(Follow up questions received were broken down into two sets)

Set 1 of 2

ADDENDUM #13

Questions and Answers

BAYOU HEALTH – MANAGED CARE ORGANIZATIONS

RFP # 305PUR-DHHRFP-BH-MCO-2014-MVA

2nd Set of Questions will be posted as an Addendum

Number	Document Reference (e.g., RFP, RFP Companion Guide)	Q & A Round 1 Question #	Section Heading	Page Number in Referenced Document	Question	Response
1	Addendum # 5 Questions and Answers	Question #17	Voluntary Opt-in populations	7	The Department estimates a 20% take up rate for the voluntary opt-in members. Can the Department please provide information as to where/how this estimate was arrived at? If the estimate was partially obtained from data available from other states, can the Department please provide information about the states and plans utilized?	The 20% projected take-up rate is an estimate only for general analysis, and is not based upon any specific information. As the PMPMs for the HCBS enrollees are based upon expenditures and member months, the projected take-up rate does not impact the calculation of the PMPM.
2	Addendum # 5 Questions and Answers	Question #88	Behavioral Health Services	35	With applied behavior analysis considered best practice for specific populations (e.g., autism spectrum disorder), including those who may be opting-in to Bayou Health, would the state consider services delivered by a Board Certified Behavior Analyst (BCBA) consistent with "Basic" or "Specialized" behavioral health services?	Neither. Applied Behavior Analysis (ABA) services delivered by Board Certified Behavior Analysts (BCBA's) will be managed separate and apart from Bayou Health and LBHP. Neither Bayou Health Plans nor the contracted LBHP contractor will be at risk for ABA services provided by Board Certified Behavior Analysts. Diagnostic evaluations and other covered specialty behavioral

						health services provided by contracted psychologists and/or medical psychologists to members, including any with autism diagnoses, will be the responsibility of the LBHP contractor.
3	Addendum # 5 Questions and Answers	Question # 395	Voluntary Opt-in populations	167	Can the Department please provide information about who currently provides case management services for those participants who may opt-in to Bayou Health?	The listing of current case management providers is posted in the procurement library as "Case Management Providers."
4	RFP	22.11.2	Procurement Library/Resources Available To Proposer	273	After accessing the historical Medicaid claims data files on the flash drive, we conclude we still require the claims columns or layout of the claims file with any available data dictionaries. We also need to know the corresponding gender definitions for the 1 and 2 value. Finally, can you confirm that the claim files consist of 151 fields and is a caret (i.e ^) separated file?	The claims history file layouts are contained in the MCO System Companion Guide in Appendix D. Appendix J has common code values and their meanings. There is an additional set of data included in the flash drive called eligdata.txt that contains the following information for Medicaid eligibles: elig_id (13-byte unique numeric ID) sex (1=male, 2=female, other value=unknown) dob (date of birth, formatted yyyymmdd) zip code (5- or 9-byte numeric zip code of most recent mailing address).
5	Addendum 8 Questions and Answers - Question 3	2.1.1.7	Requirements for MCO	1	Should the Network Development plan discussed in Appendix KK, G.1 be an attachment to the RFP response or should we imbed the plan in our G.1 response?	The Network Development Plan can be attached to the proposal as an appendix, but the appendix must be referenced in your response to G.1.
6	Addendum 8 Questions and	22.11	Procurement	273	The answer for question 49 indicates that Mercer Certification Rate Development and	Yes; all rate certification letters actually used since Bayou Health

