
Pete Ricketts, Governor

ADDENDUM SEVEN QUESTIONS and ANSWERS

Date: November 19, 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.

The following are the responses to Questions 221 – 382 for the first round of questions.

<u>Question Number</u>	<u>RFP Section Reference</u>	<u>RFP Page Number</u>	<u>Question</u>	<u>State Response</u>
221.	IV. P.8-13 MCO Reimbursement	145	<p>"Please provide a few detailed numerical examples to demonstrate the timing and order of calculation of the following adjustments/ limitations to capitation revenue, and how they are applied and interact with each other. In parentheses, we have shown our understanding of some of the specifics of these calculations:</p> <ol style="list-style-type: none"> 1) Risk Adjustment (begins 7/1/2017, calculated annually? for each rating period? calculated by category of aid and region, for selected categories of aid) 2) Minimum MLR (begins on contract start date?, calculated annually on a six to nine month lag, for program in total) 3) Risk Corridor (begins on contract start date?, calculated annually on a nine month lag, for program in total) 4) MLTC Quality Performance Program (effective contract 	<p>The application of risk scores will not begin until the second contract period, 1/1/18-12/31/18. The State and its contracted actuary will work together in determining the best risk adjustment methodology to use at that time. The Minimum MLR will be in effect beginning on the contract start date and will be calculated on an annual basis between 6-9 months after the end of the contract year. Although the MLR will be settled annually, as mentioned in Attachment 15 "the MCO must calculate the MLR and submit it to MLTC quarterly". The 85% Minimum MLR requirement will be calculate as an aggregate of Regions 1 and 2 and will be calculated across all categories of aid. The risk corridor will be in effect beginning on the contract start date and will be calculated at the end of each contract period between 6-9 months after the end of the contract year. The risk corridor calculation will be an aggregate of Regions 1 and 2 across all categories of aid. The administrative cap requirement is built into the capitation rates on a prospective basis. The contracted actuary ensured that the amount of non-medical load built into the rates meets the administrative cap requirement. The UNMC amount built into the capitation rates will remain the same throughout the entire contract period. The contracted actuary developed the UNMC Supplemental PMPM by COA, COS, and Rating Region. MLTC Quality Performance Program and Performance Penalties are effective Year 1 and calculated annually on a 6 – 9 month lag for program end total. Attachment 26:"MLR and Risk Corridor Examples" contains an illustrative example of this scenario. Please see Section IV.P.9.d-e.</p>

		<p>start date, calculated annually on a six month lag, for program in total)</p> <p>5) State Performance Penalties (effective in contract year one, with metrics provided before year two, calculated annually</p> <p>6) Administrative Cap (begins on contract start date?, calculated annually on a nine month lag, for program in total)</p> <p>7) UNMC Supplemental Payments (begins on contract start date? calculated into the capitation rate on a quarterly basis, separate payments by category of aid and region)</p> <p>In particular, please ensure that these examples illuminate the answers to the questions in parentheses and demonstrate all of the calculations that would result in each of the following situations:</p> <p>1) MCOs rebate to the state under the MLR,</p> <p>2) MCOs deposit into the reinvestment accounts under</p>	
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			<p>the risk corridor and the MLTC quality program</p> <p>3) MCOs receive money back from the state under the risk corridor"</p>	
222.	Attachment 15	Attachment 15 and page xiii	<p>Attachment 15, Medical Loss Ratio Requirements, defines Net Qualified Medical Expense (the numerator in the MLR calculation) as follows:</p> <p>the sum of:</p> <ul style="list-style-type: none"> a. Claims incurred b. Claims incurred but not paid, plus provisions for adverse deviation and loss adjustment expense c. Medical incentive bonuses d. Reinsurance premiums less reinsurance recoveries e. Activities that improve health care quality, per 45 CFR 158.150 f. Less related-party medical margin <p>Whereas, page xiii defines Medical Loss Ratio as: The percentage of qualifying revenue (for the risk corridor and MLR calculations) spent on covered services for</p>	Confirmed. Item 4 under the MLR Calculation section of Attachment 15 defines "allowable QI expenses".

			<p>members and allowable QI expenses under this contract.</p> <p>For purposes of the MLR calculation, are "allowable QI expenses" those as defined in the definition of Net Qualified Medical Expense in Attachment 15?"</p>	
223.	Attachment 15	All	<p>Please provide numerical examples of how related party medical margin is to be included in the calculation of Net Qualified Medical Expenses.</p>	<p>If a related party subcontractor was paid premiums of \$100 by the MCO and had expenses of \$75, an amount of \$25 would be deducted from the Net Qualified Medical Expense calculation.</p>
224.	Attachment 15	All	<p>Please provide numerical examples of how affiliate/related party underwriting losses/gains on reinsurance are to be included in the calculation of Net Qualified Medical Expenses, which is defined in Attachment 15 as follows: the sum of:</p> <ul style="list-style-type: none"> a. Claims incurred b. Claims incurred but not paid, plus provisions for adverse deviation and loss adjustment expense c. Medical incentive bonuses d. Reinsurance premiums less reinsurance recoveries 	<p>Yes, these examples are correct.</p>

			<p>e. Activities that improve health care quality, per 45 CFR 158.150</p> <p>f. Less related-party medical margin</p> <p>For example, if a related party reinsurer was paid reinsurance premiums of \$100 by the MCO and had incurred reinsurance underwriting losses of \$120 paid to the MCO, would losses of \$20 be included as a subtraction in item d. in the calculation above, then added back for positive \$20 in item f., since under this scenario the related party reinsurer had an underwriting loss of \$20?</p> <p>Conversely, if a related party reinsurer was paid reinsurance premiums of \$100 by the MCO and had incurred reinsurance underwriting losses of \$75 paid to the MCO, presumably an amount of \$25 would be added in item d. of the calculation and an amount of \$25 would be deducted in item f. of the calculation. Is this correct?"</p>	
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225.	Glossary of Terms	xiv	<p>Within the definition of Non-Quality Improvement Administrative Expenses (definition from glossary pasted below), as it relates to item 1., Direct Administration, please comment as to whether the use of the term "medical management" is for costs that do not meet the definition of activities that improve health care quality per 45 CFR 158.150. Said differently, please confirm that costs that meet the definition of improving health care quality per 45 CFR 158.150 are not included in the definition of "direct administration" as used in defining Non-Quality Improvement Administrative Expenses.</p> <p>Non-quality improvement (QI) administrative expenses: All non-benefit expenses of operating pursuant to the requirements of this contract, other than medical, prescription drugs, DME, and other benefits for the contract year. Non-benefit, administrative expenses</p>	<p>Costs that meet the definition of improving health care quality per 45 CFR 158.150 are not included in the definition of "direct administration".</p>
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			<p>include:</p> <ol style="list-style-type: none"> 1. Direct administration: customer service, enrollment, medical management, claims administration, etc. 2. Indirect administration: accounting, actuarial, legal, human resources, etc. 3. Net cost of reinsurance: reinsurance premium less projected reinsurance recoveries. Net cost of related party reinsurance is excluded." 	
226.	IV.P.12 and Attachment 15	147 & Attachment 15	<p>Is the definition of "quality improvement" administrative costs that are allowed to be included up to 3% in the determination of the MCO's administrative cap the same definition as "activities that improve health care quality per 45 CFR 158.150" as those are included in the numerator in the calculation of the MLR? We recognize there is the 3% limit for the Administrative Cap and there is not a specified limit for purposes of the MLR; in this question we are inquiring as to the consistency of the definition (not extent) of the</p>	See response to Question # 178.

			quality improvement costs.	
227.	IV. P.8-13 MCO Reimbursement	145	<p>"Please provide an explanation as to why there is different treatment of the MLTC Quality Performance hold-back within each of the following calculations:</p> <ol style="list-style-type: none"> 1) Minimum MLR (earned holdback not factored into the calculation) 2) Risk Corridor (earned holdback not factored into the calculation) 3) Administrative Cap (earned and forfeited holdback is factored into the calculation) <p>For example, by ""is factored in"" do you mean that these amounts are added back in to the calculation for the Administrative Cap? Similarly, is forfeited holdback factored into the calculation of Minimum MLR and Risk Corridor?</p> <p>Also, please explain how the State Performance Penalties are factored into each of the above calculations."</p>	The MLTC Quality Performance hold-back is not factored into the risk corridor or the Minimum MLR. The MLTC Quality Performance hold-back is factored in to the Administrative Cap. It is required to be factored in to the administrative cap so that if an MCO earns the entire hold-back they will remain beneath the administrative caps required by statute. The State Performance Penalty is included in the minimum MLR, risk corridor, and the Administrative Cap.

228.	IV P.9. Risk Corridor	146	The numerator (profit or loss) in the calculation of the risk corridor is defined, but the denominator is not. Please include a description of the revenue to be included in the denominator of this calculation.	See response to Question #33.
229.	IV P.9. Risk Corridor	146	Please provide a definition of the term "Total allowed administration calculated for the administrative cap" as used in the definition of the risk corridor: does this reflect the full allowance for administration, or the portion of that allowance used by a specific MCO?	"Total allowed administration" as used in the calculation of the risk corridor reflects the portion of allowance used by a specific MCO.
230.	IV. P 10 and 11 MLTC Quality Performance Program and State Performance Penalties	146	In terms of the actuarial certification, are both the MLTC Quality Performance hold-back and State performance penalties considered withholds?	In terms of the actuarial certification, only the MLTC Quality Performance hold-back is considered a withhold.
231.	IV. P 10 and 11 MLTC Quality Performance Program and State Performance Penalties	146	What percentage of the MLTC Quality Performance hold-back does Optumas assume will be earned back (as part of the actuarial certification)?	The contracted actuary has not conducted this analysis for the Heritage Health program.
232.	IV. P 10 and 11 MLTC Quality Performance Program and State	146	What percentage of the State Performance Penalty does Optumas assumed will be	The contracted actuary has not conducted this analysis for the Heritage Health program.

