

ADDENDUM FOUR

DATE: December 11, 2012

TO: All Vendors

FROM: Ruth Gray, Buyer
 State Purchasing Bureau

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

Following is an amended answer to Question 86 submitted for the above mentioned Request For Proposal. This Addendum is to be considered as part of the Request For Proposal.

QUESTIONS	ANSWERS
<p>1. RFP Page 25; Project Description and Scope of Work; IV.D and IV.E</p> <p>Section D.3 states the Aged are eligibles within the scope of work, while Section E.6 states clients with Medicare are excluded. Please clarify the inclusion/exclusion of dual eligibles.</p>	<p>Medicare Savings Program/Qualified Medicare Benefits (MSB/QMB) are the only Medicare eligible clients excluded from Behavioral Health Managed Care. See NAC 469 Chapter 11 for additional information.</p> <p>All other Medicare beneficiaries are included in Behavior Health Managed Care.</p>

QUESTIONS	ANSWERS
<p>2. RFP Page 26; Substitute or Value-Added Behavioral Health Services; G.</p> <p>May a proposed Value Added service include a service that the BH-MCO provides directly (such as on-line education material on self-help methods for treating depression) or must it be a provider-based treatment in which a claim for a specific Medicaid member is generated?</p>	<p>A proposed Value Added service could be one that is directly provided by the Behavior Health Managed Care Organization.</p>
<p>3. RFP Page 37; Member Rights and Responsibilities; K.1.f.vii.b and c</p> <p>These sections require member education on benefits not furnished by the enrollee's PCP and also on benefits not covered under the contract. Please clarify the kinds of services you see the behavioral health Contractor educating the enrollee about, other than behavioral health services.</p>	<p>Per 42 CFR 438.10 Information Requirements, the BH MCO must provide information to enrollees on the BH MCO's referral policies for specialty Behavioral Health Services. In addition, the BH MCO must provide enrollees with information about how and where to access any benefits available under the State Plan.</p>
<p>4. RFP Page 51; Provider Network Development and Management</p> <p>Will vendors be permitted to accept accreditation reports from providers in lieu of a site visit for the purpose of credentialing?</p>	<p>The RFP is amended to read: Section IV. L.2.a.iii: Ensure that all facility providers are credentialed prior to becoming network providers.</p>

QUESTIONS	ANSWERS
<p>5. RFP Page 57; Care Utilization and Quality Management; M.8.a.iii</p> <p>This section requires the Contractor to cover services from a non-network provider if the network provider or other provider determines the services are needed and not all of the services are available within Network. Please clarify that this is subject to prior authorization by the Contractor.</p>	<p>The BH MCO policy could include prior authorization of services from a non-network provider and subject to approval by MLTC.</p>
<p>6. RFP Page 57 and 59; Provider Network; L9.a.i and L.9.b.i.a</p> <p>Requires the Contractor to coordinate emergency and rural services at the regional level with each RBHA. Please clarify the intent of these sections.</p>	<p>The RFP is amended to remove “Delivery of emergency services should be coordinated the regional level with each RBHA” from Section IV.L.9.a.i. Additionally the RFP is amended to remove “and in coordination with the DBH RBHA for that region” from Section IV.L.9.b.i.a.</p>
<p>7. RFP Page 59; Care Utilization and Quality Management; M.9.c.i</p> <p>Requires that post stabilization services remain covered until the Contractor contacts the Emergency Room and takes responsibility for the enrollee. Please clarify that the physical health MCO is responsible for all Emergency Room services, regardless of whether they are post-stabilization.</p>	<p>No, the BH MCO is responsible for coverage and payment of emergency behavioral health services and post stabilization care.</p>

QUESTIONS	ANSWERS
<p>8. RFP Page 60; Care Utilization and Quality Management; M.9.c.ix</p> <p>It appears it is the intent to allow network providers to to pre-approve post stabilization services. Please clarify this approval is limited to the Contractor.</p>	<p>The intent of Section IV.M.9.c. is to comply with 42 CFR 438.114.</p>
<p>9. RFP Page 60; Care Utilization and Quality Management; M.9.c.vi</p> <p>This section implies that screening and treatment for an enrollee after they are stabilized from the emergency condition are required to be covered by the Contractor. Please clarify.</p>	<p>Please see response to question #7.</p>
<p>10. RFP Page 60; Care Utilization and Quality Management; M.9.c.vii</p> <p>Please clarify that it is intended that an enrollee in an Emergency Room setting is determined to be stable by a provider that is not part of the ER setting.</p>	<p>Please see response to question #8.</p>
<p>11. RFP Page 61; Provider Network; L.9.c.xii</p> <p>Please clarify that any of the listed conditions would end the contractor's financial responsibility for post-stabilization care. This means that item c would have an "or" instead of an "and".</p>	<p>Yes, item c should have an "or" instead of an "and".</p>

