Addendum #1

QUESTIONS AND ANSWERS
MANAGEMENT OF BEHAVIORAL HEALTH SERVICES FOR THE
NON-MEDICAID POPULATION LOUISIANA
OFFICE OF BEHAVIORAL HEALTH
RFP # 305PUR-DHHRFP-BHS NonMedPop-OBH

Question #	RFP Page #	RFP Section #	Question	DHH Answer
1	12	I.A.i	Are LGEs required to participate with the ASO, or would any LGEs be able to opt out? What incentives will the LGEs have to cooperate with the program?	Contractual agreements shall be between the ASO and DHH-OBH and the LGEs and DHH. Contractual agreements between DHH-OBH and the LGEs will include language that reflects the requirements for participation.
2	13	I.B.2	An array of services available to the Medicaid population under the Louisiana Behavioral Health Partnership (behavioral health) and the Bayou Health (primary care) is described. The ASO is asked to provide the same or a similar system of management, quality monitoring and outcomes measurement for the non-Medicaid population. Please confirm that the ASO would not be responsible for providing services delivered in a primary care environment.	The ASO would not be responsible for providing services delivered in a primary care environment, but should refer or recommend services when possible.
3	13	I.B.4	There are a number of funding sources that are currently used by DHH-OBH and/or the LGEs to provide services to the non-Medicaid/uninsured population. A brief review of these sources suggests that some, if not all, of these funding sources are not structured in a fee-for-service (FFS) model, but are based on providing services in a cost-reimbursement model. Is there a specific role for the ASO relative to these funding sources? If the ASO has a role, and assuming all of these funding sources are not in a FFS model, is the ASO expected to convert these programs at each LGE into a FFS structure to be able to use the same authorization, quality monitoring and outcomes measurement system, or will the ASO be required to develop a separate monitoring program for those funding streams/programs that are not in a FFS structure?	As per page 13 (B) (4) of the RFP, these funding sources are managed by DHH-OBH and/or the LGEs.
4	14	1.C.2	What entity is performing claims payment and adjudication	Depending on population and/or funding source one, of

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			functions? Is that process the same for all populations managed by the ASO? If the ASO is **not** adjudicating non-Medicaid claims, are claims available to the ASO in secure-batched HIPAA compliant format for loading?	several LGEs or the state would handle payment. Payments made to providers by the state and/or LGEs are not in traditional "claim format" and not available as stated in the proposed question. LGEs are awarded funds through block grant or state general funds.
5	18	III.A.1.e	Will there be a common tool used by LGEs/contracted providers to determine level of need?	Please refer to page 11 of the Service Definitions Manual for the Uninsured for guidance on assessing level of need. http://www.dhh.state.la.us/assets/docs/BehavioralHealth/Non-Medicaid/Non-Medicaid_SDM_v1_08282015.pdf
6	18	III.A.1.f	Are any member eligibility/roster feeds available from other (non-ASO) agencies as applicable? These might include: adults in acute care unit judicially committed, tuberculosis service users, HIV population and additionally DCFS members, OJJ members.	No. Child-serving agencies may provide eligibility information to the ASO; however, it is unlikely that these would come over as feeds.
7	18 – 19	III.A.1.f.1-15	Will an individual's priority population status be identified on an incoming eligibility feed from DHH-OBH, or is it envisioned that an alternative process will be used?	No. The priority populations are listed in the RFP for reference; however, there is no indicator for these populations. The LGE or subcontracted provider will determine if the member is of the priority population and refer to the ASO for service authorization.
8	22	II.A.6.11	Can DHH-OBH clarify what data sources will be available to the vendor to calculate HEDIS-like measures?	DHH-OBH is removing this requirement until additional information can be gathered as to available data sources for HEDIS-like reporting.
9	27	III.B.3.f	What are the specific criteria (financial and medical necessity) for eligibility determination for the non-Medicaid/uninsured eligible adults, children and youth? Who is responsible for "enrolling" these eligible individuals and maintaining and monitoring their eligibility status? Will there be a mechanism for notifying the ASO when a member becomes Medicaid eligible?	The LGE shall be primarily responsible for monitoring Medicaid eligibility status of clients. The ASO shall formulate a monitoring plan relative to LGE processes regarding verification of Medicaid eligibility.
10	30-36	III.B.4.a,b, e, h	The current SMO, that serves both Medicaid and non-Medicaid members, requires 15 key positions. The RFP for non-Medicaid services requires 12. Given that the services and population outlined in the RFP are of a significantly different size and scope, will the ASO be able to propose a cost effective staffing plan that meets all of the functional requirements presented in the RFP, subject to approval by DHH-OBH?	Yes, upon DHH-OBH approval. This may be negotiated upon DHH-OBH receipt of the ASO organizational chart, to be provided 30 days prior to the contract start date (as noted in Section III.B.4.g, page 31).

