NEBRASKA Administrative Services

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Director

Pete Ricketts, Governor

ADDENDUM SIX
QUESTIONS and ANSWERS

Date: November 18, 2015

To: All Bidders

From: Michelle Thompson/Teresa Fleming, Buyers
AS Materiel State Purchasing Bureau

RE: Addendum for Request for Proposal Number 5151Z1
to be opened December 22, 2015 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.

Due to the high volume of the questions, the state is providing the rsponses to questions 1 – 220 at this time. The State will provide responses for the remaining questions at a later date.

Question Number	RFP Section Reference	RFP Page Number	Question	State Response
1.			Our organization is most certainly equipped to do the full-risk physical health managed care program, but we would partner for behavioral and pharmacy. Would this arrangement be acceptable to you?	While the RFP does not prohibit sub-contracting, it does require that MCOs deliver an integrated approach to service delivery and care management.
2.			We have been reviewing the RFP for Medicaid, and it would be very helpful if we could have clarification on the definition of PCMH and also on which provider types can be primary care providers. With the passage of LB 107, NPs no longer have collaborative or supervisory agreements with physicians. So under this definition, NPs would not qualify. NPs offer a great opportunity for patient centered medical homes and also to be defined as a covered primary care provider under Medicaid, which increases the access for this vulnerable population. "Primary care provider (PCP)A medical professional chosen by or assigned to the	See Addendum 3 – Revisions to the RFP.

			member to provide primary care services. Provider types that can be PCPs are doctors of medicine (MDs) or doctors of osteopathic medicine (DOs) from any of the following practice areas: general practice, family practice, internal medicine, pediatrics, and obstetrics/gynecology (OB/GYN).Advanced practice nurses (APNs) and physician assistants may also serve as PCPs when they are practicing under the supervision of a physician who also qualifies as a PCP under this contract and specialize in family practice, internal medicine, pediatrics or obstetrics/gynecology”	
3.			LB 107 was passed into law the last legislative session whereby Nurse Practitioners (NPs) in Nebraska no longer need physician supervision. The law became effective September 1st of this year. If you could explain the inclusion of NP supervision in the RFP (see below) it would be appreciated. It appears that LB 107 would render this	See response to Question #2.

			definition inconsistent with NP practice law: "Primary care provider (PCP) A medical professional chosen by or assigned to the member to provide primary care services. Provider types that can be PCPs are doctors of medicine (MDs) or doctors of osteopathic medicine (DOs) from any of the following practice areas: general practice, family practice, internal medicine, pediatrics, and obstetrics/gynecology (OB/GYN). Advanced practice nurses (APNs) and physician assistants may also serve as PCPs when they are practicing under the supervision of a physician who also qualifies as a PCP under this contract and specialize in family practice, internal medicine, pediatrics or obstetrics/gynecology" Additionally, on the requirements for the PCMH practice – am I reading it correctly that in order for a practice to qualify, that it must include a physician? Again, NPs in Nebraska can now practice without physician	

			supervision as per LB 107 and are providing significant portions of primary care services particularly in the rural areas of our state. There is research supporting NPs as PCMH providers. I am hopeful this is an oversight in the proposed RFP and that NPs are included in the PCMH definitions.	
4.	Section II(H), Submission of Proposals; Section III(NN) Proprietary Information	p. 4; p. 23	Please confirm that the State will await the outcome of any objections, legal challenges, or litigation in connection with a FOIA request to obtain proprietary, confidential, or trade secret information submitted in accordance with the instructions in this section before releasing it.	The State will not contact the bidder before responding to a FOIA request. The State will withhold the appropriately identified copywritten materials and proprietary information as identified by the bidder.
5.	Section II(H), Submission of Proposals; Section III(NN), Proprietary Information	p. 4; p. 23	Please confirm that proprietary or confidential information submitted in accordance with the instructions in Section III of the RFP will not be posted for public viewing even if the State disagrees with a bidder's assertion that the information is protected as confidential, proprietary, or a trade secret.	Appropriately identified copywritten materials and proprietary information will not be posted for public viewing. See the response to Question #4. Per Section III, NN Proprietary Information, “Bidders may not mark their entire Request for Proposal as proprietary.”
6.	Section II(H), Submission of	p. 4; p. 23	Please confirm that "non" should be inserted before the	The following language is hereby amended as follows: IMPORTANT NOTICE: Pursuant to Neb. Rev. Stat. §84-602.02,

	Proposals; Section III(NN), Proprietary Information		word "confidential" so that this statement should read as follows: "The language above should read "All non-proprietary or non-confidential information as defined by Law WILL BE POSTED FOR PUBLIC VIEWING."	all State contracts in effect as of January 1, 2014 will be posted to a public website beginning July 1, 2014. All non-proprietary or non-confidential information as defined by Law WILL BE POSTED FOR PUBLIC VIEWING.
7.	Section III(E), Ownership of Information and Data	8-9	Some Contractors may have license agreements with other companies for the use of certain proprietary computer software programs. Please confirm that the State of Nebraska will not require Contractor or any subcontractor to violate any aspect of license agreements or other contracts they may have with other companies for the use of certain proprietary computer software programs or make any modification to the proprietary software included in such license agreements or other contracts.	This section requires the Contractor to either own the license or obtain a license to utilize the software or other copywritten material the Contractor intends to use to perform under the contract. Any costs associated with license(s) will be the responsibility of the Contractor.
8.	Section III(E), Ownership of Information and Data	pp. 8-9	Please confirm that the State of Nebraska will not publish, duplicate, use, or disclose a Contractor's confidential, proprietary, or trade secret information without giving the	Subject to State law and the posting of contracts, it is the responsibility of the bidder to properly identify proprietary information as defined by the Nebraska State Statutes. See the response to Question #5.

			Contractor advance notice of its intention to do so and awaiting the outcome of any objection, legal challenge, or litigation that may occur as a result of the Contractor defending its position regarding the confidential and proprietary nature of the information to any appropriate State agency, Court of competent jurisdiction, or in any other appropriate venue.	
9.	Section III(E), Ownership of Information and Data	8-9	Please confirm that the intention of the State is not to have the unlimited right to publish, duplicate, use, and disclose Contractor's intellectual property, confidential, and proprietary information, including, but not limited to, inventions, patents, copyrights, trademarks, trade secrets, trade names, operating systems, policies, proprietary aspects of computer systems, proprietary computer software programs, proprietary software computer system design documents or other system documentation, and coding.	See response to Question #8.

10.	Section III(CC), Administration-Contract Termination; Section III(NN), Proprietary Information	19	Please confirm that the deliverables and/or data and documentation contained in the proposal that shall become the property of the State under either of these provisions do not include intellectual property, confidential, or proprietary information used or to be used in connection with work performed on this Contract, including, but not limited to, inventions, patents, copyrights, trademarks, trade secrets, trade names, operating systems, policies, proprietary aspects of computer systems, proprietary computer software programs, proprietary software computer system design documents or other system documentation, and coding and that upon completion or termination of the Contract, Contractor will be able to retain such information for use in connection with work on other current and future Medicaid contracts nationwide.	If a deliverable is created for the State as required by the contract, then the State owns the deliverable.
11.	III.EE.1 Performance Bond	19	Is the $50,000,000 performance for each region or statewide?	The performance bond is statewide per awarded Contractor.

12.	Section III(NN), Proprietary Information	23	If a particular page of a bidder's proposal or exhibit thereto contains proprietary information, but the page in its entirety is not proprietary, should the bidder redact the proprietary information and submit the remainder of the page with its proposal and then include an unredacted copy in a sealed envelope? If this is not the proper procedure, please explain what process bidders should use when submitting proprietary information included on a page that also contains non-proprietary information.	The bidder may submit the redacted version within the technical response and submit the proprietary information in a separate sealed envelope in accordance with Section III. NN Proprietary Information. See the response to Question #5.
13.	Section III(EEE), License/Service or Other Agreements Section V(A)(2)(j), Sub-Contractors Attachment 5	28-29; 198; Attachment 5, p. 2	Since Section V(A)(2)(j) does not require the bidder to submit subcontractor agreements with the subcontractor information to be submitted with the bid and since Attachment 5 states that subcontracts are to be submitted for review and approval 90 days prior to the contract start date, please confirm our understanding that the "service or other such agreements" that must be submitted with the bid under Section III(EEE) if bidders	Yes, Section III (EEE) does not include bidder agreements with subcontractors.

			wish the State to consider them do not include agreements with subcontractors for the performance of a service or function related to the fulfillment of an MCO's obligations under the contract and that therefore subcontract agreements are not subject to any of the requirements in Section III(EEE).	
14.	Section III(EEE), License/Service or Other Agreements; Section IV(I)(12)(b), Provider Outreach and Application Processing;	28-29; 100	Since Section IV(I)12)(b) addresses what must be submitted with the bid with respect to provider templates, please confirm that the "Service or other such agreements" that must be submitted with the bid if bidders want the State to consider them do not include provider agreements and that therefore provider agreements are not subject to the requirements of this provision.	Provider agreements are not subject to the provision set forth in Section III(EEE).
15.	Section III(EEE), License/Service or Other Agreements	7; 28-29	Please confirm that the State will not view the submission of all "license/service or other agreements" as proposed alterations to the Terms and Conditions but only those that actually conflict with or alter	Any terms and conditions, user agreement, or other document or clauses offered or purport to be included as a part of this RFP shall be subordinate to the original RFP. The Bidder shall specify which clauses the Bidder proposes to incorporate into the contract; documents will not be incorporated in their entirety unless the Bidder states the document is proposed in its entirety. For Bidder proposed clauses to be binding, the State

			the State's Terms and Conditions.	must acknowledge and accept the clause in writing.
16.	Section III(EEE), License/Service or Other Agreements	28-29	Since a reading of contract provisions is subjective and open to interpretation and since the State may view a provision in a license/service or other agreement as conflicting with or altering the State's Terms and Conditions, when the bidder did not intend to alter those terms at all, please confirm that if a bidder submits a "license/service or other agreement" with its bid that the State interprets as conflicting with or altering the State's Terms and Conditions, the State will notify the bidder and provide it with an opportunity to cure the alleged conflict or alteration before determining that the license/service or other agreement is a proposed alteration of the Terms and Conditions that may be cause for a rejection of the bidder's proposal.	Subject to the response in Question #15, the State will compare the terms offered by the bidder to the terms of the State.
17.	Section III(EEE), License/Service or Other Agreements	28-29	Please list examples of the types of "license/service or other such agreements" that must be submitted with the bid under this provision.	Examples may include a service level agreement, user agreements, license agreements and bidders supplemental conditions to the State's Terms and Conditions.

18.	IV.A.1.c Description of Current Program	30	Will these 40,000 individuals that are currently in BH managed care but not PH managed care be enrolled with an MCO starting on 1/1/17? What is the cost by category of service on a PMPM basis for this population in FY 14 and FY 15?	Yes, the individuals currently in BH managed care but not currently in PH managed care will be enrolled in an MCO on 1/1/17. These individuals are categorized in the LTSS (Institutional) – Dual, LTSS (Institutional) - Non-Dual, LTSS (Home and Community Based) – Dual, LTSS (Home and Community Based) - Non-Dual, and Dual aid categories. The FY14/FY15 combined expenditures by services category have been provided for these populations as Attachments 10-C and 10-D.
19.	IV.A.10.h Included Populations	32	How far back will retroactive enrollment be allowed? How will DHHS ensure that MCOs that receive a disproportionately higher percentage of these retroactive members are compensated appropriately?	Retroactive enrollment will be no earlier than the contract start date. The MCO will receive a capitation payment for each month of retroactive enrollment.
20.	IV.A.10.h Included Populations	32	Can DHHS add an indicator on the eligibility file that will designate whether a member is a regular enrollee, an immediate enrollee, or a retrospective enrollee? How were these three cohorts taken into account in rate development?	If the EBS or MMIS has access to this information, it can be added to the file. Current rates do not account for retroactive enrollment. Immediate enrollment is inherent in 17 months of the base data. The remaining 7 months are adjusted to account for immediate enrollment. The adjustment value was calculated by comparing the PMPM cost for members whom were in at least their second month of eligibility for the February to June 2014 time period to the PMPM cost for all members whom were eligible during that period. The difference between these two PMPM costs would estimate the impact of immediate enrollment for those members who had enrolled in the managed care program after the policy was implemented. Regular enrollees are fully inherent in the base data.
21.	IV.B.4.d. Eligibility and Enrollment (d)	35	Will all newborns be assigned to the same MCO for multiple births?	The Heritage Health Enrollment Broker will facilitate the assignment of multiple births to the same MCO for continuity of care.
22.	D.3. a. and b, 3. Additional Required	50	Are the MCOs permitted to use independently licensed	Yes.

