

ADDENDUM TWO

DATE: November 20, 2012

TO: All Vendors

FROM: Ruth Gray, Buyer
State Purchasing Bureau

RE: Questions and Answers for RFP Number 4166Z1
to be opened January 7, 2013

Following are the questions submitted and answers provided for the above mentioned Request For Proposal. The questions and answers are to be considered as part of the Request For Proposal.

QUESTIONS	ANSWERS
1. We did review 44-4701 which led to my question below. We understand the list of items, however, one of the items is an application on a "form prescribed by the director". We were not able to locate the application form on the "Forms" section of the website, which prompted my question to you. Are you able to provide us with the application form needed for the PLHSO license?	Bidders must acquire the necessary forms from the Department of Insurance.

QUESTIONS	ANSWERS
<p>2. RFP Section: Glossary of Terms Per the definition of "licensing" on page "X" of the RFP, please confirm any Bidder not licensed as required by the Nebraska Department of Insurance (DOI) at the time of proposal submittal may (i) submit an attestation that the appropriate licensure will be obtained prior to a executing a contract with MLTC and (ii) provide verification that the licensure is not suspended, revoked, denied or found to be noncompliant by Nebraska DOI at the time of contracting, if awarded.</p>	<p>ADDENDUM ONE is rescinded.</p> <p>The RFP is hereby amended to:</p> <ol style="list-style-type: none"> a. Remove Licensing from Glossary of Terms, page x; b. Remove II.L.5 (page 6); and c. Add the following language to IV.J.2. Managed Care Organization Licensure: Bidders must acquire appropriate Nebraska licensure and provide proof-of-licensure with the proposal. If the Bidder is not licensed as required by the Nebraska Department of Insurance (DOI) at the time of proposal submittal, the Bidder shall attest that the appropriate licensure shall be obtained prior to executing a contract with the State. The Bidder shall provide verification that the licensure is not suspended, revoked, denied or found to be noncompliant by Nebraska DOI at the time of contracting.
<p>3. RFP Section: B. Provider Network; Page 130</p> <p>This section references "The following deliverables, at a minimum, will be due under a contract resulting from this procurement." However, there are no deliverables listed below the question. Please clarify where these deliverables are listed in the RFP.</p>	<p>The referenced sentence, "iv. The following deliverables, at a minimum, will be due under a contract resulting from this procurement", should be a stand-alone sentence. It refers to the following sections: c. Member Communications through j. Policies and Procedures. The bidder must acknowledge and demonstrate an understanding of sections c. – j. in their proposal response.</p>
<p>4. RFP Section: 12.a.II. Management; Page 89</p> <p>In the Scope of Work (SOW), the RFP states that "The Contractor must include QM processes to assess, measure, and improve the QOC provided to Members in accordance with:</p> <ol style="list-style-type: none"> a) All QM requirements identified in the contract; <p>Is the reference indicating the SOW or is there a sample contract? If this is referring to a sample contract, please provide the sample contract.</p>	<p>Section 12.a.II is referencing the Scope of Work. There is not a sample contract provided with the RFP.</p> <p>Reference Section III. A. General which outlines the components of the final contract.</p>

QUESTIONS	ANSWERS
<p>5. RFP Section: III. Terms and Conditions; Page 16</p> <p>Please clarify in section DD. if the 1.5% of incentives is included in the 3% profit limitation or separate.</p>	<p>The 1.5% of potential contract incentives is considered separate from the 3.0% profit limit calculation.</p>
<p>6. RFP Section: III. Terms and Conditions; Page 18</p> <p>The RFP states in section II. that the contract is for a pre-paid contractor. Please clarify if section II. Invoices is applicable.</p>	<p>In Section III. Terms and Conditions; "Invoices" are part of the standard RFP boilerplate. Invoices are not applicable to this Request for Proposal.</p>
<p>7. RFP Section: IV. Project Description and Scope of Work; Page 25</p> <p>Does item 1 in section E. Excluded Populations mean that the contractor will not be at-risk for any members who gain retroactive eligibility, or just Medicaid?</p>	<p>The Contractor will be responsible for members enrolled during the month of enrollment. The Contractor is not at risk for the period of retroactive Medicaid eligibility.</p>
<p>8. RFP Section: O. Transition and Implementation; Page 110</p> <p>Please provide the current metrics for the performance measures in number 11 under Performance Measurement.</p>	<p>The metrics will be developed in collaboration with the awarded bidder.</p>

QUESTIONS	ANSWERS
<p>9. RFP Section: k. Methodology/ Work Statement; Page 133</p> <p>In section k. Methodology/Work Statement, letter i. states that:</p> <p>“In addition to the specific requirements outlined in the text of this document, bidders must respond to the statements and questions contained in the chart below. Responses must be complete and succinct. These statements and questions relate directly to the major program elements described in Section IV Project Description and Scope of Work.”</p> <p>Further, letter ii. States:</p> <p>“The bidder’s responses to these statements/questions are in addition to information requested in other sections of the RFP. It is expected that the bidder not limit its proposal to just responding to these questions/statements.</p> <p>Referencing to requirements section F. SUBMISSION OF PROPOSALS, the proposal states that “Elaborate and lengthy proposals are neither necessary nor desired.”</p> <p>Is the bidder expected to answer in full both the requirements and questions or is it the state’s desire that the bidder incorporate the requirements outlined in Section IV. Project Description and SOW into section k. Methodology/Work Statement questions?</p>	<p>The bidder is expected to respond in detail to both the requirements and questions in Section IV. and also incorporate responses into Section K.Methodology/Work Statement.</p>
<p>10. RFP Section: k. Methodology/Work Statement; Page 133</p> <p>The questions in the table are broken out with denotation of the SOW section they reference only. Some of the SOW sections have multiple questions. Is it the state’s wish for the bidder to respond to these questions in the table format? If the state prefers a narrative response, not in the table layout, does the state allow the bidder to further number the questions (i.e. IV.J.1, IV.J.2, IV.J.3) so that the layout of questions is clear?</p>	<p>The bidder must respond to all questions/statements/comments in Section IV. It is at the bidders discretion to choose either a narrative or table format.</p> <p>No, the bidder must not further number the questions.</p>

QUESTIONS	ANSWERS
<p>11. RFP Section: k. Methodology/Work Statement; Page 139</p> <p>In section IV.L under Provider Network Development and Management, the following question is repeated “If your BH MCO proposes to use Subcontractors to provide any of the services provide a listing of those Subcontractors with their experience in providing care to Medicaid members and a description of the services they will provider if not already described.” If it is not the state’s intention for the bidder to respond to the same question twice, than should one of these items be omitted?</p>	<p>Section IV.L under Provider Network Development and Management, the RFP is hereby amended to eliminate the duplication statement that reads: “If your BH MCO proposes to use Subcontractors to provide any of the services provide a listing of those Subcontractors with their experience in providing care to Medicaid members and a description of the services they will provider if not already described.”</p>
<p>12. RFP Section: IV. Project description and Scope of Work; Page 25</p> <p>Is the state expecting a full narrative response to requirements such as E. Excluded Populations?</p>	<p>The bidder must provide a response to all areas outlined in the RFP requiring a response. Excluded Populations is an example of an area not requiring a response.</p>
<p>13. RFP Section: V. Proposal Instructions; Page 147</p> <p>If it is the state’s desire that the bidder respond to each of the requirements as outlined in Section IV Project Description and Scope of Work separately in a full and complete narrative, than please clarify where this is to be included in the Technical Proposal submission layout.</p>	<p>The bidder is to respond to each of the requirements as outlined in Section IV Project Description and Scope of Work as part of their technical proposal response.</p>
<p>14. RFP Section: V. Proposal Instructions; Page 147</p> <p>In section V. letter I. Technical Approach ii. please provide clarification. Is the “Proposed Implementation Approach” identified referring to the questions in k. Methodology/Work Statement beginning on page 133?</p>	<p>Yes, the proposed implementation approach is referring to the questions in k. Methodology/Work Statement.</p>
<p>15. RFP Section: V. Proposal Instructions; Page 147</p> <p>Please clarify whether section V. letter I. Technical Approach i. is the “Understanding of the Scope of Work” referring to the response to the requirements outlined in section IV. Project Description and Scope of Work? Or is this intended to be a summarized restatement of understanding?</p>	<p>Section V. Technical Approach is referring to the requirements outlined in Section IV. It is not intended to be a summarized restatement of understanding.</p>

