender if requested.

36. Requirement 3.06.113 is being modified as follows:

The Vendor shall maintain a function to process claims against an ESC disposition file or table (maintained in the Reference Data Maintenance function) to provide flexibility in claims dispositioning. The Vendor shall allow dispositions and exceptions to edits/audits based on bill/claim type, submission media, ~~or~~ provider type, ~~individual provider number, revenue, procedure or diagnosis codes~~. The Vendor shall provide the capability to disposition edits/audits to:

- (1) Pend to a specific location for correction
- (2) Deny with explanatory message(s) on provider remittance statement
- (3) Pay and report to the Contractor or to the Agency with explanatory messages (for use in postpayment activities)

37. Requirement 3.07.056 is being modified as follows:

The Vendor shall maintain an on-line mass-adjustment selection screen, limited to select users, to enter selection parameters including but not limited to: time period, provider number(s), provider type, provider specialty, ~~provider location~~, recipient number(s), age (min/max), gender, aid category, claim type(s), region code, revenue code, procedure and modifier(s), diagnosis code, NDC, error status code (ESC), and health program. Any claims meeting the selection criteria will be displayed for review and will have the capability to select or unselect chosen claims for continued adjustment processing.

38. Requirement 3.07.099 is being modified as follows:

The Vendor shall by the 5th day of the month generate ~~a~~reports which identify~~s~~ and segregate~~s~~ claim-specific and non-claim-specific adjustments by type of

Alabama Medicaid Agency

Amendment 2 to ITB #10-X-2205737

transaction (payout, recoupment, or refund) and provider type. These reports shall be stored in COLD.

39. Requirement 3.08.023 is being modified as follows:

The Vendor shall maintain the on-line ~~real-time~~ capability to identify, through DSS, T/E cases that closed with no recovery and those for which payment was received.

40. Requirement 3.08.026 is being modified as follows:

The Vendor shall maintain TPL-related data from the adjudicated claims history files, to include but not be limited to:

- Diagnosis codes indicating trauma;
- TPL payment/denial indicators (TPL Input/Output Codes, NCPDP); and
- ~~On non-paper claims, the~~ insurance company and policy identifiers, including policy and group numbers.

41. Requirement 3.08.134 is being modified as follows:

The Vendor shall create Medicaid eligibility extracts for Medicare according to the CMS schedule. The file shall be transmitted or uploaded to Medicare per their specifications. The extracts shall include Medicaid recipients with current eligibility or recipients whose eligibility has been terminated within the past ~~twenty-four (24) twelve (12)~~ months and recipients with current Medicare coverage. The extract shall include all recipients with Medicare Part A, Part B and Part B-DMERC. The data in the extract shall contain the data required by Medicare and be in the format defined by Medicare.

42. Requirement 3.10.021 is being modified as follows:

The Vendor shall, by the 5th day of the month following ~~receipt of the CMS quarterly update~~ quarter-end, produce a report of all NDCs terminated as a result of the CMS Quarterly update file.

43. Requirement 3.10.022 is being modified as follows:

Alabama Medicaid Agency

Amendment 2 to ITB #10-X-2205737

The Vendor shall use the NDC termination date from the CMS Quarterly update file to ensure that claims submitted after the termination date are not paid by systematically removing the NDC from coverage as of the termination date. The Vendor shall identify and report to the Agency all NDCs that have been removed from coverage due to an update of the NDC termination date no later than the 5th day of the month following receipt of the CMS quarterly update~~quarter end~~.

44. Requirement 3.10.023 is being modified as follows:

The Vendor shall provide the capability to remove from coverage all NDCs for labelers identified as terminated from the rebate program on the CMS Quarterly update file as of the termination date. The Vendor shall identify and report to the Agency all NDCs that have been removed from coverage due to an update of the file no later than the 5th day of the month following receipt of the CMS quarterly update~~quarter end~~.

45. Requirement 3.10.024 is being modified as follows:

The Vendor shall produce a quarterly report of invoices with any unit rebate amounts of zero no later than the 5th day of the month following receipt of the CMS quarterly update~~quarter end~~.

