

Pete Ricketts, Governor

ADDENDUM NINE QUESTIONS and ANSWERS

Date: December 17, 2015
To: All Bidders
From: Michelle Thompson/Teresa Fleming, Buyers
AS Materiel State Purchasing Bureau
RE: Addendum for Request for Proposal Number 5151 Z1
to be opened January 5, 2016 at 2:00 p.m. Central Time

Questions and Answers

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. It is the Bidder's responsibility to check the State Purchasing Bureau website for all addenda or amendments.

Materiel Division • Marilyn Bottrell, Administrator

<u>Question Number</u>	<u>RFP Section Reference</u>	<u>RFP Page Number</u>	<u>Question</u>	<u>State Response</u>
1.			Considering that the Coalition for Community Pharmacy Action (CCPA)'s independent study of the cost to dispense based on 2013 data found the national cost of dispensing to be \$10.55 and the cost of dispensing in Nebraska to be \$10.62, what specific methodology was cited in "discussions with the state and research of other states" (per answers to various Question 37 and others in Round 1) to justify dispensing fees of \$2.50 for chains and \$4.45 for independents with less than six stores?	Please see response to Addendum 6, Question #37.
2.			What specific data-driven rationale and/or empirical research was cited in "discussions with the state and research of other states" (per answers to various Question 37 and others in Round 1) to justify differentiating dispensing fees for chain vs. independent pharmacies?	Please see response to Addendum 6, Question #37 for independent and non-independent pharmacy assumptions. For the purpose of capitation rate development for Heritage Health, the State's actuaries used the experience of another Midwestern state on its transition to a managed pharmacy benefit. This state experienced a significant drop in dispensing fees, below the fee used in the development of Heritage Health rates. This, along with discussion with Nebraska's pharmacy team served as the basis for adjusting non-independent pharmacy expenditures downward to account for lower dispensing fees.
3.			How will the Department ensure that pharmacies that do not fall under the category of an "independent pharmacy" will be paid dispensing fees	For nearly all other Heritage Health services, no rate floor exists. Reimbursement for pharmacy must consider both ingredient and dispensing fee components. Recognizing the unique nature of the pharmacy program MLTC has provided additional protections for pharmacy services, including

			that adequately cover their cost of dispensing?	requirements regarding timely updates to ingredient cost reimbursement and MAC transparency within the contract, as well as the minimum dispensing fee for smaller independent pharmacies. It is also important to note that network adequacy requirements exist to ensure that MCOs contract with a sufficient number of pharmacies based on their membership. MLTC will continue to evaluate these policies to ensure that recipients maintain adequate access to pharmacy services.
4.			Considering that when using cost as a determining factor for classifying specialty drugs, there is an increased risk that either some drugs will be inaccurately classified as specialty drugs, or others that are truly specialty drugs, will be inaccurately excluded, is the Department able to further revise the definition of the term "Specialty Drug" in the RFP?	The State does not intend to revise this term. Please see the Glossary of Terms for the definition of the term "Specialty Drug".
5.			Can you refer me to particular policymakers dedicated to the pharmacy-related provisions of the RFP?	Pharmacy-related provisions of the RFP were developed in conjunction with the MLTC Pharmacy Unit. Final decisions were made by MLTC leadership, including the Director and Deputy Directors. The MLTC organizational chart can be found at: http://dhhs.ne.gov/Org%20Charts/MLTC.pdf
6.	ATTACHEMENT 2 ACCESS STANDARDS		When looking at availability of Providers across both Regions we offer for your consideration as an indicator of access ONE PCP FTE per 10,000 population. This will ensure a more accurate picture as to the actual numbers of practicing and available Providers.	Access standards are set forth in Attachment 2.

7.	ATTACHEMENT 5 POLICIES, PROCEDURES AND PLANS		It is our understanding that “Letters of Intent” are not required as a part of the bidder’s proposal. Is this true? If bidders make this request how should a provider respond?	A letter of intent from bidder(s) is not a requirement of the RFP. Please see Addendum 10.
8.	RFP SECTION Q PROJECT DESCRIPTION AND SCOPE	PAGE 149 PROVIDER REIMBURSEMENT	Will current Medicaid Rates be used to set the base rate for Provider Reimbursement? There is no mention or direction as to what will set the base rate for reimbursement. How will those base rates be determined if the Medicaid Rates are not used?	The MCO may negotiate rates with its network providers, except as otherwise provided for in the RFP. The following sections of the RFP provide specific provider reimbursement requirements: IV.E.16 Family Planning Services IV.Q.4 Indian Health Protections IV.Q.5 Psychiatric Residential Treatment Facilities IV.Q.8. Payment to Out-of-Network Providers IV.Q.9 Reimbursement to FQHCs and RHCs IV.Q.14 Emergency Medical and Post-Stabilization Services IV.Q.16 Pharmacy Reimbursement
9.	Attachment 6/Attachment 19	N/A	Please clarify if the state is requesting samples of all reports in Attachment 6? Or only the 3 listed in Attachment 19, Question 115?	Bidders are required to provide examples of the reports listed in Attachment 19, Question 115. Bidders are not required to provide samples of reports listed in Attachment 6 unless otherwise required in the RFP, Attachments or Addendums.
10.	3. Technical Approach (b)	198	Please clarify if additional attachments allowed (in response to Attachment 19 questions)?	Attachments that are not specifically requested may not be considered in the evaluation process.
11.	Attachment 6	Pg 10	Please clarify if the reference to Section IV.O is a scrivener error? IV.O is not Provider Network.	Attachment 6 is hereby amended and superseded by Attachment 38. Please see Attachment 38.
12.	Attachment 2		Will MLTC be providing access standards for hospitals (non- behavioral health)?	Attachment 2 is hereby amended and superseded by Attachment 39. Please see Attachment 39.

13.	Attachment 6	Pg 1	If MLTC will require bidders to submit templates of all reports outlined in Attachment 6, will the MLTC template or MLTC approved format be provided to bidders for RFP submittal?	Please see the response to Question #9 above.
14.	Attachment 2	Pg 2	Will zip code classification be allowed to demonstrate pharmacy access?	Pharmacy access must be demonstrated in accordance with Attachments 2 and 3.
15.	IV.D.3.a Additional Required Staff	50	Does the following requirement: "Prior authorization staff must include a State-licensed registered nurse or physician's assistant." apply to Pharmacy Prior Authorizations?	Please see Addendum 10.
16.	IV.D.3.j Additional Required Staff	51	We are prepared to locate Member Services functions locally in Nebraska as required on p. 50-51 of the RFP. For clarification, are Member Services functions required to be located in Nebraska inclusive of Customer Service Representatives who staff our toll-free call center?	Customer service representatives staffing the toll-free call center are not required to be located in the State. Please see Addendum 10.
17.	IV.E.11.c Nebraska Medicaid Preferred Drug List	59	Can the State provide the MLTC guidelines for off-label drug use or point to URL?	Guidelines are in accordance with Social Security Act 1927.[42 U.S.C 1396r-8] (g). https://www.ssa.gov/OP_Home/ssact/title19/1927.htm
18.	IV.E.11.c.ii Nebraska Medicaid Preferred Drug List	59	Can the State provide a current copy of the national drug code (NDC) file delegating the preferred or non-preferred status of each NDC?	Current PDL listing by therapeutic drug class can be found at: https://nebraska.fhsc.com/downloads/PDL/NE_PDL.pdf

