

ADDENDUM THREE, QUESTIONS and ANSWERS ROUND TWO

Date: June 6, 2022
To: All Bidders
From: Greg Walklin
Director of Procurement and Grants
RE: Addendum for Request for Proposal Number 112209-O3
to be opened July 1, 2022 at 2:00 p.m. Central Time

Questions and Answers

Following are the questions submitted and answers provided, during the second round, 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.

<u>Question Number</u>	<u>RFP Section Reference</u>	<u>RFP Page Number</u>	<u>Question</u>	<u>State Response</u>
1.			Will the State require the incumbent MCO to provide a member's new MCO with historical managed care claims and authorization details for transitioning members? Will MLTC provide claims and auth data to a member's new MCO related to their FFS experience?	<p>Yes, incumbent MCOs will be required to provide claims and authorization details for transitioning members. This will be vetted during implementation.</p> <p>MLTC will provide claims and authorization data to new MCOs related to FFS experience. This will be vetted during implementation.</p>
2.			The released addendums state: "This addendum will become part of the proposal and should be acknowledged with the Request for Proposal." Please clarify how and where addendums should be acknowledged within the Request for Proposal.	Addenda do not need to be explicitly referenced in any bidder response, but bidders should ensure they are responding to the RFP—as amended by any addenda.
3.			Please confirm that initial enrollment period associated with a 7/1/2023 go-live date will be 18 mos. and then move to an annual calendar year-based Open Enrollment period in November 2024 in line with OE schedule defined in the RFP.	<p>DHHS intends to align the contract periods to the calendar year; therefore, with the July 1, 2023 start date the first contract period would be truncated from the start date to December 31, 2023.</p> <p>The state plans at this time to allow for an open enrollment period in November 2023 for the first full contract year.</p>
4.			Please confirm that FFS claims broker services can have distinct branding apart from the MCO's Heritage Health program.	Yes, FFS claims broker services can have a distinct branding apart from the MCO's Heritage Health program.
5.	Throughout RFP	Page 19, and 129	On page 19 the QAPI Acronym is listed as Quality Assurance and Process Improvement; however, on page 129 and throughout the RFP document it is referenced as Quality Assessment and Performance Improvement Plan (QAPI). Please confirm that the language should be Quality Assessment and Process Improvement	"QAPI – Quality Assurance and Performance Improvement Committee" in the Acronym List is hereby amended to read "QAPI - Quality Assessment and Performance Improvement."

Section V – Project Description and Scope of Work				
6.	Section V.C.7 – Participation in the Nebraska Health Information Initiative	35	Given CyncHealth's role in statute, please confirm that bidders are not expected to identify CyncHealth as a subcontractor in RFP response submissions?	Bidders are not expected to identify CyncHealth as a subcontractor.
7.	Section V.E.9.b.iii – Covered Services and Benefits - Core Benefits and Services	50	Please confirm if Professional resource family care is a new service as there is no fee schedule rates or providers for this service	Professional resource family care is a new service to align with Family First Prevention Services Act and Medicaid service definition is in development.
8.	Section V.E.30 – Covered Services and Benefits - Excluded Services	60.	When a member is identified to move from skilled level of care to custodial level of care in a nursing facility or to a [sic] ICF/DD, we understand that the member is covered under MLTC FFS. Is that member disenrolled from the plan at that time? What is the expectation for the MCO with a custodial NF member?	The member continues to enrollment with the MCO. The MCO continuous to be responsible for the care and case management of the patient. MCO is responsible for physical health, behavioral health, pharmacy, vision, and dental health services for the patient outside of the LTSS routine services and supports defined in the per diem as defined in 417 NAC 12-007.
9.	Section V.E.33. Covered Services and Benefits – Community of Care for Members Transitioning between MCOs	63	Will the State be able to provide the MCO with claims history for members that are transitioned from FFS to the MCO on/or before their effective date?	Please see response to Question 1.
10.	Section V.F.8 – Member Services and Education – Provider Directory for Members	70	Please confirm what MLTC's expectation is in instances where the provider address provided to MCOs is different than the address supplied to the MCO by the provider directly. Which address should an MCO display in their provider directory to satisfy this requirement?	MCOs must credential a provider in the same manner the provider is enrolled with Nebraska Medicaid (address(es), NPI, provider type, etc)
11.	Section V.J.4.c.iii – Provider Services – Provider Website	94	In this section the language reads, "Web-based referral search system that will allow MCO and MLTC staff, providers, members, and any other interested persons to locate network providers through an online searchable	The State confirms the web-based referral search system described in section V.J.4.c.iii can also be considered the MCO's provider directory.