	Performance Penalties		earned (as part of the actuarial certification) - especially given the metrics are not yet available?	
233.	IV. P 11 State Performance Penalties	147	In this section it is stated that this program is effective beginning on the contract start date. However, performance metrics will be provided to MCOs prior to year two of the contract. Can this information be provided earlier in order to allow MCOs to manage to and report on performance relative to these metrics during the first contract year?	As Heritage Health is a new program, the State will use operational and quality reporting required in the first year of the program, including but not limited to measurements found in Attachments 7 and 14, to establish minimum performance metrics for year two of the contract that will be subject to the minimum performance metric penalty required in Neb. Rev. Stat. §71-831.
234.	IV. Q. 3. Provider Reimbursement	149	What assumptions were built into the rates to account for the requirement to pay enhanced payments in accordance with section 1202 of the Affordable Care Act?	The current managed care entities reimburse providers consistent with the requirements of section 1202 of the Affordable Care Act. The rates are built using encounter data from current managed care entities, so the enhanced payment levels commensurate with section 1202 are fully inherent in the base data.
235.	IV. Q. 8. c. Payments to Out-of-Network Providers	149	Please provide additional information regarding out of network providers that can be paid at 90% of the Medicaid rate - are there any provider types excluded from this provision?	IHS provider types are excluded from this requirement set for in the RFP.
236.	IV. Q. Provider Reimbursement	149	Are there any other special reimbursement requirements beyond what is documented	The MCO may negotiate rates with its network providers, except as otherwise provided for in the RFP.

			in this section? For example, are MCOs allowed to contract with providers at values below the Medicaid Fee Schedule?	
237.	IV. Q. Provider Reimbursement	149	What assumptions were built into the rates regarding provider reimbursement requirements and experience under managed care and/or fee for service?	The Heritage Health capitation rates are based on the reimbursement levels underlying the managed care encounter data for services currently provided via managed care and FFS reimbursement levels for services currently provided via FFS.
238.	IV. Q. Provider Reimbursement	149	Where any specific assumptions built into the initial rates to account for the requirement that MCOs enter into value-based purchasing agreements with providers?	No assumptions were built into the initial rates to account for value-based purchasing agreements.
239.	IV. Q. Provider Reimbursement	149	What assumptions were built into the rates to take into account access to care requirements?	No assumptions were built into the rates to take into account access to care requirements. The base data consists of FFS data and data from the current managed care entities. All of these organizations are able to meet access to care requirements, so the data was considered sufficient to account for access requirements.
240.	IV. Q. 10. Critical Access Hospital Contracting and Reimbursement	152	"Please clarify each of the following with regard to Critical Access Hospitals: 1) What assumptions are built into the rates? 2) What protections exist if MCOs experience utilization at these facilities different than that assumed in the rates?"	Rates are built using the payments made by current managed care entities to critical access hospitals. This includes both claim payments and supplemental payments made outside of the claims system. Currently no protections exist. Currently, the State does not allow for a settlement process and this is currently under review.

			3) Will the State consider a settlement process with MCOs to ensure that there is no variation in payment between MCOs based on differing utilization of Critical Access Hospitals?"	
241.	IV. Q. 11. University of Nebraska Medical Center (UNMC) Physician/Practitioner Payments	152	<p>"Please clarify each of the following with regard to the UNMC supplemental payments:</p> <p>a) please describe the process of developing the amount to be paid to each provider eligible for these supplemental payments</p> <p>b) please describe the assumptions for the development of the amount built into the rates on a quarterly basis to account for these payments"</p>	<p>To develop the UNMC rate the contracted actuary receives a list of UNMC Provider IDs from the State as well as the current managed care entities. These lists are 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 unmanaged 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. The UNMC PMPM amount is provided in Attachment 11. Additionally, UNMC services are concentrated in professional service categories. Lab and Radiology, PCP, EPSDT, Specialist, and Other Practitioner represent 96% of the UNMC utilization. UNMC services are concentrated in Rating Region 1; Rating Region 2 has about half as many services provided by UNMC. Statewide, UNMC utilization represents about 3.5% of Lab and Radiology services, about 0.5% of PCP and Other Practitioner utilization, and less than 0.5% of the other service categories.</p>
242.	IV. Q. 11. University of Nebraska Medical Center (UNMC) Physician/Practitioner	152	Since the UNMC amounts built into the rates are estimates, there is the potential for the actual payout	<p>The process outlined in the RFP is the methodology currently approved by CMS so there is not an intention to implement a reconciliation process.</p>

	Payments		to be more or less, which puts the MCOs at risk. If this is intended to be a true pass through (i.e., every dollar received is paid out to providers or paid back to the State)?, there needs to be a reconciliation process so there are not winners and losers. Does DHHS intend to implement a reconciliation process?	
243.	IV. Q. 9. Reimbursement to FQHCs and RHCs	152	<p>"Please provide the following for FQHCs and RHCs:</p> <p>a) a listing of FQHCs and RHCs and the current encounter rates by region</p> <p>b) What payment methodology is embedded in the base data (e.g. encounter rates vs. rates per service)?</p> <p>c) what adjustments were made to the base data to include these provider types in the final rates(e.g., payment methodology changes)?</p> <p>d) please clarify that MCOs pay FHQC and RHC providers similar to other PCPs, clinics, etc."</p>	See Attachments 27 and 28: "FQHC-2015-Rates and "Rural Health Clinic Rates Effective 07012015" respectively. The base data prior to adjustment contains reimbursement at each FQHC's PPS rate. FQHCs receive the PPS rate for each patient encounter. These rates are traditionally been updated annually; however, effective January 2016, the State is moving to a re-based APM payment. To account for the impact the reimbursement change will have on the Heritage Health capitation rates, the contracted actuary 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 consistent with the overall rate development. MCOs are expected to pay FQHC and RHC providers at the designated per visit rate.
244.	IV. T. 4. Encounter	177	Will historical data be	Historical pharmacy data will be provided to MCOs upon member assignment.

	Data		provided to MCOs upon member assignment, to assist with care management and other operational requirements?	
245.	IV.Z. Claims Broker Services	192	<p>"A description of the annual calculation of the per claim administrative fee is described in this section. Please provide:</p> <p>a) additional detail regarding the timing of the payment of this fee.</p> <p>b) an estimate or an actual value for the initial amount of this fee upon program implementation.</p> <p>c) Please provide an estimate of the volume of claims that would be expected to be processed by the claims broker MCO."</p>	This information will be provided to the awarded contractor during the implementation timeframe outlined in Section IV.Z.3.
246.	V. Proposal Instructions	196	This section states that "Content requirements for the Technical and Cost Proposal are presented separately in the following subdivisions; format and order" however no additional information is provided regarding a cost proposal. Please provide any additional information regarding any cost proposal	No additional cost proposal information is required.

			information that bidders should provide.	
247.	Attachment 1	All	Please provide a breakout of the members shown in this exhibit into those that would be expected to be covered by the contract, and those who would remain covered under fee for service.	As nearly all Medicaid eligible individuals will be included in Heritage Health, the State does not currently have an exact figure by county for the number of individuals that will continue to receive core benefits and services through the fee-for-service program. This information will be posted to the procurement website as part of the second round of questions and answers.
248.	Attachment 11	All	Please break out the Non-Medical Load (NML) shown in the Optumas Pre-Bidders Conference presentation into the relevant components for each category of aid and each region.	See Response to Question #112.
249.	Attachment 11	All	Please describe the process used to arrive at the varying NML components by category of aid and region, considering both the PMPM values and the percentages.	See Attachment 21: "Non-Medical Load Assumptions". NML is based on the experience of current Managed Care Entities.
250.	Attachment 11	All	Please confirm that the values shown in this exhibit represent the lower bound of the actuarially sound rate range.	Confirmed.
251.	Attachment 11	All	It was stated that these rates are the lower bound of the range. Has DHHS historically paid the low end of the rate range? If no, at what point in the range have the MCO	MLTC has historically paid the physical health managed care rates at the mid-point range. The behavioral health rates have been variable.

			capitation rates been set?	
252.	Attachment 11	All	Please provide the high and low end range of each assumption and adjustments used to create the high and low end rates.	The rates that have been discussed during the bidder's conference reference the lower bound, thus all assumptions that were shown in the power point reflect the lower bound assumption values. The ranges around the assumptions will not be shared.
253.	Attachment 11	All	It was stated that these rates are the lower bound of the range. When the rates are updated for retroactive eligibility and other changes, is it DHHS' intention to pay at the low end of the range?	While it has not been historical practice for MLTC to pay at the lowest end of the rate range, a final decision will be made in the context of the Department's budget.
254.	Attachment 11	All	"Are the rates shown in this exhibit net or gross of each of the following: a) MLTC hold-back (1.5%) b) State Performance Penalties (0.25%)"	The rates shown in the "Medical PMPM" columns of Attachment 11 are gross MLTC hold-back (1.5%) and net State Performance Penalties (0.25%). The rates shown in the "Developed Rate" and "Total Rate" columns of Attachment 11 are gross MLTC hold-back (1.5%) and gross State Performance Penalties (0.25%). The State Performance Penalties is considered a component of non-medical load and is added in along with other administrative funding.
255.	Attachment 13	All	Based on the wording of this Statute, it appears that these requirements apply to "at-risk managed care service delivery for behavioral health services." Please confirm that this statute applies to the anticipated contract, which covers service delivery for behavioral health and physical health services.	Confirmed.