QUESTIONS	ANSWERS
<p>16. RFP Section: P. Finance, Reporting Requirements and Rate-Setting; Page 132</p> <p>In section h. under Quarterly Reporting to MLTC, the following questions are repeated as c) and d)</p> <p>“a) Crisis services utilization, relative to number of persons (broken out by child/adolescent and adult) served and to national benchmarks;” and</p> <p>“b) Emergency department utilization, again using benchmarks and age breakouts;”</p> <p>If it is not the state’s intention for the bidder to respond to the same questions twice, than should one of these items be omitted?</p>	<p>No, it is not the state’s intention that the bidders answer the same questions twice. Section IV. P. is amended to remove c.) and d.).</p>
<p>17. Can MLTC please provide a list of bidders who have submitted questions or otherwise indicated that they might possibly bid? Can MLTC also provide contact information for the bidder and their lead representative?</p>	<p>The State can only release those documents subject to a public records request and in accordance with Neb. Rev. Stats. §§84-712 et seq.</p>
<p>18. RFP Section: III. Terms and Conditions; Page 16</p> <p>Please clarify in section DD if the max is 4.5% including incentives or if the 1.5% is already included in the 3% profit corridor.</p>	<p>See response to question #5.</p>
<p>19. Section: General</p> <p>There are multiple references to other state agencies and some specific requirements regarding data sharing, reporting and care coordination. Since Medicaid funds may not be used for a non-Medicaid purpose, please confirm that the contractor is responsible only for information and reporting for the enrolled Medicaid members for which we receive data and that care coordination is limited to those Medicaid members who may be receiving services through other State agencies in addition to Medicaid funded services</p>	<p>It is correct that the contractor is responsible only for information and reporting for the enrolled Medicaid members.</p>

QUESTIONS	ANSWERS
<p>20. Page 1; Section: Scope of the request for proposal</p> <p>States that the initial term is three years effective from the date of contract award through June 30, 2016. If contract award is April 15, 2013, the amount of time transpiring from contract award through June 30, 2016 is three years and two and one-half months. The amount of time transpiring from contractor start date, September 1, 2013 through June 30, 2016 is two years and ten months. Could you please clarify the three year initial term?</p>	<p>The RFP is hereby amended to read as follows: A contract resulting from this Request for Proposal will be for a period of three (3) years effective from Contractor start date with the option to renew for two (2) additional one (1) year periods as mutually agreed upon by all parties.</p>
<p>21. Page 6; Section: Procurement Procedures, N</p> <p>Are the capitation rates subject to premium tax? If so, what is the premium tax rate and will the capitation rate be adjusted to include this tax?</p>	<p>The bidder should verify with the Department of Insurance any requirements for a premium tax.</p> <p>Premium taxes are not included in the capitation rate.</p>
<p>22. Page 8 and 143; Section: Terms and Conditions</p> <p>Page 8 of the RFP requests the bidder to "... provide a binding signature of intent to comply." Pages 8-23 include the Terms and Conditions and provide a place for Accept & Initial. However, page 143 does not include the terms and conditions as a section to be submitted. Please confirm that these pages must be initialed and submitted.</p>	<p>By signing the "Request For Proposal For Contractual Services" form, the bidder guarantees compliance with the provisions stated in the Request for Proposal, agrees to the terms and conditions and certifies bidder maintains a drug free work place environment.</p> <p>Bidders are expected to closely read the Terms and Conditions and provide a binding signature of intent to comply with the Terms and Conditions; provided, however, a bidder may indicate any exceptions to the Terms and Conditions by (1) clearly identifying the term or condition by subsection, (2) including an explanation for the bidder's inability to comply with such term or condition which includes a statement recommending terms and conditions the bidder would find acceptable. Rejection in whole or in part of the Terms and Conditions may be cause for rejection of a bidder's proposal.</p> <p>Bidder should return the Terms and Conditions in Section III of the RFP with its proposal response.</p> <p>Bidder should accept and initial the Terms and Conditions in Section III of the RFP and return with its proposal response.</p>

QUESTIONS	ANSWERS
<p>23. Page 16 and Data Book; Section: Administrative Spending Cap</p> <p>What is the process of obtaining approval or acceptance of administrative costs greater than 7%?</p>	<p>Administrative costs can only exceed 7% for approved QI expenses defined on RFP page xv. MLTC will answer any questions related to QI and Non QI expenses during the Operational and Financial Readiness Review as outlined on RFP page 109. As part of the Quarterly and Annual Financial Reporting Package (RFP pages 16 and 126), the Contractor will submit reports related to the Risk Corridor calculation (which will include the administration expenses itemized by functional areas for purposes of meeting the administration expense tests on RFP page 125). MLTC then reserves the right of audit (RFP Page 29) to ensure administrative expenses were categorized pursuant to the Contract.</p>
<p>24. Page 16; Section: Terms and Conditions, Penalties</p> <p>This item states the State may withhold all monies due and payable to the contractor. Does this include the claims portion of the capitation? If so, what will be the cash source for the contractor to continue to be able to pay claims?</p>	<p>In the event that the contractor fails to perform any obligation under the contract, the State may withhold all monies due and payable to the contractor, without penalty, until such failure is cured or otherwise adjudicated. In the extraordinary event monies are deemed necessary to withhold, amounts withheld will be commensurate with the obligation being unmet.</p>
<p>25. Pages 16 and AttC; Section: Terms and Conditions – Administrative Spending Cap</p> <p>If Administrative expenses can be up to, but not exceed, 10% of contractual cap due to necessary administrative spending used to improve the health status of members served, why was this not taken into consideration in the development of the offered capitation rate? Attachment C states that an administration load of 7% was considered.</p>	<p>It is the expectation of the State that the capitation rate being offered is appropriate for an Contractor to achieve appropriate profits with an administrative expense load to accommodate both QI and Non-QI expenses. The capitation rate being offered has 10% retention built in for administration and profit; in addition, 1.5% of potential contract incentives are being offered.</p>
<p>26. Page 16; Section: Terms and Conditions</p> <p>This section refers to Contractor Incentives of at least 1 ½ % - is this outside of the capitation rates? Can you also clarify the maximum value, when it says 'at least'? How does this relate to those items in the Performance Measurement section?</p>	<p>See responses to questions #5 and #67.</p>