19.	IV.E.11.c.iii and c.v Nebraska Medicaid Preferred Drug List	59	On c.v. the timeframe appears to conflict with above 1 day requirement stated on c.iii: "The MCO must implement Pharmacy and Therapeutics Committee-reviewed PDL changes posted to the MLTC PDL website on the first day after the 30 calendar day public notice posting of such changes". Please provide further clarification.	The State will provide a biannual PDL file following review by the Pharmacy and Therapeutics Committee, as well as a weekly file with changes to the PDL. With respect to requirements for the weekly file, please see the response to Question #24-Addendum 6. Section IV.E.11.c.v refers to the biannual PDL file.
20.	IV.E.29 Excluded Services	67	Please clarify if state psychiatric hospitals fall under the definition of institutional care and whether services offered to Members in these institutions will be paid by MLTC on a FFS basis. In the event that a member enrolled in an MCO is admitted to a State psychiatric hospital, would the member be disenrolled from the MCO?	Services provided in State psychiatric hospitals are not excluded services per Section IV.E.29. A member would not be disenrolled as a result of an admission to a State psychiatric hospital. Per Section 1905(a) of the Social Security Act, federal financial participation is not available for Medicaid services provided to any individual under age 65 who is a patient in an institution for mental disease (IMD) unless the payment is for inpatient psychiatric services for individuals under age 21. Under this exclusion, no Medicaid payment can be made for services provided either in or outside the facility for IMD patients in this age group. Per Public Law 100-360, an IMD is defined as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in provided diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. The IMD exclusion applies only to institutions with at least 17 beds.
21.	IV.F. 14.d. Member Education	82	Please provide further clarity on Member Education Activities in Provider Offices, and, particularly, how these activities differ from Provider Marketing guidelines outlined in Section G(6)(f). For example, does the restriction against conducting member education in provider offices	The State hereby amends the RFP to remove Section IV.F.14.d on page 82. Providers may display MCO-provided health education materials consistent with the guidelines included in IV.G.6.f.ii. Providers may display MCO marketing materials consistent with requirements in IV.G.6.f.iii.

			apply only to non-existing members of the MCO? In addition, is MCO staff allowed to provide leave-behind branded educational materials (i.e. brochures, flyers) for the provider staff to display in the provider office?	
22.	IV.J.5.e Provider Outreach, Education, and Training	107	Can the State provide clarification regarding its expectations of the provider advisory committee to “create network development and management strategies and procedures”?	The State anticipates that the provider advisory committee will provide MCOs with feedback on policies and procedures that will aid in addressing provider issues including but not limited to: service authorization, credentialing, care coordination, and claims adjudication. The MCO would consult with the provider advisory committee before making major decisions on policy changes regarding its network strategy whenever feasible, and would actively solicit feedback from the group on strategies to improve the administrative experience of network providers.
23.	IV.J.5.e Provider Outreach, Education, and Training	107	Can the behavioral health subcommittee be incorporated within the provider advisory committee (i.e. and not as a separate committee)?	The Behavioral Health Provider Advisory Committee may be considered a subcommittee of the Provider Advisory Committee so long as the Behavioral Health Provider Advisory Committee is comprised of behavioral health providers and providers knowledgeable about behavioral health related issues.
24.	IV.N.11.e.iv.a Restricted Services	132	RESTRICTED SERVICES (aka Pharmacy Lock-in): Assigning a care manager to review, document, and manage the clinical or organizational needs of a member enrolled in restricted services. What if a member does not agree to Care Management, is this mandatory on the member?	Any member identified for care management activities must be offered care management services. In the case of an individual declining care management, the MCO must document this in the member’s record. The MCO must still assign a care manager. The State requires the MCO to provide its proposed policies and procedures for applicable care management activities and any plan for ongoing communication with members who refuse care management.
25.	IV.N.11.e.i Restricted Services	132	"The MCO must be able to implement in it's claims system a restricted services	The State will provide information available in its MMIS for restricted services for each individual enrolled with a

			<p>status for a member and have the ability to communicate this status to MLTC and other MCOs". Please clarify the Party that is sharing lock-in information when a member joins a plan:</p> <p>(A) Is it MLTC sending info on a FFS member only joining the plan? OR (B) Is it MLTC sending both FFS and/or another MCO member joining the plan?</p> <p>If the answer is "A", then is there any requirement for a member who transfers to another MCO? How would this occur?</p>	<p>MCO, including the type of restriction (any combination of pharmacy, primary care provider or hospital). This includes both individuals who have been fee for service and individuals who have been enrolled with another MCO. Restricted services transfer information occurs at the same time as the enrollment transfer and is reported in the supplemental enrollment file.</p>
26.	IV.O.6.f Program Integrity – The MCO and MFAU	136	<p>The RFP states that "The MCO must subrogate to MFAU any and all claims it has or may have, related to Nebraska Medicaid, against pharmaceutical companies, retailers, providers, or other subcontractors, medical device makers, or durable medical equipment manufacturers in the marketing or pricing of their products." Is the intent of this clause to encompass any and all potential subrogation claims, including but not limited to, claims where the MCO may be a member of a class action?</p>	<p>Yes, that is the intent of this requirement.</p> <p>Section IV.0.6.f is hereby amended as follows: "The MCO must subrogate to DHHS any and all claims it has or may have, related to Nebraska Medicaid, against pharmaceutical companies, retailers, providers, or other subcontractors, medical device makers, or durable medical equipment manufacturers in the marketing or pricing of their products."</p>
27.	IV.Q.16.a Pharmacy Reimbursement	153	<p>Can the State provide a list of independent pharmacies from MLTC with corresponding</p>	<p>The State cannot provide a list at this time. The State will provide this information to the awarded MCOs.</p>

			pharmacy NPI? (defined as those with ownership of six (6) or fewer pharmacies), unless otherwise agreed between the MCO and the pharmacy provider?	
28.	IV.Q.16.c Pharmacy Reimbursement	153	"The MCO must maintain in each paid claim record which methodology was used to determine final payment amounts, i.e. state maximum allowable cost, national average drug acquisition cost, or the submitted usual and customary charge." Please confirm that these are examples only and that we can reimburse at Wholesale Acquisition Cost (WAC) or Average Wholesale Price (AWP) methodology.	The MCO must calculate dispensing fees, administration fees, and any other fee payment amounts as approved by the State. A MCO must maintain in each paid claim record which methodology was used to determine final payment amounts. The approved methodologies include: State maximum allowable cost, national average drug acquisition cost or the submitted usual and customary charge. The State will allow other standard national drug pricing.
29.	IV.Q.17.f.iii Maximum Allowable Cost Program	153	"If an update is warranted, the MCO must make the change retroactive to the date of service and make the adjustment effective for all pharmacy providers in the network." Does this requirement apply even if a pharmacy did not contest the MAC price?	If reimbursement rates are contested and as a result, are increased, this retroactive adjustment must be posted on the MCO's public website and available for all network pharmacies to reprocess claims retroactively.
30.	IV.S.4.h.ii Provider Identifier	166	"The MCO must deny prescriptions written by prescribers who are not enrolled with Nebraska Medicaid." What about members traveling out of state in emergency situations? What about Rx's written in hospital Emergency	Please see Provider Bulletin 12-36: http://dhhs.ne.gov/medicaid/Documents/pb1236.pdf The State will provide a weekly Medicaid-enrolled provider file.

