ADDENDUM #16
Response to Questions
Set 2 of 2

BAYOU HEALTH – MANAGED CARE ORGANIZATIONS
RFP # 305PUR-DHHRFP-BH-MCO-2014-MVA

Question #	Document Reference (*e.g.*, RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number in Referenced Document	Question	Response
1	RFP	Provider Reimbursement	9.1.1	118	Will the Department clarify that for cost-based reimbursed providers, the rate that would be received in the Medicaid fee-for-service program includes the cost settlement process and those associated amounts? While these providers understand that there is flexibility in the contract process, confirmation that these processes and amounts remain an option are important.	Not answered because not a follow-up to a previously submitted question and answer.
2	RFP	Specialists	7.3.3	81	When evaluating network adequacy, does the Department do any independent analysis relative to the number of total providers, not just those that participate in Medicaid and particularly specialists? For example, how many urologists are in Region 8 and how many accept Medicaid currently.	Not answered because not a follow-up to a previously submitted question and answer.

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3	RFP	Provider Handbook	10.4.2	126	Why is the Department designing Bayou Health in a way that gives a plan the ability to make a material change in their contract with providers by a change in the provider handbook without negotiation or consideration?	Addressed in Addendum 8 response to question 304.
4	Addendum 8	Questions	#74	28	Following up on DHH's statements relative to outliers: (1) Is DHH stating that it is providing a back-stop to the MCOs' risk on outliers in the form of limiting what they have to pay hospitals for outlier claims and through a pool established in the Medicaid FFS program prior to the implementation of Bayou Health? Would that make the plans shared risk? (2) Can hospitals and MCOs contract for outliers independent of the pool? (3) Can Plans contract with providers a rate of reimbursing outliers that differs from the state manual? (4) When in conflict, what rate should MCOs pay as an outlier? Per the terms of their contracts with providers or as outlined in the state manual?	(1) The outlier program has always and will continue to be capped as determined by DHH. (2) Yes. (3) Yes. (4) Per the terms of the contract between the MCO and the provider.

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5	General Question				Historically, Legacy Medicaid reimbursed rural physicians for providing in-home physician clinic visits. Will this process carry forward as reimbursable through the MCO contracts?	Not answered because not a follow-up to a previously submitted question and answer.
6	RFP	9.3.2	Reimburseme nt to Out-of-Network Providers	119	Is the 90% rate floor only for OON?	Section 9.3.2. refers to Out-of-Network providers. See Addendum 8 response to Questions #200 and #381.
7	RFP	9.6	Inappropriate Payment Denials	120	Is the self-reported data on inappropriate payment denial in a standard format across all plans?	Yes, the department is in the process of updating this reporting format.
8	RFP	9.7.6	Payment for Emergency Services and Post-Stabilization Services	Addendum 8 Question 301	What is meant by “mandates for ER utilization”?	The mandate refers to provider notification of the MCO and/or PCP of the ER visit within a specified time frame. See specific language in RFP Section 9.7.6.
9	RFP	General Question			If a patient is under observation status longer than 30 hours can the plan deny the entire claim or just the amount of time over the prescribe 30 hour limit?	The denial should be limited to the amount over the MCO prescribed hour limitation, subject to meeting all other MCO policies and procedures for approval and payment as applicable.

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10	RFP	6.4.2	Behavioral Health Services	50	Regarding the third bullet in the response which reads: "FQHC/RHC encounter in which no services were provided by a behavioral health specialist." Does this represent a change in current policy as outlined in the existing BH services bulletin 12-18 which states that "All claims for Behavioral Health services that are provided in an RHC should be submitted to the Bayou Health plan regardless of the nature of the service that is being provided"?	Yes, this is a change from current contracts. IB 12-18 will be marked obsolete. A new Informational Bulletin will be published to clarify the mixed service protocol/billing for Behavioral Health Services.
11	RFP and Appendix J	12.16	ACD System	166	Please confirm there are no Provider Call Center performance metrics.	No, the Provider Call Center performance metrics can be found at http://new.dhh.louisiana.gov/index.cfm/page/1700 Monthly Report 181. This and all reporting requirements are subject to update by DHH as needed to support and monitor the Bayou Health program.
12	RFP Addendum 3	6.42.3	LaHIPP	4	Who will be responsible for submitting the bill to the MCO for the co-payments and deductibles, the member or the provider?	The provider will be responsible for submitting claims to the MCO for the patient responsibility.
13	RFP Addendum 3	17.12	LaHIPP	8	Who will be responsible for submitting the bill to the MCO for the co-payments and deductibles, the member or the provider?	The provider will be responsible for submitting claims to the MCO for the patient responsibility.

