

ADDENDUM ONE QUESTIONS and ANSWERS

Date: May 16, 2022

To: All Bidders

From: Greg Walklin, Director of Procurement and Grants
Nebraska Department of Health and Human Services

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 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.

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

Please note the following:

- References to page numbers provided throughout this addendum are to the numbered pages of the RFP, not the page number of the PDF. Where appropriate, we have changed the page number referenced to make all consistent.
- Because of the complexity of this RFP, and to ensure clarity in response, questions have been organized by RFP section. This should allow more clarity for bidders.
- As a result of questions received, DHHS has revised the Optional Services Proposal Instructions for the Optional Services. For the ease of bidders, DHHS has elected to replace the Optional Services Proposal Instructions entirely, and incorporated the revised version in Addendum 2.

Question Number	RFP Section Number	Page Number	Question	State Response
1.	n/a	n/a	Please confirm restatement of the question in the response does not count toward the page limit.	Yes.
2.	n/a	n/a	In sections with page limits, please confirm that slip sheets, title pages, and pages intentionally left blank do not count toward the page limit.	Yes.
3.	n/a	n/a	Does DHHS have a preference as to the font type, point size, and margins?	No. Per Section J of the RFP, please note, however: "If the bidder's proposal is presented in such a fashion that makes evaluation difficult or overly time consuming the State reserves the right to reject the proposal as non-conforming."
4.	n/a	n/a	Please confirm that DHHS will accept a 10pt font size for tables graphics charts, diagrams, and callouts.	Yes. Per Section J of the RFP, please note, however: "If the bidder's proposal is presented in such a fashion that makes evaluation difficult or overly time consuming the State reserves the right to reject the proposal as non-conforming."
5.	n/a	n/a	Please confirm if DHHS would like the print copy of the RFP to be single sided or double sided.	Print copies are not required to be provided, but may be. If provided, either single-sided or double-sided is acceptable.
6.	n/a	n/a	Is there a financial proforma required as a part of submission? If so, is there a preferred template?	Bidders should provide financial information as set forth in VI.A.2, Financial Statements.
7.	Throughout the response	n/a	Are we allowed to cross reference	Yes.

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			sections of the response?	
8.	Throughout	n/a	The State RFP is in Arial 9 pt font, will the state confirm that Arial 9 point font is acceptable for Bidder's RFP response?	Yes. Per Section J of the RFP, please note, however: "If the bidder's proposal is presented in such a fashion that makes evaluation difficult or overly time consuming the State reserves the right to reject the proposal as non-conforming."
9.	Not Listed in RFP	n/a	Will the State confirm that Bidder Proposals may include letters and statements of support from local stakeholders (including providers, community based organizations, etc.), as supplemental attachments to effectively demonstrate a Bidder's ability to successfully achieve the Agency's objectives.	Section VI.8, states as follows: "Bidder should provide at least three (3) customer references. For each reference, Bidder should provide the customer's name, contact information (including current telephone number, address, and email address." Bidders may include other letters, statements of support, or other supplemental attachments in their responses, but those would still be subject to any applicable page limits.
10.	n/a	n/a	Can the state please share the most recent CMS rate certification letter and accompanying documentation?	Please refer to Attachments 17-20, which are attached to this Q&A Addendum and hereby incorporated into the RFP.
11.	Membership	Various	Throughout the document, Heritage Health is noted. Does this include the Heritage Health Adult Expansion?	Yes, Heritage Health Adult is included in Heritage Health.
Glossary				

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12.	Glossary: Administrative Expenses	VI	Administrative fees – Please clarify what constitutes services were actually provided? Will the corporate allocation methodology and allocation entries be sufficient to satisfy verification?	DHHS will review and audit any allocated expenses, including corporate expenses, were administrative services that were provided to the MCO and are reasonable.
13.	Glossary of Terms	VII	The RFP defines “Bidder” as “A vendor who submits a proposal in response to a written solicitation.” Please confirm that for the purposes of responding to Section VI.A.8 and the Technical Approach Statements and Questions that bidders may reference the contracts, experience, and outcomes of their affiliate health plans (under common parent ownership) from other Medicaid programs. As most MCOs with national experience are legally structured to have a single legal entity dedicated to operating solely within a single state Medicaid	Yes, such reference is permitted, provided the nature of the affiliation is clear.

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			program, experience across other Medicaid programs is through contracts that are held by distinctly separate legal affiliate companies operating in other states.	
Section I – Procurement Procedure				
14.	Section I Procurement Procedure Subsection J. Submission of Proposals	5	It appears that part of the first sentence is missing. Can DHHS please provide the rest of the sentence, or clarify what is missing? “The Technical Proposal should not contain any reference to dollar amounts of the proposal, if. However, Information such as data concerning labor hours and categories, materials, subcontracts and so forth, shall be considered in the Technical Proposal so that the bidder’s understanding of the scope of work may be evaluated.	The fourth sentence of the second paragraph of I.J is hereby deleted. The Technical Proposal for the Optional Fee For Service Scope, however, should not contain any reference to dollar amounts (the cost) of the Optional Fee for Service Proposal.
15.	Section I Procurement Procedure	5	The first sentence indicates that the State is accepting either	For administrative ease, the State prefers electronic submission of proposals. However, paper copies of proposals may also be submitted. If a paper copy is

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	Subsection J. Submission of Proposals		electronically submitted responses or hard copy; however, the third paragraph indicates, "It is the bidder's responsibility to ensure the RFP is received electronically and submitted by the date and time indicated in the Schedule of Events." Please clarify if the State prefers electronic copy, hard copy, or both.	submitted, it is also the bidder's responsibility to ensure the bidder's paper proposal is received by the date and time indicated in the Schedule of Events.
16.	Section J. Submission of Proposals	5	Section J: Submission of Proposals states that the technical proposal should not contain any reference to dollar amounts. Can the State please provide a definition that clarifies what would be considered a dollar amount to avoid?	Please see response to Question 14.
17.	Section I.J.1.a.ii	5	<p>The electronic proposal file names section is listed as I.J.1.a on page 5, should this be b as there is an "a" above for the ShareFile location?</p> <p>The state does not specify file naming for</p>	<p>The second section marked with "a" under I.J.1 is hereby amended to be designated with "b" instead.</p> <p>Yes.</p>

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			the cost/proprietary submission. Will the state accept RFP 112209 O3 Company Name, Cost Proposal, and RFP 112209 O3 Company Name, Proprietary Information?	
18.	Section I, J Submission of Proposals	5	Will DHHS allow the submission of a test file in order to ensure there are not issues with uploading the proposal submission?	Yes. Bidders may submit test files and request confirmation of submission to DHHS.RFPQuestions@nebraska.gov . In order to give enough time to process these requests, the requests for test files and confirmation must be received by 5:00 pm. central time on June 30, 2022, or one working day before proposals are due, whichever is later.
19.	Section I, J Submission of Proposals	5	Is there a file size limit for the Nebraska Share File Submission site?	The state is not aware of any file size limit for Share File submissions.
20.	Section I Procurement Procedure Subsection J. Submission of Proposals 2. For bidder's submitting paper/hard copy responses	6	2.b. indicates that the cost proposal and proprietary information should be presented in separate sections for hard copy. For electronic submission does the State want the cost proposal and proprietary information uploaded as separate files?	Yes. Please see the first page of the RFP. However, see also answer to question 21, below.
21.	Section I Procurement Procedure Subsection J. Submission of Proposals	6	In the pre-proposal conference DHHS indicated that confidential/proprietary information should be	Yes.