			departments? Please describe how an MCO can regularly receive an up-to-date listing of Medicaid providers so that this requirement can be met.	
31.	IV.X.7.b Transitioning from the MLTC FFS Pharmacy Program to the MCO Pharmacy Program	189	"The MCO must load to its pharmacy claims processing system the current prior authorization records from MLTC or its designee prior to the contract start date." Can the State provide a sample file layout and data dictionary to ensure all of the necessary elements are included (i.e. authorization start and end dates)? Would the MCO obtain all FFS Pharmacy claims information for members transferring from FFS? If a member is in a FFS Lock-in Program and transfers to the Plan, will the MCO get this information in the data file? Is the MCO expected to continue the lock-in?	The State is not able to provide a sample file layout and data dictionary as the State does not have this information. The fields may be developed in the spring with MMIS and shared with MCOs during readiness review. The State will provide the needed data to meet this requirement. The State will provide historical pharmacy claims available in its information system for each individual enrolled with the MCO, including fee-for-service claims. The State will also provide information on restricted services for each individual enrolled with the MCO, including the type of restriction (any combination of: pharmacy, hospital, or primary care provider). MCOs are required to use this information to continue restricted services. The MCO's restricted services policies and program must be in compliance with requirements in Section IV.N.11 Restricted Services, including but not limited to implementing a restriction program consistent with the provisions of 471 NAC 2. Per Attachment 5, the MCO must submit its proposed policies and procedures for approval of restricted services 45 days prior to the contract start date. This proposal must also include a procedure that verifies enrollees in a restricted status are able to access services provided by only approved providers by the contract start date.
32.	Capitation Rate Development - General	Attachments 20 and 23	The capitation rate development in Attachment shows annualized gross medical per member per month trends by rate cohort. Attachment 23 shows annualized medical expense trends by category of service (COS) by category of aid (COA). Please show a cross-walk of how trends by COA	No, the same COS trends were not applied to all rate cohorts within a given COA. Trend assumptions by COS and detailed rating cohort will be provided in early 2016. Please see Attachment 36 for a crosswalk of the rating cohorts into the broad COAs.

			and COS may be reconciled to develop and cross-check the final projected medical expense. Were the same COS trends applied to all rate cohorts within any given COA?	
33.	Capitation Rate Development - General	Attachments 20 and 23	Please show the separate cost and utilization components of the medical expense trends for COA and COS.	As outlined in the "NE – Heritage Health Second Bidder's Conference Presentation – Optumas", utilization trend and unit cost will be provided to awarded MCOs when the final rates are developed in early 2016.
34.	Amendment 6 Question #79	P.27 in the Amendment	Please provide further clarification the Amendment six answer to question 79: "MCOs may negotiate supplemental rebates for medications outside of the State's PDL. MCOs are prohibited from negotiating supplemental rebates for any medications listed in the State's PDL."Do the restriction on negotiating Supplemental rebates for PDL Drugs apply only to "Preferred Drugs"? or to both Preferred and Non-Preferred PDL Drugs?	Covered outpatient drugs include drugs on the Nebraska Medicaid PDL (preferred and non-preferred) and drugs not on the PDL. The PDL consists of drugs within multiple therapeutic drug classes. The MCO may not negotiate supplemental rebates for preferred or non-preferred drugs within the PDL therapeutic drug classes covered by the Nebraska Medicaid PDL.
35.	Amendment 6 Question #37	P. 15 in the Amendment	Please provide further clarification to Amendment six, response to question 37, which specifies a \$2.50 dispensing fee to "Non-independent" pharmacies. Is this a mandatory minimum dispensing fee or can we apply lower dispensing fee reimbursement to pharmacies that may already be	The \$2.50 dispensing fee was assumed for non-independent pharmacies for capitation rate development. While there is not a mandatory minimum dispensing fee reimbursement to non-independent pharmacies, the MCO and its PBM must receive active agreement from the pharmacy for participation in the Medicaid network, even if they have an existing contract for non-Medicaid services. Please see Section IV.I.8.b in the RFP.

			contracted with the PBM?	
36.	Amendment 6 Question #210	P. 68 in the Amendment	Answer to Question 210 states: "RFP 5151 Z1 only applies to the MLTC Division." Please confirm that in the event the Legislature were to move responsibility for children in the juvenile justice system back to the Department that MCOs will be responsible only for the same Medicaid costs for these members as when they were under the jurisdiction of the Probation Office.	The MCO will be responsible for the services in the benefits package for Medicaid eligible clients enrolled in the health plan. This responsibility would not be impacted by potential administrative changes regarding the juvenile justice system.
37.	Attachment 19		Please provide the State's definition of an "affiliate", as that term is used in the RFP.	For the purpose of this RFP requirement, an affiliate is considered any person, firm, corporation (including, without limitation, service corporation and professional corporation), partnership (including, without limitation, general partnership, limited partnership and limited liability partnership), limited liability company, joint venture, business trust, association or other entity or organization that now or in the future directly or indirectly controls, is controlled by, or is under common control with the MCO.
38.	Response to Q &A #301, Attachment 6, Reporting Requirements, and Section IV.T, Reporting and Deliverables.	178	When we originally read and interpreted the RFP Section IV.T and Attachment 6 around the audit requirements, we interpreted the combination of the sections that follow to mean that the annual financial audit conducted of the contracted insurer for purposes of the Nebraska Department of Insurance requirement, which does include obtaining management letters and any	See Attachment 38.

			<p>applicable audit recommendations, would be acceptable for the audit requirement and timeline from the following example: For the contract year ended 12/31/2017, the submission of audited financial statement could be submitted on June 1, 2018, consistent with the audit timing filing with the Nebraska Department of Insurance. However, after reading the response to #301 we are questioning our prior conclusion and requesting further clarification.</p> <p>Upon reading the response to #301, which confirms the Nebraska Department of Insurance filing date (from p.10 of Attach 6) has been amended to read June 1, the response also states that "the deadline for the Audited Financial Statement is 30 calendar days following the 12th month of the contract year". We respectfully request clarification if this response is intentional, and if the Audited Financial Statement (from p.9 of Attach 6) is intended to be the same or different audit requirement? If 30 days after the 12th month of the contract year is intended to mean January 30, 2018 submission of an audited financial statement for</p>	
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			<p>the contract year ended 12/31/2017, we respectfully request that be reconsidered as that is a very unusual and aggressive timeline that is unlikely feasible under normal business circumstances. Typically, the full 45 day reporting period is utilized (for example, the time period associated with the quarterly financial reporting required per p.7 of Attachment 6), and there is typically a longer period for preparation of annual financial statements, such as an additional 15 days for a total of 60 days. Then, when there is an audit requirement, there is additional time that is required to allow for the external auditing firm to conduct its fieldwork, testwork, quality control, and audit report issuance processes. For the statutory financial statement audit, this period is three months from the date the statement subject to audit has been prepared (e.g., 2017 contract year financials prepared by the entity by March 1 and then audited by the external audit firm during March-April, and finished in May to allow for the issuance of the audit report by June 1). We respectfully request clarification whether there is a</p>	
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			single audit requirement and if the deadline is submission of the audited statutory financial statement, management letter, and any audit recommendations by June 1. Our recommendation is for a single audit financial statement audit requirement that already exists for purposes of the Nebraska Department of Insurance.	
39.	Q	150	Under a value-based provider contract, will the State make allowances for provision of services for which no current encounterable procedure code exists? For example, if the provider/MCO identifies and addresses a member need that likely leads to better health outcomes, but that service is not a covered benefit, is there a mechanism such that the MCO is not “penalized” in the minimum MLR requirement?	<p>A qualifying expense for purposes of the MLR calculation must fall under the categories listed in Attachment 15 – Medical Loss Ratio Requirements.</p> <p>Value-based contracting is an evolving concept and MLTC will review policy decisions based on future CMS guidance.</p>
40.	Q	150	In a value-based provider contract, will the value of the contract be included in the MLR requirement, or the encountered services only?	<p>Only encountered services will be included for purposes of the MLR calculation.</p> <p>Value-based contracting is an evolving concept and MLTC will review policy decisions based on future CMS guidance.</p>
41.	5151Z1 Addendum Seven for Questions and Answers - 221-382	N/A	Please clarify if the vision data includes medical/surgical vision expenditures or merely routine exams, hardware, etc.?	Vision data includes medical/surgical vision expenditures in addition to routine eye exams, hardware, etc.
42.	5151Z1 Addendum	Q. 101	The answer to this question	The 0.25% State Performance Penalty is not a component

