Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
1	RFP	2.1.1.2	Scope of Work, Requirements for MCO	7	What types of "Managed Care Organizations", i.e. HMO, PPO, etc. would DHH qualify as a proposer, assuming the organization is licensed by LDOI under La. R.S. 22:1016?	The MCO is a federally qualified HMO that provides prepaid primary care case management services to Medicaid recipients pursuant to a contract with the department.
2	RFP	2.1.1.3	Scope of Work, Requirements for MCO	7	La. R.S. 12:24 does not cover nonprofit corporations. Please confirm a nonprofit corporation would not qualify as a proposer in response to the RFP.	LSA-R.S. 12:24, *Articles of Incorporation*, pertain specifically to for profit corporations; whereas, LSA-R.S. 12:202, *Articles of Incorporation*, specifically pertain to nonprofit corporations. A nonprofit corporation may qualify as a proposer if it is able to satisfy all requirements of the RFP and is a federally qualified HMO. However, for a definitive answer to your question, please contact the Louisiana Department of Insurance.
3	RFP	2.1.1.7	Scope of Work, Requirements for MCO	7	What methodology will DHH use to determine whether network capacity is sufficient for enrollment of 250,000 Medicaid members? What data must proposers submit to ensure accurate conclusion by DHH?	Maximum points will be given for documented capacity to develop a robust statewide network of providers to serve 250,000 members; however, scoring will give consideration to proposals that demonstrate an understanding of the strengths and weaknesses in their network capacity, including a realistic assessment of the number of members that can adequately be served, the timeframe needed to get to full capacity and their plan to remediate any

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						gaps in coverage. DHH will consider the evidence provided in the network development plans submitted that demonstrate a capacity to recruit and maintain a statewide network of providers that meet the time and distance and ratio requirements specified in Section 7 of the RFP. 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 demonstrating an understanding of the Louisiana Medicaid provider market, including known shortages, access issues, strategies for remediation and methods for guaranteeing coverage of state plan services. By 1/1/2105 contracted MCOs will be required to submit detail Provider Registry data as described in the Systems Companion Guide for all contracted providers, updated provider maps and pass a departmental

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						readiness review which includes certification of network adequacy.
4	RFP	Chapter 5	MCO Reimbursement	39	Page 38 concludes at Section 5.11.4.4. Page 40 begins at Section 5.11.5. Page 39 is blank. Was any portion of the RFP to be found on page 39?	No portion of the RFP was on page 39.
5	RFP	17.3.4	Payment to Providers	232	Is the $0.10 per prescription fee in La. R.S. 46:2625(A)(1) included in "any state imposed provider fees", which should be paid by MCOs to pharmacy providers?	Yes.
6	RFP	22.15	Proposal Clarifications	275	Does DHH's right to seek clarification under this Section permit DHH to allow a proposer to supplement its proposal after the original deadline for submission? Would allowing a proposer to submit required elements not contained in the proposer's original submission be an example of a permitted "clarification"?	1. No. Clarifications are generally administrative in nature and are provided to resolve contradictory statements in a proposal. A clarification response should not reveal a previous unknown deficiency that is a part of a proposal that, when compared to a pertinent or mandated standard, fails to meet the State's level of compliance. 2. No, this would not be an example of a permitted clarification.
7	RFP	25.4.2	Confidentiality of	286	If the MCO is a publicly traded company, would it be a	No, an MCO which is a publicly traded company is not prohibited from notifying

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			Information		violation of this provision to provide notice to shareholders that the MCO has submitted a proposal responding to this RFP?	shareholders that it has submitted a proposal in response to this RFP, so long as notice is done within the parameters of the RFP as pertaining to communication and confidentiality requirements and restrictions.
8	RFP	25.6	Contract Controversies	287	We note that contract controversies shall be governed by La. R.S. 39:1524-26. Does DHH consider the MCO services to be consulting or social services under La. R.S. 39:1481 *et seq. (Professional, Personal, Consulting, and Social Services Procurement Code)?*	The contracts are social services contracts.
9	RFP	25.15	Employment of Personnel	289	Does DHH regard discrimination based on sexual orientation in the list of prohibited MCO hiring or employment practices under this RFP?	Yes, given the U.S. Equal Employment Opportunity Commission (EEOC) has extended Title VII protection to sexual orientation for federal government employees and as this contract is funded with federal funds, it is the intent of the contract to prohibit the MCO from discriminating based on sexual orientation. See Addendum #10.
10	RFP	Cover Page	Request for Proposals	I	Please confirm the October 15 due date on the cover page of the RFP should be amended to match the due date posted in	Yes, the due date is September 26, 2014, at 4:00 p.m. Central Time. Changes cannot be made to the actual RFP document once posted. See Addendum 2.

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					the schedule of events listed in Addendum #2.	
11	RFP	1.2	Purpose of the RFP	1	Will the State consider awarding MCOs on a regional basis?	No.
12	RFP	1.9	Schedule of Events	5	Please advise the steps the State will take to assist non-incumbent plans to meet all requirements prior to contract go-live.	All plans will be required to complete a readiness review with the DHH. Incumbent plans will undergo an abbreviated review based on currently demonstrated capacity and new contract requirements. For non-incumbent plans DHH and support contractors (primarily the Fiscal Intermediary) will meet regularly with the plan's implementation team to review the components that must be passed for readiness review and provide guidance, testing and feedback, as applicable. The state's EQRO will assist the state in conducting the readiness reviews, which will include a desk review of documents submitted by the plan and a feedback cycle with the contractor, followed by an onsite review and a subsequent feedback and correction cycle as appropriate to ensure the plan is operationally ready for implementation.
13	RFP	1.9	Schedule of Events	5	Please describe if and how the State will provide flexibility on	DHH intends to implement according to the published schedule. Any changes to the

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					the timeline for key dates.	schedule will be posted as an addendum to the RFP.
14	RFP	2.1.1.7	Requirements for MCO	7	Please define a date by which an MCO's network must be fully contracted and ready to meet adequacy requirements. If this date is the enrollment period start date indicated at the bidder's conference (Nov. 20), will the State consider allowing additional time for a non-incumbent awardee?	Initial network development plans will need to be approved by DHH prior to the open enrollment period. Certification of network adequacy will need to be completed by 1/1/2015. Limitations on the maximum membership may be imposed on individual plans based on network capacity demonstrated and would remain until additional capacity is increased.
15	RFP	2.1.1.8	Requirements for MCO	7	Will the State also consider whether the fiscal intermediary has a conflict of interest to serve as evaluator of each applicant's response?	The fiscal intermediary will not serve as an evaluator for any proposals submitted in response to this RFP.
16	RFP	2.1.1.2	Requirements for MCO	7	Please confirm a Certificate of Authority from the Louisiana Department of Insurance granting licensure to act as an HMO satisfies this requirement to bid, and that no separate or additional licensure or certificate is required to qualify as a "Medicaid risk bearing entity pursuant to La. R.S.	Yes, a prepaid entity is required to have a license or certificate of authority from the Louisiana Department of Insurance (LDOI) for participation in the Louisiana Medicaid Program. However, the financial solvency of a prepaid entity is also regulated by the LDOI which may involve additional requirements. For a definitive answer to your question, please contact the Louisiana Department of Insurance.