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			<p>removed from the electronic or hard copy response and provided in separate packaging or files. To ensure ease of review for evaluators, would DHHS allow Bidders to submit an unredacted version for evaluators, and a redacted version for public release? This would ensure that only confidential content would be removed/redacted as opposed to removing entire pages or sections that may only contain partially confidential information.</p>	
22.	V. Award	9	<p>Please describe how the State's selected criteria will comply with the requirements of Neb. Rev. Stat. § 81-161, which establishes criteria which "shall be given consideration."</p>	<p>Costs for Medicaid Managed Care services have been specifically stipulated in Neb. Rev. Stat. § 68-995. By reviewing technical proposals, DHHS is reviewing how bidders can provide the appropriate services for Medicaid recipients at the capped costs and capped profits set forth in statute and in the RFP.</p>
Section III – Contractor Duties				
23.	Lobbying Section III, R	25	<p>What is the appropriate course of action or response when a bidder has a registered</p>	<p>Satisfaction of all state of Nebraska lobbying disclosure obligations is required.</p>

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			Nebraska multi-client lobbyist on retainer and those lobbyists continue to interact with, officially and socially, and make their own political contributions to the Governor and state legislators during the RFP period?	
Section V – Project Description and Scope of Work				
24.	Section V.A.1.g.ii – Program Description and Section V.C.20 – Business Requirements	28 38	The document states conflicting dates around the start dates for FIDE DSNP. Section A.1.g.ii. states MCO must have this in place no later than 1/1/24. Section C.20 says FIDE DSNP needs to be in place no later than the contract start date (identified as 7/1/2023). Please confirm the FIDE DSNP start date requirement is 1/1/2024?	<p>The RFP Glossary of Terms and the Acronym and Initialism List is hereby amended to remove the following term:</p> <p>FIDE DNSP</p> <p>The RFP Glossary of Terms is hereby amended to add the following term:</p> <p>“HIDE SNP: Highly integrated dual eligible special needs plan (HIDE SNP). HIDE SNPs integrate care for dually eligible beneficiaries under a single managed care organization, in accordance with the Medicare Improvements for Patients and Providers Act of 2008 and the CMCS Informational Bulletin from November 14, 2019.”</p>

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				<p>The Acronym and Initialism List is hereby amended to add “HIDE SNP – Highly Integrated Dual Eligible Special Needs Plan”</p> <p>Section V.A.1.g.ii. is revised to state:</p> <p>“All MCOs must have a state wide HIDE SNP that shall be inclusive of behavioral health services, exclude long term services and supports, and be in place no later than January 1, 2024.”</p> <p>Section V.C.20. is revised to state:</p> <p>“The MCO must have a state wide HIDE SNP that shall be inclusive of behavioral health services, exclude long term services and supports, and be in place no later than January 1, 2024.”</p>
25.	Section V.A.1.g.ii – Program Description and Section V.C.20 – Business Requirements	28 38	Please revise XX to reflect the DSNP start date to state that the effective date for the DSNP is 1/1/24 and not contract start date	Please see response to Question 24.
26.	Section V.A.1.g.ii – Program Description and Section V.C.20 – Business Requirements	28 38	The model contract states that they MCO must have a FIDE DSNP in place no later than January 1, 2024 in section VI. A Program Description. In section	Please see response to Question 24.

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			<p>VI. C Business Requirements, the contract states the MCO must have a FIDE DSNP in place no later than the contract start date. We would like to clarify that the requirement is to have the FIDE DSNP in place for a January 2024 start date. We would also like to clarify if the requirement is for a statewide FIDE DSNP in year one.</p>	
27.	Section V.A.g.ii – Program Description	28	Does the MCO FIDE DSNP need to cover a statewide network?	Please see response to Question 24.
28.	Section V.A.g.ii – Program Description	28	<p>In review of requirements for a FIDE DSNP the following has been noted: The traditional requirements for a FIDE DSNP, require an MCO to have an agreement and receive capitated managed care payments for members with full LTSS services, including Nursing Facilities. Is that DHHS's intent? If not, would consideration be given to MCO requirement for</p>	Please see response to Question 24.

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			a HIDE DSNP program as opposed to FIDE?	
29.	Section V.A.g.ii – Program Description	28	Will there be restrictions or specific requirements on supplemental benefits (e.g. comprehensive dental, over-the-counter benefit, etc.) that can be offered on the Medicare FIDE-DSNP?	DHHS is not requiring the provision of or restriction of any specific supplemental benefits to be offered as part of the required HIDE SNP plan.
30.	Section V.A.g.ii – Program Description	28	Can you confirm DHHS will continue to allow other DSNP products in the state other than FIDE DSNPs; provided the MCO offers at least one FIDE DSNP product?	Yes, DHHS will continue to allow other DSNP products in the state other than the HIDE SNPs provided the MCO offers at least one HIDE DSNP product.
31.	Section V.A.g.ii – Program Description	28	Are PPO DSNP programs allowed to be FIDE DSNP programs?	Both PPO and HMO plans are allowed to be HIDE SNPs.
32.	Section V.A.g.ii – Program Description	28	Has DHHS developed a member assignment algorithm between Medicare and Medicaid? For instance, if a member is enrolled in an MCO 1 Medicaid plan and Medicare FFS, will this	The Medicaid MCO enrollment will not force enrollment of the HIDE SNP. The current auto assignment algorithm does not factor in HIDE SNP enrollment, though this may be considered for future assignment algorithm revisions.