	Six for Questions and Answers - 1-220		refers to the answer to question 33, which does not address the State Performance Penalty. Please confirm that amounts both earned and unearned of the State Performance Penalty are factored into the Administrative Cap calculation, in a similar fashion to the QPP holdback.	of the 10% Administrative Cap calculation.
43.	5151Z1 Addendum Six for Questions and Answers - 1-220	Q. 158	Please describe how the savings estimates for the Dual population were developed. What was the benchmark state(s) and what was the data source used to determine that level of savings on a Dual population (where the MCOs are not primary in managing members' care) in the first year of a new program.	Savings estimates for the Dual population are based on the prevalence of Behavioral Health services and anticipated changes in Physical Health experience when the two services are delivered under an integrated program. Duals frequently have a high need for Behavioral Health services, and the databooks provided in Attachment 10-C confirm this for the Heritage Health Dual population. When the care for these Dual enrollees is integrated under one delivery system, it is anticipated that better outcomes for Physical Health needs will occur, leading to a reduction in Physical Health utilization.
44.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q. 217 and Q. 265	In the answer to these questions, it is stated that all costs within the window are included in the delivery kick payment. However, there are no values included for behavioral health services or pharmacy. Please explain why this would be the case.	These costs are currently not included in the supplemental maternity payment, but are included in the standard rating cohort in which the member resides absent of a delivery event. Behavioral health and pharmacy costs will be included in the supplemental maternity payment in Heritage Health contracts.
45.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q. 221	The answer to this question states "The UNMC amount built into the capitation rates will remain the same throughout the <u>entire contract period</u> ." Please clarify that this is a typo, and that this portion of the capitation rates will be recalculated each year	The answer to Addendum 7, Question # 221 is amended as follows: The application of risk scores will not begin until the second contract period, 1/1/18-12/31/18. The State and its contracted actuary will work together in determining the best risk adjustment methodology to use at that time. The Minimum MLR will be in effect beginning on the contract start date and will be calculated on an annual basis between

			as part of the rate development and certification process.	6-9 months after the end of the contract year. Although the MLR will be settled annually, as mentioned in Attachment 15 “the MCO must calculate the MLR and submit it to MLTC quarterly”. The 85% Minimum MLR requirement will be calculate as an aggregate of Regions 1 and 2 and will be calculated across all categories of aid. The risk corridor will be in effect beginning on the contract start date and will be calculated at the end of each contract period between 6-9 months after the end of the contract year. The risk corridor calculation will be an aggregate of Regions 1 and 2 across all categories of aid. The administrative cap requirement is built into the capitation rates on a prospective basis. The contracted actuary ensured that the amount of non-medical load built into the rates meets the administrative cap requirement. UNMC amounts are revisited each rate cycle, which is typically every 12 months. The contracted actuary developed the UNMC Supplemental PMPM by COA, COS, and Rating Region. MLTC Quality Performance Program and Performance Penalties are effective Year 1 and calculated annually on a 6 – 9 month lag for program end total. Attachment 26:“MLR and Risk Corridor Examples” contains an illustrative example of this scenario. Please see Section IV.P.9.d-e.
46.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q. 221	Please clarify whether or not the revenue and medical expenses for each of the calculations in this question includes UNMC supplemental payments, and if not, why not, especially since MCOs are at risk for these amounts.	All calculations listed in the response to Addendum 7, Question #221 will be applicable to the UNMC portion of the rate development.
47.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q. 231 and 232	Please confirm that, as stated in the Second Pre-Proposal Conference, once the MCOs are selected, the quality metrics are finalized, Optumas will perform an analysis to ensure that paid rates, including the portion of all withholds that is expected to	This is confirmed.

			be reasonably achievable by MCOs, fall within the actuarially sound rate range.	
48.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q. 240	Regarding Critical Access Hospitals: a. Please split out cost settlement (i.e., amounts paid above Medicaid) in the base data. b. Please share the list of adjustments (e.g., trend) and the values that were applied to these settlement amounts when developing the rates in Attachment 11.	The base data contains \$8.3 million dollars in Critical Access Hospital settlement payments made outside of the claim/encounter payment system for FY14 and \$8.1 million for FY15. The Critical Access Hospital settlements are added into the base data. As such, all rate adjustments outlined in Attachment 22 are applicable to the Critical Access Hospital portion of the capitation rate.
49.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q. 243	Regarding FQHCs and RHCs: a. Please provide the 1/1/16 APM payment schedules. b. Please clarify that under the new APM methodology effective 1/1/16, the FQHCs and RHCs will no longer cost settle with the state since the APM will reflect full payment to these facilities.	The 1/1/16 APM payment schedules are not currently available for public release. The State does not cost settle with FQHCs and/or RHCs.
50.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q. 244	Please confirm whether or not historical encounter/FFS data for physical and behavioral health services (i.e., non-pharmacy) under the contract, will be provided to plans upon member assignment.	Please see response to Addendum 7, Question #244.
51.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q. 245	Please clarify whether or not claims broker services will be needed for all services paid though fee for service (even for those members in managed care) in addition to	The Claims Broker will potentially handle all FFS claims. This could include Long-term Services and Supports related claims as those services are not currently included in the Heritage Health program. However, this will be dependent on final timing of CBS implementation and other program decisions regarding LTSS.

			all populations receiving benefits through fee for service. (For example, will long term services and supports be included for those managed care members receiving those services through fee for service?)	
52.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q. 254	In the answer to this question, it is stated that "The rates shown in the "Medical PMPM" columns of Attachment 11 are gross MLTC hold-back" but our calculations (based on the data and assumptions provided by Optumas) do not show that the QPP hold-back of 1.5% has explicitly been added into the rates. Please clarify how the QPP hold-back of 1.5% of premium is added to the rates.	Rates are developed based on reported base data, not capitation payments. Since rates are developed using reported experience, there is no need to add in an additional 1.5%. When the rates are finalized, the State's actuaries will remove the withhold consistent with CMS guidance.
53.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q. 254	Please confirm the value to which the 1.5% is applied to calculate the amount to be deposited into the reinvestment accounts: does this amount include NML? UNMC Supplemental payments? Or is it just 1.5% of the Medical PMPM?	The 1.5% hold back referenced in Section IV.P.10 and required by Neb. Rev. Stat. §71-831 (Attachment 13) is 1.5% of the capitation payment.
54.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q. 257	The answer to this question refers to a different question that does not address the definitions of related parties. Please confirm that all references to related parties for each of the admin cap, risk corridor, and MLR calculation	The response to Addendum 7, Question #257 is hereby amended to read: "See response to Question #53." References to related parties in the RFP refer to the same definition of related parties contained in the Glossary of Terms.