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11	40	III.B6.j	Will ICF/DD and nursing facilities be required to share clinical information, including planned discharges, with the ASO?	No, the ASO is responsible for developing coordination strategies.
12	45	III.E.7	Is the mention of flash drives receiving written approval only applicable to anything not physically resident within a SAN or NAS device? (modern IT data center storage may employ flash drives for speed and reliability)	The concern toward flash drives is information security as flash drives are portable. The use of a flash drive for a SAN/NAS device is not the concern; rather, the portability of the USB drive. DHH-OBH would ask the contractor provide attestation of the security of the SAN/NAS device (including physical location and access). DHH-OBH would then approve this attestation for the continued use of the device.
13	46	III.E.9.a.1 III.E.9.a.3	Can DHH-OBH provide an inventory (or at least unique count) of data systems that would need to be interfaced to the ASO MIS? This question would seem to be open ended to any Electronic Health Record (EHR) operated by any provider, and many EHRs are not easily interfaced.	Because the uninsured population is not pre-identified for the ASO, the extraction or interface with EHRs/data warehouses would need to ensure that the ASO was accessing data relevant to their population. For this reason, extraction and interface could mean receiving a file from an LGE or DHH-OBH from an FTP site and pulling it into the ASO's MIS. For example, service authorizations could be run against the DHH-OBH data warehouse and DHH-OBH could supply a response file with necessary data.
14	46	III.E.9.a	Under the Behavioral Health Management system description, it indicates that the system should be able to capture/extract clinical and billing information. What data sources will the ASO use to perform this function and who will supply those sources?	Because the uninsured population is not pre-identified for the ASO, the extraction or interface with EHRs/data warehouses would need to ensure that the ASO was accessing data relevant to their population. For this reason, extraction and interface could mean receiving a file from an LGE or DHH-OBH from an FTP site and pulling it into the ASO's MIS. For example, service authorizations could be run against the DHH-OBH data warehouse and DHH-OBH could supply a response file with necessary data.
15	46	III.E.9.d	Can DHH-OBH define "near real-time"?	The data is collected by the ASO immediately, but is not aggregated until later. For example, if the ASO were to send a daily file to DHH-OBH, the expectation would be that the data within that file is real time up until the file was created to send.
16	47	III.E9.f	Can this deliverable be clarified? Is this simply providing the ability for DHH-OBH or other partners to obtain large	This will be removed from the statement of work.