46. Requirement 3.10.025 is being modified as follows:

The Vendor shall produce a report no later than the 5th day of the month following receipt of the CMS quarterly update ~~quarter end~~ to identify any NDC where the drug rebate amount invoiced is greater than the reimbursed amount for the NDC.

47. Requirement 3.10.030 is being modified as follows:

The Vendor shall produce a quarterly report of all instances where the unit type paid on pharmacy and physician claims is different from those reported on the CMS Quarterly update file. This report shall be available on-line no later than the 5th day of the month following receipt of the CMS quarterly update~~quarter end~~.

48. Requirement 3.10.034 is being modified as follows:

Alabama Medicaid Agency

Amendment 2 to ITB #10-X-2205737

The Vendor shall produce a daily report by ~~CCN labeler and invoice~~ of all payments that have not been fully ~~dispositioned~~posted.

49. Requirement 3.11.002 is being modified as follows:

Generate annual CMS-372 Lag report for each HCBS waiver program. The reports are to be produced the first day of the 16th month after the end of the waiver year. The Elderly and Disabled (E&D) Waiver, Living at Home Waiver (LAHW), Mental Retardation (MR) Waiver, HIV-AIDS Waiver ends on September 30th. The Technology Assistance (TA) Waiver year end is February ~~21st~~22nd. State of Alabama Independent Living (SAIL) Waiver year end is March 31st. The report must meet all CMS & federal reporting requirements including the requirements stated in the State Medicaid Manual.

50. Requirement 3.11.007 is being modified as follows:

The Vendor shall provide a monthly report of all changes to LTC recipient liability or eligibility end dates. The report shall include but not be limited to recipient ID, eligibility start and end dates, liability amount before change and after change, claim amount before reprocessing, claim amount after reprocessing and adjusted amount. The report shall be produced by the 5th day following the last checkwrite of a quarter of the month.

51. Requirement 3.11.014 is being modified as follows:

The Vendor shall limit claim payment for recipient therapeutic leave days. Nursing facility residents are allowed six (6) therapeutic visits per calendar quarter not to exceed twenty-four (24) visits per calendar year. ~~Each therapeutic visit must not exceed three (3) days.~~ ICF/MR therapeutic leave days are limited to fourteen (14) days per calendar month.

52. Requirement 3.12.011 is being modified as follows:

The Vendor shall produce monthly Patient First Reports to the Agency and PMPs, of recipient enrollment. The report shall be produced after all monthly updates to managed care data. The Vendor shall ensure providers are only provided access to information on recipients assigned to them. The Vendor shall provide secured Web access to providers for the viewing and downloading of the following reports:~~The~~

Alabama Medicaid Agency

Amendment 2 to ITB #10-X-2205737

~~report shall be mailed to the providers prior to the first of the month. The reports provided shall include but are not limited to:~~

~~PCCM Provider Referral Report~~
Patient 1st Roster
~~Newborn Summary Report~~
~~Newborn Error Report~~
Capitation Payment Report

Additionally, a quarterly PCCM Provider Referral Report shall be produced, placed on the Web Portal for secured Web access to providers for viewing, downloading, and mailed to the providers within five (5) days of the beginning of each quarter. The Vendor shall provide secured Web access to providers for the viewing and download of the following reports:

~~—Patient 1st Roster~~
~~—Capitation Payment Report.~~

53. Requirement 3.12.014 is being deleted which read:

The Vendor shall produce and mail Patient 1st Reminder Postcards thirty (30) days after the initial assignment letter.

54. Requirement 3.12.016 is being deleted which read:

The Vendor shall produce and mail Patient 1st Annual Reminder Postcards within two (2) days of the recipient's certification anniversary.