	Answers - Question 49		Library/Resources Available To Proposer		Rates documents for Prepaid plans for 2013 and 2014 will be posted to the Procurement Library. However, as of 8/22/2014 there are only 2012 documents posted. Will DHH be posting the 2013 and 2014 rate documents?	implementation have been posted to the Procurement Library.
7	RFP	17.8.5	17.8 Encounter Data	237	Will the FI be able to share their EDIFECS version and updated severity files in order to make sure we're editing to the same level?	Molina's current version of EDIFECS is v8.4 and they edit to SNIP levels 1 and 2.
8	RFP	4.4	In-State Key Staffing Positions	29	The Member Service Coordinator position (4.4.11) is listed in 4.4 (in-state staff positions), but it is not listed in 4.2 (key staff positions). There is a similar position in 4.2 (key staff) called a Member Services Manager (4.2.16). Is the Member Service Coordinator position a different position than the Member Services Manager position?	These are separate positions that may be filled by the same person. If filled by the same person it must be located in state. If Member Services Manager is a corporate or regional level position, then the MCO must provide a separate FTE to serve as the Member Service Coordinator in state.
9	Addendum 8 Questions and Answers - Question 37 Procurement Library - LA Medicaid Fee Schedules	24.9	Provider Manual - Hospice	4	For Hospice physician services eligible for additional reimbursement, how does the state reimburse codes included in the physicians services fee schedule that have a manual pricing (MP) indicator? Example: 99429 & 99481 are listed on the physicians services fee schedule with an MP indicator. What is the reimbursement methodology for these codes?	The same methodology as applied in Professional Services. Claims with manually priced procedure codes must be submitted with appropriate clinical documentation. Medical Review staff then determines the reimbursement.
10	Addendum 8 Questions and Answers - Question 54 Procurement Library - LA Medicaid Fee Schedules	17.3	Provider Manual - ESRD	1	Since the rates are not published, how often are the adjusted rates distributed? Is there a distribution list that we can be added to? Please outline the code criteria and fee schedule used for reimbursement of separately billable codes (CAPD, COPD, EPO and injectable drugs). Please confirm the rate documented within the ESRD Provider Manual Section 17.3, for Epogen is current. *Epoetin alfa (EPO) is reimbursed per*	A report listing composite rates of all active hemodialysis centers can be provided. Current rates range from $117-$140.47. Of course, all applicable rate reductions as stipulated in the ESRD Provider Manual would need to be applied. Separately billable codes except for EPO are published on the Professional Services Fee Schedule on LaMedicaid.com.

					1,000 units (rounded to the nearest 100 units) administered. The following formula is used in calculating EPO reimbursement: *(Total number of EPO units/100) X **$1.00** = Reimbursement* How often is the rate updated? Where is the update published?	The Epogen reimbursement methodology is current in the ESRD Provider Manual. There is no set schedule for updating rates. Any rate adjustments will be posted on LaMedicaid.com.
11	Procurement Library - MCO Systems Companion Guide Addendum 8 Questions and Answers - Question 74	25.7	Provider Manual - Hospital	12-14	Please confirm the Outlier reimbursement process: 1. Provider submits claim to MCO for reimbursement 2. MCO reimburses according to Per Diem methodology 3. Provider submits claim to DHH for Outlier Pool consideration 4. If eligible, DHH provides detailed reimbursement info to MCO 5. MCO issues provider supplemental Outlier reimbursement – per LDHH direction based upon threshold criteria, claim eligibility and Outlier pool status	Confirmed, with the clarification on #2 that claim reimbursement may differ depending on the terms of the contract between the MCO and the Hospital.
12	Addendum 8 Questions and Answers - Question 75	12.16.14.1	Table of Monetary Penalties	259	The RFP states that the MCO must "answer 95% of calls within thirty (30) seconds or direct the call to an automatic pickup system with IVR" for the member call center. On page 259, it lists for the Provider Call Center penalties associated with the metric: "answer 90% of calls within 30 seconds". Is it permissible for the MCO to use an automatic pickup system with IVR for the Provider Call Center?	Yes, use of an IVR for the provider call center is permissible, but both call centers must meet or exceed the standards for maximum hold times to speak to a live operator or agent.
13	Addendum 8, questions 196 & 196	RFP Section: E	RFP Heading: Qualificatio ns and	85	The response to question 195 states that “breach” and “non-compliance” are used interchangeably. If that is the case, please explain the difference between question E.3	E.3 refers to contractual non-compliance between the State and the MCO. E.7 refers to any regulatory actions or sanctions