256.	Attachment 13	All	<p>Each of sections IV.P.10, 11, 12, 14, and attachment 15 which is referenced by section IV.P.13 make a reference to this attachment, but section IV.P.9 does not. Please confirm that section IV.P.9 was written in accordance with paragraph (2) of this attachment, and that this is the only section of the scope of work written to conform to the requirements in this paragraph.</p>	<p>Section IV.P.9 is written in accordance with paragraph two (2) of Attachment 15.</p>
257.	Attachment 13, 15 and IV.P.9 - 14	All	<p>"The concept of revenue for the MCO and related parties is addressed multiple times in multiple calculations. The language is similar but not always consistent in each of these sections. Please define what is meant by this language, providing any instances in which the definition would be different between calculations.</p> <p>For example, the definition of Risk Corridor Calculation on page xvi states that the calculation ignores any forfeited hold-back, and the definition of Qualifying</p>	<p>See response to Question #33.</p>

			Revenue (for the risk corridor calculation) per page xv states that any earned holdback is not factored into the calculation. If a MCO had \$150 of holdback and it was determined the MCO earned \$100 of the holdback through the QPP, how much of the \$150 holdback is included in the calculation/definition of Qualifying Revenue for the risk corridor? "	
258.	Attachment 15	All	"Please define the term ""Risk Bearing Partners."" In particular, a) please clarify whether providers with whom an MCO has a value-based contract as described in section IV.Q.6 (p. 150) would be included in this definition b) please clarify whether providers with whom an MCO has a contract including a physician incentive plan as described in section IV.Q.6 (p. 150) would be included in this definition"	Providers with whom an MCO has a value-based contract or providers with whom an MCO has a contract including a physician incentive plan as described in Section IV.Q.6 would be included in this definition.
259.	Attachments 10-11	All	Please provide a detailed development of the copayment assumption built into the rates, including the	Allowed copayment amounts are specified at 471 NAC 3-008. Copayments are collected at the discretion of the MCO, but the capitation rates are developed in accordance with 42 CFR 447.56(d). This adjustment is a 0.02% reduction in the total PMPM in each Rating Region.

			actual amounts collected historically by MCOs and by the state under fee for service during the base period, and any adjustments made to arrive at the expected amounts to be collected by MCOs under the contract	
260.	Attachments 10-11	All	At the bidders' conference, it was stated that only FY2015 experience was used to develop the Foster Care rates because PRTF experience in FY2014 was much higher than FY2015. Please explain the reason for the decrease. Was there a policy change?	The current managed care entity described the variance in utilization for PRTF as a decrease in requests for PRTF. It was assumed that the utilization levels inherent in the FY2015 data was more indicative of future utilization patterns.
261.	Attachments 10-11	All	"Regarding the base data: a) Please discuss any issues or concerns related to data collection. b) Does the data book capture all expenses that will be the MCOs' responsibility, even those paid outside of the claims system? c) Please confirm that encounter data represents actual reimbursements by MCOs and were not repriced to 100% of a fee schedule? d) Please provide average	There are no concerns about data collection. Data sources are comprised of FFS data and MCO encounters. Current MCOs are involved in validating the encounter data. The results of this validation confirm that encounter data is not underreported. All payments are captured. Supplemental payments such as CAH settlements and PCP shared risk agreements are added in to the base data. Encounter data represents actual reimbursements by MCOs were not re-priced to 100% of a fee schedule. The level of detail requested in part d of the question is not available.

			payment rates (reflected in the data book) relative to the fee schedule by region, category of aid, and category of service."	
262.	Attachments 10-11	All	<p>"Can the databook be further split by:</p> <p>a) to separate populations and services under managed care versus fee for service during the base period?</p> <p>b) separate out all base data and assumptions for pharmacy by generic, specialty and brand</p> <p>c) by hospital type (e.g., critical access hospital, out-of-state, etc.)?</p> <p>d) drug utilization and unit cost for HEP-C treatments,</p> <p>e) ASD-related benefits."</p>	<p>No populations were under FFS for their Behavioral Health services. Physical Health services were provided under FFS for the following populations: AABD 21+ M&F-WWC; LTSS (Institutional) – Dual; LTSS (Institutional) - Non-Dual; LTSS (Home and Community Based) – Dual; LTSS (Home and Community Based) - Non-Dual; Dual. Pharmacy services were provided via FFS for all populations. This level of detail is contained in the base data books that are attachments to the RFP. This level of detail is not available for part b of the question. The impact of ASD related benefits is itemized in the Pre-Proposal presentation provided by the contracted actuary.</p> <p>Please submit further detail for c and d during the second round of questions.</p>
263.	Attachments 10-11	All	Please provide the IBNP assumptions by region, category of aid, category of service and data type (FFS versus managed care).	See the Attachment 25: "IBNR Assumptions by Source". IBNR factors are shown on a statewide basis because payment patterns do not materially differ between rating regions.
264.	Attachments 10-11	All	Please provide a detailed development of the dispensing fee assumption built into the rates, including	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

			the dispensing fee amounts reflected (classified into independents and non-independents as appropriate) in the base period, and any adjustments made to arrive at the dispensing fee amounts expected under the contract.	is based on discussions with the state and research of other states.
265.	Attachments 10-11	All	<p>"Please provide a narrative describing how the underlying cost data and delivery counts are collected and adjusted in the development of the supplemental delivery payment and the capitation rate for all related categories of aid in order to account for each of the following:</p> <ol style="list-style-type: none"> 1) limitations on payment (i.e. due to stillbirth or missing inpatient claims) 2) adjustments for maternity time periods that do not fall completely within the base period extended, to ensure that all costs associated with the deliveries shown on that exhibit were included, regardless of when the care was delivered. For example, please confirm that a delivery that occurred a month after the beginning of the experience period or a month 	<p>A qualifying delivery procedure code must be found on an encounter in order for the maternity experience to be captured in the rates. Currently the State does not pay a supplemental payment for stillbirths, so those expenses are not in the supplemental payment and remain in the regular monthly capitation rate. When a qualifying delivery event is found in the data, the contracted actuary captures all other expenses for that member in the five months prior to delivery date and the two months post-delivery. All of these expenses are re-categorized from the member's original aid category to the Maternity aid category. The maternity cell separately captures maternity-related services for all populations, dating back 5 months from the date of delivery (5 months prenatal) and going forward 2 months after the delivery (2 months post-partum). Prenatal costs for delivery occurring within the first five months of the base data period, and postpartum costs for deliveries occurring within two months of the end of the base data period could be understated in the base data. As a result, an adjustment has been made to reflect the missing prenatal and postpartum services for deliveries occurring on the left and right tails of the base data. The contracted actuary reviewed the average per-member-per-delivery costs for delivery events occurring between December 2013 and April 2015 (step one) and compared these costs with the per-member-per-delivery costs for deliveries occurring July-November 2013 and May-June 2012 (step two). The differential between the deliveries identified in step one and step two was used to adjust costs observed in step two. The overall impact of this is an upward adjustment to the</p>

			<p>before the end of the experience period would have been removed from both the counts and the claims.</p> <p>Additionally, please provide a breakout of the base data for the maternity supplemental payment using categories of service that reflect the specifics of this payment. In particular, it would be helpful to have the costs split into physician, facility, prenatal, postpartum, and delivery costs, for example."</p>	<p>Maternity cell of 1.8%. Maternity experience split by service type can be found in Attachment 10-A and Attachment 10-B by viewing the Maternity aid category. Please note that for this aid category member months are actually deliveries, as the denominator for the supplemental payment is a delivery event, not a covered month. Physician, facility, prenatal, postpartum, and delivery costs can not be independently itemized.</p>
266.	Attachments 10-11	All	Please confirm that the values shown in the MM's column of the maternity exhibit are actually meant to represent deliveries	Confirmed.
267.	Attachments 10-11	All	Please describe how third party liability/ coordination of benefits are reflected in the data and rates.	Capitation rates are net of any third party payments or member share of cost.
268.	Attachments 10-11	All	Please describe the eligibility conditions for the Katie Beckett 00-18 M&F rate cell.	<p>Medicaid eligibility for children whose parental income is disregarded due to the determination that the child meets hospital level of care. This includes families with a child or children under 18 years old who have one or more of the following:</p> <ul style="list-style-type: none"> • A ventilator to breathe • A tracheostomy • Need for complex nursing services to be provided at home • Use excessive amounts of medical supplies, equipment,

				and/or therapies
269.	Attachments 10-11	All	All of the values are identical in each of 10-A and 10-B for the Katie Beckett 00-18 M&F Rate cell. Please confirm that this is a statewide rate cell and the counts represent a statewide count.	Confirmed.
270.	Attachments 10-11	All	<p>"Summary detail was provided during the Pre-Proposal conference regarding at least 7 policy changes. However, these changes were grouped into 5 impacts, for which only summary information was shown. Please provide each of the following, with detail down to the level of region, fee for service versus managed care, category of service, unit cost and utilization impact, fiscal year, and any other breakout necessary to understand the change:</p> <p>a) a narrative describing each of the policy changes, including the effective date and the development of the impact of each item, describing each of the data, assumptions and methods used to calculate the impact.</p>	<p>Please see Attachment 22: "Heritage Health Rate Development Narrative". This question appears to be applicable to the Immediate Enrollment adjustment and the Behavioral Health copay adjustment. Immediate enrollment was effective February 2014, so they are inherent in 17 months of the base data and absent from seven months. Beginning January 2014, the State implemented a \$2.00 copay for certain Behavioral Health services. The January 2014-June 2015 base data already reflected the copay implementation, so only the September-December 2013 Behavioral Health encounters were adjusted to reflect the copay policy change. The only adjustments included to get the data on a comparable basis as show in the attachments were IBNR, Subcapitation Payments, and Supplemental Payments. 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 worth \$13.8 million on a statewide basis. Subcapitation represents predominantly Vision subcapitated agreements, while Supplemental Payments represents non-claims payments, such as CAH settlements. The value of all adjustments applied to get from Attachments 10-A--10-D is in the "NE Heritage Health Bidder's Conference Rate Presentation (Optumas)." Additionally, see Attachment 20: "COA-level Rate Development", to see the application of rate adjustment values.</p>

			<p>b) the impact of the policy change further broken out (beyond the breakouts listed above) into</p> <p>1) how much of the impact of the policy change is already reflected in the base data</p> <p>2) how much of the impact of the policy change was included as an adjustment to the base data in order to get all of the base data on a comparable basis, as shown in attachments 10-A - 10-D</p> <p>3) how much of the impact of the policy change was included as an adjustment after the summary of the base data shown in attachments 10-A - 10-D was complete, and before final rates were developed as shown in attachment 11"</p>	
271.	Attachments 10-11	All	<p>"The trends used to develop these rates were shown in the Pre-Proposal Conference Rate Presentation by COA and separately by COS.</p> <p>a) Please confirm that the trend rates shown are per year trends, and, if so, please</p>	<p>Trend rates shown are annual trend rates. Trends are developed and applied by category of service and category of aid. This allows for each detailed trend rate to be compounded for the necessary amount of time depending on the data source. "COS and COA Trends" contains the trends by category of service and major category of aid.</p>