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			<p>member be passively moved to the MCO 1 FIDE Medicare plan, with a prescribed opt-out period? If a member is enrolled in an MCO 1 Medicaid plan and MCO 2 FIDE Medicare plan, will MCO 2 receive the member for both Medicare and Medicaid? If a member is enrolled in Medicaid FFS and MCO 1 FIDE Medicare plan, will the member be auto-assigned to MCO 1 Medicaid plan?</p>	<p>If a member is enrolled in FFS Medicaid as they wait for MCO assignment, the auto assignment will follow existing protocols.</p> <p>If a member is enrolled in FFS Medicaid due to defined circumstances, they will remain in FFS Medicaid until those circumstances change. At which time, they will be enrolled with an MCO in accordance will existing protocols.</p>
33.	Section V.A.g.ii – Program Description	28	<p>FIDE SNP Requirements- Is the FIDE SNP required to be state wide? Is the MCO required to implement the FIDE SNP with all Dually Eligible members? Or is a subset (65+) allowed?</p>	<p>The HIDE SNP is required state wide.</p> <p>The MCO shall not limit the HIDE SNP to members 65 and older.</p> <p>The MCO may limit HIDE SNP enrollment to members who are also enrolled in their partner MCO plan.</p>
34.	Section V.A.g.ii – Program Description	28	<p>Can the State please confirm if their expectation is that the FIDE DSNP is an exclusively aligned plan or an all requirement FIDE?</p>	<p>Please see response to Question 33.</p>

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35.	Section V.A.g.ii – Program Description	28	Can the State please confirm timeline for a minimum of 80% network alignment to ensure the FIDE SNP network is adequate for new enrollees upon AEP for 1/1/24 effective?	DHHS is not performing network adequacy validations for the HIDE SNP and has not required timeline beyond the implementation effective January 1, 2024.
36.	Section V.A.g.ii – Program Description	28	Can the State confirm if a Bidder's FIDE DSNP network has gaps but the provider is not willing to participate in the Bidder's Medicaid network, only Medicare, and when that specialty is only required for the FIDE DSNP network, that's acceptable for the Bidder to not have 100% congruency of the physical medicine network?	DHHS encourages network congruency to the greatest extent possible. DHHS is not currently mandating a network congruency expectation through this contract.
37.	Section V.A.g.ii – Program Description	28	Can the State confirm that Bidders have until January 1, 2024 to establish the LTSS components of their FIDE DSNP network, while the CMS required 40 specialties must be complete by June 2023?	Please see response to Question 24; additionally, the LTSS requirement is not applicable.
38.	Section V B. 3.a and 3.e -	30	The RFP document indicates "Prior to the	The auto-assignment algorithm does not include balanced acuity distribution.

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	Eligibility and Enrollment		<p>Contract Start Date, all current Heritage Health members and enrollees will be allowed an open enrollment period to select an MCO and choose a PCP. Current MCO members who do not select an MCO during that time frame will be assigned automatically to one as of the Contract Start Date."</p> <p>Please describe any considerations in the auto-assignment algorithm to ensure a balanced acuity distribution among the MCOs.</p>	
39.	Section V B. 3.a and 3.e - Eligibility and Enrollment	30	<p>To ensure capitation rates are appropriately adjusted to reflect each MCO's member mix and acuity/cost profile starting in the first year of the contract: please describe the review DHHS will perform, starting at what point after the annual enrollment and auto-assignment of members, as well as the frequency of review</p>	<p>As detailed in the RFP, the first contract period of the contract will include risk mitigation via a symmetrical risk corridor. The state will explore risk adjustment beginning no later than the second full year contract period.</p>

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			to understand the acuity and cost distribution of members by MCO.	
40.	Section V.B.3f - Eligibility and Enrollment	30	Please confirm the assignment methodology the state will apply to new Medicaid beneficiaries, who lack an existing PCP relationship. Will the State consider an equitable distribution of new Medicaid beneficiaries, who lack an established PCP relationship among awardees.	Please see section V.B.5. PCP Assignment
41.	Section V.B.3. - Eligibility and Enrollment	30	Section V.B.3. identifies that "all current Heritage Health members and enrollees will be allowed an open enrollment period to select and MCO and choose a PCP. Current MCO members who do not select and MCO during that time frame will be assigned automatically to one as of the Contract Start Date....The automatic assignment methodology will not take into consideration the enrollee's previous	As stated in the RFP, Section V.B.3.e., "The automatic assignment methodology will not take into consideration the enrollee's previous MCO assignment during the initial Heritage Health enrollment period."

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			<p>MCO assignment during the initial Heritage Health enrollment period.” Would the state consider providing the open enrollment period for members, but then seek to maintain existing enrollee relationships with their current MCOs (where a current MCO continues as of the new Contract Start Date)? This current methodology will disrupt continuity of care and historical relationships with care coordinators, MCO’s extended provider networks and services, and value added benefits, in addition to creating potential disruption for an enrollee’s overall familiarity and history with an existing MCO.</p>	
42.	Section V.D.1 – Staffing Requirements	38	<p>Please confirm that key staff may be employed by a subcontractor. For example, the Dental Director position notes he/she must be "empowered to represent the Dental</p>	Key staff may be employed by a subcontractor.

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			Benefit Manager" which implies they would be employed by a dental subcontractor.	
43.	Section V. D. Table 1 – Staffing Requirements	40	Can the state clarify if all positions in Table 1 are full-time or just the CEO, Medical Director and Dental Director?	Per section V.D.2.a.ii of the RFP, "all positions listed in the table must be full time, i.e. a minimum of 40 hours per week, with the exception of the Business Continuity Planning and Emergency Coordinator, which shall be an additional duty assignment."
44.	Section V. D. Table 1 – Staffing Requirements Section V. F. – Member Services and Education	42/70	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/EPSDT 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. This question will be addressed with additional information in the response to the second round of written questions. The answer provided then will supplement this answer.
45.	Section V, D.3.1 - Additional Staffing Requirements	45	Please clarify if all utilization management authorization review staff must be located in Nebraska?	Utilization management authorization staff do not need to be located in Nebraska, however the staff indicated in section V.D.3.a-d. must be licensed in the state of Nebraska.
46.	Section V. 3.b. - Additional Staffing Requirements	45	The "Dental Management Coordinator" role is mentioned two times in this section, but not defined anywhere in	Section V.D.2. Table 1. Key Staff is revised to add a definition for the Dental Management Coordinator position: Title: Dental Management Coordinator Minimum Duties:

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			the SOW. Please provide a description of this role.	<p>The Dental Management Coordinator must be a state-licensed dentist if they are required to make medical necessity determinations. If the position is not required to make medical necessity determinations, this individual may have a master's degree in health services, health care administration, or business administration. The Dental Management Coordinator's responsibilities include:</p> <ol style="list-style-type: none"> 1. Developing, implementing, and monitoring the provision of care coordination, disease management (DM), and case management functions; 2. Ensuring the adoption and consistent application of appropriate dental services medical necessity criteria; 3. Monitoring, analyzing, and implementing appropriate interventions based on utilization data, including the identification and correction of over- or under-utilization of services; and 4. Monitoring prior authorization functions and ensuring that decisions are made in a consistent manner, based on clinical criteria, and that all decisions meet timeliness standards.
47.	Section V. 3.d. - Additional Staffing Requirements	45	There are no instances where concurrent review is applicable for dental service authorization requests. Please confirm this language does not apply to dental.	There are no instances where concurrent review is applicable for dental service authorization requests. MLTC confirms this language does not apply to dental.
48.	Section V. 3.d. - Additional Staffing Requirements	45	The RFP states that concurrent dental review staff must include a state-licensed dentist or dental hygienist. Staff must work under the	Please see response to Question 47