QUESTIONS	ANSWERS
<p>12. RFP Page 62; Provider Network; L.10.a.ii.d</p> <p>This section requires the Contractor's Care Management program to manage the member's care throughout treatment. Please clarify that care management is not required for services that are not determined to be medically necessary.</p>	<p>Per L.10.a.ii.d, the BHMCO is required to provide care coordination throughout the member's treatment (as long as eligibility is maintained) to transition the member to a service that is medically necessary and appropriate to meet the member's needs.</p>
<p>13. RFP Page 76; Care Utilization and Quality Management; M.5.c.iii</p> <p>This section requires expedited access to Medicaid services following discharge from care coordination by the physical health plans. Please clarify. Do you really mean that the Contractor must collaborate with the physical health plans to ensure appropriate and expedited access for members that receiving care coordination services from the physical health plans, community health plans and FQHCs?</p>	<p>Section IV.M.5.c.iii. requires the BH MCO to support expedited access to covered and medically necessary behavioral health services, which means collaboration with the physical health MCO's.</p>

QUESTIONS	ANSWERS
<p>14. RFP Page 76; Care Utilization and Quality Management; M.5.c.iv and v</p> <p>These sections required expedited access to covered and medically necessary Medicaid service after discharge from the federal Indian Health Service and the Nebraska Pharmacy Program. To our knowledge, there were not be an occasion when the member would be discharged from these services and remain eligible for Medicaid. Please clarify.</p>	<p>The RFP is amended to remove Section IV.M.5.c.iv and v.</p>
<p>15. RFP Page 77; Care Utilization and Quality Management; M.5.a.ii</p> <p>The RFP states: "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." Will a PCP prescribing psychotropic medication be required to receive authorization from the BH-MCO?</p>	<p>No.</p>
<p>16. RFP Page 79; Care, Utilization & QM, Utilization Management; IV.M.9.c</p> <p>Will the state allow the BH-MCO to request that ERs, providers, or hospitals contact the BH-MCO for initial authorization prior to admission to inpatient hospitals?</p>	<p>The BH MCO policy could include this requirement, and is subject to approval by MLTC.</p>

QUESTIONS	ANSWERS
<p>17. RFP Page 91; Care Utilization and Quality Management; 12.a.vi.a</p> <p>This section indicates the Contractor will survey all members and members with complex needs. Please clarify that two member surveys are required, as one is a subset of the other.</p>	<p>Yes, two member surveys are required; one for all members and one for all members with complex needs.</p>
<p>18. RFP Page 96; Care Utilization and Quality Management; M.12.ix.a.xxv</p> <p>This section requires reporting on ER utilization, using benchmarks and age breakouts. Since the Contractor is not responsible for ER services, please clarify how this information will be obtained.</p>	<p>Reporting of ER utilization is required as clarified in response to question #7.</p>
<p>19. RFP Page 98; Care Utilization and Quality Management; M.12.d.ii</p> <p>The RFP outlines a QAPI Committee containing 22 individuals (6 of whom are non voting). Since this big of a committee indicates the meeeting will be informational instead of a working committee, much of the work will need to be done in sub-committees. Please clarify that all identified individuals must participate in the QAPI Committee instead of subcommittees to the QAPI Committee.</p>	<p>The QAPI committee members and tasks are based on the policies and procedures of the BHMCO and must be approved by MLTC.</p>

QUESTIONS	ANSWERS
<p>20. RFP Page 102; Care Management and Coordination Information; 5.b.i</p> <p>Question 65 of the Q&As has a response to ammend the language in 5.b.i. Did the State mean to strike the sentence "if medications are prescribed, the Contractor must obtain a list of medications prescribed by primary care providers (PCPs) and other specialists for a complete and reconciled medication list that is updated every 90 days."?</p>	<p>Yes.</p>
<p>21. RFP Page 112 and 113; Quality Management</p> <p>Pages 112 and 113 reference Ambulatory follow up within 7 and 30 days of discharge from 24-hour facility (inclusive of acute inpatient, PRTF and residential) and requires measurement using current NCQA HEDIS specifications. Current HEDIS specifications does not use PRTF and residential in the calculation of Ambulatory follow up with 7 or 30 days. Will the behavioral health organization be required to provide a modified HEDIS measure (inclusive of acute inpatient, PRTF and residential) or the current NCQA HEDIS technical specification using acute inpatient only?</p> <p>Additionally, if the intent is to use a modified HEDIS definiton, please clarify how the benchmarks will be modified.</p>	<p>The performance measure specification will be developed in collaboration with the awarded bidder after contract award.</p>