			Experience		and E.7 as the two questions appear to be largely duplicative.	directly imposed by other entities, such as but not limited to CMS, State Department of Insurance, etc.
14	Addendum 8, question 221	RFP Section: 6.3.1.1, 6.4.1.2	RFP Heading: Core Benefits & Services	93	The response states: "The MCO responsible for pharmacy payment will be determined by the specialty of prescriber. If the prescriber is a behavioral health provider authorized to prescribe then the pharmacy claim will be reimbursed by the behavioral health MCO." Can DHH help clarify the following: • Does SMO manage the benefit of <u>all medications</u> prescribed by BH specialist, or just BH medications? • If the SMO is responsible for the management of just BH medications, can DHH provide a description of what is considered a BH medication; for example, what classes of drugs are expected to be on the SMO formulary/PDL?	The SMO manages all medications prescribed by a Behavior Health Specialist.
15	Addendum 8, question 329	RFP Section: 6.4.1.2	RFP Heading: Specialized Behavioral Health Services	135	The response states, "Responsibility is based on provider type of the prescribing providers. Additional information is available in the LBHP/SMO RFP released 8/15/14." The SMO RFP indicates the Go Live date will be 3/1/15 while the MCO Go Live date will be 2/1/15. Which entity will be responsible for Pharmacy Behavioral Services for the month of February 2015 since these 2 entities will have different Go Live Dates?	While the decision has not been finalized by the Department, it is our intent that the MCO will continue to manage the entire pharmacy benefit until 3/1/2014. An adjustment to the PMPM will be needed to account for this added responsibility. These terms will be worked out with MCOs after the contract award.
16	Addendum 8, question 329	RFP Section: 6.4.1.2	RFP Heading: Specialized Behavioral Health Services	136	Since the SMO and MCO will both adjudicate pharmacy claims for members depending upon the specialty of prescriber, would DHH please clarify how it envisions directing the timely sharing of pharmacy claims data so that MCOs and the SMO can appropriately and timely	The prescription management program through the Louisiana Board of Pharmacy for controlled substances may be utilized for this purpose. Prescriber and Pharmacy contracts should require

					monitor member health. The ability to receive/analyze integrated data is critical to MCO/SMO ability to carry out activities such as identifying potential drug over/under utilization and duplicate therapies, as well as case management oversight and interventions. It would be very difficult to do this effectively through an MOU between the parties.	prescribers and pharmacists to access the Prescription Monitoring Program before filling the Rx to minimize chances of duplication or abuse of controlled substances. Beginning in early Oct DHH will facilitate a workgroup of new MCO and SMO contractors, prescribing providers and pharmacies in order to finalize all of the operational details for testing before go-live in March.
17	Addendum 8, questions 130 & 336	RFP Section: R.2	RFP Heading: Customer Service	56 & 140	DHH's response in line 336 states that member call center "reports can be provided for Louisiana only." DHH's response in line 130 to a similar question states, "Affiliates should be included when determining the largest contract [for submitting hotline reports]." Please confirm that incumbents should submit call center reports for Bayou Health only vs. their largest affiliate.	Yes, incumbents can provided reports for Louisiana only.
18	Addendum 8, question 3	RFP Section: 2.1.1.7	RFP Heading: Scope of Work, Requirements for MCO	2	DHH's response in line 3 states, "The evidence should include but is not limited to a listing of currently contracted providers for Louisiana Medicaid or other commercial products in the state, or who have indicated intent to contract with the proposer to serve the Louisiana Medicaid population, maps depicting the geographic distribution of providers by type, as well as a written description." Will DHH please clarify which submission vehicle proposers should use to submit the provider listing: Appendix FF MCO Provider and Subcontractor Listing or the Provider Registry File and Provider Registry Site File? Also, please confirm that DHH will accept	Appendix FF has been revised per Addendum 14. All proposal responses should be submitted in both written and electronic versions of the proposal.