			<p>describe the process of calculating a single trend rate for a category of aid for which different components of the total PMPM are trended for different time periods.</p> <p>b) Please provide these assumptions at the level of detail used in the rate development (i.e., break these trends out by both of these dimensions at one time)."</p>	
272.	Attachments 10-11	All	<p>Please clarify any adjustments made to the pharmacy costs shown in the data book and rates. Specifically, have the expenses been reduced for both federal and supplemental rebates?</p>	<p>The pharmacy amounts in the data book and rates have not been reduced for rebates.</p>
273.	Attachments 10-11	All	<p>Please provide the values of the pharmacy rebates separated by federal and supplemental and by fiscal year, region, and rate cell.</p>	<p>Pharmacy rebates are not included in the capitation rate development. Therefore, this level of detail is not available.</p>
274.	Attachments 10-11	All	<p>Please confirm that there is no premium or provider taxes.</p>	<p>The contracted actuary did not build in premium or provider taxes into the capitation rates.</p>
275.	Attachments 10-11	All	<p>Please provide membership projections by rate cell for CY17 and any later time periods available.</p>	<p>This level of detail is not available.</p>

276.	Attachments 10-11	All	Please provide the definition of units for each category of service shown in the data book.	See Attachment 29: "Unit Definitions for Category of Service".
277.	Attachments 10-11	All	Please clarify whether or not GME expenditures are reflected in the base data or rates. If so, please provide these values separately.	GME expenditures are not included in the base data or the rates.
278.	RFP Section IV.Z	191	Regarding the Procurement of FFS Claims Management and Processing services, can the State share how it will evaluate which MCO will be awarded this business and what the award criteria will be?	See the Evaluation Criteria by clicking on the link below: http://das.nebraska.gov/materiel/purchasing/5151/5151.html
279.	RFP Section IV.S.10	169	Does the State have documentation that it could make available to bidders on the Encounter Submission process? For example: should we assume that the HIPAA 837 I&P Companion Guides on the Nebraska Medicaid website are not only for Provider submissions for FFS Medicaid - but are also for MCO's to submit encounter data? In addition, does the State have any information it could share on the format of ancillary	The 837 I&P Companion Guides on the Nebraska Medicaid website are for both- Provider submissions of claims and for MCO submissions of encounters. The MCO receives the 999 File Acknowledgement, and 277 Claims Acknowledgement Transactions. A Month-To-Date Summary Report is also sent to the MCOs.

			encounter submission file formats (e.g. error files returned from the State, acknowledgement files, provider file submissions)?	
280.	Attachment 7	1	There is an asterisk on page 1 of Attachment 7 next to Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC); however there is no explanation of the asterisk. Can the state provide clarification?	The State is hereby amending to remove the astrick on page 1 of Attachment 7.
281.	Attachment 7	2	There is an asterisk on page 2 of Attachment 7 next to Child and Adolescent Major Depressive Disorder, Suicide Risk Assessment (SRA); however there is no explanation of the asterisk. Can the state provide clarification?	The State is hereby amending to remove the astrick on page 2 of Attachment 7.
282.	Attachment 14	n/a	Is the calculation for Claims Processing Timeliness and Pharmacy Claims Processing Timeliness business days or calendar days?	See section IV.S.3.
283.	Summary of bidder's corporate experience	197	The RFP language states that the State will use no more than 3 narrative project descriptions submitted by the bidder during its evaluation of	See the response to Question #44.

			the proposal. For entities that have more than 3 project descriptions to provide, would the State prefer that bidders provide only 3 or all applicable experience?	
284.	Attachment 19	17	Question 97, regarding value-based purchasing, asks bidders to provide evidence of effective use in Nebraska or other markets. Medicaid membership tends to be more medically-complex than Commercial membership. To allow for a more accurate comparison, for evaluation purposes, would the State consider that evidence be limited to only Medicaid experience? Alternatively, would the State consider weighing Medicaid experience differently than commercial?	A bidder should include in its response to Question # 97 a description of the MCO's approach to implementing a value-based purchasing model with Medicaid membership. In its presentation of evidence of effective use in Nebraska or other markets, a bidder should identify whether the applicable membership was Medicaid or commercial.
285.	RFP Section F. Member Services and Education, part 4, Item d	70	The SOW says "The MCO must distribute member materials to each new member within 30 calendar days of enrollment. One of these documents must describe the MCO's website, the materials that the members can find on the website and how to obtain	See response to Question #144.

			written materials if the member does not have access to the website." On page 80, Item b.1 it says "The MCO must send a welcome packet to new members within ten business days of receiving the new member file." Please clarify the difference between new member materials and the welcome packet?	
286.	II. Procurement Procedures, H.	4	Does the State want extra copies in addition to the one (1) original?	No, the State is only requesting one (1) original of the entire proposal response.
287.	II. Procurement Procedures, H.	4	Is there a specification for font size and style?	See response to Question #56.
288.	II. Procurement Procedures, H.	4	What are the margin and spacing requirements for the final proposal?	There are no such requirements.
289.	II. Procurement Procedures, O.	6	The RFP indicates only top scoring bidders may receive reference checks. Will the bidder be required to supply reference contact information? If so, where should bidder include this information within RFP the response?	The Bidder may provide references within the proposal response. References may be in a separate identified tab within the proposal response.
290.	III. Terms and Conditions, F. 3. a & c	10	Section a. states MCOs must file all contracts of reinsurance or a summary of the plan of self-insurance,	If the MCO chooses to self-insure, the maintenance of reinsurance agreements will not apply.

			however section c. states the MCO must maintain reinsurance agreements throughout the contract period including any extension(s) or renewal(s). If the MCO chooses to self-insure, how do the requirements of 3. c. apply to a self-insured MCO?	
291.	IV. Project Description and Scope of Work, D. 3. j.	51	With respect to “additional staffing requirements,” are all prior authorization, concurrent review, and member services staff required to physically work in Nebraska? Which specific care management staff are required to work in Nebraska?	Per Section IV.D.3.j. all additional required staff in Section IV.D.3 must be located in the State with the exception of claims and encounter processing staff and certain care management staff.
292.	F. Member Services and Education, 11.	77-79	Is there currently a Nebraska requirement for all providers to utilize a consistent electronic medical records (EMR) program to aid MCOs in easily obtaining records?	There is no requirement for providers to utilize a consistent electronic medical record program. A provider may select a vendor, if the provider opts to install an electronic medical record in their practice.
293.	F. Member Services and Education, 13. c. iii.	81	What defines an “attempt to contact the member”? Do mailings count in this requirement for 3 attempts?	Attempts may include written correspondence sent via the US Postal Service or documented telephone calls.
294.	F. Member Services and Education, 13. c. iii.	81	The second part of iii. states that if the member has lost or never received a welcome	This is acceptable.

			packet that the MCO must resend it. If the welcome packet was returned to the MCO due to an invalid address and the member is unable to reach, is it acceptable not to resend the packet to the invalid address as long as the member is added to the monthly unable to reach report sent to MLTC?	
295.	M. Quality Management, 1. c.	118	How is "sufficient number of qualified personnel" defined? Is there an expected ratio?	The Bidder should propose the number of qualified personnel to comply with all QM requirements in a timely manner.
296.	M. Quality Management, 4. a.	120	How many child (adult guardians) and adult Medicaid members are required to be in attendance at QAPIC meetings? Is it a specific ratio or percentage of total membership?	The Bidder should propose the number of family members/guardians of children or youth who are Medicaid members and adult Medicaid members to participate in the QAPIC.
297.	IV. Project Description and Scope of Work, P. 5.	144	Is there a separate billing process for Supplemental Delivery payments or is submission of the encounter data evidence of the delivery to generate payment?	See response to Question #99.
298.	IV. Project Description and Scope of Work, P. 7. b. iii	145	Please clarify the reimbursement of the HIPF to the MCO and timing of payments. Will the MCO receive a lump sum	An estimate of HIPF liability will be built prospectively into the capitation rate. After the final tax bill is paid the following year the State will calculate a settlement payment based on the difference between what was paid during CY2017 in the capitation rates and the actual HIPF amount.

			adjustment for reimbursement of HIPF payment?	
299.	IV. Project Description and Scope of Work, P.12. c.	148	If the MCO contracts with a TPA for administrative services at a percentage of revenue, what documentation is the MCO required to provide under section c.?	The MCO must provide documentation to enable the State to support any expenses provided on the quarterly financial report.
300.	IV. Project Description and Scope of Work, Q. 6. b.	150	Please provide details on how the percentage of the value based purchasing agreements will be calculated. Will all provider types be included in this calculation (i.e. practitioner, ancillary, hospital)?	See response to Question #103.
301.	Attachment 6: Reporting Requirements	9-10	<p>The reporting requirements for the Audited Financial Statement and the Department of Insurance Financial Report is 30 calendar days following the 12th month of the contract year</p> <ul style="list-style-type: none"> • The quarterly filings are not due until 45 calendar days following the end of a quarter • The filing checklist on the Nebraska Department of Insurance website 	The deadline for the Audited Financial Statement is 30 calendar days following the 12 th month of the contract year. The due date for the Department of Insurance Financial Report in Attachment 6 is hereby amended to read as follows: "June 1".

			shows due dates of 6/1 for audited financial statements, and 3 /1 for annual statement	
302.	Attachment 19: Proposal Statements and Questions, Question 106.	19	<p>“Prioritized business functions for resumption of operations and responsible key personnel”</p> <p>We generally do not share the specific priority of functions nor key personnel at a named person level, rather, we speak to the process for prioritizing functions and reviewing key personnel lists. Would this be acceptable or does it need to be more specific?</p>	This would be acceptable.
303.	Evaluation Criteria	N/A	Can the department please provide a more comprehensive scoring breakdown, specifically relating to scoring for staffing (i.e., will the MCO be evaluated on how many positions are filled at time of RFP submission, or will MCO be evaluated on proposed staffing plan meeting the RFP requirements?	<p>In order to protect the integrity of the evaluation process, the factors that will be scored within the evaluation criteria will not be provided.</p> <p>See the Evaluation Criteria by clicking on the link below: http://das.nebraska.gov/materiel/purchasing/5151/5151.html</p>
304.	RFP, Section IV.B.1.	RFP page 33	Could MLTC provide the file layout/format or data	The 834 transaction is sent to the MCOs to provide eligibility data along with proprietary supplemental and unborn files. Please see Attachment 30: “Supplemental Enrollment File” and

			dictionary of the Eligibility Data being supplied?	Attachment 31: "Unborn File".
305.	RFP, Section IV.I.17.vi.	RFP page 103 and RFP Attachment 5, page 7	Could MLTC elaborate on the specific provisional credentialing requirements for behavioral health providers?	Regulations applicable to licensure of mental health practitioners are available at 172 NAC 94. http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-172/Chapter-094.pdf
306.	RFP Attachment 2, Access Standards, Geographic Access Standards, #4	RFP Attachment 2, page 2	Could MLTC clarify how the access standard will be measured? For example, will it be measured by the number of miles from the member's personal residence (no greater than X miles) or by the number of hours of travel time by car (no greater than X number of hours)?	Access standards are measured by the number of miles from the member's personal residence as set forth in Attachment 2.
307.	RFP Attachment 4	RFP Attachment 4	At what frequency will MCOs assess medical home providers for continued participation?	See Section IV.I.7.e.
308.	RFP Attachment 19, #45	RFP Attachment 19, page 8	Will MCOs be permitted to query the enrollment data to confirm the provider identification number in order to ensure that providers are enrolled in Medicaid and have a valid identification number?	MMIS will provide the MCOs a file (interface) with current provider information.
309.			It has come to my attention that the most recent Medicaid contractual information is not up to date with the law in	See response to Question #2.