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					22:1016."	
17	RFP	3.6.1.1	Voluntary Opt-in populations	18 - 19	Please provide an estimate of the impact of the 1915 (c) population the department expects will opt-in to the Bayou Health program. For those that do opt-in, what is the impact on their eligibility for the expected MLTSS program?	The Department estimates a 20% take up rate for the voluntary opt-in members. There is no anticipated impact on their eligibility for the expected MLTSS program.
18	RFP	11.1	Maintenance of MCO for Enrollees	130	Please describe the State's process for open enrollment. For example, will the State allow current enrollees to stay with their existing plan, or must all members re-enroll upon go-live of the new contracts?	All members will be given the option to select the plan of their choice during open enrollment. If a member does not actively select a health plan, 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. Members in an incumbent MCO plan who do not make a proactive choice will remain in their current plan. Any auto-assignment of members will consider the availability of current providers within each plan, the health plan of other family/household members, enrollment in a prior health plan

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						and departmental consideration of the distribution of membership needed to ensure program sustainability.
19	RFP	22.18	Proposal Format	276	Will the State accept attachments in any file format? (i.e. – MS Word Document, MS Excel document, PDF, etc.)	Yes
20	RFP	23.	Evaluation Categories and Maximum Points	279	Please confirm which scoring grid is accurate: Appendix KK or the scoring grid on page 279 of the RFP? There are scoring discrepancies in parts V and X.	The scoring listed in Appendix KK is correct. The total points for Part V is 220 and Part X is 225. RFP Section 23 is corrected to match Appendix KK per Addendum #3.
21	RFP	23.1	Announcement of Awards	279	Please confirm the awards for Managed Care for Long Term Supports and Services contracts will be independent of the Bayou Health contract awards. Please confirm scoring of each RFP (MLTSS and Bayou Health) will independent of the other.	The awards for Managed Care for Long Term Supports and Services contracts will be independent of the Bayou Health contract awards. The scoring of each RFP (MLTSS and Bayou Health) will independent of the other.
22	RFP - Appendix G	N/A	Rates with Actuarial Rate Certification Letter	1	Please clarify if the State will allow potential MCOs to bid below the rates the State sets when released.	No, price is not being bid.
23	RFP - Appendix KK	E.2	Qualifications and Experience	7	This question awards a direct advantage to incumbent MCOs.	Yes, DHH values the stability of member, provider and health plan relationships that

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					Was this the State's intention? If so, please provide a rationale for this scoring. Also, does this apply to current Shared Savings plans, or only current Prepaid plans?	promote the continuity of care and care coordination for members. It applies to both plan types.
24	RFP - Appendix KK	E.4	Qualifications and Experience	7	Please clarify the contract type for this question. Is this limited to only State Medicaid contracts?	It is not limited to only State Medicaid contracts; however scoring will reflect a preference for State Medicaid and CHIP contract experience.
25	RFP - Appendix KK	E.4, E.7, R.2, U.2	Qualifications and Experience	7	For the purposes of this RFP response, should U.S. territories that are not States be included?	Please include all 50 states, the District of Columbia, and the U.S. territories of Guam, Puerto Rico, the U.S. Virgin Islands, Northern Mariana Islands, and the American Samoa.
26	RFP - Appendix KK	E.3	Qualifications and Experience	8	Please provide the State's definition of a CAP.	For response to E.3. a CAP would be defined by the terms of the proposer's contracts listed in response to E.1. In general it would include only formal written plans of action the contractor was required to submit to the state and to comply with the actions and timeframes specified to correct deficiency in a contract deliverable or term of compliance.

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27	RFP - Appendix KK	E.3, E.7	Qualifications and Experience	8	Please provide the State's definition of a regulatory action or sanction.	A regulatory action or sanction is any action or penalty imposed by a federal or state entity for violation of federal or state law, non-compliance of a contract deliverable or violation of the contract terms and conditions.
28	RFP - Appendix KK	F.3	Organizational Structure	11	In regards to the two page job description limit: is two pages defined as per job description, or total?	The two-page limit applies to each job description.
29	RFP - Appendix KK	U.2	Quality Management	28	Will the State accept equivalent quality performance metrics for a contract other than Medicaid and CHIP? For example, equivalent HEDIS measures achieved on a commercial or Medicare plan?	Yes, if proposer does not have Medicaid or CHIP experience, they may submit equivalent HEDIS measures from other relevant plan experience.
30	RFP - Appendix KK	U.3	Quality Management	29	Will you accept experiences from other states or are you looking for solely Louisiana based experience?	Yes. Out of State Experience will be accepted for Medicaid HMO product lines.

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31	RFP - Appendix KK	V	Program Integrity	32	Please provide the complete question language for question V.1, i.e. - …"Include other best practices, you have utilized in other contracts that could be to…" Appears there should be further text to finish that sentence.	The question should read, "Describe your approach for meeting the program integrity requirements including a compliance plan for the prevention, detection, reporting, and corrective action for suspected cases of Fraud and Abuse in the administration and delivery of services. Include best practices you have utilized in other contracts that could be utilized in this contract." This has been corrected in Addendum #3.
32	RFP - Appendix KK	V.1	Program Integrity	32	Please expand on the scoring criteria for this question. Will the scoring be broken down by each requirement (i.e. – prevention, detection, reporting, etc.)?	The scoring is not broken down by individual element. It will be based on the completeness and appropriateness of the response in addressing all elements of Section 15 of the RFP.
33	RFP - Appendix KK	BB.1	Veteran Initiative and Hudson Initiative	40	Please expand on why the bond rating for a company is requested a second time, in addition to the question in section C. Also, please expand upon the	The bond rating request was included in this section in error. The reference was removed in Addendum #3. The exact methodology will be determined later by an evaluation team before any proposals have been reviewed. In the past,

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					scoring criteria for this question. Will points be awarded based on number of subcontractors used, by services subcontractors perform or via another method?	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. The total number of possible points assigned for the use of subcontractors cannot exceed 10% of the total evaluation points on this RFP once aggregated.
34	RFP - Appendix KK	BB.1	Veteran Initiative and Hudson Initiative	40	Do the sites listed in BB.1 contain the only qualified businesses for this question or is there another resource MCOs are permitted to use to confirm potentially qualified businesses?	Veteran and Hudson businesses are certified through the Louisiana Economic Development (LED) which keeps a complete list of certified businesses. The sites listed in BB.1 should contain all qualified businesses, but to the extent that it's an incomplete list, refer to the website for LED http://www.opportunitylouisiana.com/index/incentives.
35	Systems Companion Guide		MCO Responsibilities	3	Provider identification includes NPI, Taxonomy & 9-digit ZIP. Regarding the ZIP, please confirm you're referencing the Service Location address and not the Billing address.	If the provider is a facility, then the ZIP will be the billing address. If the provider is an individual/person, then the ZIP will be the service location.