					electronic files for the provider listing and geo maps.	
19	Addendum 8, question 46	N/A	N/A	17	Appendix FF is only listed in the List of Appendices to RFP and not in the remainder of the RFP or System Companion Guide. Is this provider subcontractor listing required in the proposal submission?	Appendix FF has been revised to provide a summary table of the number of providers in-network Addendum 14.
20	Addendum 8, question 81	RFP Section: 7.3.3	RFP Heading: Specialists	32	Orthodontist is a specialty listed in Appendix TT; however, services provided by an orthodontist are not covered services and benefits for Bayou Health. Please clarify this discrepancy.	Orthodontist deleted per Addendum 16.
21	Addendum 8, question 253	RFP Section: 14.5.54	RFP Heading: Quality Management	106	Please clarify that it is acceptable to credential the personal care service agency provider.	Yes
22	Addendum 8, question 388	RFP Section: 7.5.2	RFP Heading: Geographic Availability Monitoring	164	Please confirm the network adequacy standards for Personal Care Service providers and Hospice Service providers (e.g. geographic standard)? Appendix UU does not address Personal Care Services and neither Appendix UU nor Appendix TT includes hospice services.	Appendix TT has been amended per Addendum 15. For general network adequacy standards that apply to PCS and Hospice see RFP sections 7.1.1 and 7.1.2.
23	Addendum 8, question 17	RFP Section: 3.6.1.1	RFP Heading: Voluntary Opt-in populations	7	Can DHH please provide the rationale for estimating the 20%? Was the 20% applied uniformly across all categories or weighted toward particular categories?	The 20% projected take-up rate is an estimate only for general analysis, and is not based upon any specific information. As the PMPMs for the HCBS enrollees are based upon expenditures and member months, the projected take-up rate does not impact the calculation of the PMPM.
24	Addendum 8, question 43	RFP Section: 5.1	RFP Heading: Maternity	16	Can DHH please provide the "applicable procedure and/or diagnosis codes" to be used to identify maternity claims?	The applicable Procedure and/or diagnosis codes will be added to the procurement library

			Kick Payments			
25	Addendum 8, question 73	RFP Section: 5.1.2	RFP Heading: Maternity Kick Payments	27	Please clarify whether DHH is referring to "Kick payments for ELECTIVE deliveries in their response to this question. If not, would DHH provide the rationale for pending until medical necessity indication for all deliveries 39 weeks or prior?	Kick payments for deliveries prior to 39 weeks will be pended for verification of medical necessity for the elective delivery. The department will work with the MCOs to finalize our processes prior to implantation.
26	Addendum 8, question 80	RFP Section: 11.0	RFP Heading: Eligibility, Enrollment and Disenrollment	32	Could DHH please provide more detail about the Enrollment Broker's enrollment responsibilities in Appendix W (mainly around how they will ensure that members are enrolled timely and accurately)?	The Enrollment Broker has daily, weekly, monthly, quarterly and annual file transfers with the fiscal intermediary. MCOs are required to review the file transfers for accuracy report discrepancies to DHH for correction.
27	Addendum 8, question 175	RFP Section: 5.6	RFP Heading: Determination of MCO Rates	75	Would DHH entertain implementing a process for excluding "break-through" drugs (such as the Hepatitis C drugs) until manufacturer price and utilization trend experience can be collected?	The department will consider but cannot commit at this time.
28	Addendum 8, question 53	RFP Section: 10.4.3	RFP Heading: Provider Handbook	19	In response to the question: Section requires that provider handbook must be made available to DHH for approval 30 days PRIO the date the MCO signs the contract with DHH. Should this be changed to within 30 days of the d the MCO signs the agreement?" DHH responded "yes." Please confirm that DHH will amend the language in the RFP and subsequent contract to reflect this clarification.	Confirmed.
29	Addendum 8, question 88	RFP Section: 6.4.2	RFP Heading: Behavioral Health Services	35	The previous DHH response indicates that the MCO is not responsible for specialized behavioral health services, and includes "FQHC/RHC encounters in which any service was provided by a behavioral health specialist" in that category. Please confirm that this means	Correct. As long as a member sees a behavioral health specialist during an FQHC/RHC visit, the SMO is responsible for the entire visit, regardless of any other services rendered at the same