	Staff		behavioral health practitioners to perform prior authorization and concurrent review?	
23.	IV.E.8.b. Rehabilitation services - iv.i)	57	Please provide the definition for Assertive community treatment (ACT) and Alt ACT.	See http://dhhs.ne.gov/medicaid/documents/act.pdf
24.	IV.E.11. Pharmacy Services - c. Nebraska Medicaid Preferred List	59	Can the timeframe be adjusted to 3 business days, by allowing the extension it would provide for adequate testing and quality processes.	Upon initial receipt of the file, an extension of three business days would be acceptable, but thereafter, the file must be uploaded in one business day.
25.	IV.F.13. Communication with New Members, b.ii.	80	Will the MLTC enrollment file list the "responsible party" for each new member? If not, can you explain what methods should be used to determine who is the "responsible party"	Yes, this information will be provided via the enrollment files.
26.	I. PROVIDER NETWORK REQUIREMENTS, 14. Provider Credentialing and Re-Credentialing	100	Currently the TAT for NE Medicaid is that of 45 days from the date of the receipt of a completed application thru Committee review/decision. For the expansion RFP for physical health, behavioral health and pharmacy, the state has a 30 calendar day TAT. Is the state willing to approve a 45 day TAT from receipt of a completed application to match what is currently in place for the NE Medicaid medical providers?	The 30 day TAT requirement will remain as written in the RFP.

27.	IV.L.4. Basic CM Services, e, viii	115	Does the state expect the MCOs to facilitate the development of group visits or help members participate in the existing group visits?	MCOs must facilitate the development of group visits for members assigned to high risk care management.
28.	IV.L.6.b Special Considerations for Pregnant Members	116	What is considered adequate? Is there a specific ratio the MCOs must adhere to?	There are no specific ratios that are required by the MCOs. Attachment 2 includes provider network access standards.
29.	IV.N.5. Service Authorization for Pharmacy Services	128	Please clarify what is meant in 5.a.iii by "Process Supporting Tables"	"Process supporting tables" references any proprietary table(s), resource table(s) or any other reference guide(s) used in the evaluation of the call center team for determining approval, denial or dose recommendations of medications.
30.	IV.P.2.i Capitation Rate Determination Process, i	143	What is the net rate increase comparing the current managed care rates to the RFP rates on an apples to apples benefit basis -- ignore pharmacy, behavioral health, and LTSS rate cells? What is the trend that was applied? How does this trend compare to the actual managed care trend experience from FY 2014 to FY 2015?	Growth rates for the current managed care rates in physical health from FY2014 to FY2015 are influenced by policy decisions such as immediate enrollment. This is expected to be a one-time impact, as such the assumed growth rates as indicated in the RFP and will commensurate with historical growth rates seen in the program.
31.	IV.P.4. Transplant Services	144	Will there be separate compensation for transplants? Case rate?	Costs associated with transplants are carved into the base data and are included in the capitation rates shown in Attachment 11. There will not be a separate case rates paid for transplants.
32.	IV.P.8.a Risk Adjustment	145	What risk adjustment methodology will be used after the first contract year? We recommend a methodology that is widely used and includes pharmacy	MLTC will work with the Actuaries and the MCOs in determining the best risk adjustment tool for the Heritage Health program.

			encounters such as CDPS + Rx.	
33.	IV.P.9.c Risk Corridor	146	Can you please define the qualifying revenue? Will the qualifying revenue exclude the 1.5% QPP hold back?	See Page xv of the RFP for the definition of qualifying revenue (for the risk corridor calculation). Since the 1.5% QPP hold back is not considered earned income, it will not be included in the risk corridor calculations.
34.	IV.P.11.c. State Performance Penalties	147	Please confirm that the provisions to appeal liquidated damages assessments identified in Section 2.i. on page 184 apply to this provision.	The provisions in Section IV.V.2.i would apply to the liquidated damages listed in Section IV.P.11.c.
35.	6. Value-Based Contracting, c.	150	Please define "risk- sharing".	Risk is defined as the chance or possibility of gain or loss associated with caring for a given population. A MCO awarded under this RFP will be at risk for whatever volume of care is provided to its members. A risk-sharing agreement with a network provider is one in which the MCO transfers some portion of risk to a network provider, such as payment of a fixed rate for which the network provider is to provide or arrange care for an assigned group of members.
36.	IV.Q.15 Payment for Emergency Services	153	Please clarify the definition of a "medical emergency."	The definition of "medical emergency" is synonymous with the definition of "Emergency medical condition", which can be found in the Glossary of Terms on page xi.
37.	IV.Q.16.a Pharmacy Reimbursement	153	What is the average dispensing fee for non-independent pharmacies? What is the percentage of non-independent pharmacies assumed in the rate development? What is the basis for the dispensing fee reduction estimate in the rate	Non-independent pharmacies were assumed to have a $2.50 dispensing fee and independent pharmacies were assumed to have a $4.45 dispensing fee. The independent pharmacy dispensing fee is the State FFS dispensing fee set for independent pharmacies. The $2.50 non-independent pharmacy dispensing fee is based on discussions with the state and research of other states. In Rating Region 1, 85% of prescriptions were filled by non-independent pharmacies. In Rating Region 2, 58% of prescriptions were filled by non-

			development?	independent pharmacies.
38.	IV.Z.1 Claims Broker Services	192	What is the current administrative cost paid on a per claims basis by DHHS? How will the per claim administrative fee paid to the CBS be determined?	Due to the current MMIS system, the State does not have current administrative costs paid on a per claim basis. Please see RFP Section IV.Z.1 for determination of the administrative fee paid to the CBS.
39.	V(A)(2)(e), Relationships with the State	197	Please confirm that for purposes of this question "any dealings with the State" is limited to contracts entered into with the State or other projects or initiatives the bidder, its organization, or any predecessor or party named in the bidder's proposal has worked on with the State in the last five years, and does not include day-to-day contact with State personnel related to existing contract requirements, obligations, or administration.	Section V.A.2.e pertains to contracts entered into between the State and the bidder.
40.	V(A)(2)(g), Contract Performance	197	Please confirm that contracts terminated for default must be reported for bidders and any proposed Sub-Contractor, but information regarding contracts terminated for convenience, non-performance, non-allocation of funds or any other reason, is required of the bidder only,	Per Section V.A.2.g, the bidder must provide if they or any proposed sub-contractor has had a contract terminated for default during the past five (5) years as detailed in this section. The bidder must provide if they have had a contract terminated for convenience, non-performance, non-allocation of funds, or any reason.

			since in the ordinary course of business contracts terminate for reasons other than default every day and requiring this information of each subcontractor could result in inundating the State with volumes of information.	
41.	V(A)(2)(g), Contract Performance	197	To avoid inundating the State with information for lines of business unrelated to the current RFP, please confirm that the State is seeking information regarding terminations of contracts for services related to Medicaid/CHIP programs only.	Per Section V, A, 2, g, “It is mandatory that the bidder submit full details of all termination for default experienced during the past five (5) years, including the other party's name, address, and telephone number. The response to this section must present the bidder’s position on the matter.”
42.	V(A)(2)(h), Summary of Bidder's Corporate Experience	197	Is this question seeking two separate items: (1) a summary matrix; and (2) narrative project descriptions; or, is this question seeking one item (e.g., a summary matrix of bidder's experience in a tabular format to include the information requested in subparts (a)-(e) above)?	The summary matrix should consist of the items listed in subparts a – e.
43.	V(A)(2)(h), Summary of Bidder's Corporate Experience	197	Please confirm that the "summary matrix" sought in this question should be in tabular form and include the information enumerated in subsections (a)-(e).	The summary matrix may be in a tabular form.
44.	V(A(2)(h), Summary of	197	Please confirm that the	The bidder may submit more than three (3) projects, but the State

	Bidder's Corporate Experience		"summary matrix" sought in this question, which bidder is interpreting as a tabular summary of its experience to include the items listed in subsections (a)-(e), can include more than three projects.	will use no more than three (3) narrative project descriptions. The bidders are discouraged from submitting more than three (3) project descriptions.
45.	V(A)(2)(h), Summary of Bidder's Corporate Experience	197	For what time period or "look back period" should bidders report the information requested in this section?	The State does not identify a time period.
46.	V(A)(2)(h), Summary of Bidder's Corporate Experience	197	Please confirm that bidders are permitted to provide more than three (3) narrative project descriptions of other projects and experience from which the State will then choose no more than three (3) on which to evaluate the proposal.	See the response to Question #44.
47.	V(A)(2)(h)(i)(e), V(A)(2)(h)(ii), and V(A)(2)(h)(iii) Summary of Bidder's Corporate Experience	198	Please confirm that the reference to "Sub-Contractors" and "Sub-Contractor(s) experience" refers only to bidders' experience as a subcontractor, as opposed to a primary contractor, on similar projects and that bidders are not required to provide summary matrices and/or narrative project descriptions regarding previous similar projects for	Corporate Experience is the bidder's role as the prime Contractor and/or as the role of the Sub-Contractor.

			each of their proposed subcontractors.	
48.	Attachment 11 – Rates	Attachment 11	In the effort to maintain transparency, can DHHS share the capitation rate calculation sheet that was used to trend the base data and adjust it to the rates in Attachment 11?	See Attachment 20: "COA-level Rate Development" for the step-by-step development of the rates at a COA level.
49.	Attachment 12 - Historical Transplant Cost Distribution Data	Attachment 12	Please provide the transplant data separated by year. Has there been an increase in transplants in recent years versus earlier years? How has this been accounted for? By placing the transplant costs in the capitation rates, how will DHHS avoid underpricing the transplant costs for an MCO that receives a disproportionate share of overall transplants? We recommend a transplant kick payment instead of an adjustment to all members' capitation rates to more equitable compensate MCOs for their incurred costs. We also recommend transplant kicks that vary by type of transplant -- heart, bone marrow, lung, intestine, kidney, or pancreas/kidney.	Transplant costs by year are: $5.4 million in FY10, $4.5 million in FY11, $7.1 million in FY12, $7.6 million in FY13, and $6.0 million in FY14. MLTC does not intend to use a transplant kick payment. Bidders may purchase reinsurance or take other appropriate steps to mitigate the risk of fluctuation in the costs of transplants.
50.	Attachment 19, Proposal Statement	Attachment 19, p.1	Please confirm that the information sought from	The information sought is that related to Medicaid or CHIP contracts.

	and Questions, No. 2		bidders' parent company, affiliates, and subsidiaries in response to Question 2 includes only regulatory actions, monetary or non-monetary sanctions, letters of deficiency, and corrective actions related to Medicaid/CHIP contracts.	
51.	Attachment 19, Proposal Statements and Questions, No. 3	Attachment 19, p.1	Please confirm that the information sought from bidders' parent company, affiliates, and subsidiaries in response to Question 3 includes only investigations related to Medicaid/CHIP business.	See response to Question # 50.
52.			As a business owner this who would like to be able to accept Medicare and Medicaid patients someday, the language of this is limiting and very concerning to me. "Primary care provider (PCP)A medical professional chosen by or assigned to the member to provide primary care services. Provider types that can be PCPs are doctors of medicine (MDs) or doctors of osteopathic medicine (DOs) from any of the following practice areas: general practice, family	See response to Question #2.