			<p>Nebraska. The antiquated language “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” would prohibit me from continuing to provide care for Medicaid patients in Nebraska as I no longer have a collaborating or supervising physician. This verbiage needs to change immediately to reflect the changed law in Nebraska.</p>	
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310.	Glossary of Terms	RFP page xv	<p>"We request two points of clarification relating to the definitions of "Qualifying revenue (for the risk corridor calculation)" and "Qualifying revenue (for the administrative cap calculation)".</p> <p>(1) Both definitions indicate that qualifying revenue is "[t]he aggregate of revenue earned by an MCO and related parties, including parent and subsidiary companies and risk bearing partners under this contract." Please confirm that no amounts would be double-counted as revenue based on these definitions. For example, amounts received by MCO as premium and then paid to a related party in order to reimburse that related party for administrative costs would be counted as qualifying revenue only once.</p> <p>(2) Both definitions indicate that qualifying revenue ignores "federal and state</p>	Points one and two are confirmed.
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			premium taxes and non-operating income.” Please confirm that this includes amounts paid to MCOs to reimburse them for the Health Insurance Providers Fee (see § IV(P)(7) on page 145)."	
311.	Glossary of Terms	RFP page xvi	Please confirm that in the definition of “Risk corridor calculation”, the reference to “a contract” should be “this contract”. Could the RFP be revised to reflect this?	The definition of "Risk corridor calculation" is hereby amended to read as follows: Risk corridor calculation: The computation of a MCO’s profit or loss by MLTC’s actuary, as a percentage of the aggregate of qualifying revenue for the MCO and related parties, including parent and subsidiary companies and risk-bearing parties under this contract. The calculation ignores revenue taxes, non-operating income, and any forfeited hold-back.
312.	Glossary of Terms	RFP page xvii	"We have two clarification requests related to the definition of “Subcontractor”: (1) Please confirm that the reference in the first sentence of the definition to “a contract” should be “this contract”. (2) Please confirm that a provider (such as a hospital) that credentials its own staff would not be considered a subcontractor based on such credentialing activities.	1.) See response to Question #311. 2.) Confirmed.

			Could the RFP be revised to reflect these clarifications?"	
313.	Glossary of Terms	RFP pages ix and xvi	<p>"We are concerned that the definitions of "administrative expense rate" and "related-party administrative expense" could be interpreted to mean that actual administrative costs incurred by the MCO and paid to a related party would not be included in the calculation of the MCO's administrative expense. Could the State revise the RFP clarify that administrative expenses actually incurred will be counted toward administrative expense even when paid to a related party? For example, these definitions could be revised:</p> <p>"Administrative expense rate: The percentage of qualifying revenue a MCO may spend on administrative expenses. Administrative expense rate equals the costs that were incurred in the contract year. In the event the MCO paid any amounts for administrative services to a related party, only those administrative costs actually incurred by the related party</p>	<p>The State is reviewing this question further.</p> <p>This information will be posted to the procurement website as part of the second round of questions and answers.</p>

			<p>in connection with the administration of this contract will be included in such costs.”</p> <p>“Related-party administrative expense: Fees paid by a MCO, or any of its subsidiaries, to a related party such as a parent organization such as flat monthly administration fees. Such fees are not considered in the calculation of administrative expense under this contract. Related-party administrative expense does not include amounts paid to a related party for administrative costs actually incurred by the related party in connection with the administration of this contract.” "</p>	
314.	Glossary of Terms	xvii	<p>The definition of specialty drug is somewhat restrictive. Can the MCO use its own list of specialty drugs to be dispensed through specialty pharmacies or can ONLY drugs that meet this definition be dispensed through specialty pharmacies?</p>	See response to Question #75.
315.	RFP § II(H)	4	<p>Are there any font or font size requirements applicable to</p>	See the response to Question #56.

			the proposal responses?	
316.	RFP § III(F)(4)	10	<p>"The RFP requires that the MCO maintain Errors and Omissions ("E&O") coverage at \$10,000,000 per occurrence and Cyber Liability coverage at \$10,000,000 each occurrence. Neither Managed Care E&O coverage nor Cyber Liability coverage is commercially available on an occurrence basis. In connection with another recent RFP, we surveyed 15 insurance carriers and E&O policies are only written on a claims-made basis. The markets stated it could not be changed.</p> <p>Please confirm the State will accept claims made policies for E&O coverage and Cyber Liability coverage. If necessary the MCO could agree to purchase tail coverage if the coverage is moved to a new carrier."</p>	Yes, the State will accept the Cyber and E&O coverages on a claims made basis. The E&O coverage and Cyber Liability coverage is not commercially available on an occurrence basis therefore the claims made basis is acceptable.
317.	RFP § III(GG)	20	This section provides that "State will render payment to Contractor when the terms and conditions of the contract	Capitation rates will be paid prospectively.

			and specifications have been satisfactorily completed on the part of the Contractor as solely determined by the State.” Medicaid MCOs are typically paid for services in advance of (or at the beginning of) the month for which the payment is made. Advance payment also seems to be contemplated by RFP § IV(P) generally. Please confirm that MCOs will be paid prospectively.	
318.	RFP § III(II)	21	Please confirm that the provisions of RFP § IV(P)(7), which relate to the reimbursement by the State of the Health Insurance Providers Fee, take precedence over the language of this section.	Confirmed.
319.	RFP § III(NN)	23	Could the State provide more details regarding the submission process related to proprietary information? The instructions state that 1 original proposal should be submitted and proprietary information should be included in a separate package. Does that mean that the original should be a redacted version with the	Either way is acceptable as long as the proprietary information is labeled and in a separate sealed envelope.

			proprietary information removed (and the redacted information provided in a separate envelope)? Or would the State rather receive one complete copy of the proposal and one redacted copy suitable for public posting?	
320.	RFP § IV(A)(1)	30-31	RFP numbering in this section jumps from 1 to 9...was anything omitted as a result?	The jump from IV.A.1 to IV.A.9 was inadvertent. No information was omitted.
321.	RFP § IV(B)(1)(c)	33	The RFP states that Medicaid and CHIP eligibility will be conducted annually. Continuous eligibility in CHIP is limited to six months by statute. Will the annual review amount to continuous eligibility or will reviews continue on a rolling basis if and when DHHS is alerted to a change in family circumstances that could affect eligibility?	Review will be annual unless MLTC is alerted of a change that may affect eligibility.
322.	RFP § IV(B)(3)(f)(iii)	34	This provision provides than an MCO will be removed from the auto assignment algorithm if it has 40% or more of statewide enrollment. In the event the State only awards two contracts, what threshold would be used?	In the event only two contracts are awarded, this provision will be revised to reflect 65% or more statewide enrollment.

323.	RFP § IV(C)(10)(a) and (b)	41-42	Will the State require the MCO to open an Insolvency Bank Account? If yes, how much is the minimum Insolvency amount required by the State? When is it required to be opened and funded?	This will not be required.
324.	RFP § IV(C)(10)(a) and (b)	41-42	Aside from the Insolvency Bank account (if any is required), will the State also require the MCO to open a separate Statutory Deposit Bank Account? If yes, how much is the required statutory deposit amount? When is it required to be opened and funded?	This will not be required.
325.	RFP § IV(C)(14)and RFP § IV(K)(2)	43 and 110	The first section referenced specifies "The MCO must submit all proposed subcontracts for the provision of any services under this RFP to MLTC for prior review and approval a minimum of 120 calendar days prior to their planned implementation." whereas the 2nd section referenced specifies "2. The MCO must submit all subcontracts for the provision of any services under this RFP to MLTC for prior review and approval a	The MCO must submit all subcontracts for the provision of any services under this RFP to MLTC for prior review and approval a minimum of 90 calendar days prior to their planned implementation.

			minimum of 90 calendar days prior to their planned implementation." Can MLTC confirm if the submission must be made at least 90 or 120 days?	
326.	RFP § IV(D)(3)(j)	51	Please clarify the requirement that "[a]ll additional required staff in this section must be located in the State with the exception of claims and encounter processing staff and certain care management staff." We have found that having a mix of in-State and out-of-State personnel is the best way to serve members. For example, we plan to have member services and provider services personnel based in Nebraska to provide in-person services to members and providers. However, we also maintain member and provider call centers elsewhere that also would be available to assist Nebraska members and providers. Likewise, we would have in-State at least one Nebraska-licensed registered nurse or physician's assistant on our prior authorization staff, as	See response to Question #291.

			required, and we would support the prior authorization function through centralized services elsewhere. Please confirm this type of structure is consistent with this requirement.	
327.	RFP § IV(E)(1)(d)	52	<p>"We note that the requirement that services be rendered by providers enrolled as MLTC providers does not apply to emergency services pursuant to § IV(Q)(15) on page 153. Please confirm that this requirement would also not apply to the following services:</p> <ul style="list-style-type: none"> • Urgent care services performed out of state; • Specialty services unavailable within the MCO's network (for example, a member is referred to a specialty center out of state); and • Value-added services." 	Confirmed.
328.	RFP Glossary of terms and § IV(E)(11)(b) - (d)	58-60	Please provide additional clarification regarding the difference between the Contractor's formulary and the preferred drug list ("PDL"). We understand that	See response to Question #75.