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36	Systems Companion Guide		MCO Responsibilities	3	Regarding Taxonomy – is Taxonomy required on encounters for all providers, or only those identified as requiring Taxonomy on the State's weekly provider file?	A taxonomy is required on all encounters for the billing provider and the rendering/attending/servicing provider and the referring provider, if they are not atypical.
37	Procurement Library - LA Medicaid Fee Schedules	24.9	Provider Manual - Hospice	4	Hospice - According to the Hospice Provider manual, physician services are reimbursed in addition to the four basic payment rates for hospice care. a) What are the appropriate CPT-4 codes that will reimburse for Hospice Physician services or do all codes on physician fee schedule apply? b) Is reimbursement allowed for codes not on the professional fee schedule when billed with rev 657? If yes, are they reimbursed at a provider specific CCR?	a) If the physician is employed by the hospice (or a consultant/volunteer considered an employee) the hospice uses revenue code 657. If the physician is not an employee of the hospice (and the condition is unrelated to the terminal illness) the physician is reimbursed for professional services using the appropriate CPT code for the services from the Professional Services fee schedule. b) No.

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38	Procurement Library - MCO Systems Companion Guide	2	Encounters	5	What file(s) will be used for processing the encounters file? ~Registry File ~Site File ~Provider Supplemental Record File How is the provider data on the outbound provider file used to edit the encounters?	The MCO's Registry File is used in the encounter edit process. The Site file and Provider Supplemental File are not used in the encounter edit process. If the provider (billing, rendering/servicing/attending, referring) on the encounter is not found in the MCO's Registry File, then Molina will use the MMIS Provider file to edit the encounter provider data. If the provider is not found in the Registry or on the MMIS Provider file, then the encounter will be denied. This is why it is important for the MCO to timely coordinate provider registry data with Molina.
39	Procurement Library - MCO Systems Companion Guide	2	Encounters	5	What CCN files are linked together? How are the provider files and encounter files matched? Are member enrollment files linked to provider files and what are the matching criteria?	Encounter files contain NPI/taxonomy data for billing, rendering/servicing/attending, referencing, etc. providers, when those providers are not atypical. Likewise, provider files (outbound and registry) contain NPI/taxonomy data. The match is based on NPI/taxonomy data. It is the responsibility of the MCO to administer and maintain linkages between members and PCP providers. DHH requires the MCO to submit this linkage information on a weekly basis to Molina. The PCP provider identifiers are NPI and taxonomy,

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						and the member identifiers are Medicaid ID number, date of birth and Social Security Number.
40	Procurement Library - MCO Systems Companion Guide	2	Encounters	5	Will there be a rejection threshold for the outbound files? If yes, for what files, what will the benchmark be and is there a compliance timeline for resubmission?	DHH does not currently have a rejection threshold for EDI (encounter) files; however, rejections returned to the MCO for correction should be resubmitted to the FI in the next payment cycle. Additionally, requirements specified in Section 17.8.3.2 are applicable.
41	Systems Companion Guide		Atypical Providers	6	Claims from Providers not enrolled with LA Medicaid are to be submitted with the provider's "Assigned Medicaid Provider ID", which is the pseudo ID assigned by the FI when a provider is contracted with an MCO but has not enrolled in LA Medicaid. How do providers/MCOs obtain pseudo IDs from the FI?	It will be present on the Registry response file sent from Molina to the MCO.
42	Procurement Library - MCO Systems Companion Guide	2	Encounters	6	Is the Provider Supplemental Record Layout a new file requirement? Is this an outbound file submitted by CCN to FI?	The Provider Supplemental file is a new file requirement. This file provides additional information for non-Medicaid providers, as mandated by CMS for the T-MSIS project. This is an outbound file submitted by the MCO to the FI in the same manner as the Provider Registry file.

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43	RFP	5.1	Maternity Kick Payments	31	1. How does the State plan to identify a maternity claim? 2. Is the State expecting the plan to submit proof electronically or will the State use the encounter submission process to identify Maternity claims? 3. Will the State send maternity payments within the 820 file?	1. Encounter claims with applicable procedure and/or diagnosis codes. 2. Encounter submission process. 3. No. Maternity payments will be sent via EFT to the MCO bank and not via the 820 file, but there will be sent an associated non-payment 820 file for the maternity payments.
44	RFP	6.1.4	General Provisions, MCO Core Benefits	43	Surgical Dental – How will surgical dental be defined? Is it to include only accidental-type surgeries where there has been damage to sound, natural teeth, or would wisdom tooth extractions (for example) be considered surgical dental if performed in a facility?	"Surgical Dental Services" consist of only medically necessary oral and maxillofacial medical procedures required in the treatment of injury or disease related to the head and neck. Extraction of unerupted, partially erupted, or impacted teeth, are not considered a surgical dental service except when the care is indicated in preparation for, or as a result of, dental trauma caused by the medically necessary treatment of an injury or illness. Oral Surgeons are limited to bill for the CPT codes attached that are covered under the Professional Services Program. The hospital charges in conjunction with carved out dental services (see Dental Services Manual) are the responsibility of the

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						Health Plan. These services include the hospital facility fees and anesthesia services.
45	RFP	17.8.4.1	Encounter Data	236	Does the term 'document-level' mean the header level of the claim?	Yes, the term “document level” means the header level of the claim. Further clarification is available in Section 7 of the MCO Systems Companion Guide regarding how the FI assigns ICNs to encounters.
46	Appendix FF		MCO Network Provider Subcontractor Listing Spreadsheet Requirements	N/A	Requirement 5 indicates that all Medicaid providers are required to submit their Medicaid provider numbers on the network listing spreadsheet. Are all providers participating in this program required to be Medicaid providers who have a Medicaid provider number? Or can providers who do not have a Medicaid provider number also participate?	Provider enrollment with the State is not required. Health Plans must ensure that all contracted providers meet state and federal requirements as specified in the RFP.
47	System Companion Guide	N/A	N/A	N/A	For physician administered drug claims, what crosswalk does Molina use to validate the correct combination of proc/rev code and NDC information (NDC, NDC units, NDC basis of measure)?	Molina does not use a crosswalk; it requires a valid 11-digit NDC and other drug information to be included if the CPT or HCPC is a J-code.