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14	Appendix D	Appendix D	Veteran Hudson Initiative	1-2	Appendix D – Veterans Hudson Initiative – contains the following broken hyperlink, listed two times in the document: https://smallbiz.louisianaforward.com/index_2.asp. Please provide a working hyperlink, as Respondents will likely be interested in accessing qualification requirements, online certification, and a current list of certified Veteran-Owned and Service-Connected Disabled Veteran-Owned and Hudson Initiative small entrepreneurships.	The correct link is https://smallbiz.louisianaeconomicdevelopment.com/Account/Login.
15	Appendix J	J	Performance Measures	1	Please clarify hybrid methodology as it relates to non HEDIS measures- Will facilities and providers be required to submit additional clinical encounter data to support collection and reporting?	Allowable hybrid methodology will be specific to each measure and may include but is not limited to supporting documentation from other databases, public health records and/or chart review of medical records.
16	RFP Addendum 5	2.1.1.2	Scope of Work, Requirements for MCO	7	We understand that MCOs must meet the federal definition of a "Medicaid Managed Care Organization" as defined in 42 CFR 438.2, however, please confirm that bidders are not required to be a "federally qualified HMO" to bid, but rather that federally qualified HMOs are one of the various types of Managed Care Organizations that are permitted to bid (in addition to Louisiana licensed HMOs, etc.)?	Bidders are allowed, but not required to be a “federally qualified HMO.”

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17	RFP Addendum 5	R.2	Customer Service	25, 40	The response to this question conflicts with the response to question #130 which identifies that "affiliates should be included when determining the largest contract." Please confirm that the response to Question #336 is correct, as reports for the Bayou Health program may be most directly relevant to bidder performance against the Bayou Health program metrics.	The response to Addendum 5 Question 336 is correct.
18	RFP	6.4	Behavioral Health Services	49	In response to Q105, which asked "How will the more complicated Basic versus Specialized services be determined?" DHH stated that "Emphasis is on which provider rendered the service, as opposed to the diagnostic code." Please provide clarification as to how these specialized behavioral health providers will be identified, such as a list of provider NPIs?	The process has not been finalized, but it may be either NPI, Medicaid Provider Type and Specialty Type or a combination of both. DHH will work with winning proposers and providers to finalize and test the process prior to the go live date.
19	RFP	6.36.2	Care Transition	72	In response to question 364, DHH wrote that "The transition period shall not exceed thirty (30) calendar days from the effective date of the member's enrollment in the receiving MCO, <u>unless the member</u>. (See Section 6.32 for exceptions for Individuals with Special Health Care Needs.)" The response seems to be incomplete. Please complete the underlined statement.	See revised language in Addendum 17.

Question #	Document Reference (*e.g.*, RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number in Referenced Document	Question	Response
20	RFP	9.4	Provider Reimburseme nt	119	To follow up on Q233, please describe MCO reporting requirements for member reimbursement if not via encounter process.	The plan is responsible for accounting for the payment to the recipient for medical payments previously paid by the recipient for Medicaid covered services up to the allowed amount. If the plan has the ability to capture the payment through an encounter process that will be sufficient. If the plan is unable to capture the payment via the encounter process the plan should be able to provide a claims listing of what was submitted by the recipient for reimbursement. The claims listing should include the date id service, the date of payment by the recipient, amount that was paid by the recipient, the amount billed and the amount that the plan reimbursed.
21	RFP	11.3.3.2	Eligibility, Enrollment & Disenrollmen t	131	In response to Q235, DHH stated that "Previous relationship with a CCN-S plan may be considered dependent on the availability of the members PCP in network. See response to questions, 18, 133." It doesn't appear that the responses to questions 18, 133, or 235 answer a specific aspect of this question. Will DHH allow the relationship with a prior CCN-S plan to be taken into consideration if that plan will not be participating as an MCO, but their parent company or affiliate is selected as a MCO?	Yes, depending on availability of the member's PCP in network.