QUESTIONS	ANSWERS
<p>27. Page 17; Section: Terms and Conditions – Performance Bond</p> <p>Performance Bond – would state consider parental guarantee in lieu of a performance bond?</p>	<p>No, the State will not consider a parental guarantee in lieu of a performance bond.</p>
<p>28. Page 20; Section: Best and Final Offer</p> <p>Is this intended to be an opportunity to improve on the technical proposal, since the capitation rates are offered?</p>	<p>No, the Best and Final Offer is part of the RFP standard boilerplate and is not relevant to this RFP.</p>
<p>29. Page 26; Section: Covered Services, F.</p> <p>Page 26 indicates the “Contractor shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition;” Is this indicating that diagnoses such as Pervasive Developmental Disorder (including Autism) will now be covered?</p>	<p>The successful Contractor will be responsible to provide the medically necessary Behavioral Health services listed in Attachment A. These services do not include Pervasive Developmental Disorder or Autism.</p>
<p>30. Page 29; Section: Reinsurance</p> <p>Is a plan of self-insurance subject to an approval process? If so, what are the criteria for evaluation and approval?</p>	<p>The RFP is hereby amended to read in Section IV.J.4: “The Contractor shall provide MLTC the risk analysis, assumptions, cost estimates, and rationale supporting its proposed reinsurance agreements.” (4th paragraph.)</p>
<p>31. Page 31; Section: Administration Staffing, 9.xi</p> <p>Is the Tribal Network Liaison required to be a full-time position? In some sections of the RFP it suggests it is and in others it suggests a function to be performed by a staff person to be identified.</p>	<p>The decision to determine the full or part time status of the Tribal Network Liaison is at the discretion of the BH MCO as long as the duties are successfully performed in accordance with the job descriptions and the work is performed in compliance with the Contract.</p>
<p>32. Page 32; Section: Business Requirements, J.9.10.a</p> <p>Adequate Capacity, a. Appropriate range of preventive, primary care and specialty services that is adequate for the anticipated number of enrollees for the service area... As this is a behavioral health managed care contract, please clarify.</p>	<p>For the purposes of this RFP, preventive, primary care, and specialty services are those behavioral health services reflected in Attachment A.</p>

QUESTIONS	ANSWERS
<p>33. Page 32; Section Business Requirements, J.12</p> <p>Clinical Laboratory Improvement Amendment – please clarify the relevance of this section for this behavioral health RFP.</p>	<p>Laboratory results prepared by clinical laboratories, as ordered by Contractor providers and paid using Medicaid funding, must provide verification of CLIA Licensure or Certificate of Waiver during the provider registration process.</p>
<p>34. Page 33; Section: Fraud Waste and Abuse, J.13.i</p> <p>Section 13(i) requests our methodology to recover overpayments and sanction providers. However 13(f) requires a policy for referral of suspected fraud and abuse to MLTC Program Integrity. This section also requires reports of all cases that require preliminary investigation, including the disposition of the case, implying that contractor will handle the investigation and disposition. This is contradicted by Item (m) which states that MLTC “will seek all appropriate remedies for fraud..” What remedies for fraud, waste, and abuse will be available to the MCO and which will be reserved for MLTC?</p>	<p>It is expected that the Contractor have policies and procedures for investigation and disposition of fraud, waste, and abuse. It is also required that the Contractor report such cases to MLTC for determination of any further action.</p>
<p>35. Page 43-44; Section: State Fair Hearing, K.vii.a)(1)</p> <p>Section (vii)(a)(1) requires the member to exhaust the contractor appeal process before requesting a state fair hearing. On the next page (vii)(a)(4) specifically permits the member or provider to request a state fair hearing at the same time a contractor appeal is filed. The next item again states that the appeal process must first be exhausted. The bottom of p. 46, section (xiv)(b) again states that a state fair hearing may be requested at the same time an appeal is filed. Please clarify.</p>	<p>A member may request a State Fair Hearing within ninety days from the date on the original notice of action.</p> <p>The RFP is hereby amended to remove Section (vii)(a)(1) requiring the member to exhaust the contractor appeal process before requesting a state fair hearing.</p>

QUESTIONS	ANSWERS
<p>36. Page 48; Section: Establishing the Network</p> <p>There is a requirement that the MBHO have a network of crisis response providers available 24/7. Crisis response is not listed as a covered benefit in Attachment A and is currently a non-Medicaid service covered by the Division of Behavioral Health. Please clarify the expectations for the Medicaid program as crisis stabilization services are not identical to crisis response.</p>	<p>The RFP is hereby amended to remove Section IV. L.1.b. requiring the MBHO to have a network of crisis response providers available 24/7.</p>
<p>37. Page 63; Section Provider Quality Management Strategy, 11.f</p> <p>Implement and submit subject to MLTC approval, a network management strategy to engage with primary care providers, specialty providers, high-volume prescribers, and hospital emergency departments to improve access for Members who may be under- or over-utilizing behavioral health services. Please clarify how this addresses access as this would be a coordination of care, to ensure that services are appropriate and timely.</p>	<p>The State considers this requirement to be a key component of Provider Quality Management Strategy by identifying access issues through the over/under utilization of services.</p>
<p>38. Page 64; Section: Network Provider Policy and Procedure Manual/Handbook, 13.a.ii.h)</p> <p>Administrative and billing instructions, including a list of procedure codes, units and payment rates. As the MCO would be negotiating and establishing rates, this information be proprietary. Is it necessary to include this information in the handbook?</p>	<p>No, it is not necessary for this information to be included in the handbook.</p>
<p>39. Page 66; Section: Network Provider Protocols, 14.a.v.a)</p> <p>Inform MLTC immediately upon enrolling any provider who is not also a NE PH Medicaid provider in its Provider Network. Should this read a “NE BH Medicaid provider”? If not, please clarify.</p>	<p>Yes, the statement should read a “NE BH Medicaid provider”.</p>

QUESTIONS	ANSWERS
<p>40. Page 66: Section: Network Provider Protocols, 14.a.ii.c.</p> <p>The requirement to coordinate care for members receiving services from other state agencies is listed under requirements for reporting adverse incidents. This appears to be an error. Please clarify.</p>	<p>The RFP is hereby amended to remove 14.a.ii.c).</p>
<p>41. Page 67, Section: Provider Advisory Committee, L.15.b</p> <p>There are a large number of examples of "major provider organizations" and other potential members. Please confirm that making invitations to these organizations is sufficient to meet the requirement as participation can not be promised by the MBHO.</p>	<p>The Contractor is expected to extend invitations, provide examples of the benefits of participation, assure collaborative communication processes and generally provide a good faith effort to establish ongoing and seamless communication.</p>
<p>42. Page 71; Section: General Requirements for Care Management, M.1.b.iii</p> <p>Section b, item iii. Why are adults listed with Adolescents? Is this a typographical error or will adults not be expected to be a covered Care Management population?</p>	<p>Adults are considered to be a covered Care Management population. They were included with "Adolescents" in this category in error.</p>
<p>43. Page 72; Section: Care, Utilization and Quality Management, M.4.b.ii.a)</p> <p>States that the clinicians that authorize services must be LIMHP, psychologists or psychiatrists. Would RNs be acceptable, particularly with the expectations regarding coordination with co-morbid physical health conditions? Additionally, LMHP clinicians would appear to meet the intent of this section.</p>	<p>The Contractor shall ensure that only professionals acting within the scope of all applicable state laws and their professional licenses shall make final decisions regarding medical necessity determinations.</p>
<p>44. Page 73; Section: Care Management, M.4.b.ii.(e)</p> <p>Would the care management support functions relevant to peers and family members be reimburseable as a Medical Cost or a QI Admin charge?</p>	<p>The State requires additional information to answer this question, as the response to this question would depend on the type of care management support function. Please refer to page xv. Quality Improvement (QI) Expenses and the definition for substitute or value added behavioral health services, page 26.</p>