QUESTIONS	ANSWERS
<p>22. RFP Page 113 and 95; Performance Measurement; n.11.v.9 and M.12.ix.a.3.xiv</p> <p>This section requires Emergency Room data not collected by the contractor because the contractor does not pay ER claims. Please clarify that the physical health plans will be required to provide detailed ER claim data in order that the Contractor may perform this calculation.</p>	<p>Please see response to question # 18.</p>
<p>23. RFP Page 114; Performance Measurement; N.111.v.10</p> <p>This measure requires the Contractor to tract involuntary admissions. Please clarify what is meant by "involuntary admissions" and the source of such data.</p>	<p>The RFP is amended to remove Section IV N.11.a. Item # 10.</p>
<p>24. RFP Page 114 and 115; Quality Management</p> <p>Pages 114 and 115 reference HEDIS measures for Prescribed Attention Deficit Hyperactivity Disorder (ADHD) and Initiation and Engagement of Alcohol and Other Drug. Will the managed behavioral health organization only be responsible for the performance of the behavioral health providers with respect to these indicators?</p>	<p>See response to question # 21.</p>

QUESTIONS	ANSWERS
<p>25. RFP Page 117; Performance Guarantees and Incentives; IV.N.11.a.16</p> <p>The gurantees and Incentives require an "Annual Facility Survey", yet on page 91 requires a "Provider Survey". We would interpert a provider survey to include satisfaction of all providers, an a facility survey to only include hospitals, residential centers, etc. Please clarify what is meant by facility in this context.</p>	<p>The IV.N.11.a. Performance Guarantees and Incentives require an annual professional provider satisfaction survey and an annual facility satisfaction survey. These two surveys meet the provider survey requirements on page 91.</p>

QUESTIONS	ANSWERS
<p>26. RFP Page 134; IV.J - Business Requirements: Describe your BH MCO's policies and procedures to ensure safeguards are in place which are at least equal to the Federal Safeguards of 41 USC 423, section 27; IV.J. - Business Requirements: Describe your BH MCO's policies and procedures to ensure safeguards are in place which are at least equal to the Federal Safeguards of 41 USC 423, section 27.</p> <p>We request clarification on what the State wants to see in response to the following provision under standard IV.J – Business Requirements from the RFP: “Describe your BH MCO's policies and procedures to ensure safeguards are in place which are at least equal to the Federal Safeguards of 41 USC 423, section 27.” 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?</p>	<p>It is the intent of MLTC that comply with the State Conflict of Interest Safeguards in that the BH MCO may not contract with the state unless such safeguards at least equal to federal safeguards (41 USC 423, section 27) are in place.</p>

QUESTIONS	ANSWERS
<p>Question 26 continued:</p> <p>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>27. RFP Page 134; Methodology and Work Statement; IV.L. 7th on the page</p> <p>This question refers to 41 USC 423, Section 27 which relates to "Restrictions on disclosing and obtaining contractor bid or proposal information or source selection information". How is this applicable to the potential vendor?</p>	<p>Please see response to question # 26.</p>
<p>28. RFP Page 136; Provider Network Development and Management; 12</p> <p>"Describe the timelines for credentialing and contracting and reports demonstrating your BH MCO's performance in compliance with these timelines..." Is this asking for the vendor to produce reports demonstrating compliance? Or is this asking for the vendor to describe reports that will be used to demonstrate compliance in the future?</p>	<p>Bidders must describe reports that will be used to demonstrate compliance in the future.</p>

QUESTIONS	ANSWERS
<p>29. RFP Page 137; Provider Network Development and Management; 26</p> <p>Please confirm that the "network provider protocols" you would like addressed in this section refer to the items listed on page 65-66, Item 14.</p>	<p>Yes</p>
<p>30. RFP Page 138; Provider Network Development and Management; 32</p> <p>"...describe you BH MCO's process to insure appropriate communication with the provider, follow-up communication with the member's PCP, and follow-up care for the member." Does the reference to PCP in this question refer to the member's primary behavioral health provider rather than medical PCP?</p>	<p>The reference to PCP in this question refers to the members medical PCP.</p>