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48	N/A		N/A	N/A	What date should the health plans expect the 834 file(s) when the State will move the members to the Full Risk based Rate Codes effective 2/1/15? What file format / type of file(s) will be used?	The health plans should expect the 834 file from the Enrollment Broker no later than the second to last working day of the month prior to the begin date of the contracts.
49	LA Bayou Health Managed Care RFP	22.11	22.11.2	273	The document indicates that potential proposers may receive historical Medicaid claims data. Will it be also possible to receive Mercer Certification, Rate Development Methodology and Rates to the incumbent prepaid plans for the period Jan, 2013 -Dec, 2013 and Jan, 2014 - Dec, 2014?	Rate certification letters will be posted to the Bayou Health 2014 RFP Procurement Library website: http://new.dhh.louisiana.gov/index.cfm/page/1906.
50	Procurement Library LA Medicaid Fee Schedules	25.7	Provider Manual - Hospital	12-14	Inpatient -If MCOs are responsible for outlier payments, will LDHH publish the components and calculations for the outlier reimbursement?	Yes. This information is published within the Hospital Provider Manual. http://www.lamedicaid.com/provweb1/Providermanuals/manuals/Hosp/Hosp.pdf
51	Procurement Library LA Medicaid Fee	25.7			In-State Non-Small Rural Private Hospital Outpatient Services Interim reimbursement is based	Yes. These CCRs are published on the lamedicaid.com website within the inpatient hospital per diem listing.

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	Schedules				on a hospital specific cost to charge ratio calculation from the latest filed cost reports. Updated cost to charge ratios are calculated as the cost reports are filed. Final reimbursement is adjusted as follows: February 1, 2013 and forward 66.46 Does the State identify specific CCRs by hospital for OP services?	http://www.lamedicaid.com/provweb1/fee_schedules/Inpatient_Hospital_Per_Diem_Listing_Current.pdf
52	Appendix TT	N/A	Network Providers by Specialty Type	Page 1	Personal Care Services is a confirmed benefit for the RFP, however this provider type is not listed in Appendix TT with a DHH specialty code. What is the appropriate PCS indicator to use?	Provider Type 24 (Personal Care Services – LTC/PCS/PAS) can be associated with any of the following Provider Specialties: 5A – PCS-LTC 5B – PCS-EPSDT 5D – PCS-LTC and PCS-EPSDT 5E – PCS-LTC and PAS 5G – PCS-LTC, PCS-EPSDT and PAS
53	RFP	10.4.3	Provider Handbook	126	Section requires that provider handbook must be made available to DHH for approval	Yes

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					30 days PRIOR to the date the MCO signs the contract with DHH. Should this be changed to within 30 days of the date the MCO signs the agreement?	
54	Procurement Library - LA Medicaid Fee Schedules	17.3	Provider Manual - ESRD	1	Dialysis - Providers are reimbursed a hemodialysis composite rate, but we are not finding the rates on the LDHH website. a) Where are the composite rates published? b) How often are they updated? c) Are there are any other billing requirements, i.e., Revenue Code? d) How are services not included in the composite rate reimbursed, e.g., Fee Schedule?	The hemodialysis rates are not published. However, a report listing composite rates of all active hemodialysis centers can be provided. The composite rates are not updated but are affected by rate reductions listed in the ESRD Provider Manual. Claims for ESRD services are filed using the UB-04 form. Medically necessary services for non-routine lab work and injections are billed separately and reimbursed based on the published fee schedule on LaMedicaid.com. Epogen has a specific reimbursement methodology which is explained in the ESRD Provider Manual on LaMedicaid.com. ESRD services must be billed with HCPCS codes, revenue codes and NDC information when appropriate.
55	Procurement Library - LA Medicaid Fee Schedules	Appendix C	Provider Manual - Home Health	1	Home Health -Revenue Code 560 Medical Social Services – General Classification is in the LA Medicaid Revenue Code	A. No. These services are optional and are not covered. B. n/a

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					listing, but it is not mentioned in the Home Health manual. A) Is Revenue Code 560 currently used in LA to reimburse for Medical Social Services? B) If it is an active revenue code where is the rate for 560 published?	
56	Procurement Library - LA Medicaid Fee Schedules	Appendix C	Provider Manual - Home Health	1	Home Health- How are Out of State providers reimbursed for services?	Out of state providers who are licensed in Louisiana are reimbursed based on the published fee schedule.
57	Procurement Library - LA Medicaid Fee Schedules	24.9	Provider Manual - Hospice	4	Hospice - According to the Hospice Provider manual physician services are reimbursed in addition to the four basic payment rates for hospice care. a) What are the appropriate CPT-4 codes that will reimburse for Hospice Physician services or do all codes on physician fee schedule apply? b) Is reimbursement allowed for codes not on the professional	Duplicate. See response to question 37.

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					fee schedule when billed with rev 657? If yes, are they reimbursed at a provider specific CCR?	
58	Procurement Library - MCO Systems Companion Guide	2	Encounters	5	Is there an expected testing timeline for encounters? Is there a set testing method in order for encounters to go live?	Yes. The timeline is during the first 60 days of go-live. The testing method is described in the Systems Companion Guide, and a formal test plan will be issued after contract award.
59	Procurement Library - MCO Systems Companion Guide	2	Encounters	10	Correction Process: Is there a compliance timeline for resubmission of rejected encounters?	Yes, see Section 17.8.14. Correction and resubmission should occur in the next payment cycle.
60	RFP	6.6.1	EPSDT Well Child Visits	51	EPSDT services – MCO is to provide all medically necessary services whether specified in core benefits and services and la Medicaid state plan or not. How should MCOs flag encounters so the FI will know a non-covered service was authorized by the MCO as part of EPSDT?	The MCO Systems Companion Guide will be updated to include the following information with regards to reporting of non-covered services authorized by MCOs as part of EPSDT: 837P v5010, Loop 2400 – Service Line Information: SV1-11 (EPSDT-Indicator) value = 'Y'.
61	RFP	8.9.7.3 & 8.9.7.6	Lock in restriction program	115	Section 8.9.7.3 states the MCO may use Pharmacy lock in OR Physician-pharmacy lock in and section 8.9.7.6 state that in	The MCO may choose to use Lock-In as an educational tool to assist recipients who over-utilize or misuse physician and/or pharmacy services. The MCO may choose to