			practice, internal medicine, pediatrics, and obstetrics/gynecology (OB/GYN).Advanced practice nurses (APNs) and physician assistants may also serve as PCPs when they are practicing under the supervision of a physician who also qualifies as a PCP under this contract and specialize in family practice, internal medicine, pediatrics or obstetrics/gynecology” I am a Family Practice Nurse Practitioner. I own my own practice and provide care to over 300 patients. As Nebraska law allows, I do not have a supervising physician. I would like to be able to accept both Medicare and Medicaid insurance someday, but as of yet, they are not in agreement with Nebraska law. Thank you for taking this matter into your immediate consideration.	
53.	Glossary - Related-party	xv	The examples provided for "related-party" include "subcontractors to the MCO	Related-party: The parent company of a MCO or an entity partially or wholly owned by the MCO or the MCO’s parent company that receives any revenue from the MCO for Medicaid

			performing services under this contract." Please clarify that this would apply only to subcontractors owned, either wholly or partially, by the MCO or its parent company and not to third party subcontractors.	contracted services. Examples of related parties include a clinic wholly or partly owned by a MCO or its parent company that provides services covered by Nebraska Medicaid and subcontractors to the MCO performing services under this contract. Yes, it relates to subcontractors wholly or partially owned by the MCO or its parent company. This does not include independent third party subcontractors.
54.	Request for Proposal for Contractual Services Form; IV.H-Submission of Proposals; IV.NN-Proprietary Information	i, 4, 23	"All non-proprietary or confidential information as defined by Law WILL BE POSTED FOR PUBLIC VIEWING." Should this read, "All non-proprietary or NON-confidential information…?"	See response to Question #6.
55.	II.H Submission of Proposals	4	Please verify that the Bidder must submit only one copy of the original proposal and that an electronic copy of the response is not required.	The bidder must submit one original of the entire proposal response. An electronic copy is not required.
56.	II.H Submission of Proposals	4	Is there a font style and font size that the Bidders must adhere to when responding to this RFP?	There are no such requirements.
57.	II.H Submission of Proposals	4	Is there a specific section in the Binder where the Bidder should attach the additional forms - Form A, Contractual Services Form, and the Confidentiality Sheet - or should they be included in a separate tab(s)?	The Contractual Services Form, Form A, and the Confidentiality Sheet should be included as a separate identified tab within the bidder's proposal response.
58.	III Terms and Conditions	7	"… a bidder may indicate any exceptions to the Terms and	No, a statement recommending terms and conditions that

			Conditions by (1) clearly identifying the term or condition by subsection, and (2) including an explanation for the bidder's inability to comply with such term or condition which includes a statement recommending terms and conditions the bidder would find acceptable. Rejection in whole or in part of the Terms and Conditions may be cause for rejection of a bidder's proposal. Would "a statement recommending terms and conditions the bidder would find acceptable "constitute a "rejection in whole or in part"?	bidder would find acceptable does not constitute a rejection. The bidder should provide alternative(s) for the State's consideration.
59.	III.J Contractor Personnel	12	"Personnel commitments made in the Contractor's proposal shall not be changed without the prior written approval of the State." Please clarify whether this applies to any personnel changes (individual staff, staffing levels due to changes in membership, etc.) or if it can be limited to changes of substance (key personnel, general staffing ratios, etc.).	Per Section III, J Contractor Personnel, "Personnel commitments made in the Contractor's proposal shall not be changed without the prior written approval of the State. Replacement of key personnel, if approved by the State, shall be with personnel of equal or greater ability and qualifications."
60.	III.II Taxes	21	"The State is not required to pay taxes of any kind and assumes no such liability as a	No. The Health Insurer Tax will be incorporated in future rate setting cycles.

			result of this solicitation." Does this provision extend to the Health Insurer Tax enacted through the Affordable Care Act?	
61.	IV. A.1.g.ii Description of Current Program	31	Would pharmacy services have a different start date than physical health services? Please confirm the expected start date for pharmacy services.	The anticipated start date for pharmacy services is January 1, 2017. The State reserves the right to adjust the start date of pharmacy services at its discretion.
62.	IV.4A.1.g.iii Description of Current Program	31	Are Aged, Blind, and Disabled persons, whether dually eligible for Medicaid and Medicare, in a home and community-based services waiver program, or living in an institution, included in managed care only for physical health services and not for behavioral health services or pharmacy services?	All populations included in Heritage Health will have the Heritage Health benefits package, including physical health, behavioral health, and pharmacy services. The ABD population (including those who are dually-eligible, those receiving HCBS services, and those living in ICF/DDs) is included in Heritage Health.
63.	IV.4A.1.g.iii Description of Current Program	31	This population will be included "for managed care physical health services"; will the MCO be responsible only for physical health services and not facility, behavioral health, NEMT or other services?	Section IV.A.1.g.iii is hereby amended as follows: "Inclusion of the Aged, Blind and Disabled populations who are dually eligible for Medicaid and Medicare, in a home and community-based services (HCBS) waiver program, or living in an institution, for integrated physical health, behavioral health, and pharmacy services."
64.	B.4.d.iii Eligibility and Enrollment - MCO	35, 144	Are there any time limits that would apply to enrollment and/or capitation payment	See response to Question #19.

	Enrollment Procedures IV.P.3.b MCO Reimbursement - Capitation Rates and Payment		retroactivity regarding both the enrollment transaction as well as the ensuing capitation payment?	
65.	B.5.g Eligibility and Enrollment - PCP Assignment	36	Please clarify whether it may be possible for a provider to participate with Medicare and not Nebraska Medicaid?	All providers must be Nebraska Medicaid enrolled to participate in or be reimbursed by the MCO.
66.	B.5.g Eligibility and Enrollment - PCP Assignment	36	If a dual eligible member is obtaining services from a non-par PCP, will the plan be required to continue paying for those services at the Medicaid fee schedule?	See Section IV.S.15.a.x. and Section IV.S.17 for requirements related to dual eligible members.
67.	B.6.b Eligibility and Enrollment - MCO Changes	36	Does this mean that, regardless of a member's anniversary date, their open enrollment period would always be in December?	For the duration of the contract, the annual enrollment period will take place in December for all Heritage Health members.
68.	IV.D.3.a & IV.D.3.b Staffing Requirements - Additional Required Staff	50	Are the requirements under section 3a and 3b referring to medical and pharmacy staff or just medical?	Sections 3a and 3b are referring to medical staff.
69.	IV.D.3.a & D.3.bStaffing Requirements - Additional Required Staff	50	Is Nebraska state licensure required for all Prior Authorization staff and concurrent review registered nurses, including Pharmacy?	MLTC will provide this answer in the second round of questions for this RFP.
70.	IV.4E.8.a.xix Covered Services and Benefits - Core Benefits and Services	55	What are the definitions of "skilled services", "rehabilitative services", and "transitional nursing facility services" which must be	These services are defined as those meeting requirements outlined in 42 CFR 409 Subpart D, Requirements for Coverage of Post-hospital SNF Care.

			provided as a minimum benefit package?	
71.	IV.4E.8.a.,IV.4E.28, Iv.4E.29.b & 4E.29.b Covered Services and Benefits - Core Benefits and Services, Medical Transportation Services, and Excluded Services	54-55 66-67	Custodial nursing facility services are listed as excluded services. What core benefits and services are MCOs to provide to members who are residents of nursing homes but are receiving custodial services? For example, are MCOs required to provide emergency and non-emergency ambulance services to such members?	A MCO is to provide all core benefits and services with the exception of those included in the nursing facility per diem. Services included in the nursing facility per diem can be found at 471 NAC 12-009.05 http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-471/Chapter-12.pdf
72.	IV.4E.8.a, IV.4E.29.e Covered Services and Benefits - Core Benefits and Services and Excluded Services	54-55 66-67	Home and community based services are not included as a part of the core benefits or services. What core benefits and services are MCOs to provide to persons receiving home and community based services?	A MCO is to provide all core benefits and services to persons receiving home and community-based services.
73.	IV.E.11.b.ii Covered Services and Benefits - Pharmacy Services	58	Does this include any changes post 1/1/17? Does this include post P & T formulary changes? Please confirm what is considered a "change".	Any modifications of drug coverage must be submitted for review and approval at minimum 30 days prior to implementation. Notice may be less than 30 days during the first month of implementation.
74.	E.11.b.iv.c Covered Services and Benefits - Pharmacy Services	58	Please confirm that the posting of the MAC list would occur behind a secure channel for providers.	The State confirms that the MCO MAC list is not required to be posted publicly, but the MCO must maintain a website and post current and accurate information, including the MAC pricing, to be available to the State and provider network.

75.	E.11.b.i Covered Services and Benefits - Pharmacy Services	58	The language in this section states that all formulary policies and procedures must be submitted to MLTC for approval, but the RFP states that the MCO must follow the State's PDL. Please clarify as to when this scenario would occur.	See Glossary of Terms for the definitions of PDL and Formulary. The State's PDL is not an all-inclusive list of therapeutic categories. The MCO must cover the medications listed on the State's PDL, but will also need to maintain a formulary that covers medications not listed in the PDL. Refer to the following link for additional information: http://dhhs.ne.gov/medicaid/Pages/med_pharm.aspx
76.	E.11b.iv.a Covered Services and Benefits - Pharmacy Services	58	Please confirm that the MCO formulary would need to be posted on the website, since the MCO is required to follow the State's PDL?	The MCO will be required to post and maintain the most current and accurate MCO formulary on their website. The State PDL must also be posted.
77.	E.11.b.vi Covered Services and Benefits - Pharmacy Services	59	Given that newly available medications may not be available in First Data Bank, they cannot be coded or processed yet at the point of sale, so the MCO may not always be able to fulfill the 10 day requirement. Please clarify any exceptions to this requirement.	The MCO has 10 days to implement coverage after a new drug has been loaded on a National Drug Reference File.
78.	E.11.c.iii Covered Services and Benefits - Pharmacy Services	59	Please provide additional information on the volume of changes expected.	PDL files will be shared with MCOs on a weekly basis. Large-scale PDL possible changes occur biannually in conjunction with P&T meetings.
79.	E.11.c. vi Covered Services and Benefits - Pharmacy Services	59	Please clarify if this provision would prohibit the MCO from negotiating supplemental rebates, in addition to the Medicaid rebates that pharmaceutical companies	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.

			are required to provide.	
80.	IV.E.19.a Covered Services and Benefits - Limitations on Abortions	64	Confirm that MLTC Medical Director must also review all approvals for elective abortions prior to determination notification to the requesting provider. If so, (a) how does the plan send, (b) what is required to be sent to the MLTC Med Director and (c) what is the expected turnaround time from the MLTC Med Director? Also, who will provide reviews if the MLTC Med Director is out of the office?	The State is currently establishing this process and will be provided to the awarded contractors.
81.	IV.E.21 Covered Services and Benefits – Transplants	65	Is the MCO required to follow Medicare policies for transplants (i.e. - the RFP states that if Medicare does NOT have a policy the MLTC Medical Director will determine).	The MCO must cover transplants (including donor services) that are medically necessary and defined as non-experimental by Medicare. Per Section IV, E.21, "As required by 471 NAC 18-004.40, the MCO must cover transplant services, including donor services that are medically necessary and defined by Medicare as non-experimental."
82.	IV.E.28.a Covered Services and Benefits - Medical Transportation Services	66	The section states that NEMT is only covered for medical transportation by an ambulance; however, the other NEMT are not listed under Excluded Services IV.E.29, page 66/67. Please clarify.	See Addendum 3-Revisions to the RFP.
83.	IV.E.29	66-67	Eligible populations include	The MCO is responsible to provide all services in the core

	Covered Services and Benefits - Transplants		“Medicaid beneficiaries who participate in a HCBS Waiver program"; however, all HCBS waiver services are excluded from MCO responsibility. Which party will be financially responsible for any HCBS services for waiver-eligible individuals that are assigned to a “wait-list?”	benefits package and any value-added services as approved by the State for its members. This responsibility is not affected by the member’s waiver status.
84.	IV.F.2.b.v, IV.F.2.xi. Member Services and Education - Member Services Call Center	69	Please confirm that the lines on Section IV.F.2.b.v and IV.F.2.xi were left intentionally blank.	The lines were unintentionally left blank. No requirements are missing or intended for these numbers.
85.	IV.H.7.a. and IV.H.7.c Member Services and Education - Access to State Fair Hearings	92	Please clarify if the member is required to exhaust the plan’s internal appeal process prior to submitting a request for a State Fair Hearing?	The member is required to exhaust the plan's internal appeal process prior to submitting a request for a State Fair Hearing.
86.	IV.I.4.i Provider Network Requirements - Establishing the Network	96	"The MCO must strive to improve the ability of its behavioral health provider network to meet all the health needs of members through strengthened collaboration with PCPs, service providers, inpatient hospital providers, and consumer/peer providers.” Will the State allow providers to bill for same-day services for physical health and behavioral health visits when co-located in the same provider office?	Yes.