					as long as a member sees a behavioral health specialist during an FQHC/RHC visit, the SMO is responsible for the entire visit, regardless of any other services rendered at the same time.	time.
30	Addendum 8, question 109	RFP Section: 6.4	RFP Heading: Behavioral Health Services	46	The original question was asking DHH for "appeal mechanisms" available to the MCOs if the SMO refuses to accept a referral. DHH's response only addressed the member grievance process. Please clarify mechanisms ***available to MCOs*** if the SMO refuses to accept a referral for a member.	The process for coordination and referrals should be delineated in the MOU between the MCO and the SMO. DHH will have the right to final determination on disputes between an MCO and the SMO.
31	Addendum 9, question 291	RFP Section: 8.5.4.1.3.1	RFP Heading: Informal Reconsider ation	119	Please explain in detail which service reconsiderations by a provider on a member's behalf need a signed, written consent, and which ones do not. For example, does the MCO have to obtain the member's written consent for the provider to initiate an informal reconsideration (peer to peer) related to any medical necessity determination including pharmacy reconsiderations and appeals on their behalf?	The DHH requirement for written consent of the member applies to the State Fair Hearing process. MCO policy and contract terms with the provider would determine requirements for reconsideration.
32	Addendum 8, question 177	RFP Section: 6.1	RFP Heading: Value Added Benefits	78	The Q&A response states that "Weight will be given to proposers with higher PMPM values." RFP Section 22.19.3 states that "Each Proposal Team Member shall evaluate each proposal against the evaluation criteria in this RFP as specified in Appendix KK, rather than against other proposals." Please clarify what criteria DHH will apply to PMPM values to decide how much weight to assign to a proposer, since DHH will not be comparing the PMPMs of proposers.	PART X: ADDED VALUE TO LOUISIANA MEMBERS, PROVIDERS & EMPLOYEES to be based on a comparison of relative value across proposers. Specifically fifty percent of the points in each Section of Part X will be awarded on a comparative basis with the highest value of the proposed receiving the maximum and other proposers receiving a ratio of points equal to the ratio of the value of their enhance benefits compared to the maximum proposed. Any proposers submitting the same

						value benefit will receive the same point. The remaining fifty percent of the points for each Section will be awarded based on alignment with DHH priorities.
33	Addendum #8	Question #34	Appendix D	12	Please define how plans will be awarded points for contracting with LA Veteran and Hudson Initiative organizations. For example, is the state's plan to award points based on LOIs, or will points be awarded solely based on the scope of historic business? Please define if business arrangements with Veteran and Hudson Initiative businesses need to be directly related to Bayou Health to be awarded points.	If a proposer is not a certified small entrepreneurship itself, it can be awarded points only by engaging one or more certified small entrepreneurships as subcontractors directly related to the Bayou Health MCO contract. Points will be allocated based on the following criteria: the number of certified small entrepreneurships to be utilized; the experience and qualifications of the certified small entrepreneurship(s); and the anticipated earnings to accrue to the certified small entrepreneurship(s). The proposer shall include in its proposal the names of its certified Veteran Initiative or Hudson Initiative small entrepreneurship subcontractor(s), a description of the work each will perform, and the dollar value of each subcontract. LOIs or other relevant documentation may also be included with the proposal.