QUESTIONS	ANSWERS
<p>45. Page 74; Section: Care Management, M.4.I</p> <p>This requires that the MBHO determine if the care management member has PCP and if not refer them to the Medicaid PH provider. Since every member is enrolled with a Medicaid PH Health Plan responsible for physical health care, would not the responsibility for assigning a PCP be their responsibility?</p>	<p>The RFP is hereby amended to remove IV.M.4.b.ii.I.1.2.3.4.5.6.7.8. and 11.).</p>
<p>46. Page 74; Section: Care Management, M.4.i.1)</p> <p>It would seem reasonable to allow psychologists to deny psychological testing, can this be modified to accomidate?</p>	<p>When a psychologist is practicing within their scope of practice, they may deny psychological testing.</p>
<p>47. Page 75; Section: Care Management, M.4.I.6, 7 and 8.</p> <p>Please confirm that the responsibility for care coordination for members who are receiving DBH, DCFS and DDD services are those Medicaid members also receiving services from those entities. Please inform on how the Contractor will be notified, or have access to DBH, DCFS and DDD data to indicate that coordiantion is needed.</p>	<p>See response to question #45.</p>
<p>48. Page 75; Section: Care Management, M.4.I.11</p> <p>How is the MBHO going to be alerted to Children with SED or with behavioral challenges in contact with multiple agencies serving children as we will only receive Medicaid data?</p>	<p>See response to question #45.</p>

QUESTIONS	ANSWERS
<p>49. Page 77; Section: Care, Utilization, and Quality Management, M.6.a.ii</p> <p>Regarding the statement, "At the time when a BH provider initiates an evaluation and/or treatment for the member, the PH MCO is no longer responsible for a BH-related service. Authorization for BH services from that point forward must be obtained from the BH-MCO" how does this impact the authorization and payment of psychotropic medication prescribed by a PCP while the member is receiving psychotherapy from a BH provider?</p>	<p>It is expected that care between the PH MCO and the BH MCO is coordinated and each provider is providing treatment, as medically necessary.</p>
<p>50. Page 86, Section: Retrospective Utilization and Review of Network Providers, M.10.h.c.</p> <p>Please confirm that the requirement for tracking the utilization of out-of-home placements for children is limited to those that have been admitted as a result of a behavioral health authorization as a Medicaid member.</p>	<p>Yes.</p>
<p>51. Page 88; Section: EPSDT, M.11.e</p> <p>Please clarify the requirement that "The contractor shall perform EPSDT services and access to EPSDT exams under the NMMPH program. This RFP is not for the NMMPH.</p>	<p>The RFP is hereby amended to remove IV.M.11.e.</p>
<p>52. Page 90; Section: Quality Mangement, M.12.a.iii.f</p> <p>Are PIPs limited to improving the health care of Medicaid Members?</p>	<p>PIPs are focused on health-related benefits, services, care and processes provided to Medicaid members.</p>
<p>53. Page 91; Section: Quality Assurance and Performance Improvement Requirements, M.12.a.iv.c) 4</p> <p>Please clarify that the contractor is required to include a question in the member satisfaction survey regarding transportation, but is not responsible for address the transportation system issues as there is an independent vendor for that service.</p>	<p>The Contractor is not required to include a question in the member satisfaction survey regarding transportation.</p>

QUESTIONS	ANSWERS
<p>54. Page 95; Section: Quality Reporting, M.12.a.ix.3) xi</p> <p>Monitoring psychotropic medications for children ages 12 years and under, including vulnerable populations such as children in foster care or in state custody; is required. Unless these children are Medicaid members and the contractor has authorized the out of home placement for behavioral care, the contractor would not know about the out-of-home or if they are a ward of the State. Is this reporting limited to just those Medicaid members for which we have information?</p>	<p>Yes, this reporting is limited to just those Medicaid members for which BH MCO has information.</p>
<p>55. Page 96; Section: MLTC Quality Reviews, M.12.b – 2nd paragraph</p> <p>Please clarify that the participation regarding SAMHSA grant funding is limited to only the experience of Medicaid members and that the focus of QI efforts by the contractor would be specific to improved care coordination, but not Block Grant service delivery.</p>	<p>The interpretation is correct.</p>
<p>56. Page 98; Section: Quality Improvement Committee, M.12.d.a) through h)</p> <p>Is the expected number of members at least 24 individuals, 6 of whom are non-voting?</p>	<p>Please refer to Page 98; Section: Quality Improvement Committee, M.12.d.a) through h) for the number of members required on the Quality Improvement Committee.</p>
<p>57. Page 99; Section: Information Systems, N.3.</p> <p>Please define the population referenced as “potential member and provider...” and how they would interface with the MCO to enable the collection of the data requested in the RFP. Wouldn't data only pertain to eligible members who were sent over on the enrollment file?</p>	<p>Yes, data would only pertain to eligible members who were sent on the enrollment files.</p> <p>Section IV.N.3 (second paragraph), the RFP is hereby amended to remove the word “potential”.</p>
<p>58. Page 100; Section: Health Information Systems- Encounter Data, N.3.c.</p> <p>Should "all services provided to the member" instead read, "all covered services provided to the member?"</p>	<p>Yes.</p>

QUESTIONS	ANSWERS
<p>59. Page 100; Section: Information Systems, N.4.n.</p> <p>State and Federal Requirements. Should this be understood to mean the MCO will capture DBH data elements for those persons that are Medicaid members receiving services that are also funded through DBH, or is the expectation the MCO will obtain the required data on -Medicaid eligible persons receiving those services as well?</p>	<p>The RFP is amended to remove Section IV.N.4.n.</p>
<p>60. Page 101; Section: Health Information Systems – Encounter Data, N.4.q.ii.</p> <p>Please identify with more specificity the non-Medicaid services that will be required to be included in the IS system and the expected data elements.</p>	<p>The RFP is amended to remove Section IV.N.4.q.ii.</p>
<p>61. Page 101; Section: Health Information Systems – Encounter Data, N.4.q.iv.</p> <p>Will the entire data set be transferred to the state monthly, or is this requirement referring to the monthly encounter data file?</p>	<p>It is referring to the encounter data file. This file can be submitted to the State more frequently than monthly.</p>
<p>62. Page 101; Section: Information Systems, N.4.q.ii</p> <p>Please clarify the anticipated source(s) of information regarding services received by members through publically financed non-Medicaid services, and the expectation(s) for the use of that information for the coordination of those non-Medicaid services.</p>	<p>See response to question #60.</p>
<p>63. Page 106; Section: Information Systems, N.8.f</p> <p>Third Party Liability. Please explain how the coinsurance, co-payments or deductibles required by a member’s TPL coverage that are considered the responsibility of the Contractor are factored into the PMPM calculations in Attachments B and D.</p>	<p>See Attachment C-Adjustments to the FFS Base Data.</p>