			database.” Can the state confirm that the web-based referral search system described in section J.4.c.iii can also be considered the MCO’s provider directory?	
12.	Section V.N.17.d.iv - Utilization Management	123	The subsection iv. Exceptions to Requirements makes references to “service authorization” and “prior authorization”. There are other references to both of these terms throughout the RFP and Attachments. For the purposes of the RFP, we assume the terms “service authorization” and “prior authorization” are synonymous. Are we correct in our assumption? If we are not correct, please clarify.	Service authorization may include prior authorization, concurrent review, retrospective review, peer-to-peer discussion, and reconsideration reviews. In the section V.N.17.d.iv service authorization is synonymous with prior authorization.
13.	Section IV.O.2a – Program Integrity - Recovery of Payments	125	Would the state consider changing the number of days for reporting or returning overpayments to a more standard 180 or 365 days instead of 60 days?	No.
14.	Section V.Q.5 – Provider Reimbursement – Indian Health Protections	136	Is the expectation to reimburse I/T/U providers at the all-inclusive encounter rate as identified in Amendment 2 of the current contracts or to allow negotiated rates for I/T/U providers?	MLTC expects MCO’s to pay at least the all-inclusive encounter rate for eligible services.
15.	Section V.X.4.i.d – e - Transition and Implementation	166	Part d states "If applicable and as necessary, the incumbent MCO must transition to the successor MCO pending grievances, appeals and member/provider service issues to ensure timely resolution, and Part e states " The incumbent MCO must have a sufficient number of qualified staff to meet filing deadlines and attend all court or administrative proceedings." Is the successor MCO to handle pending grievances, appeals and member/provider service issues of an incumbent MCO? If yes, please clarify why part e	Incumbent MCOs are responsible for handling pending grievances, appeals, and member/provider service issues.

			requires the incumbent MCO to have sufficient qualified staff for court and administrative hearing attendance? Please confirm if it would be the incumbent MCO responsibility for resolving issues in part d?	
Section VI – Proposal Instructions				
16.	Section VI.A.6.- Corporate Overview	173	Please confirm that in VI.A. Corporate Overview, Question 6. Bidder’s Employee Relations to State, the state is looking to determine which bidder employees were employed by the state in the past 12 months, as well as which bidder and proposed subcontractor employees are dually employed by the bidder/subcontractor and a state agency.	Confirmed.
17.	Section VI.A.10. - Corporate Overview	175	With respect to question 10. Subcontractors, please confirm the State is seeking information about individuals or entities delegated to perform core services required by the contract, and that vendors for administrative services are excluded from this question.	Bidders should provide the identified information about individuals or entities who fit the definition of “subcontractor” as defined in the Glossary of Terms: “Individual or entity with whom the contractor enters a contract to perform a portion of the work awarded to the contractor” (emphasis added). Entities who perform ancillary functions for an MCO are not “subcontractors.” Refer to the State Response to Question Number 64 of Addendum One Questions and Answers.
18.	Section VI.A.10.c. - Corporate Overview	175	Please clarify how the state defines “percentage of performance hours.”	With this section, MLTC is seeking to understand how subcontractors will be utilized by the MCO. Any method for assisting MLTC in understanding the breakdown of work or performance between subcontractors and the MCO may be utilized.
Attachments				
19.	Attachment 10		Do liquidated damages listed in Attachment 10 apply to the Optional FFS Claims Processing business?	The liquidated damages listed in Attachment 10 do not apply to the Optional FFS Claims Processing business.
20.	Attachment 14 Geographic	Page 2, item 4.	Can you advise what the access standard is for behavioral health inpatient	The MCO must, at a minimum, contract with an adequate number of behavioral health ...