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			<p>direction of the Dental Director or the Dental Management Coordinator (if this person is a state-licensed dentist or dental hygienist) to conduct inpatient concurrent reviews. There are no instances where concurrent review is applicable for dental service authorization requests. Please confirm this language does not apply to dental.</p>	
49.	Section V. 3.d. - Additional Staffing Requirements	45	<p>The "Dental Management Coordinator" role is mentioned two times in this section, but not defined anywhere in the SOW. Please provide a description of this role.</p>	Please see response to Question 46.
50.	Section V.E.9.b.iii – Covered Services and Benefits	49-50	<p>Please confirm Rehabilitation Services are age-based for individuals age twenty (20) and under.</p>	Rehab services are defined in state regulation and Medicaid Medical Services Definitions.
51.	Section V. E.9.b.vii – Covered Services and Benefits	50	<p>Please confirm Rehabilitation Services are age-based for adults age twenty (21) and over.</p>	Please see response to Question 50.

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52.	Section V.E. 12. f. i-ii - Covered Services and Benefits	51	In E.12.f.i, can the State please clarify what is meant by a “reasonable attempt to notify a prescriber”? For E.12.f.ii, can the State please clarify what is meant by “routine and continuous”, e.g., is there a certain amount of emergency fills allowed in a certain timeframe? How do these requirements differ from the current requirement to only provide an emergency supply for “life and limb”?	<p>Reasonable would be calling, faxing, emailing the provider or contacting the practice location and conferring with one of their partners.</p> <p>MCOs are required to follow 42 CFR § 1306.13 on seventy-two (72) hours supply and 471 NAC 16 009.01(D)</p>
53.	Section V.E. 12. i. - Covered Services and Benefits	52	Per current guidance from the State, can the State confirm that the one business day requirement for medical benefit pharmacy PA requests would be met with a response to the provider indicating that we have received the request and the decision will follow, or will the State be requiring that drugs under the medical benefit receive a final	<p>Drugs under the medical benefit must receive a response, which may include an acknowledgement, within 24 hours of a PA request.</p> <p>Reference: 42 U.S.C. § 1396r–8(d)(5)(a)</p>

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			decision within one business day?	
54.	Section V.E. 29.m.iv – Covered Services and Benefits	60	RFP Section E, Requirement 29.m.iv states that the MCO must ensure its broker's information system is designed to automate trip assignment to providers based first on the lowest cost for the appropriate mode of transportation and second on provider performance. If the MCO automates trip assignment using such a model, effectively, a provider with a high number of complaints would be required to be scheduled ahead of a provider with limited complaints, but higher cost. We do not believe this to be the intent of the trip assignment algorithm and would like the State to confirm that MCOs can determine the most effective way to get trips scheduled and members transported in order to	The MCO is responsible for ensuring and determining the most cost effective and appropriate mode of transportation for its members.

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			<p>deliver high quality care to our members.</p> <p>We understand the need to be cost-conscious and will continue to be responsible stewards of State Medicaid dollars, however in order to deliver the best quality care to our members, can the State confirm that the State will allow the MCOs to determine the most effective way to gets trips scheduled and members transported.</p>	
55.	Section V.E.32.e– Covered Services and Benefits	61	Please confirm if dental coverage for individuals age 21 and older will be limited to \$750 per fiscal year. (471 NAC § 6-004.02)	471 NAC 6-004.02 limits dental coverage for individuals are 21 and older to \$750 per fiscal year. That said, DHHS is working towards the removal of the Annual Benefit Maximum.
56.	Section F, Requirement 9.h – Member Services and Education	71	If an MCO is not going to tie provider payment to member assignment, does the MCO still need to issue a new ID card for dental home switches?	Yes.
57.	Section F, Requirement 9.h – Member Services and Education	71	Is the State intending for the member to carry two separate ID cards?	There will be one member ID card which will include information re: medical, dental and pharmacy.

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58.	Section F, Requirement 9.h – Member Services and Education	71	<p>Is the state intending for the member to carry two separate ID cards?</p> <p>If an MCO is <i>not</i> going to tie provider payment to member assignment, does the MCO still need to issue a new ID card for dental home switches?</p>	Please see response to Questions 56 and 57.
59.	Section V, G.1.e.iv - Member Marketing	75	<p>Section 1.e.iv. media marketing materials must be distributed within 30 calendar days of DHHS approval. 30 calendar days after DHHS approval of these materials, the approval is no longer valid. Please clarify if this means we can use marketing materials in excess of 30 calendar days but they must be implemented initially within 30 calendar days or may all materials only be used for 30 days following approval?</p>	Marketing materials must be implemented initially within 30 calendar days after DHHS approval. The approved marketing materials may continue to be used after the initial implementation within 30 calendar days.
60.	Section V.I. - Provider Network Requirements	84	Is it possible for the State to provide a copy of the Provider Master	The Nebraska Provider File will be provided to the awarded MCOs during the implementation phase.

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			File (PMF), listing all providers who are currently enrolled with the State, as this could help us to determine where providers are located from an adequacy perspective.	
61.	Section V.I.16 - Provider Network Requirements	90	Are there preferred vendors or entities that should be utilized for provider credentialing and recredentialing and how early can that work begin?	DHHS does not have preferred vendors/entities for provider credentialing and recredentialing. Work can after execution of the contract.
62.	Section V.I.16 - Provider Network Requirements	90	Does DHHS have a CCVS vendor of choice?	Please see response to Question 61.
63.	Section V.I.16 - Provider Network Requirements	90	Can the state provide additional detail about the interface between MCOs and the future CCVS will be?	The interface will be dependent on structure of contract the MCOs have with the CCVS vendor.
64.	Section V. K. - Subcontracting Requirements	97	Please clarify the definition of "subcontractor" and the state's expectations with respect to prior review and approval of subcontractors. Are software vendors, print/fulfillment vendors, etc. considered subcontractors and	See definition of "Subcontractor" on RFP Glossary of Terms, page xvi, and 42 C.F.R. § 438.230. Compliance with RFP section V. K is required for all subcontractors.