			<p>MCOs are required to follow Nebraska's PDL. However, the RFP contemplates a separate MCO formulary (see, in particular, § IV(E)(11)(b)(iv)(a)) which must be approved by MLTC. Does this mean that the MCO can cover more drugs than are on the Nebraska PDL? What types of differences between MCO formularies and the Nebraska PDL does MLTC anticipate?</p>	
329.	RFP § IV(E)(11)(b)(ix)	59	<p>This section states that MCOs are permitted to require prior authorizations under certain circumstances so long as the prescriber and the pharmacy are notified within 1 business day of approval or denial. Please confirm that MCOs are not required to contact the pharmacy with respect to retrospective DUR determinations.</p>	<p>The MCO is not required to contact the pharmacy if an auto-drug look back was performed and payment was denied due to lack of drug-utilization history.</p>
330.	RFP §§ IV(H)(3)(a)(ii) and IV(N)(4)(b)	88 and 127	<p>Section IV(H)(3)(a)(ii) states that "any decision to deny a service authorization request . . . must be made by a health professional who has appropriate clinical expertise in treating the member's</p>	<p>Regardless of reasoning for service authorization denials and limitations, all decisions must be made by a health professional who has appropriate clinical expertise in treating the member's condition or disease.</p>

			<p>condition or disease." Section IV(N)(4)(b) contains similar language. Please confirm that this requirement does not prevent non-clinical MCO personnel from issuing denials and limitations based on administrative criteria not related to medical necessity (for example, request is for an excluded product, request is outside terms of coverage, etc.)</p>	
331.	RFP § IV(I)(4)(e)	96	<p>"Please confirm the following with respect to the requirement that MCO's network include providers currently serving Medicaid members:</p> <ul style="list-style-type: none"> • The requirement applies only to the MCO's initial network as of the contract start date; • MCO is not required to contract with any provider that does not pass credentialing; and • MCO is not required to contract with any provider that refuses to accept MCO's standard provider agreement applicable to such provider's type and/or specialty." 	<p>IV.I.4.e applies only to the MCO's initial network as of the contract start date. A MCO is not required to contract with providers who do not meet credentialing standards that have been approved by MLTC per Section IV.I.14. A MCO is not required to contract with any provider that refuses to accept the MCO's applicable provider agreement; however, all provider agreements must be in accordance with requirements in the RFP.</p>

332.	RFP § IV(I)(4)(j)	96	When does MLTC anticipate making available to MCOs the list of Medicaid eligible providers?	<p>A list of Medicaid-eligible providers will be posted on the procurement website as soon as it is available.</p> <p>This information will be posted to the procurement website as part of the second round of questions and answers.</p>
333.	RFP § IV(I)(8)(e)	99	<p>"This section provides that "[t]he MCO must not incorporate branding of any pharmacy onto member ID cards. However, § IV(F)(9)(h) expressly requires MCO to include on the ID card "[t]he name or identifying trademark of the MCO and the prescription benefit manager." However, in some cases an MCo's PBM might be affiliated with a national pharmacy chain.</p> <p>Given the potential conflict above, please confirm that:</p> <ul style="list-style-type: none"> • An MCO may elect to include the PBM routing information (BIN/PCN/RxGroup) without including the PBM logo on the card; and/or • The prohibition in § IV(I)(8)(e) will not prohibit MCO from including its PBM 	<p>Retail pharmacy branding may not appear on a member ID card. The MCO's contracted PBM branding may appear on a member ID card, but not if it reflects affiliation with a retail pharmacy chain.</p>

			information on the member ID card as contemplated by § IV(F)(9)(h) even if that logo includes pharmacy branding."	
334.	RFP § IV(L)(6)(h)	116	This provision requires that the MCO develop engagement tools to improve engagement with pregnant members and help identify high-risk pregnancies. This type of activity seems to be member education, not member marketing. See, e.g., the definition of "Marketing" in the Glossary of Terms and RFP § IV(G)(1)(b), which states that "[m]arketing is different than member education. Member education is defined as communication with a MCO member for the purpose of retaining the member as a member and improving his/her health status." Why would the activities contemplated in § IV(L)(6)(h) be included in the Marketing Plan? Shouldn't the MCO's plans for pregnant member engagement contemplated in § IV(L)(6)(h) be submitted separate from the Marketing Plan?	Bidders should not address IV.L.6.h in the Marketing Plan. Bidders should address IV.L.6.h in Attachment 19 - Question #35.
335.	RFP § IV(L)(6)(i)	117	Should this provision be	IV.L.6.i is hereby amended to IV.L.6.h.iii.

			numbered § IV(L)(6)(h)(iii)? If not, please clarify this requirement.	
336.	RFP § IV(O)(1)(j)	133	Please confirm that the minimum number of investigators is 1 per 100,000 members or less (as stated in § IV(D)(3)(i)) rather than 1 per 50,000 members or less as stated in this section.	See response to Question #95.
337.	RFP § IV(P)(7)	145	<p>"Please clarify the timing on the HIPF payments in 7.b.iii. using the 2018 HIPF payment as an example. Is either of the following examples correct?</p> <p>Example 1</p> <ul style="list-style-type: none"> • An estimated HIPF amount will be included in the capitation rates paid during CY2017. • MCOs will pay the 2018 HIPF based on 2017 revenue in September 2018. • After the MCOs receive their final invoices in September 2018, MLTC will calculate a settlement payment for the difference between what was paid in CY2017 as an estimate and the final HIPF 	See response to Question #298.

			<p>amount plus gross up amount for taxes.</p> <p>- OR -</p> <p>Example 2</p> <ul style="list-style-type: none"> • MCOs will pay the 2018 HIPF based on 2017 revenue in September 2018. • The State will recalculate the capitation rates payable to the MCO for the balance of CY2018 to include an estimated amount to reimburse the MCO for the 2018 HIPF fee plus an amount for the tax gross-up • After December 31, 2018, MLTC will calculate a settlement payment for the difference between the additional HIPF-related amount paid in capitation rates for the last few months of 2018 and the actual HIPF amount plus gross up amount for taxes." 	
338.	RFP § IV(P)(10)	146	Why is the 1.5% MLTC Quality Performance Program amount not explicitly built into the premium capitation rates?	The 1.5% MLTC Quality Performance Program is considered a withhold and is not additional money added to the administrative load component of the rate development.

339.	RFP § IV(P)(10)	146	This section references Attachment 13 - Neb. Rev. Stat. 71-831. Neb. Rev. Stat. 71-831 reads that the requirements outlined in Attachment 13 apply to "at-risk managed care service delivery for behavioral health services". Does this mean that the 1.5% applies only to the behavioral health portion of the premium capitation rate?	The 1.5% MLTC Quality Performance Program applies to the aggregate premium capitation rate.
340.	RFP § IV(P)(10) and (11)	146 and 147	Please explain the interaction between the MLTC Quality Performance Program and the State Performance Penalties. Is the State Performance Penalties a subset of the MLTC Quality Performance Program?	State performance penalties are not a subset of the MLTC Quality Performance Program. Quality Performance Program measures (applicable to the Quality Performance Program) are identified separately from minimum performance metrics (applicable to the State performance penalties).
341.	RFP § IV(P)(10) and (11)	146 and 147	Are the MLTC Quality Performance Program and the State Performance Penalties amounts of 1.5% and 0.25% respectively excluded from revenue in the calculation of the 3% profit risk corridor?	See response to Question #33.
342.	RFP § IV(P)(11)(d)	147	Please confirm that the modifications contemplated by this provision would only occur prior to the year in	Confirmed.

			which the performance metrics would be effective and that no modifications would be made during any year in which the modified metrics would be effective.	
343.	RFP § IV(Q)(3)	149	The enhanced payment under § 1202 of the Affordable Care Act applied to provider payments in 2013 and 2014. Would the State consider deleting this provision to avoid confusion?	The State has elected to continue enhanced payments for primary care services beyond the federal mandate.
344.	RFP § IV(Q)(6)	150	For the purpose of calculating the percentage of providers on a value-based purchasing contract, how does MLTC define provider? Will there be any effort to weight the VBP requirement by membership to ensure that a large enough percentage of members are being seen by providers in a VBP contract?	Provider is defined in the glossary of the RFP. The VBP requirement does not consider weighting by membership.
345.	RFP § IV(Q)(10)	152	Can MCOs and CAHs agree to other settlement terms, such as building any settlement due to or from a CAH into rates going forward?	Any alternative arrangement agreed upon by the MCO and CAH must be in compliance with 471 NAC 10-010.03F.
346.	RFP § IV(Q)(11)	152	With regard to the UNMC supplemental payments, please clarify the final	Amounts built into the capitation rates will not change every quarter as a result of the UNMC supplemental payment.

			sentence: "These payments are calculated into the capitation rate on a quarterly basis." Does this mean the amounts built into the capitation rates will change every quarter?	
347.	RFP § IV(Q)(11)	152	How will MCOs be required to pay the UNMC provider pass-through? Will the MCOs pay each month the per rate cell pass-through amount in the rate multiplied by the members in each rate cell?	471 NAC 18-006.02, Supplemental Payment, describes how supplemental payment amounts are determined. The MCO will make supplemental payments to UNMC related to this contract provision on a quarterly schedule.
348.	RFP § IV(Q)(16) and Optumas Presentation at Bidder's Conference	153	What percent of pharmacies are independent pharmacies and what percent of pharmacy costs are incurred at independent pharmacies?	See response to Question #37.
349.	RFP § IV(Q)(16) and Optumas Presentation at Bidder's Conference	153	What dispensing fee was assumed in the rate development for non-independent pharmacies?	Non-independent pharmacies were assumed to have a \$2.50 dispensing fee.
350.	RFP § IV(Q)(16)(a)	153	With respect to pharmacy reimbursement, the RFP states the Dispensing Fee must be consistent with the current Medicaid FFS rate for independents. Are we correct to interpret that the MCOs can manage the national network ingredient cost for all	The current Medicaid FFS rate for independent pharmacies must be provided for the duration of the contract. MCOs may manage and negotiate the network ingredient costs but must provide the dispensing fee in addition to this reimbursement for independent pharmacies, unless an alternative reimbursement arrangement is otherwise agreed to by the pharmacy.