87.	IV.I.4.i Provider Network Requirements - Establishing the Network	96	Please further clarify what will constitute "collaboration with the DHHS Division of Behavioral Health and State behavioral health regions"	Collaboration will include, but is not limited to, a commitment by the health plan to participate in meetings or on committees that identify barriers and solutions that supports the level of care needed by Medicaid clients and other clients served by the Division of Behavioral Health.
88.	IV.I.13 Provider Network Requirements - Provider Enrollment in Medicaid	100	Please clarify whether a provider who has applied for MLTC enrollment but is not yet enrolled AND is credentialed by the MCO may see patients, or whether the MCO must wait until MLTC enrollment is complete.	MLTC enrollment must be complete in order for a provider to see patients. The MCO has the option to authorize services out of network until the MCO credentialing is complete.
89.	IV.J.3.a.ix Provider Services - Provider Handbook	104	Are the "medical record standards" to be included in the Provider Manual those that are reflected in the RFP (i.e. - applicable to MCOs) or are there separate regulatory requirements for physicians?	The medical records standards are to be included in the Provider Manual and must include all standards set forth in the RFP and all applicable regulatory requirements.
90.	IV.M.11 Quality Management - Member Advisory Committee	124	Please clarify who would be considered a member's representative, for purposes of fulfilling the requirements of the Member Advisory Committee.	See Page xvi in the Glossary of Terms for the definition of Representative.
91.	IV.M.12 Quality Management - Clinical Advisory Committee	124-125	Does the State intend for plan members to participate on this committee as well? There is a reference to "members" but it's unclear whether it is intended to mean members of the	Plan members will not participate in this committee. This reference to member refers to members of the committee.

			committee or members of the plan.	
92.	IV.N.2.f Utilization Management - UM Program Description	126	Please clarify the statement regarding involvement of "actively practicing", board certified physicians in the program to "supervise" ALL review decisions and review denials for medical appropriateness. Is it the intent of MLTC that this section is referencing the physicians that should participate in the Clinical Advisory Committee/UM Committee or actual practicing providers that are reviewing UM decisions?	Active practicing providers must supervise all UM review decisions and review denials for medical appropriateness.
93.	IV.N.11.b Utilization Management - Restricted Services	131	Please confirm the type of restriction program: pharmacy, provider, or both?	See NAC 471 NAC 2-004 for categories of pharmacy and provider restriction. http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-471/Chapter-02.pdf
94.	IV.O.1.h Program Integrity - General Requirements	133	The RFP states that "The MCO, as well as its subcontractors and providers, whether contracted or non-contracted, must comply with all Federal requirements (42 CFR 455) about disclosure reporting." Please clarify the MCO's responsibility with respect to non-contracted providers.	The MCO's responsibility is the same for both contracted and non-contracted providers.

95.	IV.O.1.j Program Integrity - General Requirements	133	The staffing ratio required under the Program Integrity section is one (1) investigator for every 50,000 or fewer members; however the Staffing Requirements section (IV.D.3.i,p.51) states a ratio of one investigator for every 100,000 members or less. Please clarify which requirement the MCO should abide by.	The MCO is required to comply with the ratio requirement of one (1) investigator for every 50,000 or fewer members as stated in Section IV.O.1.j. Section IV.D.3.i is hereby amended as follows "The MCO must have a minimum of one investigator for every 50,000 members or less."
96.	IV.O.3.a.ii. Program Integrity - Prohibited Affiliations	134-135	The cited section identifies those parties with whom an MCO may not knowingly have a relationship. The listed parties include the following: "An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation, of: a) A director, officer, or partner of the MCO. b) A person with beneficial ownership of 5% or more of MCO equity. c) A person or entity with an employment, consulting, or other arrangement with the MCO under its contract with the State. " Please confirm that a company, such as a parent or affiliate company, would not	A parent or affiliate company is not considered a person with respect to this requirement.

			be considered a “person” with respect to this requirement.	
97.	IV.O.15.b Program Integrity - Investigative Collaboration	140	Please clarify whether the ten year timeframe for investigation is limited only to that timeframe in which the MCO had a relationship with the applicable member or provider.	The ten year timeframe applies to the MCO and a parent or affiliate company's relationships with a provider.
98.	IV.P.2.e MCO Reimbursement - Capitation Rate Determination Process	142	Categories of eligibility include those individuals receiving LTSS, both institutional and home and community-based services. Please clarify those covered services for these categories of eligibility that the MCO will be responsible for.	The services covered for these individuals are outlined on page 54 of the RFP, Section IV.E.8. This includes physical health services, behavioral health services, and pharmacy services, and excludes NEMT non-ambulance, dental services, and long term services and supports.
99.	IV.P.5.g., IV.P.5.i MCO Reimbursement	144	"The supplemental payment for deliveries is intended to reimburse the MCO for five (5) months of prenatal care, the delivery, and two (2) months of post-partum care.” “The MCO must submit encounter data evidence of the delivery, plus any other inpatient and outpatient services for the maternity care of the member to be eligible to receive a supplemental delivery payment.”	Yes, the supplemental payment will be issued to the MCO in which the mother is enrolled at time of delivery if maternity care (prenatal and/or post-partum care) is rendered by another MCO. The supplemental payment is initiated by the MCO sending maternity care information in the Maternity Care Payment file. In the absence of a hospital inpatient stay the MCO may submit other inpatient or outpatient services for the maternity care of the member to be eligible to receive a supplemental delivery payment.

			Will the supplemental payment be issued to the MCO in which the mother is enrolled at time of delivery if maternity care (prenatal and/or post-partum care) is rendered by another MCO? Does the encounter data for maternity care and the delivery need to be submitted by the same MCO in order to trigger the supplemental delivery payment?	
100.	IV.P.12.a MCO Reimbursement - Administrative Cap	148	"Per Neb. Rev. Stat. §71-831, 68-908, and 71-801 (2012), the MCO's administrative spending must not exceed 7%, except up to an additional 3% is allowed, if the additional amount is for the purpose of quality improvement and approved by MLTC." Please describe the MLTC approval process to determine whether certain administrative spending would qualify for "the purpose of quality improvement." Will there be a mechanism for this approval prior to submission of the RFP response? Additionally, the statutes cited above appear to refer to behavioral health services	Attachment 5 is hereby amended to include a Quality Administrative Expenses proposal for review and approval of quality activities for consideration in the 3% admin cap. The proposal is due 120 days prior to contract start date. The provision related to the Administrative Cap applies to all administrative expenditure.

			only. Does this provision related to the Administrative Cap apply to all administrative expenditures or just those specifically related to behavioral health services?	
101.	IV.P.12.e MCO Reimbursement - Administrative Cap	148	"Hold-back funds, both earned and forfeited, are factored into the administrative cap calculation." Does this include both the holdback associated with the MLTC Quality Performance Program (1.5% of the aggregate of all income and revenue) as well as the State Performance Penalties (0.25% of the aggregate of all income and revenue)?	See response to Question #33.
102.	IV.Q.6.b Provider Reimbursement - Value Based Contracting	150	Please confirm that the 30% and 50% of the provider network measures that relate to Value-Based Contracting, refer to the number of contracts or providers and not the number of members.	30% and 50% of the provider network refers to the number of providers.
103.	IV.Q.6.b Provider Reimbursement - Value Based Contracting	150	Does this include all provider types? How is the denominator determined? Is it practitioners only or does it also include facilities?	The denominator includes all providers within the MCO's network.
104.	IV.Q.10 Provider Reimbursement -	152	Medicare cost reports are not prepared until well after the CAH's fiscal year end. Is the	MCOs are to use the cost report provided by DHHS Financial Services for cost settlement activities with CAHs.

	Critical Access Hospital Contracting and Reimbursement		MCO to use a mechanism other than the Medicare cost report? If the Medicare cost report is to be used, is the MCO to use the “as-filed” cost report, or the cost report that was audited and settled by CMS?	
105.	IV. Q.17.c Provider Reimbursement - Maximum Allowable Cost Program	153	Would the MCO be able to provide the information behind a secured connection on the MCO's website?	See response to Question #74.
106.	IV.R.8.d.iv Systems and Technical Requirements - Provider Enrollment	157	Please specify what, beyond including a provider's NPI, what specific "NPI requirements" must be included in the provider enrollment system?	Any NPI requirement that is transmitted to the MCO through State interface file must be included in the provider enrollment system.
107.	IV.S.15.f.i Third-Party Liability	176	Does the 365 day timeframe apply to overpayment recoveries for any reason, or only circumstances where TPL recoveries have not been successful?	The MCO is expected to recover overpayments for any reason within 365 days. If the MCO is unsuccessful in recovery after 365 days, MLTC may pursue recovery.
108.	IV.T.3.b Reporting and Deliverables - Information Related to Business Transactions	177	Please clarify what will constitute "full and complete information" that must be provided regarding ownership of subcontractors. Also, what would MLTC consider a "significant business transaction" between the MCO and a wholly owned supplier?	Full and complete information includes all information necessary to address disclosure requirements in IV.T.3.b.i and IV.T.3.b.ii. "Significant business transaction" is specified in IV.T.3.c.