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			subject to the 120-day review and approval period?	
65.	Section V.M.5.i – Quality Management	108	Please confirm that the State's intent is that the Health Equity Committee perform oversight and monitoring of the process to complete individual member referrals.	Yes, the Health Equity Committee will perform oversight and monitoring of the process to complete individual member referrals.
66.	Section V.M.8.f.i.b – Quality Management	109	Please complete the end of the bullet which says, "MCO staff representing the various departments of the;"	Section V.M.8.f.i.b is revised to state: "MCO staff representing the various departments of the organization will have membership on the committee."
67.	Section V.M.8.f.i.b – Quality Management	109	Item i.b) under section f. Dental QAPI Committee states the following: b) MCO staff representing the various departments of the; Please confirm if there is a word missing and provide the entire corrected sentence.	Please see response to Question 66.
68.	Section V.M.9. – Quality Management	110	Element C. of the Requirements notes "The Clinical Advisory Committee must include MEMBERS	Member in this instance is a caregiver of a child, adolescent or adult who is enrolled in Nebraska Medicaid.

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			<p>who care for children, adolescents, and adults in the state across a variety of ages and races/ethnicities, have an awareness of differences between rural and urban populations, and represent pharmacists, physical health providers, and behavioral health providers." Within the definitions a "member" is defined as "A Medicaid enrollee who is currently enrolled with a specific MCO." Please confirm that reference to "member" in this section is a committee representative that would be a health care professional and not Medicaid enrollees.</p>	
69.	Section V.N.10. – Utilization Management	117	<p>Please confirm that MCOs will be provided with DUR/SUPPORT ACT data in order to fulfill their contract PDMP requirements.</p>	<p>PDMP requirements will be met with a combination of state-provided data and MCO-provided data.</p>
70.	Section V.P.2.b – MCO Reimbursement	130	<p>The Request for Proposal states "Capitation rates will</p>	<p>DHHS intends to align the contract periods to the calendar year; therefore, with the July 1, 2023 start date the first</p>

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			<p>be in effect for the initial year, or twelve (12) month contract period beginning with the Contract Start Date."</p> <p>Since the contract start date for the bid period is 7/1/2023, please confirm if capitation rate periods will be from 7/1 - 6/30 for the duration of the contract.</p> <p>If so, please confirm whether risk mitigation calculations (including risk corridors, minimum MLR and the high cost drug pool) will also be performed over the 7/1 - 6/30 period.</p>	<p>contract period would be truncated from the start date to December 31, 2023. DHHS would work with MCOs to determine the most appropriate risk mitigation to be included in the first and second contract period.</p>
71.	Section V.P.2.b – MCO Reimbursement	130	Will Capitation rates be set for a July – June rate period or a Calendar Year rate period?	Please see response to Question 70.
72.	Section V.P.2.e – MCO Reimbursement	131	The MCO Reimbursement section of the RFP states "Capitation rates are developed using encounter data...from calendar years 2019, 2020, and 2021".	Given the recent implementation of the adult Expansion population and the COVID-19 public health emergency, a firm commitment about the timeframe or how the information available from the period influenced by the pandemic will not be provided at this time. DHHS will work with the state's contracted actuary to determine the most appropriate base period to be used for rate development. DHHS and the actuary will use internal state data as well

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			<p>For the non-Expansion population:</p> <ul style="list-style-type: none"> - What timeframe will be used for base data experience? - How will experience from pandemic period be used to inform capitation rate development assumptions (such as trend, etc.) and what considerations will be made to adjust for the pandemic disruption to the program experience? 	<p>as external national data and information available to account for impacts from the pandemic.</p>
73.	Section V.P.2.e – MCO Reimbursement	131	<p>The MCO Reimbursement section of the RFP states "Capitation rates are developed using encounter data...from calendar years 2019, 2020, and 2021".</p> <p>For the Expansion population:</p> <ul style="list-style-type: none"> - What timeframe will be used for base data experience? - Will DHHS continue to use TANF and ABD adult experience for rate setting or will the rate development start 	<p>Please see response to Question 72.</p>

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			to incorporate experience from the new adult population? - How will experience from pandemic period be used to inform capitation rate development assumptions (such as trend, etc.) and what considerations will be made to adjust for the pandemic disruption to the program experience?	
74.	Section V.P.2.e – MCO Reimbursement	131	Similar to Attachment 10, for the Medicaid Expansion population, please provide experience data since implementation by rate cell and category of service, including utilization, unit cost and PMPMs.	DHHS's response assumes this question is referencing attachment 11 (Data Exhibits Dental) and not attachment 10 (liquidated damages). Given that the current expansion rates in place today are not based on actual expansion experience, the requested table is not available per this request.
75.	Section V.P.6.a – MCO Reimbursement	132	The request for proposal states "Risk-adjusted rates will not be paid in the first year of this contract." While the program will have a two-sided risk corridor in the first year limiting profits and losses to 2.5% of revenue, varying levels	DHHS does not intend to apply risk adjustment in the first contract period of the contract, as stated in the RFP. DHHS will discuss risk mitigation and adjustment with MCOs as part of the rate development process, and take comments, suggestions, feedback and questions into consideration.

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			<p>of member acuity can drive MCO experience to varying levels of profit or loss within the 2.5% band and can potentially expose some MCOs to significant loss.</p> <p>Since this RFP is not introducing a new population into the program or changing the nature of the benefits (other than the integration of dental) and there is established claims history for the population, will DHHS consider applying risk adjustment in the first year of the contract to better align revenue with costs? This can either be done by using historical experience with a membership snapshot date during the first year of the contract to reflect where members settle by MCO, or it can be done retroactively using concurrent risk adjustment.</p>	

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76.	Section V.P.6.a – MCO Reimbursement	132	<p>The request for proposal states "For subsequent years of the contract, each MCO's base capitation rates may be risk-adjusted based on the MCO's risk score, reflecting the expected health care expenditures associated with its enrolled members relative to the applicable total Medicaid population."</p> <p>Please confirm whether risk adjustment will be fully implemented for all the rate cells that are currently risk adjusted, rather than implemented using a 50% phase-in approach. Please provide timing of data obtained for risk adjustment and impact on rates.</p>	<p>DHHS will work with the state's actuary to determine which categories of aid will be risk adjusted, whether risk adjustment will be phased in, or fully adjusted when implemented. DHHS and the actuary intend to monitor the data and emerging experience (including information provided from MCOs) at program launch to inform decisions made regarding risk adjustment.</p>
77.	Section V.P.6.a – MCO Reimbursement	132	<p>In the current program, Dual rate cells are risk adjusted for acuity differential by MCO. Please confirm this adjustment will remain</p>	<p>DHHS confirms that the current risk adjustment in place for Dual rate cells is not intended to be in place for the first contract period.</p>