55. Requirement 3.12.021 is being modified as follows:

The Vendor shall produce a DSS Emergency Room Management Report on a quarterly basis by the 5th of the month following quarter end. The report shall contain a list of the provider's recipients with emergency room services for the quarter. The Vendor shall mail the report to each provider within two (2) days of producing the report. ~~The Vendor shall store a copy of the quarterly Emergency Room Management Report in COLD.~~

The report shall also be available for ad-hoc reporting with selectable criteria

Alabama Medicaid Agency

Amendment 2 to ITB #10-X-2205737

including but not limited to: DOS range, age, number of visits, provider and diagnosis.

56. Requirement 3.12.026 is being deleted which read:

The Vendor shall provide a report on all patient 1st current capitation rates for each provider including the average case management fee by month and store in COLD.

57. Requirement 3.12.030 is being modified as follows:

The Vendor shall execute the auto-disenrollment process to end date the patient 1st eligibility for recipients who:

- lose Medicaid eligibility
- ~~have a change in zip code~~
- enroll in a private HMO or managed care plan
- are changed to an excluded aid category.

The Vendor shall not assign a provider to recipients who have changed zip code until the next monthly auto-assignment. The Vendor shall update the PMP file to show the current caseload.

58. Requirement 3.12.035 is being modified as follows:

The Vendor shall support the auto-assignment process for claims history by reviewing ~~six (6)~~¹⁸ months of the recipient claims data. The system shall "count" the number of visits a recipient has in history to a particular PMP. For example, if the recipient visits Dr. Smith (Group A) two (2) times, Dr Wilson (Group A) three (3) times, and Dr. Thomas (Group B) four (4) times, they would be assigned to Dr. Wilson (Group A).

59. Requirement 3.12.037 is being modified as follows:

The Vendor shall dis-enroll any recipient with active Medicare Buy-in segment dates when identifying recipients who should be included/excluded from participation in the managed care programs. The Vendor shall make the dis-enrollment date from

Alabama Medicaid Agency

Amendment 2 to ITB #10-X-2205737

managed care ~~the last day of the month before the Medicare enrollment date as specified by the Agency.~~

60. Requirement 3.12.038 is being deleted which read:

The Vendor shall produce and mail Provider Referral Reports by the 5th of the month following quarter end. This report shall contain all referrals on recipients assigned to the provider for the quarter.

61. Requirement 3.15.012 is being modified as follows:

The Vendor shall provide reports based on Operational Performance Averages and Percentages. Selection criteria including, but not be limited to, Benefit Plan, Provider Type, Provider Specialty, Fund Code, and Payment Dates. The report shall have the capability to report by month, quarter, and fiscal year at the state's Agency's request. ~~The report shall have the ability to compare reports with different selection criteria shall include but not be limited to provider type and specialty and descriptions, paid claim amount, paid claim amount for this month, same month last year, SFYTD this year, and last year.~~ This information shall be available on-line real-time.

62. Requirement 3.15.019 is being modified as follows:

The Vendor shall provide reports based on Payment Comparisons by Provider Type. Selection criteria shall include but not be limited to, Benefit Plan, Provider Type, Provider Specialty, Fund Code, County/Region, and Payment Dates. The report shall have the capability to report by month, quarter, and fiscal year at the state's Agency's request. The report shall have the ability to compare reports with different selection criteria. The report shall include, but not be limited to, provider type and specialty and description, paid claim count and paid amount for this month, same month last year and SFYTD this year and last year. The Vendor shall provide the capability to retrieve the report information by month, quarter or fiscal year by batch upon Agency request. ~~This information shall be available on-line real-time.~~

63. Requirement 3.15.027 is being modified as follows:

Alabama Medicaid Agency

Amendment 2 to ITB #10-X-2205737

The Vendor shall provide reports based on Recipient Participation By County. Selection criteria shall include but not be limited to, Benefit Plan, Fund Code, Aid Category, Claim Type, State COS, State Sub-COS, County/Region, Age Group, Gender, Race, and Payment Dates. The report shall have the capability to report by month, quarter, and fiscal year at the Agency's request. The report shall have the ability to compare reports with different selection criteria. The report shall include, but not be limited to, Recipient County, ~~Unduplicated~~ Eligible's, Unduplicated Recipients, Percent of Eligible Participation, Paid Amount, Average Paid Amount per Eligible, Average Paid Per Recipient. This information shall be available on-line real-time.