QUESTIONS	ANSWERS
<p>64. Page 101; Section: Health Information Systems</p> <p>Page 101, Section 4,q.ii requires the IS system to include data to allow coordination with publically financed, non-Medicaid services provided to the Contractor's Members as reported by other NE state agencies. How will the contractor receive this electronic information from other State Agencies?</p>	<p>See response to question #60.</p>
<p>65. Page 102; Section: Care Management and Care Coordination Information</p> <p>This section requires the Contractor to notify member PCPs of prescriptions and new services. Will the State require the Physical Health plans to obtain the signed Authorization to Disclose statement from the member to disclose mental health and substance use disorder treatment to PCPs that would allow the Contractor to fulfill this duty in compliance with State and Federal Law? The member approval for the disclosure would have to be renewed for as long as the member's authorization is valid for, and at least annually.</p>	<p>The RFP is hereby amended to read: Section IV.N.5.b.i: The Contractor shall have the capacity to populate the Members' care management records with prescribed medications as identified through pharmacy data provided by DHHS.</p> <p>The RFP is hereby amended to remove e.f. and g. in Section IV.N.5.</p>
<p>66. Page 103; Section: Claims Payment, N.7.a.i</p> <p>This Section requires us to manage claims for Medicaid and all State funding sources, which would include DBH and CFS. Please clarify that the contractor will only be responsible for paying the Medicaid behavioral health claims.</p>	<p>Yes, The contractor will be responsible for paying Medicaid covered behavioral health claims and any substitute or value added services.</p>

QUESTIONS	ANSWERS
<p>67. Page 110; Section: Performance Measurement/Performance Guarantees, O.11.a</p> <p>The table in this section identifies a Percent Allocation for both Performance Guarantee and Contract Incentive. Please identify and explain what the percent allocation is applied to (percent of what amount?)</p>	<p>One half of one percent (0.5%) of the capitation will be subject to the Performance Guarantee Metrics outlined on page 110 of the RFP. Failure to meet these metrics will result in forfeiture of up to 0.5% of the capitation based on the Percent Allocations (of the 0.5%) listed in the table starting on RFP page 110.</p> <p>An additional amount of one and one half percent (1.5%) of the capitation will be made available to the Contractor if they meet the Contract Incentive Metrics outlined on page 110 of the RFP. The Contract Incentive metrics and Percent Allocation (of the 1.5%) can be found on RFP page 110.</p>
<p>68. Page 111; Section: Performance Measurement/Performance Guarantees</p> <p>Are the Claims Performance Guarantee Standards reversed? It is Industry Standard that Financial Accuracy be higher than Procedural Accuracy, since the amount paid can be correct, without following every procedure. Herefore payment accuracy should be 99% and Procedural Accuracy should be 97%.</p>	<p>The Financial payment accuracy threshold should read 99% and the Procedural accuracy should read 97%.</p>
<p>69. Page 114; Section: Performance Measurement, O.11.item 11</p> <p>Will the denominator for this measure be limited to only those members whose prescriber was a behavioral health care practitioner? Any delay in receiving pharmacy data from the state or from a health plan for pediatrician prescribers will leave us at a disadvantage in targeting outreach to members, particularly for the 30-day appointment.</p>	<p>See response to question #8.</p>
<p>70. Page 120; Section: Performance Assessment, O.11.b.iv</p> <p>Performance Assessment – if the target is still met, but has an error rate > 5%, will the contractor still be awarded the incentive? This section states the Contractor will pay the full penalty and earn no incentive.</p>	<p>If the Contractor’s error rate is greater than 5%, that metric will not be calculated; therefore, the Contractor shall pay the full risk penalty and earn no incentive based on that metric.</p>

QUESTIONS	ANSWERS
<p>71. Page 126; Section: Reinvestment Plan; P.4</p> <p>It is unclear how the first escrow account, the Reinvestment Holding account, becomes funded. Is it a requirement that the entire capitation get deposited into the account, or the amount less contractor's administration, or a specified portion of the capitation? Please explain in more detail the flow of funds to the contractor and the funding of this first escrow account. Also does a separate Escrow Administrator mean separate bank account?</p>	<p>Yes, there is an expectation that there be two separate accounts.</p> <p>The "Reinvestment Holding Account" is designed as a repository for the 0.5% Performance Guarantees and the 1.5% Contract Incentives to be held upon receipt of the payment from MLTC. Monthly payments by MLTC to the Contractor will include the Capitation rates (listed in Appendix B) plus an additional 1.5% of the capitation rate for potential Contractor Incentives.</p> <p>After the actual metrics are compared to the benchmarks, MLTC will instruct the Contractor the amount to transfer to the second "Reinvestment Account" and the amount to transfer to the Contractor's general accounts. Forfeited MLR rebates and/or forfeited profits (per MLTC's risk corridor calculations) will go directly from the Contractor's general accounts to the "Reinvestment Account". During the contract year if the Contractor anticipates and/or projects a MLR rebate or excessive profits, this should be accounted for according to generally accepted accounting practices and principles.</p>
<p>72. Page 130; Section: Deliverables, P.6.b.i</p> <p>The provider types required do not seem to apply to this contract. Should this instead refer to behavioral health provider types?</p>	<p>Section IV.P.6.b.i. is amended to read: Individual GeoAccess maps for all services listed in Attachment A following the Geographical Standards outlined in Section IV.L.9.ii.</p>

QUESTIONS	ANSWERS
<p>73. Page 134; Section: Business Requirements, P.6.k.ii.item IV.B</p> <p>We request clarification on what the State wants to see in response to this question. These sections of the US Code are applicable to the State when it contracts with a vendor to provide Medicaid Managed Care services and are not directly applicable to the vendor. Is the State seeking information on what our procedures are regarding Conflicts of Interest that concern State employees? Is the State also seeking information on what our procedures are with regard to any current relationship or potential acquisition or any interest that gives the appearance of a conflict of interest related to this Request for Proposal or project?</p>	<p>The State does not understand the question as relates to IV.B which is Principles of Care. Please restate question.</p>
<p>74. Page 136; Section: Methodology/Work Statement, P.6.k.ii.item IV.L.</p> <p>Please define the acronym, "NMPHC".</p>	<p>This acronym should read "NMMPH": Nebraska Medicaid Managed Physical Health.</p>
<p>75. Page 137; Section: Methodology/Work Statement, P.6.k.ii Item IV.L.</p> <p>Please clarify the use of the phrase "potential membership" as it pertains to eligibility and enrollment files. We assume the 834 files transmitted prior to the first of the month will contain only recipients who are expected to be enrolled on the first of the month. We understand that some recipients will lose eligibility prior to the first of the month. Is this the entirety of the meaning of "potential membership" used here?</p>	<p>Yes. The State does not expect the Contractor to track or monitor "potential" enrollees.</p>
<p>76. Page 137; Section: Provider Network Development and Management, P.6.k.ii item IV.L</p> <p>Page 137, Item IV.I – 8th from the top requires the Contractor to manage potential membership. This is defined as a Medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet and enrollee of a specific MCO, PIHP PAHP,HIO or PCCM. Please explain further it's application to this program.</p>	<p>See response to question #75.</p>

QUESTIONS	ANSWERS
<p>77. Page 140; Section: k. Methodology/Work Statement</p> <p>In the Work Statement item, "Describe the process and criteria used for case management, including how you will case manage and what services you will provide" can you explain what you mean by "case management?" Our understanding is that providers provide case management and the BH MCO will provide care management. Do you mean care management?</p>	<p>Yes, the work statement item is referring to care management.</p>
<p>78. Page 140; Section: Care, Utilization and Quality Management, p.6.k.ii.item IV.M</p> <p>Page 140, Section IV.M, 4th from bottom requires MCO to coordinate care management for members receiving disease management from Physical Health plan for diabetes, asthma, hypertension and obesity at a minimum. Please confirm that the health plans will be required to provide this level of collaboration.</p>	<p>The BH MCO is required to coordinate care with the PH MCO.</p>
<p>79. Page 142; Section: Transition and Implementation, page 6.k.ii item IV.O</p> <p>Page 142, Section Iv.O, 3rd O item requires the Contractor to attend all court or administrative proceedings during transition. Please confirm that this would only include those proceedings in which the current MBHO is involved with for Medicaid members at the time of the new contract.</p>	<p>Yes, this only includes proceedings for Medicaid members that are transitioning into the BH MCO's service provision.</p>