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			in place starting in year 1 of the new contract.	
78.	Section V.P.6.a – MCO Reimbursement	132	In the current program, Medicaid Expansion rate cells are risk adjusted using a medically frail relativity factor. Please confirm this adjustment or a similar adjustment will remain in place starting in year 1 of the new contract until risk score based risk adjustment can be applied to this population.	The current medically frail-based relativity factor that is used to risk adjust between MCOs is not expected to be in place for the first contract period of the new contracts, consistent with the approach intended for risk adjustment of other cohorts.
79.	Section V.P.7. – MCO Reimbursement	132	The contract states that annual MCO profits or losses must not exceed two and one half percent (2.5%) in the first contract year. Annual MCO profits must not exceed two percent (2%) in the second and subsequent contract years. Please confirm that the first contract year value applies to incumbent MCOs that are awarded a contract?	DHHS confirms that the first contract year value applies to all MCOs that are awarded a contract regardless of whether they are new to the Nebraska Medicaid program or are an incumbent.
80.	Section V.P.7.a – MCO Reimbursement	132	Please provide a template with sample calculations for the various risk corridors	See Attachment 21, which is attached to this Addendum and hereby incorporated into the RFP.

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			and minimum MLR settlement.	
81.	Section V.P.10.a – MCO Reimbursement	134	Admin spending excludes contractor incentives. Please provide examples of contractor incentives.	LB1011 in 2016 added this specific language to Neb. Rev. Stat. § 68-995. DHHS cannot advise MCOs on how to follow applicable laws.
82.	Section V, P.11 – MCO Reimbursement	134	Please confirm the quarterly financial reports are the same as what is provided under the current contract.	DHHS can confirm that the general layout and information requested on the quarterly financial templates would remain consistent with the current required reports. DHHS reserves the right to modify the templates based on program changes, business need, and/or changes in federal requirements.
83.	Section V.P.14. – MCO Reimbursement Attachment 15	134	Please confirm that the high-cost drug pool and the risk corridor will be in place starting in year 1 of the contract.	DHHS intends for the high-cost drug pool and risk corridor to be in place for the first contract period.
84.	Section V.P.14. – MCO Reimbursement Attachment 15	134	Please confirm whether the high-cost drug pool risk corridor will also cover the Medicaid population.	The high-cost drug pool risk corridor is intended to cover the Medicaid populations covered under this RFP/contract. The exception to this is for populations with separate risk corridors, which currently includes the adult Expansion population and non-Expansion HIPP population; these populations are not expected to be part of the high-cost drug pool at least for the first contract period of the new contracts.
85.	Section V.P.15. – MCO Reimbursement	135	This section of the RFP states "DHHS may implement an Expansion Adult risk corridor". Please describe alternative risk	Per the RFP, DHHS intends to implement a program wide symmetrical risk corridor for the first contract period, but may also include other risk mitigation strategies, such as an expansion adult specific risk corridor, if appropriate.

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			<p>mitigation approaches DHHS is considering in place of the risk corridor.</p> <p>What is the expected timing of when such an alternative approach will be implemented?</p>	
86.	Section V.P.15. and 16 – MCO Reimbursement	135	<p>The language describing the MLR-based risk corridors describes the target as "one hundred percent (100%) minus the rating administrative load (exclusive of margin for profit/risk/contingency)" and goes on to specifically cite an administrative load of 10.25% for the Expansion Adult risk corridor and 8.25% for the non-HHA HIPP risk corridor.</p> <p>Please confirm that the rating administrative load used in setting the corridor targets will be adjusted consistently with the administrative load in the rate build. As the administrative load in the rate build</p>	DHHS can confirm that the rating administrative load may be adjusted for future rating periods and the applicable administrative load will be used for the MLR-based risk corridor in place for the period.

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			changes, consistent with program and policy changes which impact the MCO's administrative responsibilities.	
87.	Section V.Q.13. – Provider Reimbursement	138	Will UNMC payments be at-risk for Plans or a pass-through?	Directed UNMC payments (subject to a 42 CFR. § 438.6(c) preprint for Physician and Dental Services) will be at-risk for MCOs.
88.	Section V.R.5 – Systems and Technical Requirements	141	Please confirm “Transmit and receive data related to nursing facility stays in DHHS-specified formats” is the same SNF information currently provided.	Yes, this refers to existing interfaces. Namely the skilled stay file from plans to state, and the level of care / NF stays file from state to plans.
89.	Section V.R.6.f – Systems and Technical Requirements	141	Regarding the phrase: SMART/OATH 2. We assume DHHS is referring to SMART on FHIR and OAuth2. Are we correct in our assumption? If we are not correct, please clarify.	Yes, that is correct it should have SMART on FHIR and OAuth2.
90.	Section V.R.13.b – Systems and Technical Requirements	145	Regarding the phrase: The historical encounter data submission ... We assume that the encounter data referenced above is the encounter data that	DHHS confirms that is the correct assumption.

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			<p>MCOs submit to DHHS as detailed in RFP Sections V.S.10 (p.151) and V.T.4 (p.157)</p> <p>Are we correct in our assumption? If we are not correct, please clarify.</p>	
91.	Section V.S.15.a. – Claims Management	155	<p>1)How will TPL derived from an absent parent be communicated to the MCO?</p> <p>2) Is the 90 calendar days that MLTC may require a MLTC-contracted TPL vendor to review paid claims based on date and how will the MCO be notified of claims the contractor is pursuing recovery on so as to not duplicate recovery efforts?</p>	<p>1) DHHS will communicate electronically on a monthly basis any known TPL applicable to an absent parent whose obligation to pay support is being enforced by the DHHS Division of Children and Family Services.</p> <p>2) This means 90 calendar days from the paid date of the claim. The MCO should make every attempt to recover TPL within 90 days. DHHS will notify the MCO of any TPL the department recovers after 90 days.</p>
92.	Section V.S. – Claims Management	156	<p>1) What if the MCO has a case open within 365 days from date of loss but settlement has not been finalized? Can the MCO retain rights to any recoveries for cases opened within 365 days but recovered after 365 days from date of loss?</p>	<p>1) Per the RFP – DHHS has the right to or may recover TPL over 365 days from the date of loss. DHHS will work with the MCO, as needed, for any special circumstances.</p> <p>2) The MCO must seek reimbursement for subrogation cases when claims in aggregate equal or exceed \$250 for a client in a contract year. The MCO may pursue all recoveries.</p>