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					addition to the lick in recipients, the MCO shall also lock in providers that manage the recipients. Is the MCO allowed to administer a pharmacy lock in without a physician-pharmacy lock in? These seem to conflict, please clarify.	use physician/pharmacy Lock-In which only allows reimbursement for pharmacy claims written by the Lock-In prescriber(s) and filled by the selected Lock-In pharmacy. Or the MCO may choose to utilize the PCP as the gatekeeper and allow prescriptions written by enrolled prescriber to be filled and only limit the recipient to one pharmacy to have all prescriptions filled.
62	RFP	9.2.2	FQHC/RHC Contracting and Reimbursement	118	Section states that the MCO may not enter into alternative reimbursement arrangements with FQHCs or RHCs without written prior approval from DHH. Are MCOs allowed to pay FQHCs and RHCs performance incentives in addition to the Medicaid rate?	There is no DHH prohibition on this.
63	RFP	10.6	Provider Complaint System	127	The provider complaint definition and section appear consistent with the definitions for member appeals and grievances, but Section 17.6.1 (p.234) establish a Claims Dispute Process. What is the difference?	A claims dispute is a formal process for a provider to seek payment or adjustment of payment for a specific individual claim.
64	RFP	12.11.1	New Member Orientation	153	If MCO has an existing relationship with a member in	Members currently in a CCN-S plan will require a new member orientation for the

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					the previous CCN-P or CCN-S contract, are they required to perform a new member orientation for that member?	MCO plan.
65	RFP	12.11.3.2.5		155	Requires a monthly report of unsuccessful attempts to contact members. This is similar to Report 097, which was discontinued in 2014. Is this report to be used again?	No, this report will not be used again. This was corrected in Addendum #3.

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
66	RFP	12.16.14.5 & 12.16.15.1	Call performance standards and Members rights and responsibilities	167	12.16.14.5 says "providers consider and respect those rights when providing services to members" this seems out of context and there are no rights mentioned in this section. Does DHH mean this item to be in the members' rights and responsibilities section? 12.16.15.1 seems to end mid-sentence - is this where 12.16.14.5 was intended to be?	This was corrected in Addendum #3.
67	RFP	13.2.3	Time Limits for Filing Member Appeal or Grievance	172	Member must be allowed 30 days from date on Notice of Action to file appeal or grievance. Are there exceptions contemplated for members who may not have received the NOA?	The 30 day requirement is a minimum. The MCO may allow exceptions at its discretion.

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68	RFP	13.4	Special Requirements for Appeals	173	Oral inquiries must be confirmed in writing unless the enrollee or the provider request expedited resolution within how many days?	Oral inquiries do not require written confirmation. This was corrected in Addendum #3.
69	RFP	13.4.2.1	Special Requirements for Appeals	173	Does the requirement that member be allowed a reasonable opportunity to present evidence in person as well as in writing contemplate that we need to provide a formal hearing on the appeal?	Yes.
70	RFP	13.6.2.1	Extension of Timeframes	177	This section says the MCO may extend the timeframes (for appeals) from Section 13.7.1 of this Section by up to fourteen (14) calendar days, but Section 13.7.1 prohibits punitive action against a provider who requests an expedited resolution. Appears to be a wrong reference.	The reference was corrected in Addendum #3.
71	RFP	13.7	Expedited Resolution of Appeals	179	The provider may submit an expedited appeal on the member's behalf with member's written consent. Is that the only instance where a provider needs written	8.5.4.1.3.2 – written consent is required for an informal reconsideration. When the provider is acting as the member's authorized representative, written consent is required.

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					consent? Appears inconsistent with broad definition of "action" in provider complaint section.	
72	RFP	17.11.2.1	Independent audits	242	SSAE 16 SOC type II audit is required annually to be submitted by March 31 each year. Does DHH intend to have an audit report submitted on 3/31/15 since the MCO will not have been in operation for a full year at this time?	The audit should be based on the calendar year. Incumbent plans will submit a report on or before 3/31/15 covering the review period of 1/1/14 - 12/31/14. New plans will submit their first report on or before 3/31/16 covering the 11 month period of 2/1/15 - 12/31/15. Incumbent plans will submit their second report on or before 3/31/16 covering the reporting period of 1/1/15 - 12/31/15.
73	RFP	5.1.2	Maternity Kick Payments		Kick payments are paid to MCO upon submission of satisfactory evidence of the occurrence of a delivery. Please confirm what will constitute "satisfactory	Occurrence of a delivery will be derived from encounter submissions. Kick payments for a delivery prior to 39 weeks gestation will pend until an indication of medical necessity for the delivery is received by the FI from

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					evidence of the occurrence of a delivery" – is this derived from the MCOs Encounter submissions, or is a separate report required?	DHH/OPH/LEERS. Due to the timing of MCO encounter submissions process in addition to claims lag from providers, DHH anticipates that medical necessity indicator will be received by the FI such that payments to MCOs will be made consistent with current timeframes for kick payment processing (without further delay).
74	Procurement Library - MCO Systems Companion Guide	Sec. 25.7	Provider Manual - Hospital	12-14	Inpatient - We have identified varying information regarding responsibility for outlier payments. a) Who is responsible (MCO or State) for making outlier payments directly to providers? b) If MCO is responsible, will the state continue funding the outlier pool? c) If so, how will those claims be processed against the outlier pool? d) Will the criteria for outlier	a) The Health plan is responsible for outlier payments for its enrollees. b) The state will continue to include the projection of outlier payments in the PMPM rates. c) DHH will provide Health plans detailed information on outlier payments due. d) Yes.

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					threshold remain as published (150k and age based)? Background According to Section 25.7 of the Hospital Manual, Outlier payments to hospitals shall be made semi-annually and settled directly with the state. The manual varies from the State response on the 2011 RFP FAQ which states, “Outlier payments for children are included in the PMPM. The capped catastrophic outlier pool significantly reduces the amount of outliers that will be paid. Plans are already aware of Medicaid outlier payments and will still negotiate payment of outliers, just at a reduced rate."	
75	RFP and Appendix J	12.16.14.1 and Appendix J	Call Center Performance Standards - Service Level **AND** Appendix J: Administrative	166	LA Bayou Health RFP 12.16.14.1 reads: Answer ninety (90) percent of calls within thirty (30) seconds or direct the call to an automatic call pickup system with IVR options.	This was corrected in Addendum #3.

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
			Measures		LA Bayou Health RFP Appendix J reads: % of Call Center calls answered within 30 seconds less than or equal to 95%. Please confirm that the accurate performance standard is 90% of calls within 30 second or direct the call to an automatic pick up system with IVR options.	
76	RFP and Appendix J	Appendix J & 12.16.14	Call Center Performance Standards - Average Speed of Answer	5	LA Bayou Health RFP Appendix J reads: Measure = Call center average speed of answer; Minimal Performance Standard = 30 seconds. An Average Speed of Answer performance guarantee does not appear in section 12.16.14 Call Center Performance Standards of the LA Bayou Health RFP. Please clarify the final set of call	This was clarified in Addendum #3.