QUESTIONS	ANSWERS
<p>80. Page 143 & 145; Section: Proposal Instructions</p> <p>Section A, on page 143, describes 4 sections for the Technical Proposal: including the Form, the executive summary, the coproarte overview and the technical approach. The Technical Approach includes 1) Understanding the Scope of Work, 2) Proposed Implementation Approach, 3) Technical Considerations, and 4) Detailed Project Work Plan. Please confirm that subsection 2 on Implementation Approach are the questions on pages 133-142. What is expected to be submitted for subsection 3 technical considerations? How is this different than the Executive Summary and/or Describing the understanding of the Scope of Work, or the responses to Implementation Approach (subsection 2)?</p>	<p>Bidders are responsible for reading the RFP in its entirety and determining the format for which they choose to proceed with in their proposal response.</p>
<p>81. Attachment B</p> <p>Can you provide a summary of the programs and member counts in FY11 that make up this member month count? Are there members in this count that are not part of the current managed care programs?</p>	<p>The membership data shown in Attachment B is the level of detail available. All of the members listed are part of the managed care program. Individuals that are excluded from the managed care program are not included in Attachment B.</p>
<p>82. Attachment B, C and D</p> <p>We are unable to replicate the capitation rate offered, and in fact arrive at a rate significantly higher when using the Restated FY11 data as a base, applying the noted trend, managed care savings and administrative costs adjustment. The offered rates appear to be understated by \$3.3 - \$3.6 million. Can an additional exhibit be provided with steps through this calculation?</p>	<p>An additional exhibit will not be provided. Actuarially sound rate ranges were developed for each rate cell. The capitation rates in Attachment B are each within the actuarially sound rate range.</p>

QUESTIONS	ANSWERS
<p>83. Attachment C; Section: Trend and managed care savings</p> <p>It appears that the assumptions may be double counting the managed care assumptions in addition to the trend assumptions. The care is currently managed and due to that management a reason for the historical negative trends. It appears duplicative to not only continue to assume this level of trend decline, but to then also apply a managed care factor on data that is currently managed. What is the rationale for applying negative trends forward for over a three year projected period (FY11 midpoint of 12/30/10 to initial rate period 9/1/13-6/30/14 midpoint 1/30/14 = 3.086 years) and then additionally applying moderate to significant managed care assumptions?</p>	<p>The rationale for applying negative trends forward is that historical costs and utilization have been declining (in some cases significantly). For the rate cells with negative aggregate assumed trends, the assumed trend is less negative than actual trend levels experienced. Trend assumptions were developed by rate cell and service category from historical utilization and cost patterns. Prior to analyzing the cost patterns the fee schedule changes were incorporated to avoid basing assumptions off of cost levels that were affected by fee schedule changes. The trend assumptions were set assuming no additional management or implementation of a risk-based contract. The managed care assumptions were set by comparing utilization and cost levels to those of other state Medicaid managed care programs and to other benchmarks levels to determine if additional managed care savings were achievable by service category and rate cell. In setting the managed care savings assumptions, there was a focus on the use of more cost-effective alternatives to inpatient and residential services which would decrease use of care in more acute settings and increase the utilization of less intensive services.</p>
<p>84. Attachment C</p> <p>Please provide explanation of the factors that were considerations in determining the managed care impact assumptions as well as the reasons for differences between the various rating categories. Are higher levels of care deemed to receive a higher factor than lower levels of care?</p>	<p>See response to question #83.</p>
<p>85. Attachment C; Section: Administrative Cost</p> <p>This does not recognize the Quality Improvement Administrative Rate that was discussed in the RFP. How is it possible for Quality Improvement Administration costs to be recovered if they are not provided for in the rate?</p>	<p>See responses to questions #23 and #25.</p>
<p>86. Attachment C</p> <p>This does not recognize incentive that is discussed on page 16 item CC. Is the incentive provided outside of the stated capitation payment?</p>	<p>Yes.</p>

QUESTIONS	ANSWERS
<p>87. Attachment C; Section: Data Book</p> <p>Would the State provide membership for FY 12 as well as each month subsequent to current for each rating category?</p>	<p>Membership information will be posted on December 11, 2012 with second round questions and answers.</p>
<p>88. Att. D; Section: Data book</p> <p>Please provide count of claims adjudicated for the three historical periods reflected in Attachment D.</p>	<p>Claim units can be developed from the membership and utilization rates provided in Attachment D.</p>
<p>89. Attachment C; Section: Data book</p> <p>Please provide explanation of the factors that were considerations in determining the managed care impact assumptions as well as the reasons for differences between the various rating categories. Are higher levels of care deemed to receive a higher factor than lower levels of care?</p>	<p>See response to question #83.</p>
<p>90. Page xii</p> <p>What is LAE as used to define net qualified medical expense?</p>	<p>Loss Adjustment Expense (LAE) is an administrative reserve in the event an insurance company must pay for the adjudication of outstanding claims at the end of a contract period.</p>
<p>91. Page 16; Section SG&A</p> <p>It is stated that SG&A cannot exceed 7% of costs unless the admin is spent on programs that may improve the health status of the underlying population.</p> <ul style="list-style-type: none"> • It is possible that startup costs of implementing clinical and cost programs exceed 7%? • What outcomes measures qualify for increasing the % SG&A to 10%? 	<p>Outcome measures are not considered when determining whether the Contractor's administrative expenses will be considered either QI or Non QI (see answer to question 23). Amortization of first year administrative expenses is subject to generally accepted accounting practices and principles.</p>
<p>92. Page 25; Section: E.1. Excluded populations</p> <p>How would the exclusion of retroactive members work? Does this mean that the State never would send a retroactive effective date on a member?</p>	<p>See response to question #7.</p>
<p>93. Page 29; Section: 4. Reinsurance</p> <p>As a stand alone MBHO, re-insurance is not needed. What plans of self-insurance would be acceptable?</p>	<p>See response to question #30.</p>

QUESTIONS	ANSWERS
<p>94. Page 109; Section: 10:</p> <p>The RFP does not state when the readiness review(s) would take place. Please elaborate on the timeline for these reviews.</p>	<p>The readiness review(s) timeline will be determined in collaboration with the awarded bidder after contract award.</p>
<p>95. Page 121; Section: d: Network Performance Requirement</p> <p>How far in advance of go-live will the Contractor know where the members are in order to avoid this penalty?</p>	<p>The State will provide potential enrollee numbers by county and this information will be posted on December 11, 2012 with second round questions and answers.</p>
<p>96. Page 128; Section: Attachment C and 5.d.vi</p> <ol style="list-style-type: none"> 1. The utilization data did not take into account the CPT code changes effective for 1/1/2013. We expect the addition of modifiers to adversely impact utilization. Will the state and/or M&R adjust the proposed CAP rates to take these coding changes into account? 2. M&R's methodology assumes a great impact from the implementation of managed care. However, the impact of managed care in the first year will not immediately have its full impact on costs and utilization. Would the state consider adjusting the CAP rates to take into consideration the fact that full impact of managed care will not be realized until well into the first year of the contract? 3. The start of the contract is being delayed by 2 months and the first period is being shortened from 12 months to 10 months, thus reducing the time in the first year for managed care to effect the savings projected in M&R's calculations. Will the state adjust the CAP rates for this later start? 	<p>The rates presented in Attachment B are those intended for use in the initial rate period.</p>
<p>97. Page 136; Section: iv.L</p> <p>Please define the acronym "NMPHC"</p>	<p>See response to question #74.</p>