Question #	Document Reference (*e.g.*, RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number in Referenced Document	Question	Response
22	RFP	14.5.54	Quality Management	196	In response to Q253, DHH stated that "DHH will consider the option of extending the timeframe for credentialing through the authorization of a 60 day provisional credentialing to currently enrolled Louisiana FFS Medicaid providers in good standing." Provisional credentialing is not recognized by NCQA under current credentialing standards. Therefore, we ask for reconsideration, as this may impact plan accreditation with NCQA.	The standard for provisional credentialing for up to 60 days for newly contracted providers (who are currently enrolled and in good standing with Louisiana Medicaid) was adapted from previous and current NCQA Accreditation standards (see "2014 Standards and Guidelines for the Accreditation of Health Plans – Effective July 1, 2014, pg 318). Provisional credential is an option DHH has provided to facilitate initial network development. Exercising this option is at the sole discretion of the MCO and is not required.
23	RFP	15.1.13.2.	General Requirements	201	In questions 255 and 256, DHH confirmed that they will notify the MCO when contracted or non- contracted recoveries are made by the state or the RAC, and stated that the "The Medicaid Program Integrity Section and MFCU will engage in on-going communication with the MCOs." Please clarify what processes the state will use to stay in lock-step with the MCO for overpayment recoveries. The MCO has a process that starts automated reviews one week post-paid claim to identify potential overpayments. How will the state align with the MCO identified overpayments without causing redundancy for overpayment identification to the providers?	In accordance with 15.7.4: The MCO may pursue overpayments for up to five years from the date of service of a claim, but their exclusive right to pursue recovery of overpayments expires after one year from the date of service.

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24	RFP	15.1.14	General Requirements	201	In response to Q258, DHH stated that "It is DHH's expectation that the MCO shall confer with DHH regarding recoupment from the specific providers and issues specified in 15.1.13. DHH does not have this expectation for all other types of overpayment. Any cases that meet the criteria outlined in 15.1.13 will be fully known to both DHH and the MCO as it progresses." To confirm, these cases are specific to potential Fraud and Abuse, and not for all automated or complex review cases?	Section 15.1.3 addresses recoupment arising from fraud or abuse. Section 15.7 Addresses recoupment arising from improper payment which include all automated or complex review cases.
25	RFP	15.1.16.4.1	Reporting and Investigating Suspected Fraud and Abuse	201	In response to Q97 DHH stated that "A tip is any information alleging or implying misconduct on the part of a provider, beneficiary, or employee." Please confirm that the reporting occurs after triage and validation substantiates fraud or abuse as opposed to errors, which can be considered waste.	Any MCO triage and validation of tips would need to comply with the noted reporting requirements. Neither triage nor validation should be used as excuses for not reporting information that on its face has credibility. The MCO should error on the side of reporting sooner rather than later.

Question #	Document Reference (*e.g.*, RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number in Referenced Document	Question	Response
26	RFP	15.1.16.4.1.	Reporting and Investigating Suspected Fraud and Abuse	201	In response to Q259, DHH stated that "The timeline in 15.5.1 should be followed for the initial reporting of any individual instance of suspected fraud. But the MCO should, on a bi-weekly basis, submit a compiled report of all such referrals." How does this compare to "immediate" for health and safety and 3 days after confirmation for other fraud and abuse cases? Is the state requesting 26 reports per year?	Each timeline should be met based its own requirements. And, yes, the MCO is expected to submit bi-weekly reports which would total 26 annually.
27	RFP	15.7.3	Fraud, Abuse & Waste Prevention	209	15.7.3 appears to still be incomplete. Please provide an updated section.	An updated section has been provided in the addendum 17. Specifically, 15.7.3 must be read in conjunction with 15.7.2: Notice to the provider shall be prohibited in instances resulting from suspected fraud, which the MCO has identified and referred to the Department, MFCU, or other appropriate law enforcement agency, unless approved by DHH.

Question #	Document Reference (*e.g.*, RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number in Referenced Document	Question	Response
28	RFP	15.7.5	Rights of Review and Recovery by MCO and DHH	210	In response to Q268, DHH stated "The Medicaid Program Integrity Section and MFCU will engage in on-going communication with the MCOs in regard to recovery efforts and fraud, waste, and abuse prevention." Please provide more clarification to the process. It is understood, as it pertains to cases involving MFCU and DHH for fraud and abuse, but unclear as it pertains to automated overpayment recoveries more likely in the waste classification.	The MCO should not hesitate to communicate with DHH and the MFCU on its efforts to address waste just as it will communicate on its anti-fraud and anti-abuse efforts. Through that ongoing communication, guidelines and understandings will evolve which will more clearly address this concern.