QUESTIONS	ANSWERS
<p>31. RFP Page 141; Care, Utilization and QM</p> <p>The RFP states: Describe the content of your BH MCO's BH medical record, including the utilization control requirements and compliance with 42 CFR 456.42 CFR 456 describes utilization control requirements for facilities and includes a section on requirements for the facilities' written plan of care. Would the state like us to describe the content of the bidder's care management record (which contains the BH MCO's authorization information and description of treatment provided by the provider) or the content of the providers' medical record (which contains the providers notes about the treatment of the member)?</p>	<p>Bidders must describe the content of the BH MCO's care management record, including compliance with 42 CFR 456.42.</p>
<p>32. Attachment A; Medicaid Covered Services</p> <p>Under Adult Outpatient Assessment and Treatment, there is coverage provided for Psychiatric Nursing (in-home). Please clarify when the services are covered by the behavioral health contractor and when in-home nursing is covered by the physical health or in-home services vendor.</p>	<p>When the service is the Psychiatric Nursing service (which is a 1915(b)(3) waiver service), it is covered by the BH MCO.</p>

QUESTIONS	ANSWERS
<p>33. Q&A; Questions and Answers; 116</p> <p>The response to Question 116 indicates the Contractor is expected to include PCPs in its provider network. In other instances, Q&As have clarified that PCPs are not required in the network. Please clarify.</p>	<p>The Behavioral Health MCO must cover services outlined in Attachment A when medically necessary. When these services are provided by the PCP, the BH MCO must cover. (For example when Invega Sustenna is administered by the PCP, it would be covered by the BH MCO.)</p>
<p>34. Questions and Answers; Questions and Answers; #44 re: RFP Page 73; Section: Care Management, M.4.b.ii.(e)</p> <p>The response states "The State requires more information to respond to this question, as the response to this question would depend on the type of care management support function." To clarify, could certified peer specialists working as part of the contractors Care Management/Care Coordination program provide interventions such as programs to support shared decision making with patients, their families, and the patient's representatives, activities to prevent avoidable hospitalizations, education and participation in self-management programs, wellness and health promotion activities, supports to promote empowerment, and advocacy, be considered care management support activities and therefore meet criteria for the QI Admin Charge described on RFP pg. xv 1.a. and c.?</p>	<p>Peer specialists are considered value-added services and would not be considered care management support activities and would not meet the criteria for the QI Administrative Charge.</p>

QUESTIONS	ANSWERS
<p>35. Questions and Answers; Sue Mimick</p> <p>The response states that "services provided by primary care or medical providers are not excluded." This is a double negative - please clarify the exclusion/inclusion of primary care and physical health provider services.</p>	<p>See response to question #33.</p>
<p>36. Questions and Answers; Questions and Answers; 112</p> <p>This response suggests that behavioral health services provided by physical health providers are covered by the BHO. Is this response limited to the services in Attachment A? If so, will the vendor be permitted to hold a physical health provider to the same credentialing standards we have for traditional behavioral health providers and psychiatrists?</p>	<p>See response to question #33.</p> <p>Yes, the BH MCO will have to meet the credentialing standard outlined in IV.L.2.</p>
<p>37. Questions and Answers; Questions and Answers; 116.a</p> <p>Does the PCP here mean a behavioral health primary practitioner as suggested by the response to question #32? Or does it refer to the definition of PCP in the defined terms?</p>	<p>PCP refers to the PCP definition in the GLOSSARY OF TERMS.</p>

QUESTIONS	ANSWERS
<p>38. Questions and Answers; Questions and Answers; 32</p> <p>Your response clarifying that the term primary care as used in this RFP suggests that throughout the RFP, references to the PCP may be the primary behavioral health provider rather than the physical health provider. Please identify any instances where the intent of the RFP is to refer to the medical PCP.</p>	<p>See response to question #37.</p>
<p>39. Round 1 Question; RFP Page 100; Section: Health Information Systems- Encounter Data, N.3.c. Should "all services provided to the member" instead read, "all covered services provided to the member?"; Round 1 State Response: Yes</p> <p>Round 2 Question: Please clarify that the MBHO would not be required to send denied claim information in the encounter files. For example, if the MBHO denies claims for non-covered services, wouldn't the State want to see those too?</p>	<p>The BH MCO is required to send denied claims information in the encounter file.</p>