109.	V.A.2.j Proposal Submission - Corporate Overview	198	Is there a threshold (percentage of revenue or dollar amount) that would apply to Subcontractors that should be identified for this requirement? Is this requirement limited to Subcontracts for certain services (e.g. care management or coordination services)? Does this requirement exclude providers contracted for participation in the Managed Care Organization's provider network?	Providers are not considered subcontractors. Bidders should address subcontracting in Attachment 19 on Questions #56 and #57.
110.	Attachment 6: Reporting Requirements Provider Grievances	Attachment 6, p.2 of 10	Please clarify that the Provider Grievance System (Appeals and State Fair Hearing) are intended to report the provider filing on the member's behalf only.	The Provider Grievance System reports for Appeals and State Fair Hearings are meant to summarize provider-related appeals and provider-related state fair hearings. Providers acting on behalf of members in appeals and state fair hearing proceedings would be summarized in the Member Grievance System reports.
111.	Attachment 11 – Rates	Attachment 11, Page 1 of 1	What are the dollar values of the transplant costs included in the Medical PMPMs shown in Attachment 11 – Rates?	The dollar value of the transplant costs in the medical PMPMs is $5.5 million in Rating Region 1 and $1.6 million in Rating Region 2.
112.	Attachment 11 – Rates	Attachment 11, Page 1 of 1	Please show the components of the Maternity and Katie Beckett non-medical loads separately by Admin, Quality Improvement, Performance Guarantee and Profit/Risk/Contingency as	See Attachment 21: "Non-Medical Load Assumptions" which identifies the Non-Medical Load components used at each end of the rate range by COA and region.

			shown for the composites in the Optumas Bidders' Conference Rate Presentation page 15.	
113.	Attachment 12 - Historical Transplant Cost Distribution Data	Attachment 12, Page 1 of 1	Are the transplant costs shown in Attachment 12 for the four-year period SFY2010-SFY2014 in total? If so, what are the costs by each SFY? What are the costs by Region?	Transplant costs in Attachment 12 are for the five year period SFY10 to SFY14. Transplant costs by year are: $5.4 million in FY10, $4.5 million in FY11, $7.1 million in FY12, $7.6 million in FY13, and $6.0 million in FY14. Costs by Region are not available.
114.	Attachment 13 Neb. Rev. Stat. 71-831	Attachment 13, p.1 of 1	Please verify that the restrictions contained in this statue apply specifically to behavioral health services and not to the broader scope of services to be provided by the Medicaid Managed Care Organization.	As the statute is currently written, the provisions of the statute would apply to the full scope of services.
115.	Attachment 13 Neb. Rev. Stat. 71-832	Attachment 13, p.1 of 1	"(2) Provide a definition of annual contractor profits and losses and restrict such profits and losses under the contract so that (a) profit shall not exceed three percent per year and (b) losses shall not exceed three percent per year, as a percentage of the aggregate of all income and revenue earned by the contractor and related parties, including parent and subsidy companies and risk-bearing partners, under the contract;" Please verify that the	This restriction is limited to only those revenues derived from this specific contract. The State will determine the compliance review process during readiness review.

			restrictions on profits and losses applies to the contractor and related parties, including parent and subsidy (sic) companies. Please clarify that this restriction is limited to only those revenues derived from this specific contract. How will the State measure or validate compliance with this requirement?	
116.	Attachment 15 - Medical Loss Ratio	Attachment 15, Pages 1 and 2 of 2	Will the 85% Minimum MLR requirement be calculated as an aggregate of Regions 1 and 2 or separately for each region?	The 85% Minimum MLR requirement will be calculated as an aggregate of Regions 1 and 2.
117.	Attachment 15 - Medical Loss Ratio	Attachment 15, Pages 1 and 2 of 2	Will the 85% Minimum MLR be aggregated over all categories of aid or separated for LTSS versus Non-LTSS subgroups?	The 85% Minimum MLR requirement will be calculated as an aggregate of all categories of aid.
118.	General - Capitation Rate Development	N/A	Please provide an example for the calculations flow from base data to final capitation rates, including how adjustments and trends are applied.	All adjustments applied to the base data to develop the final capitation rates have been provided to the bidders as part of the pre-proposal conference presentation. See Attachment 20: “COA-level Rate Development” for the step-by-step application of these adjustment values to the base data. The Effective Trend Days shown in this document represent the effective number of days needed to trend the base data to the contract period given the different base periods for Physical Health, Behavioral Health, and Behavioral Health Foster Care. Trend is applied at a COS-level, with each COS being trended for the appropriate number of days.
119.	Attachment 19	Attachment	For those questions with	Attachments will not count toward the questions' page limits as

	Proposal Statements and Questions	19	page limits, would attachment(s) count towards the question's page limit? Is there a page limit on attachments?	there is not page limits on attachments.
120.	Attachment 19 Proposal Statements and Questions	Attachment 19 p.2 of 21	Please confirm that the correct RFP Section Reference for Question#10 should read "IV.C Business Requirements" (and not IV.B).	The RFP Section Reference for Question #10 is hereby amended as follows: "IV.C Business Requirements."
121.	Attachment 19 Proposal Statements and Questions	Attachment 19 Page 1 of 21	Please confirm that the correct reference for question #5 is Section III. F., not III.G.	The RFP Section Reference for Question #5 is correct as listed. The RFP Section Reference for Question #4 in Attachment 19 is hereby amended as follows: "Section III.F Insurance Requirements".
122.	5151Z1 Evaluation Criteria Attachment	Evaluation Criteria p.2	Please verify that only the “top-scoring bidders” may be invited for oral presentations at the State’s discretion as stated in Section II.G on page 3. If the State opts to proceed with oral presentations, will all “top-scoring bidders” be invited for oral presentations in order to allow for an equitable opportunity among “top-scoring bidders” to earn the 150 points identified in the Evaluation Criteria Attachment?	The State reserves the right to select only the top scoring bidders for oral presentations.
123.	Proposal Statement and Questions	Attachment 19, page 4	Is the work plan requested in this question part of the larger transition/implementation plan, or a stand alone?	The work plan requested should stand alone as a plan for implementation of Pharmacy Services as described in the RFP. It may also be a component of a bidder's larger transition/implementation plan.

124.	Proposal Statement and Questions	Attachment 19, page 5	Will the examples of information that will be available on the member website be counted in the 6-page limit?	Examples of information that will be available on the member website will not be counted in the page limit.
125.	Proposal Statement and Questions	Attachment 19, page 5	Will the examples of member education be counted in the 10-page limit?	Examples of member education will not be counted in the page limit.
126.	Proposal Statement and Questions	Attachment 19, page 5	Will the flowchart be counted in the page limit? If not, please consider extending the page limit as three pages to provide a "comprehensive written description" and flow chart are not likely to be sufficient.	The flowchart will not be counted in the page limit.
127.	Proposal Statement and Questions	Attachment 19, page 11	Please confirm that the page limit excludes the proposed health risk assessment template.	The proposed health risk assessment template will not counted in the page limit.
128.	Proposal Statement and Questions	Attachment 19, page 12	Will the proposed QAPI work plan be included in the 10-page limit?	The proposed QAPI work plan will not be counted in the page limit.
129.	Proposal Statement and Questions	Attachment 19, pg 17	How does the state define "30% of its provider network"? 30% of providers? 30% of contracts? 30% of spend? Other?	See response to Question #102.
130.		Attachment 19	Attachment 19 does not contain any questions related	Confirmed.

			to section IV.G Member Marketing of the RFP (pages 82-87). Please confirm that this correct.	
131.	III.	Page 7	Please confirm that rates are applicable for the initial contract term of six months (1/1/17-6/30/17).	The initial contract term will be 12 months, 1/1/17 – 12/31/17. This is consistent with the rates in Attachment 11, which represent a Calendar Year 2017 contract period.
132.	III.F.3.	Page 10	Please provide details regarding the underlying medical claims so that we may comply with III.F.3.d. For example, please provide member-specific annual spend levels for the over-certain attachment points (e.g., 50K, 100K, 150K, 200K).	The details requested in this question are not available.
133.	III.EE	Page 19	The performance bond amount of $50M appears to be for entire program. How will the amount applicable to each bidder be determined?	Each contract awarded from this RFP will require a $50 Million performance bond. See the response to Question #11.
134.	IV.A.1.f.iii	Page 31	Who is the current enrollment broker?	The current enrollment broker is The Medicaid Enrollment Center
135.	IV.A.1.g.ii.	Page 31	This states that the "Inclusion of pharmacy service in the core benefit package and the MCO capitation rate at a date to be determined by MLTC"; however, Attachments 10A-10D appears to have pharmacy included. Do the	Rates provided include pharmacy. See response to Question #61.

			rates provided include pharmacy? What is the timeline for the pharmacy inclusion?	
136.	IV.B.4.b.ii.and iii	Page 35	This section states that the MCO will not be responsible for services rendered to a member prior to the date of enrollment; however, IV.B.4.h. states that the MCO is responsible for member care on the first day of the month in which eligibility was determined. Will there be a limited amount of time that a member's eligibility will be retro'ed onto managed care?	See response to Question #19.
137.	IV.B.4.c	Page 35	Does the MCO have sole authority to manage and report member status changes or will members still be reporting changes directly to ACCESSNebraska? When contradictory information is reported, what information will be used?	The MCO is responsible for providing information to ACCESSNebraska as set forth in Section IV.B.4.c.i of the RFP. The member is responsible for contacting ACCESSNebraska to report all status changes. The ACCESSNebraska will validate the information when reported.
138.	IV.B.5.d & e	Page 36	Item 5.d outlines conditions for PCP auto-assignments (d.i - d.iii). In 5.e the requirement notes that two situations require the MCO to reach out to the member and ask him/her to make an alternate PCP selection,	The first sentence of Section IV.B.5.e is hereby amended as follows: "If either of the two (2) situations set forth in provision IV.B.5.d.ii or IV.B.5.d.iii immediately above occur, the MCO must reach out to the member and ask him/her to make an alternate PCP selection."

			referring to d.i and d.ii; however, the conditions would suggest that this should actually refer to d.ii and d.iii, since those conditions concern members who have made a PCP selection, whereas d.i concerns members who have not made a selection. Please confirm that requirement 5.e should read: "If either of the two (2) situations set forth in provision d.ii or d.iii immediately above occur, the MCO must reach out to the member and ask him/her to make an alternate PCP selection..."	
139.	IV.E.11.b.vi.	Page 59	Will the state make available and be ready to accept new procedure codes and have rates established so that the MCOs can meet this standard?	The State will accept all valid procedure codes and establish rates so that the MCO can meet this standard.
140.	IV.E.11.b.ix.a	Page 59	Does this requirement intend that all appeal rights would need to be available / exercised within one business day?	Member appeal rights are provided in Section IV.H.
141.	IV.E.12.c	Page 61	In instances in which the MCO must authorize a service not included in the State Plan, would the state be	The State's MMIS accepts any valid procedure codes. Any criteria not previously posted for these determinations must be developed and submitted to MLTC for review and approval in accordance with Section IV.N.4.c. of the RFP.

			able to accept all procedure codes not currently utilized and accept all associated rates? Additionally, would the MCO be supported in utilizing Medical Necessity Criteria not previously posted for these determinations?	
142.	IV.E.28.a.	Page 66	Are NEMT included in the contractor's rates? Are the contractors responsible for NEMT?	See response to Question #82.
143.	IV.E.29.d	Page 67	Please confirm that services rendered in school settings would be excluded.	Per Section IV.E.29, school-based services are excluded.
144.	IV.F.4.d and IV.F.13.b.i	Page 70 and page 80	The requirement for distributing new member materials appears to be within 30 calendar days of enrollment (page 70). However, there is further instruction (page 80) to send welcome packets to new members within 10 business days of receiving the new member file. Please clarify the difference in these requirements.	The first sentence of Section IV.4.d is hereby amended as follows: "The MCO must distribute member materials to each new member within ten (10) calendar days of enrollment." Welcome packets are required to be distributed within ten (10) business days of receiving the member file. Please see Section IV.F.13.b for included requirements. New member materials may be other materials not specified in Section IV.F.13.b and must be distributed within 30 calendar days of enrollment.
145.	IV.H.6.i.b.iii	Pg. 92	Assuming all services will be ordered by an authorized provider, is the intention of this language that a continuation of benefits is	See Section IV.H.6.a. for when the MCO must continue a member's benefits.

			required for all appeals?	
146.	IV.I.2.a	Pg. 94	Does this requirement intend to state that the MCO cannot pay providers of different licensing status different rates? Additionally, does this requirement prevent an MCO from restricting the services eligible for reimbursement for licensed providers when service delivery is within the scope of the practitioner's license?	This requirement is not intended to prevent an MCO from negotiating payment rates based on license type. The MCO may not restrict the services eligible for licensed providers when service delivery is within the scope of the practitioner's license.
147.	IV.J.4.c.ii	Pg. 106	Does this requirement mandate that all services must have online authorization request capability?	Online authorization capability is required for the services the MCO identifies as requiring prior authorization.
148.	IV.L.5.f	Pg. 116	As members are typically not eligible for Medicaid care during a State hospital stay (n accordance with IMD regulation), does this language mandate MCOs to coordinate care for members not eligible for managed care or is the intention to enroll members into managed care while still in State hospitals? Does this expectation extend to transition plans for youth transitioning out of State-run PRTF facilities as well?	Section IV.L.5.f requires the MCO to develop, implement, and evaluate written policies and process consistent with existing State policies and procedures regarding continuity of care. This includes collaboration and communication with other providers involved in a member's transition to another level of care, to optimize outcomes and resources while eliminating care fragmentation. The expectation for care coordination and transition planning does include youth transitioning out of a State-run PRTF.