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			data files through a secure URL?	
17	General	N/A	Will the ASO sign a collective agreement with all LGEs, or the ASO be required to sign individual agreements, which could represent a significant loss of time and critical service to members?	Contractual agreements shall be between the ASO and DHH-OBH and the LGEs and DHH. There is no contractual agreement anticipated between the ASO and the LGEs or their subcontracted providers.
18	General	N/A	Given the potential for multiple platforms, would DHH-OBH consider a phased approach to implementing electronic connectivity with the LGEs?	Yes. However, the connectivity to the LGEs or DHH-OBH could be a file exchange via an FTP site.
19	18	Section III.A.1.a	It appears that no claims payment is tried to prior authorizations. How will providers be encouraged to participate in prior authorization review with the ASO?	Contractual agreements between DHH-OBH and the LGEs will include language that reflects the requirements for participation.
20	18	Section III A.1.b	Please clarify, will DHH-OBH or its Fiscal agent supply the ASO with the non-Medicaid/uninsured recipients/eligible data in a proprietary or HIPAA compliant format (834)?	This data will not be supplied to the ASO. The ASO will provide service authorizations upon request based on the Service Definitions Manual for the Uninsured. The LGE will identify uninsured clients. http://www.dhh.state.la.us/assets/docs/BehavioralHealth/Non-Medicaid/Non-Medicaid_SDM_v1_08282015.pdf
21	18	Section III A.1.b	Will the non-Medicaid/uninsured recipients/eligible data identify DCFS or OJJ eligibility?	For service authorizations, the identification of whether a member is dually involved with another state agency should be completed by the LGE before service authorization.
22	19	Section III A.1.g	Please clarify that the ASO will be responsible for coordination of care across all agencies or is the ASO expected to track/report on multiple funding streams?	The ASO is responsible for care coordination and the tracking of service utilization through the authorization process. LGEs do not currently submit claims for non-Medicaid services for funding stream tracking.
23	20	Section III A.3.b	Will DHH-OBH or its Fiscal agent supply the ASO with the LGE and subcontracted provider data via an initial and on-going provider file transfer?	Provider data relevant to utilization should be provided to the ASO by either DHH-OBH or the LGE via an FTP interface in an agreed upon format.
24	21	Section III A.4.c	Please clarify, is the ASO required to provide DHH-OBH Fiscal agent with a file transfer of all authorizations and not just for those with “continued stay reviews”	DHH-OBH is asking for a file transfer of all authorizations.
25	24	Section III B.1.f	What positions/functions need to be located in the ASO’s administrative office? Are there ASO functions that may be performed out-of-state?	This may be negotiated upon DHH-OBH receipt of the ASO organizational chart, to be provided to DHH-OBH 30 days prior to contract start date (as noted in Section III.B.4.g, page 31).
26	31	Section III B.4.e and h	Do all key staff positions need to be full time (40 hours per week)?	No, please see proposed staffing pattern.

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27	51	Section III K.I	This section states that the initial contract term will be January 4, 2016 – June 30, 2017 and that DHH-OBH may also exercise an option to extend for up to twelve (12) additional months at the same terms and conditions of the initial contract term. Please explain should the DHH-OBH exercise their option to extend the contract, how costs for the next twelve (12) months term will be calculated.	The extended 12 month cost shall be at the same monthly rate of the previous 18 months, assuming same level of funding appropriated to DHH-OBH for this purpose.
28	51	Section III K.I	Please provide an estimate that we should assume in our pricing development for the annual number of non-Medicaid appeals and grievances.	Non-Medicaid grievances and appeals are not differentiated in current reporting; as such, this cannot be provided.
29	57	Section IV L.2	Please confirm that two hard copies are needed of the original proposal, as well as two hard copies of the redacted proposal.	One (1) original hard copy and one (1) electronic copy of the entire proposal and Redacted proposal AND two hard copies of the entire proposal.
30	57	Section IV L.2	Please confirm that two separate hard copies of the cost proposal and financial statements are needed of the original proposal, as well as two hard copies of the cost proposal and financial statements for the redacted proposal.	See above. The cost proposal and financial statements are part of the ENTIRE proposal which should follow the requirement stated above.
31	59	Section IV P.3-5	Please confirm if 3-5 are guidelines for creating the proposal, or sections that require written response.	All items in Section IV P, including items 3-5 must be submitted in the written proposal.
32	81	Attachment V, Sample Cost Breakdown	Please define what services you would like listed under the contracted staff area. For example, is this area where all subcontractor staff and/or services, should be noted if applicable?	The position titles of contracted staff should be listed under the Contracted Staff section. A separate page may be used to describe the services to be provided.
33	81	Attachment V, Sample Cost Breakdown	Please confirm all employee benefits should be listed as one total on the benefits section of Attachment V.	Benefits should be listed individually and a total for all benefits should be given.
34	81	Attachment V, Sample Cost Breakdown	Please note what items would be defined as Professional Services and listed on the Professional Services line of Attachment V.	This is to be determined by the proposer, but could possibly include auditing services, legal services, consultation services.
35	81	Attachment V, Sample Cost Breakdown	Please define what costs you would prefer to be listed under direct and indirect cost section of Attachment V.	Indirect cost could be any operating cost incurred as a whole for the company that is not directly related to the contract. All direct cost should be captured in the sections identified.
36	81	Attachment V, Sample Cost Breakdown	Due to the fact that Attachment V is provided as an example, please confirm if we can submit a pricing breakdown format that varies from the format and items noted on Attachment V.	The sample template must be used to prepare a budget and total cost.
37	81	Attachment V, Sample Cost Breakdown	Please note if we are following Attachment V's format, what line item should include the cost of the Performance Bond?	This should be an indirect cost to the proposer.