QUESTIONS	ANSWERS
<p>40. Round 1 Question 65; RFP Page 102; Section Care Management and Care Coordination Information Will the State require the PH plans to obtain the signed Authorization to Disclose statement from the member to disclose MH/SA disorder treatment to PCPs that would allow the Contractor to fulfill this duty in compliance with State and Federal Law?; Round 1 State Response: 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. The RFP is hereby amended to remove e., f. and g. in Section IV.N.5.</p> <p>Round 2 Question: We understand that the State is providing monthly downloads of pharmacy data to the contractor. In order to provide the most optimal level of concurrent care coordination the State is requesting, we would like to receive this data on a daily basis. Would that be possible? If not, how often could it be provided?</p>	<p>The pharmacy data file can be provided weekly as claims are adjudicated in the MMIS on a weekly basis.</p>

QUESTIONS	ANSWERS
<p>41. Round 1 Question 66; RFP Page 103; Section: Claims Payment, N.7.a.i; Round 1 State Response: Yes. The contractor will be responsible for paying Medicaid covered behavioral health claims and any substitute or value added services.</p> <p>Round 2 Question: Please clarify that this refers to those services provided by behavioral health providers only and that processing claims payments to PH providers (PCPs and freestanding lab claims would be processed by the PH MCO).</p>	<p>The Behavioral Health MCO must cover services outlined in Attachment A when medically necessary.</p>
<p>42. Round 1 Question 99; Section: Do members sign a coordination form during the enrollment process so that coordination of care is managed efficiently across all levels of care?; Round 1 State Response: No. The member does not sign a coordination form during the enrollment process.</p> <p>Round 2 Question: Can this be added to the State's process with the inception of the new contract as a best practice to ensure coordination of care from the onset of treatment?</p>	<p>MLTC will consider implementing this process in the future.</p>

QUESTIONS	ANSWERS
<p>43. Round 1 Question 33; RFP Page 32; Section: Section Business Requirements, J.12 Clinical Laboratory Improvement Amendment – please clarify the relevance of this section for this behavioral health RFP; Round 1 State Response: 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>Round 2 Question: In the States response to question 106, lab is not included in the cap. Will this be removed from the RFP since the MBHO is not responsible for freestanding lab services?</p>	<p>Laboratory services are included in the capitation rate. See Attachment D.</p>

QUESTIONS	ANSWERS
<p>44. Round 1 Question 100; Section: Section: Data Accuracy It is stated that the incurred dollars have been reconciled; however, there may be inaccuracies in the underlying data. Can you quantify the variance for each FY? If data inaccuracies may be present, please indicate the likely category/area of any discrepancy?</p> <p>Are services represented only for BH providers or are there PCP services included that may not traditionally be risk for MBHOs.;</p> <p>Round 1 State Response: 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. Round 2 Question: You have indicated the data represents services provided by behavioral healthcare providers only (no PCP or lab utilization).</p> <p>The State contradicts itself in Round One answers by stating lab and PCP BH services are both in and <u>not in</u> the cap.</p>	<p>See Attachment D for the listing of services included in the capitation rate. Also see page 4 of Attachment C. See also response to question # 33.</p>

QUESTIONS	ANSWERS
<p>Question 44 continued:</p> <p>Please confirm that BH services provided by a PCP and lab work performed by free-standing labs (i.e., not in the provider's offices) are excluded from the capitation to be consistent with the exclusion of this data from the Data Book.</p>	<p>Answer on previous page.</p>
<p>45. Round 1 Question 109; Round 1 State Response: The response lists 10 categories of Medicaid clients excluded under the current ASO contract with Magellan. Round 2 Question: Will these 10 categories of clients also be excluded under the new managed Medicaid program?</p>	<p>No. The category of clients excluded from Behavioral Health Managed Care are listed in section IV.E</p>
<p>46. Will developmentally disabled individuals who are living in the community be included in the covered population? If not, what is the cutoff definition for eligibility/ineligibility?</p>	<p>Yes, clients receiving services through the 1915(c) waiver are included in Behavioral Health Managed Care.</p>
<p>47. Can MBHO negotiate rates with providers for less than the Medicaid fee schedule?</p>	<p>Yes.</p>