QUESTIONS	ANSWERS
<p>98. Pages 130 and 138; Section: 6.b.i. and iv.L</p> <p>Several references to geo-access maps of providers for whom the BHMCO has received a Letter of Intent. Does the State want only providers on LOIs or should the health plan include those for whom it has a fully executed contract?</p> <p>Same question for the list of providers – only those on LOIs or do we include those who are fully contracted?</p>	<p>GeoAccess mapping must be provided which identify both LOI and fully executed providers.</p> <p>This also applies to the list of providers.</p>
<p>99. Do members sign a coordination form during the enrollment process so that coordination of care is managed efficiently across all levels of care?</p>	<p>No, the member does not sign a coordination form during the enrollment process.</p>
<p>100. Section: Data Accuracy</p> <p>It is stated that the incurred dollars have been reconciled; however, there may be inaccuracies in the underlying data.</p> <ul style="list-style-type: none"> • Can you quantify the variance for each FY? • If data inaccuracies may be present, please indicate the likely category/area of any discrepancy? • Are services represented only for BH providers or are there PCP services included that may not traditionally be risk for MBHOs. 	<p>The Data Book represents the State’s best efforts to present the historical membership, utilization and cost levels by rating category and service category. The variance will not be quantified and the State cannot opine on the likely category / area of potential discrepancies. As stated, the data was reconciled. The data represents services provided by behavioral healthcare providers only.</p>
<p>101. Section: Trend</p> <p>A number of negative trends were used.</p> <ul style="list-style-type: none"> • Please provide a breakdown of trends by utilization & unit cost? • If the utilization component of trend is negative please provide rationale? • Please explain any negative unit cost trends? 	<p>Aggregate trend values by rating category are presented in the Data Book. No additional breakdown will be provided. Negative trends were only assumed for unit costs where the State identified opportunities for increased use of lower cost providers. Trends were developed based on a review of historical utilization and cost levels for each rate cell and service category.</p>
<p>102. Section: Managed Care</p> <ul style="list-style-type: none"> • To what extent was the population managed in each of the 3 FYs? • What clinical and/or cost programs were assumed in the managed care savings factors? 	<p>Nebraska Medicaid provided managed care for behavioral health services by contracting with Magellan Behavioral Health, an Administrative Service Organization (ASO) through a non-risk based contract. Magellan coordinated, managed and provided access to mental health and substance abuse services to Medicaid eligible clients during this 3 year period.</p> <p>See response to question #83.</p>

QUESTIONS	ANSWERS
<p>103. Section: Program Changes</p> <ul style="list-style-type: none"> • Where there any operation or administrative changes to the MCD behavioral health program in any of the FYs that would have impacted the spend? • Were programs added to encourage BH therapies? • Is the state considering adding any programs in the projection year that may not be reflected in the rates? 	<p>See RFP Attachment C.</p>
<p>104. Section: Public Policy</p> <ul style="list-style-type: none"> • Please explain in detail the differences between FY11 and FY12 for public policy. • What is the impact of IBNR on FY11 & FY12?? for public policy? 	<p>The State does not understand the question; therefore, a response cannot be provided. Please provide additional information in Round Two questions.</p>
<p>105. Will there be accommodation for the 7% SG&A CAP for the first year start-up costs?</p>	<p>See response to question #23.</p>
<p>106. Who will be responsible for outpatient labs? Generally the MBHO doesn't contract with lab service providers and MHNet excludes this from its financial responsibility.</p>	<p>The PH MCO will be responsible for outpatient lab services.</p>
<p>107. How many years has incumbent (Magellan) managed the behavioral care?</p>	<p>Since 2002.</p>
<p>108. What is the incumbent (Magellan) ASO fee for the current managed care populations?</p>	<p>\$1.78 per member per month.</p>

QUESTIONS	ANSWERS
<p>109. What populations are managed by the incumbent MBHO under the current ASO agreement?</p>	<p>The Medicaid eligible clients in 482 NAC 5-001.01 are required to participate in Behavioral Health managed care unless excluded. The following clients are excluded from participation:</p> <ol style="list-style-type: none"> 1) Clients residing in nursing facilities; 2) Clients residing in Intermediate Care Facilities for the Mentally Retarded (ICF/MR); 3) Aliens who are eligible for Medicaid for an emergency condition only; 4) Clients participating in the Refugee Resettlement Program; 5) Clients receiving services through a Home and Community-Based Waiver (HCBS); 6) Clients who have excess income; 7) Clients participating in the State Disability Program; 8) Clients during the period of presumptive eligibility; 9) Transplant recipients; and 10) Clients who have received a waiver of enrollment.
<p>110. Can you please explain why the persons classified as Katie Beckett eligible had \$0 behavioral spending in FY10 and FY11?</p>	<p>There were no expenditures for Katie Beckett clients in FY10 and FY11 for Behavioral Health services.</p>
<p>111. Can you please clarify Disproportionate Share Hospital Payments? How is this process handled?</p>	<p>Disproportionate Share Hospital payments are handled outside this RFP.</p>
<p>112. Please clarify whether the behavioral services provided by primary care or medical providers are excluded from the MBHO responsibility?</p>	<p>No, Behavioral Health services provided by primary care or medical providers are not excluded.</p>
<p>113. Across all products the average managed care savings factor is -8.4%. Given that these members have been under a managed care program, please provide the rationale for the high managed savings calculation used for the cap rate development.</p>	<p>See response to question #83. Additionally, the current ASO program is not a risk-based contract arrangement.</p>
<p>114. Section: 4.d. Escrow account administration</p> <p>May the costs to administer the escrow accounts be paid out of Escrow funds?</p>	<p>The costs to administer the escrow accounts are expected to be de minimis and a requirement of the contract; therefore will be paid for by the Contractor as a general administrative expense.</p>

QUESTIONS	ANSWERS
<p>115. Section: 5.d.vii Annual CAP rate changes</p> <p>The RFP states that any annual adjustments will be determined by the state and its actuaries. Will the state consider allowing the MCO to be a party to these rate determinations?</p>	<p>MLTC has developed monthly capitation rates that will be offered to bidders on a “take it or leave it” basis. MLTC will collaborate with the BH MCO before the capitation rates are finalized.</p>
<p>116. Section: 6.b. Provider Network</p> <p>a. Item i. Mentions the inclusion of PCPs. Is the BMCO expected to include PCPs in its provider network?</p> <p>b. Item iv. Refers to “The following Deliverables...” There is nothing following this statement. Did the state intend to include additional text here?</p>	<p>a. Yes</p> <p>b. See response to Question 3.</p>
<p>117. Section: 6.c. Member Communication</p> <p>Is the state requesting a draft Nebraska Member Handbook or will an example of a current “model” member handbook be acceptable?</p>	<p>The State will be reviewing and approving a NE member handbook as part of the Member Communication deliverable that will be due under a contract resulting from this procurement.</p>
<p>118. Section: Attachment C</p> <p>Under “Adjustments to the Fee For Service Base Data” states that, “...Treatment Crisis Intervention would be entirely eliminated for persons ages 19 and 20 who will no longer be eligible to receive this service.” These individuals are not eligible for this service because they are now considered adults and, under the M&R workup, adults are not eligible for “Treatment Crisis Intervention”. However, Attachment A lists Crisis Assessment as a covered service for both adults and children.</p> <p>a. Is this a covered service for all age groups?</p> <p>b. If so, should the CAP rates be adjusted to reflect the inclusion of this service for adults?</p>	<p>a. Yes, Crisis intervention is a covered service for adults.</p> <p>b. No as this service is reflected in the “Other” category for adults in Attachment E.</p>
<p>119. Section: Glossary of Terms; Page v-xviii</p> <p>Are the definitions provided in the “Glossary of Terms”, if applicable in the context of provider agreements, required to be incorporated into a plan's provider agreements?</p>	<p>The definitions provided in the “Glossary of Terms” are required to be incorporated into a plan's provider agreements if necessary to comply with the terms of the RFP/contract.</p>