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38	81	Attachment V, Sample Cost Breakdown	Please note if we are following Attachment V's format, what line item should include the cost of reinsurance, if applicable?	Operating Costs – Insurance; broken out separately from initial insurance.
39	81	Attachment V, Sample Cost Breakdown	Please note if we are following Attachment V's format, should overhead allocations be included on each line item?	Indirect cost.
40	81	Attachment V, Sample Cost Breakdown	Please note if we are following Attachment V's format, where should we list the amortization and depreciation of capital items and start-up costs?	Amortization and depreciation should be indirect cost. Startup cost could be both direct and indirect cost depending on what the costs are.
41	81	Attachment V, Sample Cost Breakdown	Please confirm the totals reflected on this Cost and Pricing Analysis sheet will be for 18 months, the term of the 1st year of the contract.	The budget template total cost is for 18 months.
42	81	Attachment V, Sample Cost Breakdown	Please confirm there is no requirement to distinguish dollars that will remain in the State of Louisiana on the Cost Breakdown Template.	No, this is not on the cost template.
43	General	Per the Louisiana Behavioral Health Partnership Transparency Report for Fiscal Year 2014 (2015)	The member information section notes 61,472 Adult Non Medicaid Members (Statewide Total) and 851 Non CSoC Non Medicaid Youth Members, should we assume this member count in order to develop the budget? If not, how many enrollees should we assume are eligible and utilized services for Fiscal Year 2013, 2014, 2015? Please break these members out by adults and children.	The numbers in the Louisiana Behavioral Health Partnership Transparency Report represent the number of non-Medicaid members who received services. This data is based on monthly service utilization; therefore, members may be duplicated within. However, the numbers provided are an accurate description of service utilization for the uninsured. The numbers referenced in the 2014 FY Transparency Report are as follows: Adults statewide: 20,702 and Children statewide:1784.
44	General	Per the Louisiana Behavioral Health Partnership Transparency Report for Fiscal Year 2014 (2015)	Please provide service-level utilization data either in aggregate or by funding stream.	The service level utilization data is attached in the procurement library here: http://new.dhh.louisiana.gov/index.cfm/newsroom/detail/3505 DHH-OBH can only provide what services were received in aggregate. This data is for FY15.
45	General	Customer Service Call Volume	Please provide the number of customer service calls received for Fiscal Year 2014 (2015) for Non Medicaid enrollees.	Customer service calls are not differentiated by Medicaid or non-Medicaid enrollment.
46		RFP Scope of Work	Are there any requirements of the vendor to provide communication/promotional materials to the members? If so, please elaborate on the type(s) of materials (i.e. brochures, handbooks, etc.) and distribution method (electronic, hard copy, in bulk or to enrollees' homes) If materials are required	There will be a requirement for the ASO to communicate with members regarding grievances and appeals, which must be addressed in the ASO's policy and procedure for grievances and appeals (see page 28 of the RFP). Other promotional materials are not currently anticipated in the Statement of