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29	RFP	15.7.6	Rights of Review and Recovery by MCO and DHH	210	In response to Q269, DHH stated "The MCO will have processed and paid the claim(s) in question which the department or its agent finds erroneous on the face of the claim without the need for further documentation. The department will not extend an exclusive period for recovery of such claims. It is not envisioned that there would be a conflict between the health plans unique provider payment arrangements and the ability to identify claims that are improper on their face." For automated overpayment recoveries, the lack of coordination between the state and its agent will need synchronization, the answer does not demonstrate a process with clarity. Please provide more guidance.	The department expects MCOs to have claims processing edits and controls in place to prevent erroneous payment of claims on their face. For example, if the MCO pays a claim that is incorrect on its face, such as a hysterectomy for a male member, the department will not extend an exclusive period for recovery to the MCO.
30	RFP	15.7.7	Rights of Review and Recovery by MCO and DHH	210	In response to Q271, DHH stated "Any such credit balance would be sustained by the MCO and/or department until resolved or dismissed under department rules." Please confirm that, as the credit balance clears, the payments will be made to the state at the same rate the MCO clears the credit balance.	We will not confirm that as the credit balance clears, the payments will be made to the state at the same rate. There may be situations where this does not occur.

Question #	Document Reference (*e.g.*, RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number in Referenced Document	Question	Response
31	RFP	16.3.5	Connectivity	214	In response to Q327, DHH stated that "MCO assumes responsibilities for connectivity and its associated costs." Please confirm that MCOs will not be contractually responsible for the costs associated with hospitals connecting to LaHIE as part of the RFP, but that they may offer financial assistance through individual provider contracts.	MCOs may use financial incentives to subsidize HIE connectivity costs for hospitals with emergency departments in its network. The exchange of ADT data with the HIE should be included in individual provider contracts and as a condition of participation in the MCOs network.
32	RFP	17.3.4	Claims Management	232	In response to Q276, DHH stated that, "This is the $0.10 provider fee that shall be added to the dispensing fee." Will the impact of this fee be added to the MCO rate development for February 1, 2015? It has not historically been included in Mercer rate development.	Mercer utilizes the total cost of pharmacy claims as reported in encounter data for the purposes of rate setting; it does not make separate adjustments for the distinct components of pharmacy claims (i.e. dispensing fees, provider fees, etc.), as those should be included in total costs reported.
33	RFP	General Question	Enrollment Share Formula	N/A	In response to Q18, DHH stated that DHH will seek to preserve the continuity of care for the member by maintaining existing patient/provider relationships, as well as, the continuation of care coordination provided by the health plans. How will incumbent plans not be disadvantaged through auto assignment algorithm for new Medicaid recipient enrollment if preference is given to new health plan? Will DHH allow declining enrollment in a plan in order to advantage another?	In general, incumbent plans have a distinct advantage in the auto-assignment process as previous health plan linkage is considered in the hierarchy, as long as, the member's PCP is available in network at the time of the assignment. In addition, DHH also reserves the right to implement a process to provide for an initial enrollment minimum need for plan viability as determined solely at the department's discretion to support program sustainability. Any such assignments will still be dependent on the availability of the members PCP in-network.

Question #	Document Reference (*e.g.*, RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number in Referenced Document	Question	Response
34	Appendix D	Appendix D	Veterans Hudson Initiative	11	In response to Q155, DHH stated that "The goal of the Louisiana Veteran and Hudson Initiative is to encourage the use of Louisiana based small entrepreneurships. The proposer who is certified as a Veteran or Hudson Initiative small entrepreneurship will receive 10% of the total evaluation points on this RFP. If the proposer itself is not a certified small entrepreneurship, but engages subcontractors or distributors who are, points will be allocated based on the listed criteria (not to exceed 10% of the total evaluation points on this RFP in total; may be less than 10% depending on total number of possible points assigned by the evaluation team and received by a proposer). The exact methodology used to weight the criteria will be determined later by an evaluation team before any proposals have been reviewed. In the past, major subcontractors received more points than minor subcontractors. A subcontractor was deemed major or minor based on the quality and value of their service versus quantity, i.e. the sheer number of subcontractors used." Does the reference "not to exceed 10% of the total evaluation points" reference total points for the RFP or total points for Section BB?	See Addendum 13, response to Question 33. The 10% applies to the total points for the RFP.