QUESTIONS	ANSWERS
<p>120. Section: Glossary of Terms; Page vi, xii</p> <p>The RFP includes definitions for a Bid Bond and a Performance Bond, but the RFP only references a Performance Bond. We were unable to find any requirements in the RFP for a Bid Bond. Is this correct?</p>	<p>Yes. There is not a requirement for a Bid Bond for RFP 4166Z1.</p>
<p>121. Section: Glossary of Terms; Page xiii</p> <p>The definition of a PIHP cites to 44 NAC Section 4701-4727. This statute is titled "Prepaid Limited Health Service Organization". Can you please clarify whether the program anticipates operation of a PLHSO, rather than a PIHP?</p>	<p>In addition to operation of a PLHSO, the bidder must meet the requirements of Section IV.J.2.</p>
<p>122. Section: III.FF; Page 17</p> <p>If an MCO has already provided a Performance Bond under the physical health managed care program, is it required to provide the full amount of the Performance Bond under this agreement?</p>	<p>Yes, it is required to furnish the full amount of ten million dollars (\$10,000,000.00) for RFP 4166Z1.</p>
<p>123. Section: III.xx; Page 22</p> <p>Is the copy of the disaster recovery and backup plan expected at the time of proposal?</p>	<p>A copy of the "Disaster Recovery/Back Up Plan" should be provided with bidder's proposal response.</p>
<p>124. Section: IV.B.1; Page 24</p> <p>The RFP requires the respondent to describe how the BH MCO will operate as a part of a System of Care in Nebraska to serve persons with mental health/illness and substance use disorder needs without defining the capitalized term. Are there state-specific nuances to the concept that require further clarification?</p>	<p>No.</p>
<p>125. Section: IV.J.9; Page 31</p> <p>For Admin/Staffing positions listed on the same line (ie, Administrator/CEO/COO)- does this mean those positions could be combined?</p>	<p>Yes, as long as the duties are successfully performed in accordance with the job descriptions and the work is performed in compliance with the Contract, multiple responsibilities can be combined within one position.</p>
<p>126. Section: IV.M.1.b.iii; Page 71</p> <p>Does MLTC have a definition of "high risk" or is the Contractor free to define the term as a part of the Clinical criteria?</p>	<p>MLTC will develop the definition of "high risk" in collaboration with BH MCO after contract award.</p>

QUESTIONS	ANSWERS
<p>127. Section: iv.o.11; Page 110</p> <p>Can the state please offer clarification as to the potential financial incentive and/or financial penalty associated with achievement of the performance guarantees?</p>	<p>See response to question #67.</p>
<p>128. Section: IV.P.5.d.vi; Page 128</p> <p>Given certain program changes between 2010 and 2011 (e.g. change in coverage by Medicaid vs. Div. of Children and Family Services vs. Div. of Behavioral Health, cessation of funding for Institutions for Mental Disease), how are these changes reflected in the data book and the proposed rates?</p> <p>In addition, the RFP may be imposing new responsibilities of the Contractor that were not required of the ASO, i.e. the repeated requirements to coordinate or consult with a host of stakeholders including the Regional Behavioral Health Agencies. How are those Medicaid program changes accounted for in the capitated rates?</p>	<p>All adjustments made to account for programmatic changes in the rate development are included in RFP Attachment C.</p>
<p>129. Section: I.V.P.6.b.iv; Page 130</p> <p>This appears to be a format issue or incomplete clause. The clause note "The following deliverables, at a minimum, will be due under a contract resulting from this procurement" without a subsequent list of items.</p> <p>Also, please clarify those deliverables that will be due at the time of Technical Proposal submission vs. those deliverables that will be due under a contract resulting from this procurement.</p>	<p>See response to question #3.</p> <p>Deliverables due at the time of technical proposal submission include 6.a.b. Deliverables, at a minimum, will be due under a contract resulting from procurement include 6c-j.</p>
<p>130. Section: V; Page 143</p> <p>The Proposal Instructions specify that Bidders should identify the subdivisions of "Project Description and Scope of Work". Can the State please clarify which sections of the Proposal the State would like separated into the "Project Description" sections versus the "Scope of Work" sections.</p>	<p>Bidders should identify the subdivisions of "Project Description and Scope of Work" clearly in their proposals. Bidders are expected to submit proposals that reflect their proposed service capabilities in the format requested in the RFP.</p>

QUESTIONS	ANSWERS
<p>131. Section: V.A.3.I; Page 147</p> <p>It appears that subsection "Technical Approach" should be noted as subsection 4, versus V.A.3.I, to correspond to the order of the Technical proposal noted on page 143, V.A.</p>	<p>This is correct.</p>
<p>132. Section: Attachment B – Behavioral Healthcare Capitation Rates</p> <p>Using the restated FY11 data book experience along with the trend, managed care, and 90% medical loss ratio assumptions outlined in the data book, we were unable to reproduce the rates provided in Attachment B. Each rate cell seems to be low by about 3.5%. Were other adjustments applied to get to the rates in Attachment B? Please provide more detail on these other adjustments.</p>	<p>See response to question #82.</p>
<p>133. Section: Attachment C – Data Book – Statewide Managed Behavioral Healthcare; Page 12</p> <p>The rate development uses negative medical cost trends from FY11 to the contract period of -1.5% per year overall. FY12 data should be available, even if it just at a summary level. Please provide more recent experience and demonstrate how it supports the negative trend assumptions.</p>	<p>FY12 data was not used in the development of the capitation rates outlined in Attachment B.</p> <p>The State requires additional detail as to the type of summary level data being requested.</p> <p>See response to question #83.</p>
<p>134. Section: Attachment D – Behavioral Health Managed Care Datafile; Pages 19-23</p> <p>Please explain the material fluctuations in enrollment during the 3 years of experience provided in the data book for some of the rating categories. For example, the Member Months for the Families 0-5 category changed from 684,592 in FY09, to 727,660 in FY10, and 690,381 in FY11.</p>	<p>The Data Book represents the State's best efforts to present the historical membership, utilization and cost levels by rating category and service category. Additional detail on enrollment fluctuations will not be provided.</p>

QUESTIONS	ANSWERS
<p>135. Section: M. CARE, UTILIZZTION AND QUALITY MANAGEMENT; Page 80</p> <p>The RFP states the following in section vi. "Provide a mechanism in which a Member may submit, whether verbally or in writing, a service authorization request for the provisions of services." Please clarify if requests for services can come from the member on behalf of the provider.</p>	<p>The RFP is hereby amended to remove provision IV.M.9.vi.</p>
<p>136. Section: P. FINANCE, REPORTING REQUIREMENTS AND RATE-SETTING; Page 130</p> <p>Per the statement in section b. i. please clarify if the contractor is expected to include PCPs, urgent care centers and ancillary providers in GeoAccess or only those that offer behavioral health services.</p>	<p>See response to question #72.</p>