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					center performance standards.	
77	RFP	12.16	ACD System	166	Do the requirements under 12.16 ACD System refer to just the Member Services toll free number OR both Member Services AND Provider Services toll free numbers?	Section 12.16 is specific to Member Services.
78	RFP	5.3.4	Withhold of Capitation Rate	32	5.3.4 If DHH has determined the MCO is not in compliance with a requirement of this Contract in any given month, DHH may issue a written notice of non-compliance and DHH may retain the amount withheld for the month prior to DHH identifying the compliance deficiencies. Please define "MCO deficiencies" as referenced in section 5.3.4 of the LA Bayou Health RFP. Will the withhold be fractional all-or-nothing?	Deficiencies include any occurrence of non-compliance with the provisions of the contract. Each month 2% of the monthly capitation payment will be withheld. Of the 2%, any amount retained in subsequent months will be limited to the specific occurrence(s) for which written notice was given consistent with the monetary penalty, sanctions and liquidated damages provisions of the contract. The balance of the 2% not retained will be refunded on a monthly basis.
79	RFP	11.7	Assistance with Medicaid Eligibility Renewal	133	"DHH will provide the MCO with a list of members for renewal no less than 60 days prior to a	Yes, we can provide the list of member's renewal data early, but it is not recommended. The member's eligibility could change and this is prior to the Express

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					member's renewal data." Can we receive the list 90 to 120 days prior, which would allow MCOs to provide more member touch points and engagement?	Lane Eligibility file process and would result in plans contacting people who do not have to manually renew.
80	RFP	11.0	Eligibility, Enrollment and Disenrollment	130	Will the enrollment broker capture members' email, home phone, and cell phone data? They are currently only capturing addresses and unspecified phone numbers for members.	The enrollment broker captures the mailing address, physical address, and up to three contact phone numbers for all members. Phone numbers are not specified by type (home, cell, work).
81	RFP	6.1.4	Core Benefits and Services	43	Please clarify the expectation of coverage under "Surgical Dental Services" and "Respiratory Services," which are listed as covered benefits; except those prescribed by a specialized behavioral health provider.	For "Surgical Dental Services," please see the response to question 44. "Respiratory services" are not separate but would be considered as included as a part of physician, physician extender, outpatient hospital, inpatient hospital, etc services. Individual respiratory therapists are not reimbursed.
82	RFP	6.13.2	Perinatal Services	56	Please clarify/define "safety net services" as stated in Section 6.13.2 of the RFP.	Safety Net Services for inter-pregnancy care are referrals to a new form of care (determine ongoing eligibility in the current plan, enroll in an exchange product or in the

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
						new "State Plan Amendment for Family Planning" program). Or, if the patient is not eligible for one of these programs and does not want to enroll in the Federal Marketplace, referral to an LSU partner hospital or FQHC for ongoing primary care.
83	Appendix KK	Appendix KK	U.5 Quality Management	31	Would we use the current format/template to submit PIPs (the template that was supplied by our current EQRO auditor)?	The EQRO vendor, IPRO, will determine the format in which PIPs will be submitted for their review.
84	RFP	5.11.6.1	DHH Right to Conduct Identification and Pursuit of TPL	40	Would DHH consider the following revisions to this section: • Replacing date of service with paid claim date, which would be in line with industry standards – recovery activity time frames based on claim paid date not the claim's date of service. • Revising the recovery time from 1 year (from claim paid date) to 18 months (from claim paid date).	Yes, the state will consider modifying this language. If modified, updates will be issued via addendum.

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					Additionally, please confirm that this recovery time frame only applies to Other Health Insurance (from members primary carrier – commercial or Medicare) recoveries and does not include subrogation.	
85	RFP	4.4.7	Program Integrity Officer	29	The "Program Integrity Officer" is listed twice (4.4.5 and 4.4.7). Should one reference be removed? -	The intent was to include a Contract Compliance Coordinator. This error was corrected in Addendum #3.
86	RFP	14.5.13	Credentialing and Re-credentialing of Providers and Clinical Staff	197	Will DHH engage the MCOs and allow time for input prior to making a decision to transition to a statewide CVO?	Yes.
87	RFP	20.3.2	Monetary Penalties	259	The RFP outlines the following potential penalty for non-compliance: Fifteen thousand dollars ($15,000.00) per calendar day for failure to provide for arrangements to handle emergent provider issues on a twenty-four (24) hour, seven (7) days-a-week basis."	"Emergent" is defined in terms of the member's medical condition. While prior authorization is not needed, nor can it be required, for emergency services, the MCO must have staff accessible to providers 24/7 to provide information needed to stabilize, transfer, locate services or otherwise provide necessary emergent or urgent care in a timely manner.

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					What is the definition of "Emergent Provider Issues" that will apply here?	
88	RFP	6.4.2	Behavioral Health Services	50	The RFP identifies that the MCO is responsible for the management and provision of all basic behavioral health services. Will DHH provide specific guidance (to the coding level) to ensure consistency in how this is managed? Or is the intent for each MCO to utilize its own billing/coding rules based on national guidelines?	All Diagnostic coding must be consistent with the National Correct Coding Initiative. "Basic" behavioral health services are the responsibility of Bayou Health, including but not limited to ■ Drugs not prescribed by behavioral health specialists ■ Professional services not provided by behavioral health specialists (e.g., Psychiatrist, Psychologist, Mental Health Rehabilitation provider) ■ FQHC/RHC encounter in which no services were provided by a behavioral health specialist ■ Facility services except those provided in a psychiatric facility or distinct part psychiatric unit ■ Acute Medical Detoxification

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
						services "Specialized" behavioral health services are the responsibility of the LBHP, including but not limited to ▪ Drugs prescribed by behavioral health specialists ▪ Professional services provided by behavioral health specialists (e.g., Psychiatrist, Psychologist, Mental Health Rehabilitation provider) ▪ FQHC/RHC encounters in which any services were provided by a behavioral health specialist Any changes to this approach will be handled though future Information Bulletins published by Medicaid.
89	Appendix KK	Section E	E.8 Qualifications & Experience, Investigations	9	Section E.8 references investigations described "in response to item D.2 of this part." Please provide additional clarification because there is no D.2 in Appendix KK, and section D covers only privately held	The correct reference is Section C-1. See Addendum #3.

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					companies? Should this reference be to Section C.1?	
90	Appendix KK	Section M	M.2 Early Periodic Screening, Diagnosis, and Treatment	18	Section M.2, "Early Periodic Screening, Diagnosis, and Treatment," references a system described in E.1. Should this reference be M.1?	Yes, M.1 is the correct reference. See Addendum #3.
91	Appendix KK	Section N	N.1 Utilization Management	19	Section N.1 references "bullets (2) through (7) in item J.1 of this part;" J.1 pertains to Coordination of Carved Out Services and has no bullets. Is there a different section we should refer to?	The reference J.1 should be R.1. See Addendum 3
92	Appendix KK	Section P	P.1 Non-Emergency Medical Transportation	23	Section P.1 references responses to item C.6. There is no C.6 of the appendix. Should this reference be F.4?	Yes, the correct reference should be to F.4. See Addendum #3.
93	Appendix KK	Section Q	Q.1 Pharmacy	24	Question.1, it references Subcontractor section C.6. There is no C.6 of the appendix. Should reference be F.4?	Yes, the correct reference should be to F.4. See Addendum #3.