			refer to the same definition of related parties.	
55.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q. 259	Please summarize the values of both adjustments made to the rates for copays: a. Reduction embedded in base data to reflect amounts actually collected by providers over the base years. b. Reduction made during rate development process to reflect additional amounts not collected, but representative of all copays (mandatory and voluntary) being collected.	The reduction embedded in the base data reflecting amounts collected by current MCOs is not available. The amount paid by the MCOs is used as the basis for rate development, so the collected copays are not itemized. The adjustment to account for uncollected copays is a 0.02% reduction to the rates for traditional Physical Health managed populations, a 0.03% reduction for the LTSS populations, and no change for the Dual population.
56.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q. 261	Please provide a detailed list of all of the adjustments made to the encounter data (e.g., CAH settlements, PCP shared risk agreements) that are added in to the base data to reconcile to MCO financial statements.	Please see Attachments 34 and 35 for a complete list of program changes necessary to get from base data shown in Attachment 10 to the final rates shown in Attachment 11.
57.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q. 265	Please clarify that deliveries with a qualifying procedure code which resulted in a stillbirth were not considered to be "qualifying delivery events" and please also confirm how the term stillbirth is defined, including weeks gestation.	The response to Addendum 7, Question #265 is hereby amended and superseded with the following: A qualifying delivery procedure code must be found on an encounter in order for the maternity experience to be captured in the rates. Currently the State does not pay a supplemental payment for stillbirths, so those expenses are not in the supplemental payment and remain in the regular monthly capitation rate. The State pays a supplemental payment for live birth events and only those expenses are in the supplemental payment. When a qualifying delivery event is found in the data, the contracted actuary captures all other expenses for that member in the five months prior to delivery date and the two months post-delivery. All of these expenses are re-categorized from the member's original aid category to the Maternity aid category.

				<p>The maternity cell separately captures maternity-related services for all populations, dating back 5 months from the date of delivery (5 months prenatal) and going forward 2 months after the delivery (2 months post-partum). Prenatal costs for delivery occurring within the first five months of the base data period, and postpartum costs for deliveries occurring within two months of the end of the base data period could be understated in the base data. As a result, an adjustment has been made to reflect the missing prenatal and postpartum services for deliveries occurring on the left and right tails of the base data. The contracted actuary reviewed the average per-member-per-delivery costs for delivery events occurring between December 2013 and April 2015 (step one) and compared these costs with the per-member-per-delivery costs for deliveries occurring July-November 2013 and May-June 2012 (step two). The differential between the deliveries identified in step one and step two was used to adjust costs observed in step two. The overall impact of this is an upward adjustment to the Maternity cell of 1.8%. Maternity experience split by service type can be found in Attachment 10-A and Attachment 10-B by viewing the Maternity aid category. Please note that for this aid category member months are actually deliveries, as the denominator for the supplemental payment is a delivery event, not a covered month. Physician, facility, prenatal, postpartum, and delivery costs can not be independently itemized.</p>
58.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q. 265	<p>Please provide each of the following by rate cell and region:</p> <ol style="list-style-type: none"> 1) A count of qualifying deliveries during the base period 2) The associated dollars removed from the rate cell due to these deliveries <p>Also, to the extent that the total deliveries and dollars removed do not add up to the</p>	Please see Attachment 37.

			total dollars and deliveries used for the maternity kick payment for each of the two regions, please provide a reconciliation to explain the discrepancy.	
59.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q. 270	The answer to this question refers to Attachment 22 and Attachment 20. Please provide 1) a crosswalk that shows how the descriptions in Attachment 22 (narrative) align to the adjustments in Attachment 20 or elsewhere. 2) a new attachment that breaks out each of these impacts as requested, including breaking out the impacts into their COS and COA specific components, ideally also breaking the impacts out between any values included within the base data and applied between Attachment 10 and Attachment 11, and also indicating whether the changes are unit cost changes or utilization changes.	Please see Attachments 34 and 35.
60.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q. 272	Please confirm that the rates have not been reduced for MCO-collected supplemental Rx rebates. These are typically reflected in MCOs' financial statements and if data was adjusted to match these statements, reductions	Rates have not been reduced by rebates. The existing managed care program does not include pharmacy and therefore comments surrounding reported rebates are irrelevant to this rate cycle.

			for rebates could be embedded in the base data.	
61.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q. 313	We know the state indicated that this question would be answered in the second round of questions, but just want to include this question here to ensure that it is not overlooked.	Please see Addendum 10.
62.	Addendum Three: Revisions to the RFP	1	<p>Questions regarding the Auto-Assignment Algorithm</p> <p>1) How long is the initial Heritage Health enrollment period?</p> <p>2) After the initial Heritage Health enrollment period ends, will the auto assignment algorithm take into consideration the enrollee's previous MCO assignment?</p> <p>3) What steps would be taken to ensure that MCOs who contracted with the state prior to the contract period do not get a disproportionate share of members, or a significantly different mix of members than entering plans?</p>	<p>The initial Heritage Health enrollment period will begin October 1, 2016 and end December 16, 2016. Medicaid-covered individuals who have not made a Heritage Health plan choice on December 16 or whose Medicaid eligibility determination is made between December 17 and 31 will be auto-assigned to a Heritage Health plan.</p> <p>The auto-assignment algorithm will not take into consideration previous MCO assignment except in cases where the member is automatically reenrolled in his or her previous MCO because he or she loses Medicaid eligibility for a period of 2 months or less per 42 CFR § 438.56(g) as referenced in IV.B.7.c.ii.b).</p> <p>Per IV.B.3.e, "After consideration of provider-recipient relationships, the methodology will assign recipients equitably among MCOs, excluding those subject to an intermediate sanction." Per IV.B.3.f.iii, "If a MCO's membership is comprised of 40% or more of total statewide enrollment at the end of any quarter, that plan will be removed from the auto-assignment round robin process for the following quarter but members can continue to pro-actively select that plan."</p>
63.	Attachment 21	N/A	Please confirm that the values in this exhibit are shown as a percent of the rate exclusive of the UNMC supplemental payment	Non-medical load will apply to the UNMC portion of the rate when rates are finalized in early 2016.
64.	Attachment 21	N/A	Since the UNMC	Please see the response to Question #63 above.