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			2) Is \$250 the dollar threshold for subrogation or must the MCO pursue all recoveries regardless of recovery opportunity amount?	
93.	Section V.Z. - Electronic Visit Verification (EVV) for Home Health Care Services (HHCS)	167	Section Z on EVV states that MCOs must collectively contract with a single EVV-HHCS solution provider for the provision of EVV services. Is NetSmart/Tellus the service provider that has already been selected for MCOs to use?	At this time, DHHS is not requiring that MCOs utilize a state-identified EVV solution provider.
94.	Section V.Z. - Electronic Visit Verification (EVV) for Home Health Care Services (HHCS)	167	<p>Regarding this section on EVV requirements: we assume that this section requires MCOs operating under this Contract to mutually decide on one vendor for EVV services for Heritage Health.</p> <p>Our question: Are there limitations with the existing DHHS EVV vendor (Netsmart</p>	<p>The RFP does require that MCOs mutually decide on a single EVV solution provider for services subject to EVV under Heritage Health.</p> <p>At this time, DHHS is not requiring that MCOs utilize a state-identified EVV solution provider.</p>

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			Tellus) that makes this system not an option for MCOs to use for Heritage Health? Does DHHS want MCOs to decide on an alternative solution? Please clarify.	
95.	Section V.Z. - Electronic Visit Verification (EVV) for Home Health Care Services (HHCS)	167	Are there preferred vendors or entities that should be utilized and how early can that work begin?	At this time, DHHS is not requiring that MCOs utilize a state-identified EVV solution provider. The work by the MCOs to collectively identify and establish a single EVV solution provider for services subject to EVV under Heritage Health should begin upon contract execution.
96.	Section V.AA.7. - Fee for Service Claims Management and Processing – Optional Services	171	The Optional Services Proposal Response Instructions has No. 7 as “Security Authorization Procedures” the RFP on page 171 list this as “Service Authorization Procedures”. Our understanding is this should be “Service” and not “Security” - are we correct in that assessment?	The Optional Services Proposal Response Instructions have been amended and a revised version has been included with Addendum 2.
Section VI – Proposal Instructions				
97.	Section P. Request for Proposal/Proposal Requirements, Section VI. Proposal Instructions, Optional FSS_Cost Proposal	173	Can the State please confirm that no cost proposal is required for responses to the Capitated Medicaid Managed Care	Yes. Cost proposals will be required to provide the Optional Scope of Work – Fee for Service, but not Managed Care Scope of Work. Please also see the Evaluation Criteria.

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			program, as indicated during the Mandatory Pre-Proposal Conference on April 28, 2022.	
98.	Section VI.A.7 – Corporate Overview	174	Please confirm that the information requested for all VI.A.7. for organization's parent company, affiliates and subsidiaries is limited to those operating contracts for services similar to services contemplated by this RFP, Medicaid and CHIP, as noted in the fifth paragraph in that section.	The limitation of disclosures to Medicaid and CHIP contracts in section VI. A. 7. only applies to letters of deficiency and corrective actions required by federal or state regulatory entities.
99.	Section VI.A.7 – Corporate Overview	174	Please confirm that the requested information on contract terminations refers and applies to contracts with government agencies and does not apply to more common course of business contract terminations such as those with a network provider	Section VI. A. 7. applies solely to terminations by government agencies. This does not include actions where the MCO has terminated a network provider.
100.	Section VI.A.8 – Corporate Overview	174	Please confirm for this section, Bidders can include the experience of its affiliates, under the same ultimate ownership as the	Inclusion of affiliate experience is acceptable provided the nature of the affiliation is clear.

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			Bidder, that operate in other markets under contracts for similar services to those contemplated by this RFP (Medicaid and CHIP).	
101.	Section VI.A.9 – Corporate Overview	175	Please confirm bidder should only provide resumes for the Key Staff positions as outlined in the SOW Table 1. Key Staff.	Resumes should only be provided for the Key Staff positions.
Attachments				
102.	Attachment 1 – Member Counts by County	1	<p>Please share projected enrollment for the covered population for the first year of the contract and beyond, as well as assumptions around:</p> <ol style="list-style-type: none"> 1. The residual impact of the COVID-19 pandemic and associated Public Health Emergency (PHE) on enrollment levels in the first few years of the contract 2. Post COVID, long-term enrollment growth 3. The ultimate expected enrollment levels for the newly 	<p>Question 1:</p> <p>DHHS cannot speculate on the residual impacts of the COVID-19 pandemic and associated PHE on enrollment levels in the first few years of the contract given that the end date of the PHE is not known at this time. DHHS can report that as of March 2020 (prior to the Maintenance of Effort (MOE) requirements tied to Medicaid enrollment during the PHE; and prior to the implementation of Medicaid Expansion for adults) there were approximately 232,991 members enrolled in managed care. As of May 2022, there are a total of approximately 358,249 members enrolled with managed care with approximately 66,377 Adult Expansion members in managed care and 291,872 non-expansion members in managed care.</p> <p>Question 2:</p> <p>DHHS has traditionally (Pre PHE) experienced program growth around 1.5 - 2.0% in aggregate annually.</p>

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			implemented Medicaid Expansion population	<p>Question 3:</p> <p>DHHS does not expect significant enrollment growth beyond the current expansion enrollment of 66,377 for May 22. DHHS has observed that in other states that have expanded that enrollment growth plateaus around 15-18 months after implementation, expansion went live in October 20 and May 22 marks approximately 20 months since implementation; furthermore, it is reasonable to assume that given the expansion program has only existed during the PHE, where the state is adhering to enrollment MOE requirements, that some members that are currently in the program may no longer be eligible after the expiration of the PHE and MOE requirements.</p>
103.	Attachment 3 – Policies, Procedures, and Plans	Footer of all pages	Please confirm that the footer for this document should reference “Attachment 3” instead of “Attachment 5”.	Yes. The footer for Attachment 3 is hereby amended to state “Attachment 3.”
104.	Attachment 7 - Medical Loss Ratio Requirements	Page 1	How will UNMC revenue and expense be factored into the MLR reporting?	UNMC revenue and expenses related to the Directed UNMC payments (subject to a 42 CFR § 438.6(c) preprint for Physician and Dental Services) will be at-risk for MCOs and included in the Numerator and denominator of the MLR.
105.	Attachment 11 – Data Exhibits Dental	All pages	The base data model (attachment 11) provides the data in age-banded buckets. Please confirm that dental will be carved into rates following the current rate cell structure, i.e. new	DHHS confirms that the dental services currently covered via a separate PAHP will be integrated and included within the integrated Heritage Health rate structure.

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			dental-only rate cells will not be created.	
106.	Attachment 12 – Example Capitation Rates	All pages	Please provide the rate build-up for the dental rates from the base data in attachment 11, including trend, non-medical load, and other assumptions, to the age-banded rates provided in attachment 12.	Please see the additional information provided responsive to this question in Attachment 22. Attachment 22 has been included with this addendum and is hereby incorporated into the RFP.
107.	Attachment 13 - Required Reporting Templates	All pages	Can a copy of the Required Reporting Template be provided for reference?	Please see Attachment 13 for reporting requirements. Report templates will be provided to the MCOs at the time of contract execution.
Proposal Response Instructions				
108.	Proposal Response Instructions: Technical Approach Statements and Questions	1	In the RFP Section column of question #7 it reads as "V.B. Business Requirements" should it read as "V.C. Business Requirements"?	Yes. This section is amended to stat "V.C. Business Requirements."
109.	Proposal Response Instructions, Section V.F Member Services and Education	4	Can DHHS please confirm that the member education examples requested in Question 30, RFP Proposal Response Instructions Section V.F Member Services and	Yes, examples are not included in the page limit.