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94	Appendix KK	Section U2	U.2 HEDIS Scoring	28	Will DHH please clarify the reporting for the following measures reported in Section U.2: *For "Childhood Immunization Status", which combination should be reported? *For "Breast Cancer Screening," this is a 2-year continuous enrollment measure and the HEDIS 2014/tech specs changed on this measure. Will DHH please provide clarity around the reporting of this measure? *For the Ambulatory Care – ER Utilization, the lower percentiles are the higher score. How will this be factored into the average calculations? There are also components of this measure (#visits/1000 member months and #visits/1000 member years) that cannot be grouped together for an average.	MCOs should 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. MCOs should not alter the file in any manner. Details on the IDSS Import Template and additional materials are available here: http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDISDataSubmission/IDSSImportTemplateandMaterials.aspx

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					Please clarify how to report these scores. * For the Adults' Access to Preventive/Ambulatory Health Services: Should this be for 20-44 Years, 45-64 Years, 65+ Years? Or "total"? * For the Comprehensive Diabetes Care- HgbA1C component, should this be HbA1c Testing, HbA1c Poor Control (>9.0%), HbA1c Control (<8.0%), or HbA1c Control (<7.0%)? • For Chlamydia Screening in Women, should this be 16-20 Years, 21-24 Years, or Total? • For the Weight Assessment and Counseling for Nutrition and Physical Activity in Children/Adolescents should this be BMI Percentile, Counseling for Nutrition, or Counseling for Physical Activity?	

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					•For follow-Up Care for Children Prescribed ADHD Medication, should this be for the Initiation Phase or Continuation and Maintenance(C&M) Phase?	
95	RFP	8.10	Pharmacy Administrative Simplification	115	The contract reference sections 6.40.1 – 6.4.09 do not refer to pharmacy – is the reference point for this notation / section 6.3 titled “Pharmacy Services? Does this reference through section 6.3..3?	Yes, the correct reference is 6.3. See Addendum #3.
96	Appendix KK	Section J.3	J.3 Coordination of Carved our Services	15	Section 6.1.4 lists Personal Care Services as included in the benefits. However, Appendix Section KK, Section J.3 references Personal Care Services as a carved out service. Please confirm the MCO coverage of Personal Care Services.	EPSDT Personal Care Services for members under 21 years of age are included as medically necessary.
97	RFP	15.1.16.4.1	Reporting and Investigating Suspected Fraud and	201	Please provide further clarification on what DHH will consider to be “tips” that must	A tip is any information alleging or implying misconduct on the part of a provider, beneficiary, or employee.

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
			Abuse		be reported to DHH and MFCU?	
98	RFP	15.1.16.4.4	Reporting and Investigating Suspected Fraud and Abuse	202	RFP Section 15.1.16.4.4 requires that all confirmed or suspected enrollee fraud and abuse shall be reported immediately to DHH and local law enforcement. .” Previously, DHH has clarified that “immediately” is interpreted to be within 3 days. Will DHH please provide clarification regarding the standard that will be used to define “immediately”?	The glossary defines "immediate" as "In an immediate manner; instant; instantly or without delay, but not more than 24 hours." Reports of suspected enrollee fraud and/or abuse – that do not raise a health and safety concern for the beneficiary – must be reported “promptly” i.e. within three (3) business days. Any suspected enrollee fraud and/or abuse – that raises a health and safety concern for the beneficiary – must be reported immediately. The MCO shall report any of the above types of provider and/or recipient fraud to DHH through the following url: http://www.dhh.louisiana.gov/index.cfm/page/219. These reports shall also be cataloged on the Fraud Reporting tool and submitted according to its published schedule.

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99	RFP	12.13.3	Member Identification (ID) Cards	162	Please confirm that MCOs are permitted to use the MCO's mailing address on ID cards.	Yes
100	RFP	7.8.4.3	Hospitals	89	Section 7.8.4.3 indicates that "MCO's may contract with out-of-state hospitals in the trade area." Please define "trade area."	The trade area consists of any counties that border Louisiana.
101	General Question	General Question	Enrollment Share Formula	N/A	Will DHH consider implementing a minimum enrollment floor, under which plans who do not meet the minimum threshold would receive preferential auto-assignments?	DHH may consider minimum enrollment thresholds in our auto-assignment methodology.
102	RFP	15.1.10	Fraud, Abuse, and Waste Prevention	200	Will DHH confirm our understanding that DOO forms must be validated at least once annually per the new requirement?	The DOO shall be submitted as outlined at section 15.1.10.
103	Appendix J	J	Performance Measures	1	Many of measure on Appendix J are not supported by claims based data collection. Has the state defined the methodology for data collection for each of	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.

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					these measures? Will facilities and providers be required to submit additional clinical and encounter data to support data collection and reporting?	
104	RFP	6.3.1.1	Pharmacy Services: Covered Services	45	Could you please provide clarity on the criteria used to deem drugs "medically necessary" for members under the age of 21?	The MCOs should cover all prescription drugs where the manufacturer signed a federal rebate agreement. States are required to provide health care services to children under 21 that are coverable under the Federal Medical program and found to be medically necessary to treat, diagnose, correct, cure, alleviate, or prevent the worsening of a condition that endangers life, results in pain, handicap, physical deformity or malfunction regardless of whether the service is covered in the State Medicaid plan. The determination of medical necessity must be done on a case-by-case basis. A medically necessary service is defined as those that are in accordance with evidence based medical standards, or are considered by a physician to be the standard of care and for which no equally effective and less costly course of treatment is available for the recipient. The prescriber needs to give an explanation of the medical necessity for each prescription

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						For more information please refer to the La. Admin Code tit. 50, pt. I, § 1101, for the definition of medical necessity.
105	RFP	6.4	Behavioral Health Services	49	How will the more complicated Basic versus Specialized services be determined? An example might be a person with either Schizophrenia or Bipolar Disorder who needs routine meds would be appropriate for being seen for med refills at the PCP/FQHC office but what happens and how is it determined if that person needs more intense care if, for example, the meds become less effective. How is that determined? Is there a screening questionnaire that must be completed for a person to be referred to specialized care? Another example would be that of a person with a severe anxiety disorder that doesn't respond to a medication trial and needs therapy or a combination of meds, example, Severe Panic	See response #88 above. Emphasis is on which provider rendered the service, as opposed to the diagnostic code. If a PCP (non-behavior health specialist) provides the service –even if med management- then this would be handled through the Bayou Health Plan, even if primary diagnosis is schizophrenia, etc. There is no required referral screening of form at present, but all plans would be expected to utilize a standardized and uniform referral form, when such a referral form is utilized.