			pharmacy providers (e.g. AWP discount, MAC), as long as the dispensing fee requirement to mirror FFS dispensing fees is in place for independents for 6 month as required?	
351.	RFP § IV(Q)(16)(a)	153	The MCO's dispensing fee reimbursement must be, at a minimum, the current Medicaid FFS rate for independent pharmacies (defined as those with ownership of six (6) or fewer pharmacies), unless otherwise agreed between the MCO and the pharmacy provider. Does this mean that if a pharmacy has accepted alternate rates to participate in a national network we can use that network and those rates? What is the current FFS dispensing fee?	A MCO may not require a pharmacy to agree to rates already established in a separate contract. The MCO must obtain a new agreement, or addendum to existing agreement, from a participating Nebraska Medicaid Pharmacy Provider prior to the start of services under this RFP even if that pharmacy has an existing relationship with that MCO (IV.I.8.b.). The current dispensing fee is \$4.45, but is subject to change
352.	RFP § IV(Q)(16)(a)	153	The MCO must calculate dispensing fees, administration fees, and any other fee payment amounts as approved by MLTC. The MCO must maintain in each paid claim record which methodology was used to determine final payment amounts, i.e. state maximum	The MCO must calculate dispensing fees, administration fees, and any other fee payment amounts as approved by MLTC. The MCO must maintain in each paid claim record which methodology was used to determine final payment amounts, with methodologies limited to state maximum allowable cost, national average drug acquisition cost, or the submitted usual and customary charge.

			allowable cost, national average drug acquisition cost, or the submitted usual and customary charge. Are these examples of particular pricing methodologies, or intended to be the only types allowed? Will AWP discount networks be allowed?	
353.	RFP § IV(Q)(17)(c)	153	There is a requirement that the MAC must be available and searchable on the MCO website. There is also a requirement to post the provider manual. Can these requirements be satisfied through the PBMs secure provider portal as MAC/network management is a delegated function of the PBM?	This is acceptable.
354.	RFP § IV(S)(17)	176	"Does Nebraska Medicaid always pick up the patient responsibility"" or are there situations in which Medicaid would not pay the patient responsibility such as Medicare payment exceeds Medicaid amount? If Medicare pays less than the Medicaid amount and the patient responsibility amount	Applicable regulations are available at 471 NAC 3-004.04-05. Medicaid pays the deductible and coinsurance for Medicare-covered services. The amount received from Medicare for Medicare-covered services and other TPR and/or Medicaid for deductible and/or coinsurance shall not exceed Medicare allowable amount. Medicaid payment is the lower of the provider's usual and customary charge or the Medicaid allowable less all third party payment. When a claim is submitted to Medicaid with a payment from a third party resource, the provider is considered paid in full when payment from the third parties and/or Medicaid equals or exceeds the Medicaid allowable amount. The provider may only

			<p>is less than the difference between the primary payment and Medicaid allowed amount, if the patient responsibility amount paid?</p> <p>Are there any situations in which the secondary payment would exceed the patient responsibility e.g. always paying up to the FQHC encounter/PPS rate?"</p> <p>"</p>	<p>bill the client for a Medicaid non-covered service, or Medicaid copayment fees, where applicable, or if the client has received payment from the TPR.</p>
355.	RFP § IV(T)(2)	177	<p>"We have two questions associated with this provision:</p> <p>(1) Is there a particular form or format MLTC wishes MCOs to use when submitting the disclosures under 42 CFR 455.100 – 455.106? In particular, we note that § IV(T)(1)(b) states that the "State will not review a deliverable unless the format and content has been approved in advance."</p> <p>(2) Please confirm that this disclosure may be submitted confidentially and will not be posted publicly. The</p>	<p>Disclosures may be submitted confidentially and will not be posted publicly.</p> <p>Section IV.T.2 is hereby amended as follows: "Federal laws require full disclosure of ownership, management, and control of Medicaid MCOs (42 CFR 455.100-455.106). The MCO must disclose to MLTC this information at contract award, annually thereafter for each contract year, and within 30 calendar days of any change in the MCO's management, ownership or control."</p>

			disclosures required by 42 CFR 455.100 – 455.106 include Social Security Numbers and dates of birth."	
356.	RFP § V(A)(2)(b)	196	<p>"We have two requests for clarification regarding this section:</p> <p>(1) This requirement states that bidders must provide three years of financial statements. Please confirm that, where the bidder is a newly-formed subsidiary of a publicly traded company, three years of financial statements for the publicly-traded parent company will fulfill this requirement.</p> <p>(2) If publicly held, the bidder is required to provide a letter from "the fiscally responsible representative of the bidder's financial or banking organization". Please confirm that a bank reference from a bank officer would satisfy this requirement."</p>	<p>"(1) A newly-formed subsidiary of a publicly traded company that has fewer than three years of independently audited financial statements available should provide such statements it does have available and three years such statements for the parent company. (2) The purpose of this requirement is for the State to obtain contact information for the fiscally responsible representative of the bidder's financial or banking organization, not a receive a "letter". Please comply with Section V.A.2.b as written.</p>
357.	RFP § V	196-198	"Please provide additional details regarding the order in which proposal elements	The sections should be included as separate identified tabs within the bidder's proposal response. There is no such requirement for the order of sections.

		<p>should be provided. RFP § II(N) and RFP § V indicate that the following elements should be in the order indicated:</p> <ul style="list-style-type: none"> • Request for Proposal Form • Section III (Terms and Conditions) • Corporate Overview • Technical Approach (responses to Proposal Statements and Questions in Attachment 19) <p>However, we note that none of RFP § II(N), RFP § V nor Attachment 19 give instructions for the submission of the following documents, each of which is required to be submitted with the proposal:</p> <ul style="list-style-type: none"> • Form A (Bidder Contact Sheet) (RFP § § II(H), page 4, and III(X), page 16) • Certification of authorization to transact business in the State of Nebraska (RFP § II(P), page 6) • Certificate of insurance coverage (RFP § III(F)(5), 	
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			<p>page 10)</p> <ul style="list-style-type: none"> • Proposed deviations from the RFP, if any (RFP § III(R), page 14) • U.S. Citizenship Attestation Form (for individuals and sole proprietorships) (RFP § III(AAA), page 27) • Ownership and control disclosure (RFP § IV(T)(2), page 177) <p>"</p>	
358.	RFP § V(A)(3)	198	Can the MCOs provide supplemental attachments to support the technical approach above and beyond those outlined as required in Attachment 5 and Attachment 19?	See the response to Question #172.
359.	Attachment 15	1	<p>"We request two points of clarification relating to the definition of "Qualifying revenue for the MLR calculation".</p> <p>(1) Paragraph 3 indicates that qualifying revenue is "[t]he aggregate of revenue earned by an MCO and related parties, including parent and subsidiary companies and risk bearing partners under</p>	See response to Question #310.

			<p>this contract.” Please confirm that no amounts would be double-counted as revenue based on this definition. For example, amounts received by MCO as premium and then paid to a related party in order to reimburse that related party for administrative costs would be counted as qualifying revenue only once.</p> <p>(2) Paragraph 3 indicates that qualifying revenue ignores “federal and state premium taxes and non-operating income.” Please confirm that this includes amounts paid to MCOs to reimburse them for the Health Insurance Providers Fee (see § IV(P)(7) on page 145).”</p>	
360.	Attachment 15	1	<p>For the purposes of calculating the MLR as described in Attachment 15, is the amount of payback of any profit in excess of 3% added to the numerator in the calculation? That is, does the definition of net qualified medical expense include dollars paid back to the state for profits exceeding 3%?</p>	<p>The MLR reconciliation will be calculated first, and any recoupments/paybacks will be factored into the 3% risk corridor calculation.</p>

			Likewise, if the MCO receives a payment from the state because losses were greater than 3%, is that amount excluded from the numerator in the calculation?	
361.	Attachment 19	5	Question 31 Member Services Are the examples of information that will be available on the website and on portals for members included in the page count?	See response to Question #124.
362.	Attachment 19	5	Question 35 Member Services. The question asks us to "Attach examples" of member education material used with Medicaid or CHIP populations. Are these attachments included in the 10 page count?	See response to Question #125
363.	Attachment 19	5	Question 36, Please confirm that the 3 page limit to this response does not include the required flowcharts.	See response to Question #126.
364.	Attachment 19	8	Question 47, Provider Services: Are the requested sample provider outreach methods included in the 4 page count?	Example provider outreach methods will not be counted in the page limit. See response to Question # 119.
365.	Attachment 19	11	Question 59, This question requires that the bidder submit its proposed template for the health risk	See response to Question #127.

			assessment. Please confirm that this template would not be included in the page limits for this question.	
366.	B Eligibility for Enrollment (4)(a)(i) 7 Disenrollment , C (i)(a) 12 Audit Requirement (18) Moral or Religious Objections Glossary	p. 34 p. 37 p. 42 ix to xviii	If the MC) is not to discriminate on the basis of “religious beliefs” enrollment and provider claims should not be denied for “moral or religious beliefs”, or “moral or religious objections” or “moral or religious grounds” or similar formulations and noting “moral” does not appear in the glossary, should not all such language be eliminated from the RFP?	IV.B.4.a.i fulfills federal regulatory requirement 42 CFR 438.6(d) regarding prohibitions against enrollment discrimination. IV.C.i.a fulfills federal regulatory requirement 42 CFR 438.56(d)(2) regarding member disenrollment. IV.C.18 fulfills federal regulatory requirements 1932(b)(3)(B)(i) and 42 CFR 438.102(a)(2) regarding MCO responsibility when it has a moral or religious objection to providing a covered benefit or service.
367.	7 Disenrollment, C (i) (e)	p. 37	If the member may initiate disenrollment for cause under (e) “other reasons including but not limited to poor quality of care or lack of access to providers experienced in dealing with the member’s health care needs”, should this not these particular requests become, with sanctions a data point analyzed quarterly or otherwise tracked because quality of care and access to experienced providers are the core purpose of this RFP and subsequent contract.	Cause for disenrollment is a federal requirement addressed in CFR 438.56, Disenrollment: Requirements and limitations. MLTC will monitor contracts and apply Liquidated Damages and Intermediate Sanction when contract requirements are not met.