			Supplemental payments represent increased reimbursement that the MCOs are responsible for and at risk for, why are these not included in the rate development (Att. 11) as a medical costs, so that NML is applied to the amounts as well? We believe the NML percentages should be of revenue inclusive of the UNMC supplemental payments.	
65.	Attachment 22	p. 3	A number of program changes, both historical and anticipated, are described in the narrative. This is very helpful, and we are requesting that additional columns be added in the tables to the right of these descriptions to indicate the impact on the rates, and where that impact can be found (populations, services, base data, policy change factors, etc.) with additional exhibits as appropriate to describe particularly complex adjustments.	Please see Attachment 35.
66.	Attachment 23	N/A	Thank you for providing this additional detail for trends by COA and COS. Please also extend the exhibit to show the trends used for each of the four LTC categories, the Katie Beckett members, and Duals.	Katie Beckett is considered AABD for trend setting purposes. LTC categories and Duals used the same assumptions as the AABD population.
67.	Attachment 26	Example 1	In each of the risk corridor and	This information will be posted to the procurement

			MLR calculations, the qualified medical expenses are shown in the same way, including the activities that improve healthcare quality. Based on the glossary (p. xiii) this amount is defined differently for each of the two calculations, such that activities that improve healthcare quality are not included in net qualified medical expense for the risk corridor.	website no later than December 24, 2015.
68.	Attachment 26	Example 1 and Example 2	Please revise the examples to show how each of the following components of revenue would be handled within these examples: 1) UNMC payments 2) Hold-back (earned and unearned) 3) State Performance Penalty (earned and unearned)	This information will be posted to the procurement website no later than December 24, 2015.
69.	Attachment 26	Example 1 Risk Corridor	Please provide additional detail regarding the \$8,000 shown as "Total Allowed Administration." In particular, we would expect that no more than \$7,000 of this number (7% of revenue) would be for activities not categorized directly to improve healthcare quality, which would leave \$1,000 for activities that do improve healthcare quality. Additionally, we would expect this value to be shown in the line labeled "activities that	This information will be posted to the procurement website no later than December 24, 2015.

			improve healthcare quality"	
70.	Attachment 26	Example 1 Risk Corridor	Please provide another example where the amount spent on admin expenses is higher than the total allowed	This information will be posted to the procurement website no later than December 24, 2015.
71.	Attachments 10-11	N/A	Please provide a detailed crosswalk that defines the logic used to determine the categories of service used in this development, using CPT codes, place of service information, or any other information needed to determine the categories of service. Please also ensure that this detailed crosswalk includes logic for services that are excluded under the contract, in particular, long term services and supports.	As the detailed category of service logic is specific to the data elements reported in the encounter data for each of the current managed care entities, the State cannot provide this information as it is proprietary information.
72.	Attachments 10-11	N/A	Please confirm/edit/add to the following list of rate items expected to be reviewed in Spring 2016. a. HEP-C b. Retroactive Enrollment c. UNMC supplemental payments d. CAHs cost settlement amounts e. Provider rate changes (e.g., FQHC) f. Health Insurer Fee/Tax g. Program changes such as ASD, DD h. Foster care behavioral health experience i. Updated trends	All items on this list will be considered in the rate certification in the Spring of 2016. In addition to the items on this list, the Maternity case rate will be revisited to capture pharmacy and behavioral health costs. Additionally, the State's actuaries anticipate using additional runout from FFS data and current Managed Care entities. No changes to the base period are anticipated.

73.	Attachments 10-11	N/A	<p>What are the drivers in the ppm increases seen in the behavioral health component of the ABD populations? Is it new benefits, acuity, member mix? In particular, we saw PMPMs for these services in the range of \$70 between 2009 and 2011, and these services are now upwards of \$100.</p>	<p>The historical ABD population for behavioral health managed care is spread across the AABD populations in Attachments 10-A and 10-B, the Dual population in Attachment 10-C, and the LTSS population in Attachment 10-D. The average behavioral health PMPM weighted on the membership of each of these populations is consistent with the \$70 quoted in the question.</p>
74.	Attachments 10-11	N/A	<p>Please provide additional breakouts in the category of service lines in all of Attachment 10's to split out utilization and unit cost for each of the following:</p> <ol style="list-style-type: none"> 1) Pharmacy Expenditures - Hepatitis C 2) Pharmacy Expenditures - Non-Hepatitis C 3) For each inpatient and outpatient category, please split into hospital type: Critical Access Hospital, out-of-state hospital, other 	<p>This information will be posted to the procurement site no later than December 24, 2015.</p>
75.	Attachment 11	Lower Bound of Rates	<p>Please confirm the following conveyed at the pre-proposal conference. The rates in Attachment 11 include all of the following items at the stated values:</p> <ol style="list-style-type: none"> a) Non-QI admin at 7%, b) QPP at 1.5%, c) QI admin at 3%, d) Perf Guar at 0.25%, and e) profit, risk and contingencies at 2% 	<p>Slide 15 of the "NE Heritage Health Bidder's Conference Rate Presentation (Optumas)" itemizes the components of the non-medical load. Please see Attachment 21 for the breakout of the non-medical load components by cohort. The 1.5% QPP is a withhold from the rates, so it is not added in as a component of non-medical load. Rather, it is withheld from the non-medical load rates.</p>

76.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q262	Please describe what adjustments have been built into the rates to account for Hep C treatment. Given the number and costly drugs recently available in addition to recent news from CMS about utilizing these benefits, we would like a better understanding of what is included in the rates.	Hepatitis C drug utilization in Nebraska has historically been low. However, the higher pharmacy trend is meant to reflect potential increase in both average unit cost and utilization related to breakthrough therapies.
77.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q262	Please provide the state's current policy re: when Hep C drugs are allowed to be used for member treatment. Also, please provide a description of how the policy will change in Nebraska.	Current clinical criteria may be found at https://nebraska.fhsc.com/Downloads/NEcriteria_Sovaldi-201409.pdf . A current prior authorization request form may be found at https://nebraska.fhsc.com/Downloads/NEfaxform_HepatitisC-201507.pdf . Clinical criteria and prior authorization forms are reviewed and updated annually and as determined by the State.
78.	5151Z1 Addendum Six for Questions and Answers - 1-220	Q200	Please provide a count these special populations - by region, rate cell, etc.	This level of detail is not available.
79.	5151Z1 Addendum Six for Questions and Answers - 1-220	Q200	How are MCOs expected to identify these people? Is pharmacy data expected to be adequate for the identification of these members?	Pharmacy data will be provided to bolster any additional mechanisms a MCO has to assess a member for SHCN. Furthermore, per IV.E.22.d and IV.E.22.e, PCPs must notify the MCO of members who meet SHCN criteria and members may also self-identify to either the enrollment broker or the MCO that they have SHCNs.
80.	Attachment 6	Attachment 6, p. 9	Attachment 6 of the contract states HEDIS results are due "45 calendar days following the 12th month of the contract year". NCQA requires HEDIS rates be submitted by June 15th following the measurement year. For	Please see Attachment 38.

			example HEDIS rates for measurement year 2017 would be submitted in June of 2018. Will the state consider changing the due date for HEDIS reporting to align with NCQA timeframes?	
81.	IV.L.4.e.viii Care Management	115	What is the state's definition of "group visits" in this requirement? For example, is this intent for this to be interdisciplinary care team meetings with representatives of the member's unique care team? Are these support groups, i.e. classes/resources in the community? Are these groups facilitated by a provider (e.g. a PCP) on condition self-management?	Group visits include members of the interdisciplinary care team and members of the specialty treatment team as well as members and their families and additional local social and community services supports as necessary.
82.	IV. Project Description and Scope of Work, E. Covered Services, 11. Pharmacy Section, C. Nebraska Medicaid Preferred Drug List	59	After review of the state's PDL, it is noted that the drugs listed on Attachment 8 do not appear to be included in the current PDL posted on the state's website. Does the state have a separate behavioral health preferred drug list that the MCO will be required to implement?	Drugs listed on Attachment 8 are not included in the current PDL posted on the State's website. Attachment 8, which contains required edits for the pharmacy claims system to promote safe prescribing practices for mental health drugs used in children, is unrelated to the PDL. The State does not have a separate preferred drug list for antidepressants, antipsychotics and anticonvulsants.
83.	Z. FFS Claims Management and Processing	191-195	The RFP makes reference to many of the responsibilities of the MCO is awarded the FFS Claims Management and Processing duties. We would like to confirm whether the State will continue to be responsible for managing enrollment processing and	The MCO awarded the FFS Claims Broker contract will only be responsible for the claims-related activities outlined in Section IV.Z. The State, or its designated agent, will continue to oversee program responsibilities including enrollment and member communication for Medicaid-eligible individuals excluded from Heritage Health.