149.	IV.N.6.b	Pg. 129	Does this requirement mandate the use of specific set of Medical Necessity Criteria (clinical guidelines) for continued Inpatient stay specifically?	MLTC is not mandating the use of a specific set of Medical Necessity Criteria.
150.	IV.O.1.e.	Page 133	This section requires the MCO to report any suspicion of fraud to NMPI immediately. Section IV. O.12.b. (Page 138) requires reporting of tips and referrals a minimum of every two weeks. Can you clarify the reporting expectation regarding early suspicion of possible fraud?	The MCO is required to immediately report suspicion of fraud via email and on a template developed by MLTC.
151.	IV.O.1.j	Page 133	Section IV.O.1.j requires a minimum of one investigator for every 50,000 or fewer members. Section IV.D.3.i (Page 51) requires one investigator for every 100,000 members. Please clarify the staffing requirement for investigators.	See response to Question #95.
152.	IV.O.6.e	Page 136	If MFPAU chooses to intervene in an MCO hearing or review of sanctions against a provider, will the MCO be notified of this intervention in writing?	Yes, MFPAU will notify the MCO in writing of intention to intervene.
153.	IV.O.6.e	Page 136	Will MLTC consider placing a reasonable limit on the	MFPAU has the right to intervene in proceeding and suspend until the MFPAU's investigation is complete.

			amount of time the MCO may be required to suspend proceedings, particularly as provider appeals may need to be processed according to specific timeframes to maintain required accreditation?	
154.	IV.O.11.b	Page 139	Will MLTC provide the MCO with any available data regarding recipients' dates of death or dates of incarceration to facilitate the required quarterly audit?	This information will be provided via the member enrollment files.
155.	IV.O.15.b	Page 140	Is the intent of this section that the MCO will investigate cases of suspected fraud for periods of time prior to the current contract?	See response to Question #97.
156.	IV.O.17	Page 141	Section IV.O.17 requires consultation with NMPI and MFPAU prior to recoupment in "these circumstances". Section IV.O.1.f (Page 133) requires the MCO to pursue "all recovery of payments identified as FWA" and other sections require the pursuit of overpayments when TPL is identified. Please provide a definition of the specific circumstances under which NMPI/NMFPAU consultation is required prior to recouping	The first sentence of Section IV.O.17 is hereby amended as follows: "If the MCO thinks that it is appropriate to initiate a recoupment or withholding action against a provider, the MCO must consult with both NMPI and MFPAU to ensure that such action is permissible."

			identified overpayments.	
157.	IV.P.2	Page 142	Please provide enough detail to determine how rates are figured, including each step of the process, from determining base to final rate.	See response the Question #48.
158.	IV.P.2.e.xx.	Page 143	What is the rationale for coordinated care savings and amount of adjustment applied to the rates?	The only program change similar to a coordinated care saving is the service delivery adjustment applied to the dual population. Individuals dually eligible for Medicaid and Medicare were previously not enrolled in physical health managed care. The non-nursing home level of care duals represent a significant opportunity for care savings. Inpatient utilization was reduced by 10%, Outpatient utilization was reduced by 15%, and Emergency Room utilization rates were reduced by 25%. The aggregate impact of these changes to this dual population is a reduction of 5.4%. Outside of the dual population, there are no assumed savings due to coordinated care used in creating rate ranges.
159.	IV.P.2.k.	Page 143	When will the narrative on the capitation rate be available?	See Attachment 22: “Heritage Health Rate Development Narrative”, for an overview of the rate setting methodology.
160.	IV.P.5	Page 144	Can you confirm that the maternity supplemental payments made to the MCO will be counted as Qualifying revenue for both the risk corridor calculation and the administrative cap calculation?	Confirmed.
161.	IV.P.5/ Attachment 10	RFP Page 144, Attachment 10 maternity cohort	Can you provide any detail on the rate for the maternity supplemental payments? Also, can you provide any databook information on the number of qualifying births in	The rate for the maternity supplemental payments is shown as the “Maternity” category of aid on the rate exhibits. Similarly, the “member months” for this aid category represent the qualifying deliveries.

			the State?	
162.	IV.P.12	Page 147	Please provide claims volume for the most recent two fiscal years. Identify electronic receipt versus paper.	The State cannot respond to this request without additional information. Submit question with specific claim type information in order to respond to this question. Please submit further detail during the second round of questions.
163.	IV.P.12	Page 147	Please provide call volume, delineated between business hours versus after hours for the two most recent fiscal years.	The State needs additional information on the type of call volume. Please submit further detail during the second round of questions.
164.	IV.P.12	Page 147	What services need prior authorization and what are the volumes related to those services for the two most recent fiscal years.	The State needs additional information on the prior authoirizations for fee for service. Please submit further detail during the second round of questions.
165.	IV.P.12	Page 147	Since the administrative cap calculation includes the hold-back, will it just be calculated as "gross" revenue in each month, or will the hold-back only be included when settled a the end of each fiscal year? If it's only included at the end of the fiscal year, for which fiscal year will it appear in the calculation?	The capitation rates have been developed such that the administrative cap calculation is gross of the 1.5% hold-back, so that to the extent the MCO earns back the entire 1.5% hold-back at the end of the fiscal year, the administrative load provided to the MCO will remain under the required cap. It would be calculated in the fiscal year in which the hold-back occurs.
166.	IV.Q.13	Page 154	This section states that the MCO must reimburse a member for any payments made by the member, for services rendered during a period of retro eligibility. Would this apply to situations	All services that would have been covered by the Medicaid FFS program must be covered by the MCO, retroactive to eligibility. To clarify the process for member reimbursement, IV.Q.13 is hereby amended as follows: "The MCO is responsible for benefits and services in the core benefits package from and including the effective date of a member's Medicaid eligibility. The MCO must reimburse a provider and that provider must

			in which services previously rendered are determined to not be medically necessary?	reimburse a member for payments already made by a member for Medicaid covered services during the retroactive eligibility period. The date of enrollment in a MCO will match the Medicaid eligibility date."
167.	IV.R.1.c	Page 154	Approximately how many MLTC staff will require access to the MCO's systems? Will all staff require the same type of access or will individual staff access vary based on the role of the individual user?	Currently, the State does not have access to the MCOs systems. This will be determined during the readiness review process with awarded MCOs. Access wil vary based on the individual user.
168.	IV.S.3.ii	Page 164	Does this language only extend to the MCOs contracted by the State of Nebraska or would it extend to timely filing processes for other primary payers?	This language would extend to timely filing process for other primary payers.
169.	IV. S.15.b.ii	Page 174	Please clarify if the MCO may choose to pay and chase for the three listed categories of claims or if the MCO is mandated to pay and chase rather than cost avoid in these cases.	The MCO may choose to pay and chase for the three listed categories of claims.
170.	IV. S.15.b.ii.c	Page 175	Will MLTC provide an indicator to the MCO identifying Title IV-D child support individuals to assist in appropriate COB efforts?	Yes, this indicator will be provided via the enrollment files.
171.	A.2.h	Page 197	The instructions note that the State will use no more than three narrative project	See the response to Question #44.

			descriptions during proposal evaluation. Are we limited to describing three similar projects? If not, how will the State select the three to consider in the evaluation?	
172.	V. Proposal Instructions	Pages 196-198	There are several questions where additional information is specifically requested to be attached (e.g., copy of COA, work plans, sample materials). Is it permissible to include attachments that are not specifically requested?	Attachments that are not specifically requested may not be considered in the evaluation process.
173.	A.2.h	Page 197	Can bidders include experience from affiliate organizations/sister companies?	Yes.
174.	A.2.h	Page 197	Please clarify what "budget" information the state would like us to include (e.g., contract value)?	Per Section V.A.2.h.i.e, "Each project description shall identify whether the work was performed as the prime Contractor or as a Sub-Contractor. If a bidder performed as the prime Contractor, the description must provide the originally scheduled completion date and budget, as well as the actual (or currently planned) completion date and actual (or currently planned) budget." The budget as indicated above refers to the project budget verus the actual budget.
175.	N/A	Page 1	The Key Staff Resumes item from Attachment 5 requests that resumes be included in the proposal only for key personnel. However, Item	The State would prefer resumes for key personnel.

			A.2.i Summary of Bidder's Proposed Personnel/Management Approach on page 198 of the RFP requests that resumes be provided for all proposed personnel. Which does the state prefer?	
176.			What are the metric definitions associated with the measures outlined in this attachment?	All measures included in Attachment 7 are nationally recognized quality measures. More information can be found on the Adult Core Set Measures and Child Core Set Measures by visiting the CMS website at www.cms.gov. HEDIS measures can be found on the NCQA website at www.ncqa.org.
177.			For the Rx factors of 6.5% and 6.7%, could the underlying assumptions used be provided? i.e. Inflation, utilization, drug-mix, off-patent, new medications etc.	The State's actuary will conduct these analyses when developing actuarially sound rates in early 2016. At that time, this information will be available.
178.	Item 4	Page 1	Please define QI admin expenses allowed with the additional 3% admin cap and explain how those expenses differ from the expenses allowed in the MLR calculation	The Glossary of Terms is amended to add: **Quality Improvement (QI) Expenses**: These are expenses for the direct interaction of the insurer, providers and the enrollee or the enrollee's representatives (e.g., face-to-face, telephonic, web-based interactions or other means of communication) to improve health outcomes as defined below. This category can include costs for associated activities such as: **1.** Effective case management, Care coordination, and Chronic Disease Management, including: **a.** Patient centered intervention such as: **i.** Making/verifying appointments; **ii.** Medication and care compliance initiatives; **iii.** Arranging and managing transitions from one setting to another (such as hospital discharge to home or to a rehabilitation

				center); **iv.** Programs to support shared decision making with patients, their families and the patient's representatives; **v.** Reminding insured of provider appointment, lab tests or other appropriate contact with specific providers; **vi.** Incorporating feedback from the insured to effectively monitor compliance; **vii.** Providing coaching or other support to encourage compliance with evidence based medicine; **viii.** Activities to identify and encourage evidence based medicine; **ix.** Activities to prevent avoidable hospital admissions; **x.** Education and participation in self-management programs; and **xi.** Medication and care compliance initiatives, such as checking that the insured is following a medically effective prescribed regimen for dealing with the specific disease/condition and incorporating feedback from the insured in the management program to effectively monitor compliance. **b.** Improve patient safety; **c.** Wellness and health promotion activities; **d.** Health Information Technology (HIT) expenses related to Quality Improvement Activities: **i.** Data extraction, analysis and transmission in support of the activities described above; and **ii.** Activities designed to promote sharing of medical records to ensure that all clinical providers and accurate records from all participants in a patient's care. **2.** The following items are broadly excluded as not meeting the definitions above:

				a. All retrospective and concurrent Utilization Review; **b.** Fraud Prevention activities; **c.** The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network; **d.** Provider Credentialing; **e.** Marketing expenses; **f.** All Accreditation Fees; **g.** Costs associated with establishing or maintaining a claims adjudication system; **h.** Costs associated with calculating and administering individual enrollee or employee incentives; and **i.** Any function or activity not expressly listed as approved.
179.	Item 4	Page 1	Can you confirm that if QI expenses are allowed for the numerator MLR calculations, they would then be classified as medical costs and not count towards the 10% administration cap.	The QI expenses allowed for the numerator would count towards the 10% administrative cap per state statute.
180.	Bidders Conference Rate Presentation	All pages	Is cost settlement for PRTF payments to Hastings Regional Center and Lincoln Regional Center included in this program? If so, why is it not included in the rate development?	Yes, the cost settlement for PRTF payments to Hastings Regional Center and Lincoln Regional Center is included in the developed rates. It is included as part of the “Other Policy Changes” in the NE Heritage Health Bidder's Conference Rate Presentation (Optumas) on slide 11 of 20.
181.	Bidders Conference Rate Presentation		Please detail what the service delivery adjustments are and how they were created	Please see the response to Question #158.