368.	Terms and Conditions S Slip law copy LB605 Sec. 108(2)(a) 4. (c)(ii)	p. 14 p. 48- 49 p. 35	Is it not true that LB605 Section 108 (2)(a) “Medical assistance under the medical assistance program shall be suspended rather than cancelled or terminated for a person who is an inmate of a public institution”.... and incarceration is not a cause for disenrollment.	See Addendum 3 – Revisions to the RFP.
369.	Terms and Conditions S 4. (c)(i)(ii)	p. 14 p. 35	Should not “involuntary commitment” be removed as a cause for disenrollment when persons whose disenrollment has not been suspended and who are not in a public institution?	See Addendum 3 – Revisions to the RFP.
370.	Heritage Health Heritage Health	Slide 14, item 3 Slide 19, item 4	<p>If the MCO is to adhere to these program goals and principles of care would not it follow that the 10 components of Recovery below, (commentary included for context), be included as an amendment?</p> <p>NATIONAL CONSENSUS STATEMENT ON MENTAL HEALTH RECOVERY (contd)</p>	Section IV.L.3. addresses the requirements the MCOs must follow for recovery-based care which include the nationally recognized ten components of recovery.

			<p>BACKGROUND</p> <p>Recovery is cited, within Transforming Mental Health Care in America, Federal Action Agenda: First Steps, as the “single most important goal” for the mental health service delivery system. To clearly define recovery, the Substance Abuse and Mental Health Services Administration within the U.S. Department of Health and Human Services and the Interagency Committee on Disability Research in partnership with six other Federal agencies convened the National Consensus Conference on Mental Health Recovery and Mental Health Systems Transformation on December 16-17, 2004. Over 110 expert panelists participated, including mental health consumers, family members, providers, advocates, researchers, academicians, managed care representatives, accreditation organization representatives, State and local public officials, and others. A series of technical papers and</p>	
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		<p>reports were commissioned that examined topics such as recovery across the lifespan, definitions of recovery, recovery in cultural contexts, the intersection of mental health and addictions recovery, and the application of recovery at individual, family, community, provider, organizational, and systems levels.</p> <p>The following consensus statement was derived from expert panelist deliberations on the findings.</p> <p>Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.</p> <p>“THE 10 FUNDAMENTAL COMPONENTS OF RECOVERY</p> <ul style="list-style-type: none"> • Self-Direction: Consumers lead, control, exercise choice over, and determine their own 	
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		<p>path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path towards those goals.</p> <ul style="list-style-type: none">• Individualized and Person-Centered: There are multiple pathways to recovery based on an individual's unique strengths and resiliencies as well as his or her needs, preferences, experiences (including past trauma), and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey and an end result as well as an overall paradigm for achieving wellness and optimal mental health.• Empowerment: Consumers have the authority to choose from a range of options and to participate in all decisions—including the allocation of resources—that	
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		<p>will affect their lives, and are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires, and aspirations. Through empowerment, an individual gains control of his or her own destiny and influences the organizational and societal structures in his or her life.</p> <ul style="list-style-type: none">• Holistic: Recovery encompasses an individual's whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and healthcare treatment and services, complementary and naturalistic services, addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person. Families, providers, organizations, systems, communities, and	
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			<p>society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports.</p> <ul style="list-style-type: none">• Non-Linear: Recovery is not a step-by-step process but one based on continual growth, occasional setbacks, and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.• Strengths-Based: Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (e.g., partner, caregiver, friend, student, or employee). The process of recovery moves forward through interaction with others in supportive,	
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			<p>trust-based relationships.</p> <ul style="list-style-type: none">• Peer Support: Mutual support—including the sharing of experiential knowledge and skills and social learning—plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.• Respect: Community, systems, and societal acceptance and appreciation of consumers—including protecting their rights and eliminating discrimination and stigma—are crucial in achieving recovery. Self-acceptance and regaining belief in one's self are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.• Responsibility: Consumers have a personal responsibility	
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		<p>for their own self-care and journeys of recovery. Taking steps towards their goals may require great courage. Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.</p> <ul style="list-style-type: none">• Hope: Recovery provides the essential and motivating message of a better future—that people can and do overcome the barriers and obstacles that confront them. Hope is internalized; but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process. Mental health recovery not only benefits individuals with mental health disabilities by focusing on their abilities to live, work, learn, and fully participate in our society, but also enriches the texture of American community life. America reaps the benefits of the contributions individuals with mental disabilities can make,	
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			<p>ultimately becoming a stronger and healthier Nation.”</p> <p>The National Consensus Statement on Mental Health Recovery was funded by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.</p>	
371.			<p>Definition of Primary-care provider (PCP):Advanced practice nurses (APNs)...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.</p> <p>Comments: --Earlier this year, LB 107 removed all statutory requirements for physician supervision of nurse practitioners (NPs) in</p>	See response to Question #2.

		<p>Nebraska. As written, it would seem that the preceding definition is no longer consistent with changes in the law that became effective September 1, 2015.</p> <p>--There is no statutory definition for Advanced Practice Nurses in Nebraska. Nurse practitioners are one of four groups of Advanced Practice Registered Nurses (APRNs) which also include Certified Nurse Midwives (CNMs), Certified Registered Nurse Anesthetists (CRNAs) and Clinical Nurse Specialists (CNSs).</p> <p>--In this definition, it appears that it is intended that both NPs and CNMs qualify as PCPs. Nurse midwives have different statutory requirements for physician oversight of practice. It may be appropriately stated that practice for NPs and CNMs as PCPs must be consistent with requirements for state licensure and statutory provisions within each profession's Practice Act.</p> <p>--Nurse practitioners must be</p>	
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			certified in specialty practice to obtain licensure. Those individuals practicing in primary care may be certified in adult, family, pediatric or women's health specialties.	
372.			<p>Primary care services: All health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them.</p> <p>Comments: --As written, this definition excludes health care and laboratory services provided by advanced practice nursing providers, i.e., NPs and CNMs who qualify as primary care providers (PCPs) in the preceding section.</p>	See response to Question #2.
373.			<p>Provider requirements for a PCMH.</p> <p>Comments:</p>	See response to Question #2.

			<p>--As written, is it the intention to exclude NPs? This seems an oversight, considering 1. The removal of requirements for physician supervision that occurred with LB 107; 2. Nurse practitioners provide a significant portion of primary care services to rural and underserved populations in the state; and, 3. There is evidence to support NPs as PCMH providers, as well as health care providers with outcomes that meet or exceed those of physicians for equivalent services.</p>	
374.	<p>II. Procurement Procedures, H. Submission of Proposals</p>	2	<p>Please provide instructions on how to include any attachments we'd like to add to support our responses to questions in Attachment 19.</p>	<p>Attachments should be included within the applicable section or as separate identified tab(s) within the bidder's proposal response.</p>
375.	<p>IV. Project Description and Scope of Work O. Program Integrity 13. Monthly Reporting to MLTC iii</p>	139	<p>There appears to be a portion of this requirement missing for iii. Please confirm if this is to remain blank.</p>	<p>MLTC confirms that the requirement for iii. is to remain blank.</p>
376.			<p>Should not Medicaid Rehabilitation Option (MRO) be used liberally for individuals with functional and</p>	<p>The State is not mandating the use of a specific set of criteria for use of the Medicaid Rehabilitation Option.</p>

			neurocognitive deficits, generally diagnosed with severe mental illness (SMI) or severe and persistent mental illness (SPMI), who need rehabilitative assistance with such daily living tasks as household management, communication, finances, transportation and comprehension/planning who need rehabilitation services, (e.g. skills training) and other rehabilitation services through MCO?	
377.	B 4 (c) (a)(i)	p. 34	Why should “disability” not be included in the definition of “MCO must not discriminate” ..., as ‘disability’ is the norm in non-discrimination clauses and should be included as a matter of equity and with reference to the federal law, Americans with Disabilities Act, ADA?	IV.B.4.a.i fulfills federal regulatory requirement 42 CFR 438.6(d) regarding prohibitions against enrollment discrimination. The prohibition against discrimination on the basis of health history, health status, and need for health care services is inclusive of members with disabilities.
378.	B 4 (c) (a)(i) B 2 (c)	p. 34 p. 33	Will all materials, e.g. member guidebook, plan matrix, provider directory and any program or other materials be made available in alternative formats and publicized in a way that members who need	Yes. The State will address this via the contracted enrollment broker. This is outside the scope of this RFP. However, the enrollment broker services RFP will be bid out at a later date.

			alternative formats know these materials are available and accessible to them?	
379.	Glossary	p. ix	<p>If “advance directives” are used, are they part of an education</p> <p>and publicity program so that individuals are aware of them, create them correctly and include specific behavioral health and medical issues and are individualized for personal needs, such as a pet needing to be fed, flowers watered, etc., recognize that this is a legal document to be stored in a safe place, are assisted in notifying and leaving a copy with all their providers, and are offered whatever assistance the individual needs to have the Advance Directive honored in its entirety, is this available within the scope of this process?</p>	Please see Section IV.F.12 of the RFP.
380.			Will there be an “Ask a Nurse” by whatever name but retaining the function, be created and available cost-free, and publicized to the members within the scope of this process?	See Section IV.F.2 Member Services Call Center.

381.			<p>LB107 was passed and made into law in 2015, eliminating the need for Nurse Practitioners to be supervised by a Physician, yet the definition of Primary Care Provider (PCP) in the RFP references that old system: "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."</p> <p>Additionally, on the</p>	See response to Question #2.
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			<p>requirements for the Primary Care Mental Health (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 substantial 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.</p>	
382			<p>I wanted to know if Non-Emergency Transportation (NEMT) was going to be included in this procurement, or if it was going to be procured separately.</p>	<p>Please see response to Question #82.</p>

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