Question #	Document Reference (*e.g.*, RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number in Referenced Document	Question	Response
35	Appendix J	J	Performance Measures	1	In response to Q103, DHH stated that "Measures that are not part of the HEDIS reporting set will be calculated by DHH. DHH will use hybrid methodology when appropriate to calculate rates." Will DHH assume the costs associated with hybrid methodology for calculating these rates?	DHH will use encounter data to calculate population based performance measures and may choose to employ a hybrid methodology for validation purposes. DHH assumes the costs for outcomes based studies.
36	RFP	16.10.6 and 16.10.10	System and Technical Requirements	222/223	16.10.10's requirement seems to be a contradiction to 16.10.6 where there is a 72 hour Recovery Time Objective for the core systems (enrollment and claims). However in 16.10.10 the expectation is 60 minutes. Is it correct to assume that we can work with the 72 hour recovery time objective as stated in 16.10.6?	No you may not assume a 72 hour recovery time. Section 16.10.6 refers to a natural disaster such as an ice storm, hurricane etc. Whereas Section 16.10.10 refers to daily operations being interrupted due to a server error or something of that nature, that is within the control of the MCO to remedy in a more expedited manner.
37	Addendum 8	Question 94	N/A	38	The response to this question asks the bidders to submit a copy of the 2014 Import Template used to submit measures to NCQA's Interactive Data Submission System, or IDSS, for Medicaid product lines. Please clarify if the state is requesting this in addition to the completed RFP Appendix WW or in addition to.	Proposer should submit both the appendix WW and a copy of the IDSS.

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38	Addendum 8	Question 152	N/A	66	The original question asked for clarification to the Member Services position which was referred to as Coordinator (RFP page 29) and Manager (RFP page 27) in another. The state's response was that RFP 4.4.10 was amended to read "Medical Management Manager" in Addendum #3. Please clarify the position titles for both the Member Services position and the Medical Management position.	Member Coordinator should be Member Manager, corrected in Addendum 17.
39	Appendix KK	U.4	Quality Management	30	Please clarify if bidders should submit as an attachment a preliminary QAPI in addition to the narrative description of the QAPI.	The response to U.4 should be included in the body of the proposal, rather than an attachment. It should be inclusive of all elements listed.
40	Appendix J	N/A	Performance Measures	Appendix J	In response to Q181, DHH stated "For HEDIS measures certified HEDIS software will be used to calculate the measures." Will DHH consider using a certified HEDIS auditor to certify rates developed by ULM?	Yes, the department will consider.
41	RFP	R.2	Customer Service	25/40	In response to Q336, DHH stated that "Reports can be provided for Louisiana only." Please confirm that this is accurate, as the answer seems to conflict with response provided to question #130.	Confirmed (see Addendum 13 response to question #17.

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42	Appendix KK	U.5	Quality Management	31	In response to Question 83, DHH stated that "The EQRO vendor, IPRO, will determine the format in which PIPs will be submitted for their review." Please state in which format proposers should submit the PIPs for inclusion in response to Appendix KK of this RFP. Should proposers use the current template, originally provided by the EQRO for inclusion in U.5?	The proposer should use bulleted items included in Section U.5 of Appendix KK as amended for the outline/format for the preliminary PIP.
43 Correction & Clarification to Addendum 13 Question #25	Addendum 8, question 43	RFP Section: 5.1	RFP Heading: Maternity Kick Payments	16	Can DHH please provide the "applicable procedure and/or diagnosis codes" to be used to identify maternity claims?	Procedure codes used by doctors for deliveries: 59400-59622 Diagnosis codes used for the outcome of delivery for inpatients: V27.0-V27.9 Diagnosis codes identified as deliveries to bypass pre-cert: V27.0-V27.9 Surgical codes 74.0, 74.1, 74.2, 74.4, 74.99 Inpatient surgical codes 72.0-72.3, 72.5-72.9, 73.01-73.22, 73.4-73.59

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44 Correction & Clarification to Addendum 13 Question #24	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 all deliveries will be triggered by encounter data, based on procedure/surgical codes. Information about the patient and delivery will be matched up against the weekly LEERS file provided by OPH. If LEERS data indicates that the delivery is after 39 weeks or was a medically-necessary early delivery, the regular kick payment will be made. If LEERS data indicates that the delivery is an early elective delivery, a reduced kick payment will be made. If corresponding LEERS is not found for the delivery, no kick payment will be generated, and the payment will be postponed until the next month's kick payment cycle.
45 Correction to Addendum 13 Question #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 17.