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			to be distributed to enrollees' homes, please indicate the frequency and or how this request is triggered.	Work; however, outreach to members may be required upon DHH-OBH request.
47	7	Glossary, LMHP Definition	Must all LMHPs that work for the ASO be licensed in Louisiana? We anticipate having the majority of our staff in Louisiana and licensed there, but some of our after-hours staff are out of state. They are licensed but not in Louisiana.	No. As per page 20, Section III.A.3.a, the toll-free line shall be staffed in the United States. LMHPs staffing this line may be licensed in the state in which they are located.
48	13	B.1. Purpose of RFP	Please identify the requisite trainings for behavioral health providers that the ASO must provide.	The ASO must provide any and all trainings necessary for the providers to successfully work with the ASO, which might include submission of data, prior authorization and continuing authorization processes, etc.
49	18	A.1.a. Prior Authorization	Can you provide a list of covered services? Can you provide a list of covered services subject to prior authorization and any DHH-OBH rules related to the expected type and frequency of prior authorization and concurrent review?	The Service Definitions Manual for the Uninsured is posted on the DHH website as indicted in the RFP. http://www.dhh.state.la.us/assets/docs/BehavioralHealth/Non-Medicaid/Non-Medicaid_SDM_v1_08282015.pdf
50	20	2.b. Utilization Management	What is the current or expected "format and frequency approved by DHH-OBH" of UM reporting? Is there a reporting manual or a list and schedule?	Proposers shall submit a plan for UM reporting in their proposals to be approved by DHH-OBH.
51	20	#3.a Care Coordination	Requirement is to provide 24/7/365 telephone availability to members/families and providers "staffed by LMHPs". Mus the LMHPs answer the phones or can we have a contact center field the calls with LMHPs available for warm transfer if needed?	A contact center could field the calls with LMHPs available for warm transfer, as long as warm transfers are conducted in compliance with successful transfer rates and wait time standards as determined by DHH-OBH.
52	20-21 & 40	# 3 Care Coordination and #6, h. Coordination of Care Requirements.	Does the ASO provide care coordination to the members or do the LGE's?	The ASO should follow the requirements of the RFP on p. 20-21, #3 and p. 40, #6.
53	21 & 27	#4. Continued Stay Review. & #3.3. Operations Requirements.	These two areas state that when MNC is no longer met, the ASO shall refer the case to DHH-OBH for the continued stay review process. Does this only apply to inpatient and residential care? If this applies to all levels of care, when would the ASO issue a denial of care/action that would give the member appeal rights?	This only applies to inpatient hospitalization. All other authorizations would end when MNC is no longer met.
54	23	#6.a.13. Quality Management	Please provide additional information about the requirement to "conduct peer review to evaluate the clinical competence, quality, and appropriateness of care/services to individuals/families seeking services."	The ASO is responsible for ensuring the quality of services delivered by the providers. As such, the ASO shall conduct treatment record reviews assessing the clinical competence, quality, and appropriateness of care/services. The ASO shall formulate an auditing tool to be approved by DHH-OBH that

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				shall be used in the reviews that will capture such information that will allow for the evaluation of these factors. The staff performing these reviews should be "peers" to the provider, meaning an equivalent level of education/training (i.e., psychologist reviewing psychologists, psychiatrists reviewing psychiatrists, LCSWs reviewing LCSWs, etc.).
55	23	#6.f.2.	Unsure if this is an incomplete sentence or a typo; the sentence ends with “and c”.	This is a typo and has been corrected.
56	31	#4.e. Staffing	Must all key positions be full-time and work in the ASO offices in Baton Rouge? The CMO position says it is 20 hours/week.	Not all key positions must be full time; please see proposed staffing pattern. Determination of positions to be located in ASO offices in Baton Rouge may be negotiated upon DHH-OBH receipt of the ASO organizational chart, to be provided to DHH-OBH 30 days prior to contract start date (as noted in Section III.B.4.g, page 31).
57	31-36	Staffing	Must all key positions be solely dedicated to this program? Can they be shared with other programs we operate?	Yes, upon DHH-OBH approval they may be shared. This may be negotiated upon DHH-OBH receipt of the ASO organizational chart, to be provided to DHH-OBH 30 days prior to contract start date (as noted in Section III.B.4.g, page 31).
58	20	3. a	This section indicates that the 24/7/365 toll-free telephone line is to be staffed by LMHPs. Is it acceptable for staff to include Customer Service Representatives who can triage general non-clinical questions and who can connect to LMHPs to manage clinical related inquiries?	Please see answer to question #51.
59	21	3.f.	Would the ASO directly pay for interpretive services, or would the ASO coordinate services that would be paid by DHH-OBH?	No, this will continue to be paid as currently done which is paid for through DHH-OBH and/or LGEs. ASO may be expected to coordinate.
60	30	4.	Given the relatively short turn-around time from award to go-live, could the ASO use interim staff to fill key positions until the LA-based leadership is hired?	Yes, upon DHH-OBH approval. This may be negotiated upon DHH-OBH receipt of the ASO organizational chart, to be provided to DHH-OBH 30 days prior to contract start date (as noted in Section III.B.4.g, page 31).
61	70	C.1.	Is the “total proposal cost” to be monthly, annual, or entire contract term?	The performance bond amount is for the entire contract term.
62	18	A.1.A	It is our understanding that the Service Definitions Manual is currently under revision – when is the expected completion date of these revisions and positing of the final version?	The Service Definitions Manual for the Uninsured is posted on the DHH website as indicted in the RFP. http://www.dhh.state.la.us/assets/docs/BehavioralHealth/Non-Medicaid/Non-Medicaid_SDM_v1_08282015.pdf