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			Education, is excluded from the 10 page limit?	
110.	Proposal Response Instructions: V.F Member Services and Education	4	For number 30, do requested attachments count toward the 10-page limit?	Please see response to Question 109.
111.	Proposal Response Instructions, Question 30	4	Do the requested attachments count towards the 10 page limit in question 30 (technical response)?	Please see response to Question 109.
112.	Proposal Response Instructions, Section V.H Grievances and Appeals	4	Can DHHS please confirm that the flowchart requested in Question 31, RFP Proposal Response Instructions Section V.H Grievances and Appeals, is excluded from the 3 page limit?	Yes, the flowchart is not included in the page limit.
113.	Proposal Response Instructions	Various	Please confirm that when a response item references "experience in other states," incumbents may include reference to experience in Nebraska in addition to experience in other states?	Experience in any state, including Nebraska.
114.	Proposal Response Instructions	9	Will DHHS allow for the organizational	Yes.

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	Technical Approach Statements and Questions Question 49 V.K Subcontracting Requirements		chart to be provided outside of the 1 page per subcontracting organization page limit?	
115.	V.M. Quality Management No. 64	11	Do we need to have a separate Dental Quality Improvement Program, Work Plan and Evaluation? We would like to have one comprehensive Quality Program Description, Work Plan, and Evaluation that address all quality improvement activities related to physical health, behavioral health, LTSS, and dental health. Would one comprehensive set of documents meet the requirement?	MCO needs to have a separate Dental Quality Improvement program but one comprehensive set of documents would meet the requirements.
116.	V.M. Quality Management No. 73	12	Could the requirement for the Health Equity Committee be met by expanding the QI Committee to include a health equity focus instead of having a separate Health Equity Committee? Since health equity and quality are closely aligned, it would be	MCO is required to have a separate Health Equity Committee. To meet the requirement the Health Equity Committee may be a subcommittee of the QI Committee.

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			helpful for one QI Committee to oversee and address issues related to quality and health equity. One QI Committee would allow us to include a wide range of participants who can review and give feedback on quality improvement and health equity activities.	
117.	V.M. Quality Management No. 78	13	Could the requirement for the Clinical Advisory Committee be met through the Utilization Management Committee that reports to the QAPIC? Could we also use the QAPIC to review clinical practice and preventive health guidelines instead of the Clinical Advisory Committee? This would allow us to have feedback provided by a wide range of perspectives that have expertise in both clinical and quality oversight.	Clinical Advisory Committee must be a separate committee from the Utilization Management Committee. The Clinical Advisory Committee must report up to the QAPIC.
118.	Proposal Response Instructions	18	Please clarify if the requirement to provide the subcontractor's	Listing the corporate headquarters of the subcontractor is sufficient.

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	Technical Approach Statements and Questions		location includes the address(es) of its corporate headquarters or if the bidder is to list the addresses of all locations.	
119.	Proposal Response Instructions		Please validate that bidders do not need to respond to requirements for V.G, V.P, V.U, V.V, & V.Y in the Technical Approach of the proposal.	Bidders should respond to the Proposal Response Instructions in order for the State to evaluate their proposals, as set forth in the Evaluation Criteria. V.G, V.P. V.V., and V.Y. do not require any specific response in the Proposal Response Instructions.
Optional Services Proposal Response Instructions				
120.	Optional Services Proposal Response Instructions	1-2	Are there page limits for the response to questions about the Optional FFS Claims Processing? If so, what are they for each question?	All responses to the Optional Services questions should not exceed 20 pages combined.
121.	Optional Services Proposal Response Instructions	1	In the Optional Services Proposal Response Instructions, will the State please provide additional clarification on the distinction between what the State is requesting bidders to submit in Question 1 as compared to Question 2? Please provide this same	The Optional Services Proposal Response Instructions have been amended and a revised version has been included with Addendum 2.

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			clarification for Questions 5 and 6 as opposed to question 2.	
Optional Cost Proposal				
122.	Cost Proposal Template	1	In the Cost Proposal Template for the Optional Services, the State has provided estimated claims or levels of authorizations for purposes of developing a proposed initial rate for the first contract year. Since the scope of work also includes member and provider services, will the State please provide project levels of member and provider calls to a service center?	<p>In the most recent year, DHHS fielded approximately 16,250 member calls pertaining to FFS claims.</p> <p>DHHS does not currently track provider call volume for FFS utilization management.</p>
123.	Cost Proposal Template	1	In the Cost Proposal Template for Optional Services the State has provided estimated claims or levels of authorizations for purposes of developing a proposed initial rate for the first contract year. Please confirm that these estimated levels are for the full	Yes, the estimated volumes in the Optional FFS Cost Proposal form are meant to represent annual estimates.

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			year (vs. a monthly estimate).	
Evaluation Criteria				
124.	Evaluation Criteria	1	Will the 5,100 points assigned to Part 2 be divided in equal parts for each subsection (e.g. V.A, V.B). If not, how will the points be assigned to individual sections?	The points allotted to the Technical Proposal for Managed Care services are not equally divided. They have been assigned values consistent with the state's discretion and based on the state's valuation of their importance to providing Medicaid Managed Care Services.
125.	Evaluation Criteria	1	<p>Within the Evaluation Criteria, the State has not identified whether or not bidders will be given any additional preference points for the Capitated Medicaid Managed Care program if they also choose to bid on the Optional Services. Will the State please confirm that the Capitated Medicaid Managed Care program proposal will be scored separately and independently from the Optional Services?</p> <p>Additionally, will the state please confirm that whether or not a</p>	<p>Yes.</p> <p>Whether an entity submits a proposal for the Optional Services will not, in any way, be factored into the evaluation of the Medicaid Managed Care Services.</p>

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			bidder chooses to also submit a proposal for the Optional Services will not be a factor in the ultimate awards for the Capitated Medicaid Managed Care program?	
126.	Evaluation Criteria	2	Are points awarded for the FFS Optional Services? If yes, will these points be added to the Medicaid Managed Care points and used in determining the winning bids?	<p>Points will be awarded for the bid cost of the Optional Services as provided in the Evaluation Criteria. Technical Proposals for the Optional Services will be evaluated on a pass/fail basis.</p> <p>Please also see response to Question 125.</p>