			development of the 834 file to all the MCOs, development of ID cards (including replacement cards) for Fee for Service members, and mailing and development of all member materials and newsletters for Fee for Service members.	
84.	Z. FFS Claims Management and Processing	191-195	In order to meet the requirements for claims processing against duplicates, etc. will the MCO that is chosen to be the FFS Claims broker receive claims history, eligibility history, and prior authorization history for both medical and pharmacy claims. If so, how far back will the claims data go?	MLTC will work with the MCO awarded the Claims Broker contract to provide the MCO with sufficient data to allow the MCO to meet the requirements outlined in Section IV.Z. Per IV.Z.3, the implementation of the Claims Broker role is targeted for the second year of the contract to allow sufficient time for MLTC to coordinate on all aspects of the transition with the awarded MCO.
85.	Z. FFS Claims Management and Processing	191-195	Will the state close out any open grievances & appeals or provider claims disputes, open TPL recoveries, complete all claims prior to the date of service that the claims broker implementation date that are active (or have a date of service) prior to the effective date of the FFS claims management contract with the MCO?	All activities outlined in the question will be handled by MLTC for dates of services or claims paid on dates prior to the effective date of the FFS claims management contract. Per IV.Z.3, the implementation of the Claims Broker role is targeted for the second year of the contract to allow sufficient time for MLTC to coordinate on all aspects of the transition with the awarded MCO.
86.	Z. FFS Claims Management, Section 12 Provider Services	194	Will the State continue to enroll Providers and assign the State Medicaid number to all Nebraska providers? Will the state continue to process all Nebraska Medicaid	The State or its designated agent will continue to enroll providers and assign State Medicaid provider numbers to approved providers.

			Provider additions, demographic changes, etc., or will this be the responsibility of the MCO who is awarded the FFS claims management contract?	
87.	Z. FFS Claims Management	191-195	Will the MCO who is selected to serve as the claims broker be responsible for processing dental and non emergent transportation claims?	The MCO awarded the FFS Claims Broker contract will be responsible for processing dental and non-emergency transportation claims if those benefits remain in the FFS program. However, dental services are currently scheduled to be included in a capitated dental benefit manager procurement that is expected to go-live in mid-2017. MLTC continues to evaluate administration of non-emergent transportation benefits.
88.	Attachment 23	557	Please provide a breakout of the assumed trend by utilization and unit cost.	As outlined in the "NE - Heritage Health Second Bidder's Conference Presentation - Optumas", utilization trend and unit cost trend will be provided in early 2016.
89.	Attachment 21	Page 3	For the dual population, what level of managed care is currently being assumed for the members that are currently enrolled in Medicare? What is the basis for this assumption?	The level of Medicare Advantage penetration in the Heritage Health Dual population is not known. Savings estimates for the Dual population are based on the prevalence of Behavioral Health services and anticipated changes in Physical Health experience when the two services are delivered under an integrated program. Duals frequently have a high need for Behavioral Health services, and the databooks provided in Attachment 10-C confirm this for the Heritage Health Dual population. When the care for these Dual enrollees is integrated under one delivery system, it is anticipated that better outcomes for Physical Health needs will occur, leading to a reduction in Physical Health utilization.
90.	Attachment 20	Attachment 20	For pharmacy, how were high cost hepatitis C drugs considered in the base data? Additionally, what considerations were made with regard to these drugs in setting the pharmacy trend? How does FY 14 prescription drug costs compare to FY 15	Please see the response to Question #76 above. Pharmacy costs by year will be provided to awarded MCOs in early 2016.

			costs by region and rate cell?	
91.	Attachment 21	4	Can you provide a summary of the most up to date analysis on the impact of the AP to APR DRG change? When was this analysis completed? Has the recent increase in high dollar inpatient NICUs been factored into this analysis?	Please refer to Attachment 22 for a thorough description of the analysis of the change from AP to APR DRG. This analysis was conducted in the Fall of 2015. NICUs expenditures are included in the base data and were reviewed for the DRG conversion analysis. The AP to APR DRG conversion increased expenses for the maternity case rate.
92.	Addendum Eight - Revised Schedule of Events	Page 1 (Addendum 8)	Will the agency release a revised "Request for Proposal For Contractual Services Form" to reflect the new "Opening Date and Time"?	No, the State will not release a revised "Request for Proposal For Contractual Services Form".
93.	Attachment 2	1	What are the network access standards for vision, hearing, durable medical equipment , laboratory serves, home health, skilled nursing facilities, hospice, ambulatory surgical center, respite, physical therapy, occupational therapy, speech therapy, if any?	Please see Attachment 2 for all current network standards.
94.	Addendum 3, RFP § IV(E)(29)(h)	1	Addendum 3 adds the following sentence as new section IV.E.29.h: Non-emergency transportation (except as indicated in Section IV.E.8.a) - Does this mean that non-emergency transportation is excluded (carved out for the State to manage) and MCOs are not required to provide member transportation?	Non-emergency transportation is excluded ("carved out"), with the exception of non-emergency ambulance transportation, which is included ("carved in").
95.	Attachment 6 -	7	We would like to request	Critical incidents for the purpose of Critical Incident

	Quarterly Deliverables		<p>further clarification regarding the Critical Incident Reporting requirement referenced in Attachment 6, in particular:</p> <ul style="list-style-type: none"> • How does Nebraska define “critical incident”? • In some states, critical incident reporting relates only to members in long-term care. Is this also the case in Nebraska? • Please confirm that MCOs are only required to collect critical incident reports from behavioral health facilities. 	<p>Reporting per Attachment 6 include the following when they occur while the member is in the care of a behavioral health inpatient, residential or crisis stabilization unit:</p> <ul style="list-style-type: none"> • Suicide attempt • Suicide death • Non-suicide death • Unexpected death • Homicide • Homicide attempt • Allegation of abuse/neglect (physical) • Allegation of abuse (psychological) • Fire setting or property damage • Medication error resulting in requiring medical intervention • Adverse drug reaction • Unauthorized leave • Accidental injury with significant medical intervention • Emergency medical treatment resulting from injury, medication error, or adverse medication reaction • Use of restraints or seclusion requiring significant medical intervention • Unusual, unexpected illness or disease • Other serious occurrence, including sexual contact between peers or peers and staff which member is under treatment <p>The RFP requires critical incident reporting related to behavioral health providers only.</p>
96.	RFP § IV (B)(2)(d) and RFP § IV (B)(5)(c)	33 & 36	Please confirm how much time the MCO is required to allow members to choose a PCP. RFP § IV(B)(2)(d) indicates 15 days and RFP § IV(B)(5)(c) indicates 10 days.	Members have 15 days to elect a MCO and may elect PCP within this timeframe. After MCO assignment, members have an additional ten days to elect a PCP. The MCO may elect to auto-assign the member as early as the 11 th day, but must auto assign the member to a PCP within one month of the enrollment date.
97.	RFP § IV (I)(14)(b)	100	This provision requires that all providers be credentialed	There is no required credentialing timeframe prior to the contract start date.