	Access Standards		and residential service providers in the Urban areas? Rural and Frontier areas are listed, but there is no requirement for Urban specifically.	treatment providers to meet the needs of its members and offer a choice of providers. The MCO must provide access to a minimum of two (2) providers within thirty (30) miles of members' personal residences in urban areas; a minimum of two (2) providers within forty-five (45) miles of members' personal residences in rural counties, and a minimum of two (2) providers within sixty (60) miles of members' personal residences in frontier counties. If the rural or frontier requirements cannot be met because of a lack of behavioral health providers in those counties, the MCO must utilize telehealth options.
21.	Attachment 21	Expansion and HIPP risk corridor	Please provide the detail for the expansion and HIPP risk corridors that displays the details of what is included in revenue and costs, similar to the program-wide risk corridor template.	Please see Attachment 23, which is attached to this Q&A Addendum and hereby incorporated into the RFP.
22.	Attachment 21 RFP - Definitions	PW RC and MLR Calc Examples Page xii of the RFP	<p>There is no row for "Medical Incentive Bonus" in the components of the total medical expenses in the program-wide risk corridor.</p> <p>The definitions for both net qualified medical expense (for the medical loss ratio) and net qualified expense (for the risk corridor) include medical incentive bonuses.</p> <p>Please clarify if these expenses will be allowed to count toward net qualified medical expenses for reconciliation purposes.</p>	MLTC can confirm that Medical Incentive Bonus payments count toward the net qualified medical expenses for reconciliation purposes. These would be included within the "Non-Claim Medical Payments (e.g. CAH settlements, etc.)" line in the information provided in Attachment 23 and Attachment 21.
Proposal Response Instructions				
23.	Section V.B Eligibility and Enrollment	1	Can MLTC advise if question V.B.5: Describe the Bidder's process to identify unborn individuals anticipated to begin coverage at the time of birth. Describe the operational process to obtain identifying information when the unborn status changes to newborn.	Yes, this question is specific to 599 CHIP membership.

			Can MLTC advise if this question is specific to the 599P membership?	
24.	Section V.R Systems and Technical Requirements - 99	16	<p>Regarding this sentence in No. 99: Provide a description of how the MCO will comply with applicable Federal (including but not limited to HIPAA) standards for information exchange and <i>ensure adequate system access management and information accessibility.</i></p> <p>No. 102 on page 17 asks for a description of access restrictions.</p> <p>We assume that in No. 99, the Bidder should address methods of complying with Federal regulations related to systems access management and information accessibility, whereas in No. 102, the Bidder should describe the Bidder's access restrictions themselves.</p> <p>Are we correct in our assumption? If we are not correct, please clarify.</p>	The Proposal Response Instructions are complete as posted.
25.	Section V.S Claims Management – 104 and 109	20-21	For questions 104 and 109 with page limits, please confirm attachments do not count toward page limits.	Yes, examples are not included in the page limit.
Addendum 1 – Q&A				
26.	Section V.A.1.g – Program Description Q&A 24-33	RFP 28 Q&A 9-13	Please advise what behavioral health services will be required to be covered under the HIDE-DSNP beyond the behavioral health services covered in Section V.E.9?	DHHS is not requiring the coverage of any specific behavioral health services beyond those outlined in Section V.E.9.
27.	Section V.B.4 - Eligibility and Enrollment Q&A 33	RFP 30 Q&A 13	Because CMS requires HIDE D-SNP plans have streamlined integrated enrollment processes, please clarify how the State's auto-enrollment methodology will assure compliance with CMS regulations.	DHHS continues to evaluate the auto-enrollment methodology for any needed future changes. DHHS will ensure compliance with any applicable regulations.
28.	Section V B. 3.a and 3.e -	RFP 30	Please clarify the part of the answer stating "The state will	MLTC clarifies that if the contract starts July 1, 2023, the