182.	Bidders Conference Rate Presentation		Please detail the immediate enrollment policy adjustment. How was this adjustment developed?	The impact of this program change was calculated by comparing the PMPM cost for members whom were in at least their second month of eligibility for the February to June 2014 time period to the PMPM cost for all members whom were eligible during that period. The difference between these two PMPM costs would estimate the impact of immediate enrollment for those members who had enrolled in the managed care program after the policy was implemented.
183.	Bidders Conference Rate Presentation		Please detail all other policy changes (APR-DRG, FQHC APM, BH Provider Increase) – how were these developed?	APR DRG: On July 1, 2014 the State of Nebraska moved from using the AP DRG payment methodology to the APR DRG payment methodology for inpatient hospital claims. This change impacts all hospitals that are reimbursed on a DRG basis; this excludes hospitals reimbursed on a per diem basis such as Critical Access Hospitals (CAHs) and rehab facilities. The impact of this change was calculated by first re-pricing all impacted inpatient hospital claims in the SFY14 base data, at the AP DRG version 27 weights and SFY14 hospital rates specific to each hospital. This was done to ensure that the comparison between the AP DRG and APR DRG reimbursement would not be influenced by any contracting or payment differences between the MCO reimbursement and the State AP DRG fee schedule. The State's actuaries then assigned an APR DRG and severity level to all inpatient hospital claims included in the analysis based on version 31 of the grouper. This was done by utilizing software from 3M who developed the APR DRG grouper. These claims were then re-priced using the APR DRG version 31 weights and SFY15 hospital rates. The final impact was calculated by comparing the percentage change from the SFY14 AP DRG re-priced amount to the SFY15 APR DRG re-priced amount for each category of aid and MCO. The transition to the APR DRG payment methodology was intended to be budget neutral at a global level, however it should be recognized that this may break down between health plans and especially between rate cells. The overall results do show that the

				impact is close to budget neutral in aggregate but does show increases and decreases by rate cell. FQHC APM: Effective 1/1/2016 the State will begin paying Federally Qualified Health Centers (FQHCs) a new Alternative Payment Methodology (APM) rate. To account for the impact this reimbursement change will have on the Heritage Health capitation rates, the State's actuaries identified all FQHC utilization in the base data and priced it at the new APM rate. The pricing was done separately for the FY14 and FY15 base data sets, and the resulting impact was blended together at a 50/50 rate consistent with the overall rate development. BH Provider Increase: The behavioral health provider increase is a legislatively-mandated fee schedule change applicable to behavioral health providers. Recently this change has been a 2.25% increase to behavioral health provider reimbursement, but that has not always been the case and is not guaranteed to continue. For projection to the Heritage Health contract period the State's actuaries assumed the 2.25% annual increase will remain consistent. The provider increase was applied by increasing data to reflect the number of fee schedule changes between the data time period and the contract period. For example, FY14 reimbursement was increased by 2.25% to reflect FY15 reimbursement levels. Then, the combined FY14/FY15 base (already adjusted to be at FY15 legislatively-mandated reimbursement levels) was increased for two more 2.25% fee schedule changes, one effective July 2015 and another anticipated to be effective July 2016. Finally, due to the 12-month calendar year contract period, one-half of the 2.25% program change anticipated to be effective July 2017 was applied.
184.	Bidders Conference Rate Presentation		Were the same trends by Category of service applied to each category of aid? Were unit cost and utilization trends	Attachment 23:"COS and COA Trends" contains the trends by category of service and major category of aid. The trend model used to develop these figures is not available. The development process consisted of reviewing FY13, FY14, and FY15 data by

			created separately? Please provide the trend analysis to support the chosen trend numbers.	month, category of service, and major category of aid. Data was controlled for membership mix by rolling up sub-categories of aid on the most recent month's membership mix to create major categories of aid. Data was also controlled for known policy changes by increasing data prior to the policy change to be consistent with the value after the policy change became effective. Nebraska data was the primary source for trend development, but the State's actuary's national and regional experience was also used to inform trend values. Additional details, such as utilization trend and unit cost trend, will be provided when rates are updated in the spring.
185.	Bidders Conference Rate Presentation		Please provide the detail behind the UNMC PMPM adjustment.	The University of Nebraska Medical Center (UNMC) providers are reimbursed at commercial fee levels. MCOs contract at levels more commensurate with Medicaid reimbursement, a supplemental payment is required to be paid to UNMC by each MCO to make these providers whole. The State includes this supplemental payment as part of the capitation rates, which is then passed through from the MCOs to UNMC. To develop this rate pass-through the State's actuaries receive a list of UNMC Provider IDs from the State as well as the current managed care entities. These lists were used to identify claims and services attributed to a UNMC provider. The State also provided the most recent UNMC fee schedules, which were used to calculate the difference between the UNMC fee schedule and the UNMC reimbursement inherent in (a) the FFS data for currently un-managed populations and (b) the MCO encounter data for populations currently enrolled in managed care. The difference between the adjusted reimbursement and the reimbursement reflected in the FFS and encounter data at current utilization levels is the amount paid as a supplemental rate to UNMC.
186.	Bidders Conference Rate Presentation		Please provide the development of the 2.9% NML for Katie Beckett and	See Response to Question #112.

			Maternity categories. How does this account for the quality initiatives and profit?	
187.	Bidders Conference Rate Presentation		Please provide the build of NMT for each rate cell.	Effective 7/1/2015, the Non-Emergency Transportation-Ambulance service will be provided as part of the managed care contract. This service was not a required benefit under the managed care contract during the duration of the base data period (SFY14-15). While very low utilization was included within some of the base data, historical Nebraska FFS data (SFY08-10) was trended to the contract period and used to supplement the base data. The PMPM added in by cohort and Rating Region for NEMT-Ambulance services can be found in Attachment 24: "NEMT-Ambulance Rates."
188.	Bidders Conference Rate Presentation		Will the retro adjustment be included in the revised rate that will be provided in the spring?	Yes.
189.	I.A.Schedule of Events	1	Given the short time to review the RFP in advance of the first Pre-Proposal Conference, we believe a second bidders' conference would be beneficial and most efficient for all. This will ensure that all bidders have an opportunity to understand the proposal in its entirety and result in the best possible bidding process. Please confirm the State will hold the second conference on 11/19.	See Addendum 2-Revised Schedule of Events.
190.	I.A.Schedule of Events	1	It is our understanding that the Attachment 11 rates are not final. Given the	See section IV.P.2 for a detailed description of the Capitation Rate Determination Process.

			anticipated large rate adjustments that will be made in the Spring, how will the winning MCOs be involved in determining the final rates for 1/1/17-6/30/17?	
191.	III QQ. Prices	24	Please confirm that bidding MCOs will not be required to submit anything, besides QQ, as part of their acceptance of the rates under the contract.	Confirmed. No cost proposal is required.
192.	IV. A.1 b. Program Description	30	This section states: "Nebraska Medicaid currently provides health care coverage for approximately 239,000 individuals each month at an annual cost of approximately $1.8 billion." However, Attachment 11 has an average of 228,000 eligibles that produce $1.1 billion in revenue including the UNMC supplemental payment. Please describe the difference. Are the rates presented in Attachment 11 capturing all of the expenses?	The difference is caused by populations and services excluded from Heritage Health. The rates presented in Attachment 11 are capturing expenses for the included populations and services.
193.	IV. A.1 d. Program Description	30	Please describe all current and anticipated CMS waivers under which this program will operate.	The current managed care program and Heritage Health will operate under State Plan and 1915(b) Waiver authority.
194.	IV.A.11. Excluded	32	This section states that the	The details requested in this question are not available. The members with a share of cost will be contained in the LTSS data

	Populations		following members are excluded: ""Beneficiaries who have excess income or who are required to pay a premium, except those who are continuously eligible due to a share of cost (SOC) obligation to a nursing facility or for HCBS Waiver services."" Therefore, please confirm the following about the members with SOC that are the MCOs' responsibility: a) Please provide a separate databook/amounts for the members who will be the MCOs' responsibility and have SOC by fiscal year, region, and rate cell. b) Please describe all administrative obligations of MCOs with respect to the collection of this share of cost. c) Please describe the manner in which rates are developed with regard to share of cost: is the rate developed in total, with the share of cost flowing through the state to the MCOs? Is the rate developed net of the share of cost obligation? Is	book, but the State's actuaries cannot presently isolate only those members with a share of cost obligation. The share of cost payments are paid to nursing facilities or HCBS providers that are outside of the benefits package of Heritage Health. Rates are developed net of the members' cost share obligation.

			there a settlement of some kind?"	
195.	IV.B.2.f. Member Enrollment/ Assignment	33	"Please clarify the MCOs' responsibility with regards to the retroactive time period: a) Please provide the membership, expenses, and utilization (by region, category of aid and category of service) associated for the total retroactive time period that the MCOs will be responsible for covering. b) Please provide the average length of the retroactive period by category of aid and region. c) Please describe the differences between the retroactive time period and the immediate enrollment. d) Is there a maximum retroactive period that MCOs would be responsible for? e) Is there any limitation on the types of services MCOs would be responsible for retroactive from enrollment date to retroactive eligibility date?"	Please see the response to Question #19 regarding a MCO's responsibility for retroactive time periods. Data analysis will be conducted to determine the cost of retroactive time periods compared to regular enrollment time periods. As discussed during the first pre-proposal conference and stated on the "NE Heritage Health Bidder's Conference Rate Presentation (Optumas)" retroactive time period analyses have not been conducted yet. The State's actuary will conduct these analyses when developing actuarially sound rates in early 2016. At that time, splits in the data as requested in parts a), b), and c) will be available.
196.	IV.B.2.f. Member Enrollment/	33	Please confirm that any retroactive liability will only go	See response to Question #19.

	Assignment		back to 1/1/17. For example, if a health plan is assigned a member on 4/1/17 whose eligibility date is 7/1/16, is the health responsible for claims incurred back to 7/1/16 or 1/1/17?	
197.	IV.B.2.f. Member Enrollment/ Assignment	33	In Optumas' presentation during the Pre-Proposal Conference, it was stated that there is limited credibility for the ABAD members under 1, such that it would be difficult to develop an actuarially sound rate cell for only these members. It was also stated during that meeting that an adjustment would be developed at a later date to capture any additional costs for retroactivity. We feel that the retroactive requirement could be particularly volatile for this population, and therefore, the retroactive adjustment would likely be difficult to calculate and have a significant impact on plan financial stability. Please consider covering retroactive costs for this population under fee for service, rather than making it the responsibility of winning MCOs	During rate development the contracted actuary separates AABD members under 1 from other AABD members. This allows for analysis of the population's spend and credibility. The contracted actuary will continue a similar practice with regards to retroactive enrollment expenses for AABD infants. While it is not anticipated that this population will become credible enough to stand alone for rate setting. The contracted actuary will continue to analyze it and develop rates to mitigate this population's volatility as much as possible.