			within 30 calendar days upon receipt of a completed credentialing application. Please confirm that the 30-day credentialing timeframe applies only after the Contract goes live.	
98.	RFP § IV(M)(1)(b)	118	We understand MLTC's quality strategy has been submitted to CMS for approval. Can MLTC a draft of the submitted quality strategy for preliminary review?	The MLTC Quality Strategy is currently under revision to come into compliance with proposed managed care regulation changes.
99.	RFP § IV(O)(17)	141	Following up on Round 1 Q&A #156, please confirm that the MCO will not be required to consult with NMPI and MFPAU in connection with recouping overpayments due to TPL, retroactive reductions to state fee schedules, members that were retrospectively disenrolled by the state and similar situations.	Please see the response to Addendum 6, Question #156.
100.	RFP § IV(Q)(6)(b)	150	The State indicated in response to Question 103 of the first round of questions that the 30% and 50% of the provider network measure includes all providers in the network. Would this include ancillary services such as laboratories, pharmacies, DME, radiologists, therapy services, etc.?	Please see the response to Addendum 6, Question #102. All providers in the network including ancillary services will be considered in the denominator.
101.	RFP § V(A)(2)(h)	197	We wanted to follow up on Question 174 from the first	The budget refers to the contract value. Please provide original contract value projections and actual contract value.

			<p>round of Q&A. The State indicated that the originally scheduled budget and actual budget mean the project budget and the actual budget. What type of information would this be in the case of a capitated contract? Payment is made on a pmpm basis; by its structure the rate is simply the rate. Would the amount received by the MCO annually be the responsive information?</p>	
102.	RFP § IV(Q)(11)	152	<p>Will the UNMC payments be a fixed dollar amount each month, or will they vary based on the actual plan utilization with UNMC?</p>	<p>The UNMC payment is a fixed dollar amount.</p>
103.	RFP § IV(Q)(11)	152	<p>Given that the state has now advised that the UNMC payments will not be a pass-through and will instead be part of the at-risk capitation payment, will the UNMC portion of the capitation rate be removed when developing the capitation rate risk adjustments in year 2? If the UNMC payment is a fixed dollar amount, it is not actuarially sound to risk adjust these.</p>	<p>Risk adjustment factors will be applied to the aggregate rate, inclusive of UNMC.</p>
104.	RFP § IV(P)(10) and IV(P)(11)	146-147	<p>Given that the state has now advised that the UNMC payments will not be a pass-through and will instead be part of the at-risk capitation payment, will the UNMC</p>	<p>Non-medical load, the QPP Withhold, and the State Performance Penalty will apply to the UNMC portion of the rate.</p>

			portion of the capitation rate be removed when calculating the QPP Withhold and the State Performance Penalty amounts? If the UNMC payment is a fixed dollar amount that must be paid out, it is not actuarially sound to reduce the amounts by the withhold and penalty amounts.	
105.	RFP Section IV.Z	191	Regarding the Procurement of FFS Claims Management and Processing services, can the State share how it will evaluate which MCO will be awarded this business? EG: what would the award criteria be?	Please see the response to Addendum 7, Question # 278.
106.	RFP Section IV.S.10	169	Does the State have documentation that it could make available to bidders on the Encounter Submission process? For example: should we assume that the HIPAA 837 I&P Companion Guides on the Nebraska Medicaid website are not only for Provider submissions for FFS Medicaid - but are also for MCO's to submit encounter data? In addition, does the State have any information it could share on the format of ancillary encounter submission file formats (e.g. error files returned from the State, acknowledgement files, provider file submissions)?	The posted HIPAA 5010 837I and 837P Companion Guides apply for both FFS and Encounter submissions, and contain only requirements that clarify state-specific usage of the standard transaction documented in the respective ASC X12 TR3 Implementation Guides. Exceptions where requirements differ in the companion guides for FFS and Encounter are identified as "Chargeable" for FFS submissions and "Reporting" for Encounter submissions. The State returns HIPAA 837 file acknowledgements via HIPAA 5010 999/TA1 Transactions. Encounter submission results are also sent via HIPAA 5010 277Claim Acknowledgement Transaction. In addition, a month-to-date error summary and acceptance percentage report is sent in a proprietary format.

107.	Attachments 30 & 31, and Question & Answer #304 (11.19.15) RFP Section IV.B.12	Attachment 30 Attachment 31 Q/A Part 2, page 34 IV.B.12, page	The NE Medicaid 5010 Companion Guide for 834 transactions (published 3/12/13) is very short and only specifies sender and receiver IDs. Our question: although the monthly enrollment file as specified in Attachment 30 is not an 834 format, does MLTC's 834 eligibility file contain the same <i>data elements</i> as the monthly enrollment file as specified in Attachment 30?	The posted HIPAA 5010 834 Companion Guide contains only requirements that clarify state-specific usage of the standard transaction documented in the ASC X12 TR3 Implementation Guide. The Nebraska Medicaid Managed Care Client Eligibility Data Supplemental Enrollment File in Attachment 30 is a proprietary supplement to the HIPAA 5010 834 Benefit Enrollment and Maintenance Transaction which contains additional data that cannot be reported in the 834 transaction. There is limited data element duplication in the 834 and the supplemental files to enable the MCO to tie the data in the two files for each client.
108.	RFP Section IV.S.10.x RFP Section IV.P.13	IV.S.10.x: p.171 IV.P.13: p.148	Regarding this sentence: <i>Control totals will also be reviewed and verified. Additionally, the MCO must reconcile all encounter data submitted to the State to control totals and to the MCO's MLR reports and supply this reconciliation to MLTC with each MLR report submission as specified in Attachment 6 – Reporting Requirements.</i> We cannot find information in Attachment 6 that relates to MLR reports or reconciliation of encounter data to MLR reports. Does MLTC have additional information that is intended for inclusion in Attachment 6?	Quarterly and annual financial reporting requirements included in Attachment 6 reference Section IV.T – Reporting and Deliverables. IV.T.5 contains a list of required reports including IV.T.5.v – Medical loss ratio calculation.
109.	RFP Section IV.R.13.a	161	Regarding this sentence: <i>The MCO must have online retrieval and access to documents and files for six (6)</i>	MLTC will develop a policy in coordination with awarded MCOs in regards to the final disposition of claims with a once-in-a-lifetime indicator.

			<p><i>years in live systems and ten (10) years in archival systems, for audit and reporting purposes. The claims for services that have a once-in-a-life-time indicator (i.e., appendix removal, hysterectomy) must remain in the current/active claims history for claims editing and are not to be archived or purged.</i></p> <p>Does the second sentence override the first sentence? Specifically: how long must the MCO maintain "once-in-a-life-time" claims online - greater than 10 years? Wouldn't MLTC be better served to require MCO's to turn over such claims data to MLTC after 10 years?</p>	
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This addendum will become part of the proposal and should be acknowledged with the Request for Proposal.