	Eligibility and Enrollment Q&A 39	Q&A 15	explore risk adjustment beginning no later than the second full year contract period". Please confirm first year of the contract will be 7/1/2023 – 6/30/2024, and risk adjustment will be considered no later than 7/1/2024.	first contract period would be truncated to July 1, 2023 – December 31, 2023 and the first full contract period would then be January 1, 2024 – December 31, 2024. The state will consult with the actuary to monitor the program and implement or alter risk mitigation strategies at the MLTC's discretion with input from the actuary and the MCOs.
29.	Section V.B.3. - Eligibility and Enrollment Q&A 41	RFP 30 Q&A 16	In follow up to the response provided for question 41 in round one. Would the state be willing to consider providing a supplemental eligibility file with PCP assignments to each MCO prior to go live to allow MCOs to honor PCP relationships to all existing members for the initial continuity of care period? This approach would ensure a less disruptive transition for members and providers, giving members up to 90 days to maintain their existing PCP relationship. This timeframe would also align with MCO member engagement requirements, ensuring MCOs have made initial contact with members prior to making any necessary PCP changes identified by the state approved auto-assignment algorithms.	MLTC will provide a supplemental eligibility file with PCP assignments prior to the Contract Start Date. This will be vetted during implementation.
30.	Section V. D. Table 1 – Staffing Requirements Section V. F. – Member Services and Education Q&A 44	RFP 42/70 Q&A 17	Additional guidance is requested on the preferred method of management for new infants and mothers related to the 599 CHIP program and the assignment of these individuals to MCOs. Management guidance is specifically sought regarding provider billing for the 30 days after the child is born and on Medicaid.	Staffing expectation is defined in the staffing chart. In addition to the MCH/EPSTDT Coordinator the Medical Management Coordinator and Care Management Staff would work together to provide comprehensive care and case managements for members in the 599 CHIP program. Unborn children cannot be enrolled with an MCO until birth. Hospitals are responsible to notify the county of all deliveries, including Medicaid enrollees. Providers and MCOs who interact with the pregnant member can encourage them to

				provide pregnancy and birth updates to ACCESSNebraska. Providers can also provide a change report to ACCESSNebraska to report the birth of a child. MLTC communicates enrollment data to the MCOs daily. In order to ensure timely payment of claims providers should check enrollment systems often until the infant is assigned to an MCO. The infant's assignment to this MCO begins on the date of their birth.
31.	Section V. 3.b. - Additional Staffing Requirements Q&A 46	RFP 45 Q&A 18	The State's response to question 46 in Addendum One Questions and Answers indicates that the Dental Management Coordinator role is a key staff position. Can the State please differentiate the responsibilities from this key staff position and the required Dental Director key staff position, as they currently appear to have redundant responsibilities?	The key staff duties of the Dental Director and Dental Management Coordinator are described in the RFP, in addition to other staffing requirement references in the contract which describe how other staff work with the Dental Director and under the Dental Director. In addition to the above, three main responsibilities of the Dental Director are below, which are not the responsibilities of the Dental Management Coordinator: 1. The Dental Director must serve as either the chairman or co-chairman of the required Dental QAPI Committee. 2. The Dental Director also directs the Dental UM Committee. 3. The Dental Director is required to make any decision to deny a service authorization request or to authorize service in an amount, duration, or scope that is less than requested.
32.	Section V.P.2.e – MCO Reimbursement Q&A 74	RFP 131 Q&A 29	Can the state provide bidders with claims data for the statewide Medicaid expansion population since inception on 10/1/2020? This information would help MCOs make projections for this population.	No, MLTC will not provide all statewide claims for the expanded Medicaid population.
33.	Proposal Response Instructions:	Proposal Response Instructions:	Regarding Question #115 asked in the initial Question and Answer release, please	Bidders are not required to provide the Quality Program

	Section V.M Quality Management – 64	11	confirm for Question #64 that the Bidder is not required to provide the Quality Program Description and Evaluation as attachments.	Description and Evaluation as attachments.
	Q&A 115	Q&A 25	Please also confirm that the required proposed QAPI work plan can be provided as an attachment and it will not count toward the 10-page limit.	The QAPI work plan can be provided as an attachment and will not count towards the 10- page limit.

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