64. Requirement 3.15.029 is being modified as follows:

The Vendor shall provide reports based on Sterilizations. The report shall include, but not be limited to, Recipient ID, ICN, Provider Number, Procedure Code, Modifier, Primary Diagnosis, Secondary Diagnosis, Claim Type, Fund Code, Place of Service (POS), Category of Service (COS), Service Units, Age, Sex, Service Date, Payment Date, Amount Billed and Paid. Totals shall be summed by claim type (Professional, Outpatient, Inpatient, and Total). Report shall have the capability to report by month ~~and year~~. The Vendor shall also provide the capability to retrieve report information by month, quarter or fiscal year by batch upon Agency request. This report shall be produced ~~monthly~~ and stored in COLD.

65. Requirement 3.15.030 is being modified as follows:

The Vendor shall provide reports based on Abortions. The report shall include, but not be limited to, Recipient ID, ICN, Provider Number, Procedure Code, Modifier, Primary Diagnosis, Secondary Diagnosis, Claim Type, Fund Code, Place of Service (POS), Category of Service (COS), Service Units, Age, Sex, Service Date, Payment Date, Amount Billed and Paid. Totals shall be summed by claim type (Professional, Outpatient, Inpatient, and Total). Report shall have the capability to report by month ~~and year~~. The Vendor shall also provide the capability to retrieve report information by month, quarter or fiscal year by batch upon Agency request. This report shall be produced ~~monthly~~ and stored in COLD.

66. Requirement 3.16.018 is being modified as follows:

Alabama Medicaid Agency

Amendment 2 to ITB #10-X-2205737

The Vendor's SUR system shall display all codes and code descriptions on reports including but not limited to: procedure codes, procedure code modifiers, diagnosis codes, revenue codes, NDC's, ~~benefit plan codes, taxonomy codes,~~ and other codes identified by the Agency.

67. Requirement 3.17.002 is being modified as follows:

The Vendor shall ensure that DSS defines and populates ~~all elements~~ elements specified by the Agency from claims, claims history, all financial transactions and reference. This shall include but not be limited to refunds, adjustments, re-keys, voids, payouts, buy-in premiums and HIPPP payments.

68. Requirement 3.17.035 is being modified as follows:

The Vendor shall ensure that the DSS extracts MMIS data accurately and timely in the required format. DSS shall include, at a minimum, all data specified by the Agency~~all the data~~ from the following: claims (Fee For Service and encounter), claims history (Fee For Service and encounter), NCPDP data (including "other coverage or reason code), encounter data and capitation records, provider (including imputed provider specialty), managed care (including case management fees), recipient (including recipient check digit, dual eligible groupings and net voucher data), reference, pharmacy information (including preferred drug data), third party liability (TPL) (including TPL remittance advice data), long term care (including waiver information), prior authorization, financial, long term care, early periodic screening diagnosis and testing (EPSDT), management and administrative reporting (MAR), surveillance and utilization review (SUR) and federal, EDB data, referral indicator, procedure codes plus modifiers, dental detail tooth surface data and drug rebate (Federal and State/Supplemental). The DSS extract shall include Health Insurance Premium Payments (HIPPP) indicator and Parts A and B Buy-In information (including Buy-in premiums).

69. Requirement 3.17.063 is being modified as follows:

The Vendor's DSS claims and financial data shall include but is not limited to: adjudicated, ~~suspended, and~~ encounter claims data, adjustments and financial transactions, for the reporting period, from the Claims Reporting function and the Managed Care function.

Alabama Medicaid Agency

Amendment 2 to ITB #10-X-2205737

70. Requirement 3.17.069 is being modified as follows:

The Vendor's DSS shall have available in DSS the data necessary to query generate and store for on-line access, reports that depict the total TPL amounts billed by carrier and by recipient. The Vendor's DSS shall havemaintain the capability to displayobtain the amount recovered by carrier and/or recipient on the TPL A/R file.