198.	IV.3. Member Enrollment/ Assignment	34	Please confirm that there are no firm enrollment floors or caps to prevent certain MCOs from having more than or less than a certain percentage of total enrollment.	See Section IV.B.3. regarding the auto-assignment algorithm.
199.	IV.E.7. Telehealth and Telemonitoring Services	54	Please describe where the costs for these services are incorporated into the base data. Also provide the utilization and unit cost assumptions (by region and rate cell) for this service embedded in the capitation rates.	Telehealth services are currently submitted using a procedure code modifier. The claim associated with telehealth services is grouped into service categories based on different service type indicators, such as provider type, place of service, etc. The telehealth services predominantly fall into professional service categories including PCP, Specialist, and Other Practitioner. The contracted actuary does not have summaries for detailed line telehealth services available.
200.	IV.E.22. Medical Services for Special Populations	65	"Please provide the following related to the SHCN population: a) a separate data book (including membership, expenses and utilization by region, rate cell, and category of service) for the SHCN population. b) Please explain why the SHCN population is not included as a separate category of aid c) Please provide the process through which new MCOs (without historical claims data) are expected to identify	This level of detail is not available. The SHCN population is too small and volatile to maintain rating credibility as a separate category of aid. The State's actuary will continue reviewing this population to determine if it becomes credible. Historical pharmacy claims data will be provided.

			these members."	
201.	IV.I.7. Patient-Centeredness/Patient-Centered Medical Homes	97	Please describe where the costs for these services are incorporated into the base data. Please also provide the assumptions associated with these requirement in the development of the capitation rates.	Costs for services provided under a PCMH system are not itemized separately from services provided outside of a PCMH system. The non-medical loading applied to the rate is sufficient to fund health plan administrative efforts necessary to support PCMH programs.
202.	IV. I. 8. c. Pharmacy Network	98	For purposes of the provisions related to specialty pharmacies and specialty drugs, please provide a listing of NDC codes that are considered to be specialty drugs, as well as a description of the process of updating this list.	See response to Question #75.
203.	IV.L.2. Health-Risk Screening/Assessment	112	Please describe where the costs for these services are incorporated into the base data. Please also provide the assumptions built into the rates for this requirement.	The costs are considered in the admin portion of the capitation rates as they are not direct services.
204.	IV. P.2 Capitation Rate Determination Process	142	This section states that capitation rates will be in effect for the initial six month contract period beginning with the program start date. Later, it is stated that MLTC and its actuary will develop actuarially sound capitation rates. Please confirm that the	Section IV.P.2.c is amended to read: “Capitation rates will be in effect for the initial twelve (12) month contract period beginning at the contractor start date.”

			capitation rates shown in attachment 11 will be in effect from 1/1/2017 through 6/30/2017.	
205.	IV. P.2 Capitation Rate Determination Process	142	Please confirm whether the next set of capitation rates will be developed for the period 7/1/2017 through 6/30/2018 or through 12/31/2017.	The next set of capitation rates will be effective for Calendar Year 2018, 1/1/2018 – 12/31/2018.
206.	IV. P.2 Capitation Rate Determination Process	143	Please describe any adjustments made in the initial (1/1/17-6/30/17) capitation rate development to account for breakthrough therapies which have newly gained FDA approval and/ or are expected to gain FDA approval during the rating period.	No adjustments were made for breakthrough therapies. These treatments are reflected in the capitation rate to the extent they were provided in the base data. In addition, the pharmacy trend is higher than historical, in part due to the emergence of breakthrough therapies.
207.	IV. P.2 Capitation Rate Determination Process	143	Please describe any analyses/monitoring expected to be performed to measure and/ or predict the impact of breakthrough therapies which have newly gained FDA approval and/ or are expected to gain FDA approval as part of future rate development processes.	Prior to development of the final rate the State's actuary will reexamine emerging treatments that could be impactful on MCO pharmacy expenses. Historic experience will be adjusted as necessary to appropriately account for the anticipated impact of breakthrough treatments.
208.	IV. P.2 Capitation Rate Determination Process	143	One of the adjustments listed as being considered as part of the rate development is	See response to Question # 158.

			"Coordinated Care Savings." Please clarify these items and their values reflected in the initial rate development. If there are any such adjustments included within the initial rate development, please separate them between those adjustments applied to the existing managed care data and FFS, and further break down by region, category of service, and category of aid for both utilization and unit cost.	
209.	IV. P.2 e. Capitation Rate Determination Process	143	"This section of the RFP states that ""Capitation rates are developed using encounter data, fee-for-service data, and supplementary financial information, from each MCO under contract at the time of this RFP's release, for the eligible populations from State fiscal years 2013, 2014, and 2015." a) Please provide a detailed narrative and numerical exhibits (by fiscal year, data source, and rate cell) to describe the ways in which these multiple data sources were incorporated.	FY2013 data was only used for trend development. FY14 and FY15 data was blended together to create the two-year base data. Supplementary financial statements were used to validate the Managed Care Entity encounter data and to build in supplement, non-claims expense (such as CAH settlement payments). The data sources are used as follows: Physical Health Encounters are used for Physical Health services for populations currently enrolled in Physical Health managed care. Behavioral Health Encounters are used for Behavioral Health services for all populations. Fee-for-service data is used for pharmacy data for all populations and Physical Health services for populations not currently enrolled in Physical Health managed care (e.g. Duals, LTSS, Women with Cancer). More details can be found in Attachment 22: "Heritage Health Rate Development Narrative". Data was not adjusted for underreporting. IBNR adjustment values can be found in Attachment 25: "IBNR Assumptions by Source". Current MCOs were involved in validating the encounter data to ensure it was fully reported and consistent with their financial statements. The IBNR estimates reported on the financial statements were also

			b) Please clarify the values used to adjust each of these data sources for both IBNP and underreporting, and describe how the current MCOs provided input into these estimates. c) Please list and provide values for additional adjustments made to create the base data shown in Attachments 10-A and 10-B. d) Please describe how 2013 data is used to develop the initial rates. e) Please describe how the data was validated/reconciled, the sources used, and the results of the validation/reconciliation. f) Please describe how FY2015 and FY2016 data was adjusted and merged together. g) Please provide detailed information regarding any non-encounter based costs included in the base data such as provider incentives or value based agreements"	used to verify the accuracy of the IBNR adjustments, and these values were discussed with current MCOs. The only adjustments made to the encounter data to create the base data shown in Attachment 10-A and 10-B are IBRN, Supplemental Payments, and Subcapitation Expenses. IBNR is detailed in Attachment 25: “IBNR Assumptions by Source”. Across both FY14 and FY15 Supplemental Payments are worth $11.2 million on a statewide basis and Subcapitation Expenses are work $13.8 million on a statewide basis. Subcapitation represents predominantly Vision subcapitated agreements, while Supplemental Payments represent non-claims payments, such as CAH settlements. FY13 data is used only in the development of trend. Current MCOs were involved in validating the encounter data to ensure it was fully reported and consistent with their financial statement. The IBNR estimates reported on the financial statements were also used to verify the accuracy of IBNR adjustments, and these values were discussed with current MCOs. FY16 data was not used. FY15 data was blended with FY14 data to develop the base data. Non-encounter expenditures such as CAH settlements or PCP shared risk agreements are included as part of the Supplemental Payments adjustment described earlier in the question response.
210.	IV. A.1.a	page 30	The RFP states that DHHS is	RFP 5151 Z1 only applies to the MLTC division.

			comprised of 6 divisions. Please describe the process used to capture all of the expenses from each division.	
211.	IV. A.1.a	page 30	The RFP states that DHHS is comprised of 6 divisions. What reconciliation process did DHHS and Optumas use to ensure all expenses were captured from each of these divisions?	See response to Question #210.
212.	IV. A.1.a	page 30	The RFP states that DHHS is comprised of 6 divisions. Please provide the reconciliation used to ensure all expenses were captured from each of these divisions.	See response to Question #210.
213.	IV.P.2. Capitation Rate Determination Process	143	A number of detailed analyses and narratives are described in this section related to the certification of capitation rates. We appreciate that this detail will be provided to MCOs and we understand that the final documents for the initial rate period will not be available until after the contract is awarded. However, in order to understand the development of the rates, we need to have a draft version of all of these documents that would tie out to the rates	See Attachment 22: “Heritage Health Rate Development Narrative”, and Attachment 20: “COA-level Rate Development” for additional detail into the rate development process.

			shown in attachment 11, and which would include all adjustments, data, and trends to the level of detail used by the actuary as soon as possible. In particular, a number of disclosure requirements are outlined in the 2016 Medicaid Managed Care Rate Development Guide. Please ensure that your documentation reflects these requirements in order for bidders' to fully understand the rate development.	
214.	IV. P.2 h. Capitation Rate Determination Process	143	"This section states that the annual capitation review will include ""an analysis of any anticipated fee schedule changes or other programmatic changes to the HERITAGE HEALTH."" a) Please confirm that the intent of this analysis is to update rates proactively in advance of anticipated policy changes or fee schedule changes. b) Please provide this analysis, particularly of anticipated fee schedule and other programmatic changes, and how they have been	Capitation rates will be developed inclusive of any known or anticipated policy changes and fee schedule changes. The fee schedule changes built in to these rates include a 2.25% annual increase in reimbursement for Behavioral Health services and a 2% annual increase in reimbursement for Physical Health services. The provider increases are legislatively-mandated fee schedule changes. Recently these changes have been 2.25% and 2.0% for Behavioral Health and Physical Health services respectively, but that has not always been the case and is not guaranteed to continue. For projection to the Heritage Health contract period the contracted actuary assumed the annual increases will remain consistent. The Behavioral Health provider increase was applied by increasing data to reflect the number of fee schedule changes between the data time period and the contract period. For example, FY14 reimbursement was increased by 2.25% to reflect FY15 reimbursement levels. Then, the combined FY14/FY15 base (already adjusted to be at FY15 legislatively-mandated reimbursement levels) was increased for two more 2.25% fee schedule changes, one effective July 2015

			incorporated into this initial rate development. c) Please list and provide historical values and anticipated effective dates of any automatic fee schedule updates."	and another anticipated to be effective July 2016. Finally, due to the 12-month calendar year contract period, one-half of the 2.25% program change anticipated to be effective July 2017 was applied. The Physical Health provider increase was applied as unit cost trend for Physical Health Services. Recently the Behavioral Health fee schedule change has been 2.25% annually and the Physical Health fee schedule change has been 2.0% annually. The current rate development assumes these values will remain in effect until the CY2017 contract period. If the values are changed by future legislative sessions rates will be updated accordingly.
215.	IV P.5. Supplemental Delivery Payments	144	"Questions related to delivery payments: a) Please comment on the decision not to pay a supplemental kick for stillbirths, especially given the fact that the payment covers the mother's prenatal care, postpartum care, and the delivery, which can be the same or higher than a healthy delivery in the event of a stillbirth. b) Please also confirm that the rate was built exactly how the payment policy is outlined."	The supplemental maternity payment rate is established based on MLTC policy.
216.	IV P.5. Supplemental Delivery Payments	144	Please confirm payment of the maternity kick payment when there is no hospital	In the absence of a hospital inpatient stay, the MCO may submit other inpatient or outpatient services for the maternity care of the member to be eligible to receive a supplemental delivery payment. Costs associated with inpatient and outpatient maternity care are

			inpatient stay (e.g., situations when the mother deliveries at a birth center (non-inpatient) or at home), but a baby was delivered. Please also clarify how these types of events were reflected in the data.	included in capitation rate development.
217.	IV P.5. Supplemental Delivery Payments	144	"Please confirm which services are covered by the supplemental delivery payment: a) would all services (e.g., visits for broken leg) provided during the prenatal and postpartum period be covered, or only maternity related costs? b) If all costs are included within the supplemental delivery payment, please explain how the capitation rates for the relevant categories of aid are reduced for this payment. c) If only maternity related costs are included within the supplemental delivery payment, please explain why the exhibit for maternity services includes many of the same services covered by the monthly capitation rate payments (e.g. home health	a) All services b) The delivery window (5 months pre-delivery and 2 months post-delivery) is identified in the claims data. Any medical expense that falls within that window is re-classified from the original category of aid and into the Maternity case rate. c) See a above.

			and vision)."	
218.	IV. P.3 b Capitation Rates And Payment	144	Please describe in greater detail how partial months of enrollment are calculated for capitation payment purposes	Enrollment into managed care is monthly.
219.	IV. P.3 b Capitation Rates And Payment	144	Please confirm that member months are calculated in an identical fashion for the data book, capitation rate development and capitation payment purposes.	Confirmed.
220.	IV. P.8 Risk Adjustment	145	The RFP states: "For subsequent years of the contract, each MCO's proposed base capitation rates will be risk-adjusted based on the MCO's risk score…" Please clarify whether risk adjustment will start on 1/1/18 or 7/1/17.	The risk adjustment tool will be considered for the second contract period, beginning 1/1/18.

This addendum will become part of the proposal and should be acknowledged with the Request for Proposal.