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63	18	A.1.B	What mechanism will be used to provide information related to member involvement with the identified state agencies? Will this be done via 834 file or another mechanism?	For service authorizations, the identification of whether a member is dually involved with another state agency should be completed by the LGE before service authorization.
64	18	A.1.C	With the ASO agency be allowed to determine their own criteria for Medical Necessity?	The ASO will follow the definition of Medical Necessity as outlined in the Services Definitions Manual for the Uninsured.
65	18	A.1.E	Please clarify – is the ASO organization completing the screening (if so is the screening specified or determined by the ASO organization) or is the screening referenced completed by the provider or LGE?	If an individual or family member makes initial contact with the ASO, the ASO shall conduct the initial screening to determine level of need. If an individual or family member makes initial contact with an LGE or provider, the ASO shall use information gathered from the LGE or provider screening/assessment to determine level of need.
66	19	A.1.G.3	Please define “authorize treatment plan” and provide definitions/clarity of prior authorization service packages. What are these services?	An individual may need one or more services. The “service package” is the array of services available and appropriate for the individual. The ASO will develop an RSS which authorizes the provider to develop the treatment plan with the recommended services.
67	19	A.1.G.5	Please clarify the distinction between concurrent review based on Medical Necessity and review based on assessment and treatment planning.	Initial determinations of Medical Necessity will be made based on presenting problems and/or assessment/screening. Additional determinations or continued authorization will be based on assessment and treatment planning.
68	20	A.1.H	Please define “Standard, Urgent, and Emergent”	These terms are defined in the glossary.
69	20	3.A	Would it be acceptable for this line to be staffed by RNs? Please define the type of questions this 24 hour line is expected to answer? Is this a 24/7 provider relations expectation or is this a 24hour crisis line expectation?	Please see definition of LMHP in the Glossary, page 7. For acceptable staff to initially answer calls, please also see answer to question #51. As stated in section III.A.3.a (page 20), the telephone line must be available to providers as well as individuals/families seeking both routine and emergency services.
70	24	B.1.C	Please provide more information. Is the intent of this language that the ASO would manage these persons prior to full implementation or that there is a flexible for graduated implementation possibility in this contract?	The ASO will be responsible for an implementation plan due prior to go-live date. The go-live date is the date the contract becomes operational, preceded by the Division of Administration/Office of Contractual Review approval of the contract signed between DHH-OBH and the ASO. The ASO will not be managing services prior to go-live, but will be required to prepare operations prior to go-live. At this time, there is no consideration for a graduated implementation.
71	26	3.a.	Please define “tracking LGE” What is expected to be included in this tracking?	“Tracking” will be changed to “recurring monitoring.”

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72	27	3.g	Does such an RSS exist today and if so can an example be provided? Recommending that assessment be allowed for LGE and recommended services be provided based on MNC.	There is no example. The ASO will be expected to develop the RSS format that is similar to a Plan of Care used by Managed Care Organizations.
73	28	3.j	Will ASO be required to contract directly with any of these providers?	No.
74	29	3.L.3.G	Please provide more clarification around LGE override of Medical Necessity. What are the criteria in which this can happen?	The ASO is responsible for monitoring and tracking instances in which the LGEs override service authorizations based on medical necessity and providing reports to DHH-OBH.
75	30	4.C	Please define “dedicated”. Does this mean that all staff will be only able to work on ASO/non-Medicaid business or is the ASO arrangement allowed to be combined with Medicaid eligible business? Can staff serve both populations?	While staff may be able to serve both populations, specific names of individuals who are dedicated to the non-Medicaid population are expected to be provided to DHH-OBH.
76	38	5.r.3	Would DHH accept a report or example of information rather than direct access to systems as this is a major security issue and potential for confidentiality violation?	If system data could be provided on a reasonable schedule in a DHH-OBH-approved format, then we would consider a report in lieu of direct access. The direct access request assumes the system has user-defined access and is securely accessible from remote locations.
77	General	N/A	I’ve reviewed the RFP and have not been able to determine what time of license or certification is necessary. The contract template indicates the agreement will be between the DHH and the successful vendor however I would like to confirm that an insurance license is also required through the Louisiana Department of Insurance.	Page 50 states, “the ASO shall hold a certificate of authority from the Department of Insurance (DOI) and file all contracts of reinsurance, or a summary of the plan of self-insurance with DOI and DHH.”

*Questions were copied verbatim as they were received.