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					Disorder with Agoraphobia or Severe OCD.	
106	RFP	6.4	Behavioral Health Services	49	Is there a dispute resolution process for determining appropriate coverage of behavioral health services so that neither the PCP/FQHC nor specialist can cost shift?	There is no formal DHH-led dispute resolution process between MCO's anticipated. This should be addressed in the Mixed Services Protocol. Coordination of benefits between a member's physical health plan (Bayou Health) and behavioral health plan (SMO) is complex and requires cooperation and collaboration between the two plans. As circumstances of mixed service protocol are identified, those circumstances will be articulated in "informational bulletins" and incorporated as coverage/billing protocol with the MCO.
107	RFP	6.4	Behavioral Health Services	49	What services other than basic prescribing of medications will the Basic system provider (PCP/FQHC) be required to provide? Will there be a requirement for Case Management, for example?	Each Plan is expected to provide and manage its own members' basic/non-specialist behavior health treatment, care and services. If/when non-specialist behavioral health care is being provided by a PCP, it is the MCO's responsibly to manage that case and any additional required services.

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108	RFP	6.4	Behavioral Health Services	49	Will the PCP/FQHC use the behavioral health billing codes for submitting claims or will these be E&M codes with no designation? Will the PCP/FQHC be required to list the behavioral health diagnosis first on the claim?	Billing codes utilized should be consistent with National Correct Coding Initiative, and reflect/ represent the actual service provided by the given practitioner. When submitting claims, the diagnosis being treated should be listed.
109	RFP	6.4	Behavioral Health Services	49	What are the appeal mechanisms for the MCO to appeal a refusal of the SMO to accept a referral? Also relates to 6.34.2 on page 68.	A member, or a provider on member's behalf, may appeal prior authorization denials. Each Bayou Health Plan must provide member education and necessary materials relative to how to a file a grievance and appeal. Member grievance, appeal and state fair hearing procedures must be included as part of the Member Handbook.
110	RFP	6.4	Behavioral Health Services	49	When a member should be treated by a specialized provider because the services being provided by the PCP/FQHC are inadequate is the state building a mechanism to facilitate those referrals to reduce cost shifting. Will there be a joint review committee comprised of the state the MCO and the Louisiana Behavioral	No such joint review committees are planned. DHH expects that each member's care is coordinated between each plan. Each MCO is encouraged to develop a memorandum of understanding and a partnership with the SMO related to such activities.

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					Health Partner?	
111	RFP	6.8.1.8 and 6.34.3	Emergency Medical Services and Post Stabilization Services **AND** Continuity for Behavioral Health Care	53 and 70	Is behavioral health emergency considered basic or specialized? Is a person is threatening suicide but hasn't actually suffered any physical harm are services provided in this instance considered the responsibility of the Louisiana Behavioral Health Partner? In this same situation if the follow up care is a prescription by a PCP/FQHC and not by a behavioral health practitioner (not considered a best practice) the MCOs expense.	See #88 above. Mixed Services Protocols indicate that Bayou Health Plans cover all general hospital ER facility claims and all behavioral health ER facility and prof. claims when not provided by a psychiatrist or Licensed Mental Health Professional (behavioral health specialist). Such behavioral health ER services should be covered by the Bayou Health Plan. Likewise, if the Rx is by a PCP (non –specialized BH provider), according to the new Mixed Service Protocols, then it would still be responsibility of the Bayou Health Plan.
112	RFP	6.23.1 and 7.8.9.1	Medical Transportation Services **AND** Non-Emergency Medical Transportation	62 and 90	Please provide additional clarity around definition of what types of services are covered in the non-emergency medical transportation. For example, after a dentist appointment, can the member request to stop at the grocery store or the drug store to buy non-medical	No, NEMT transportation is only provided to Medicaid covered services. However if an MCO has contractually agreed to provide additional services or is providing services in lieu of state plan covered services, the MCO must cover the transportation to these services.

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					supplies?	
113	RFP	6.29	Care Coordination, Continuity of Care, and Care Transition	66	Is the Louisiana Behavioral Health Partner required to coordinate care with the members PCP/FQHC and to provide treatment updates including dates of admission and discharge for any service? And is the Louisiana Behavioral Health Partner required to send treatment updates including the dates of admission and discharge with the MCO.	Requirements for the Louisiana Behavioral Health Partnership are detailed in the Request for Proposals of the Statewide Management Organization released on 8/15/14. http://new.dhh.louisiana.gov/index.cfm/newsroom/category/47
114	RFP	6.34.1 and 6.34.10.1.1	Continuity for Behavioral Health Care	68 and 71	Is the state requiring all behavioral health services start with the PCP/FQHC and then get referred on to a behavioral health specialized provider?	No.
115	RFP	34.10.1.4	Continuity for Behavioral Health Care	78	Is the MCO (rather than the SMO) the lead managing entity for all cases with a medical and Behavioral health condition?	DHH intends for the MCO and the SMO to integrate both physical and behavioral health services at the PCP level of care. It is anticipated that the MCO and the SMO will work together to ensure the provision of services to members. An approved referral form to be utilized by the SMO and the MCO should be used for these members. DHH

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
						expects these members to have co-managing PCP members as necessary assuming that such a member has both physical and behavior health needs that are equally severe and that the MCO and SMO would ensure that the member's care is coordinated between the two plans.
116	RFP	6.37.1	Case Management	74	Does the SMO have a case management program or is case management provided only by the MCO?	The SMO will be responsible for developing a case management program as well. See question 113.
117	RFP	RFP 12.15.1	Member Call Center	165	Section 12.15.1 of the RFP references a requirement to have a member service call center with "dedicated staff." Please confirm that each member services associate is not required to be fully dedicated to Bayou Heath, but rather that the health plan is required to have designated staff who are trained in, and knowledgeable of the Bayou Health program (inclusive of all required training components and areas) to respond to	Correct

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					member services calls.	
118	RFP	RFP 21.5.4	Payment of Monetary Penalties and Sanctions	267	Please clarify under which circumstances DHH may apply a monetary penalty or sanction to "all known affiliates, subsidiaries and parents of an MCO" as referenced in 21.5.4. As these entities would not party to the ultimate contract issued under the RFP, we would like to understand DHH's intent for this provision.	Please refer to 21.5.4. Only where the facts and circumstances have demonstrated that a violation, failure, or inadequacy of performance should be imputed to an affiliate, subsidiary, or parent corporation will DHH have the authority to impose a monetary penalty or sanction to that individual or entity on behalf of the MCO.
119	Appendix KK	RFP Section 23	Evaluation Categories and Maximum Points	279	In reviewing the evaluation component and associated possible points in Section 23 against the individual section "Total Possible Points" in Appendix KK, it appears that the totals do not match up. The point values in Section 23 of the RFP total 995, with 240 points in the Member Management Section and 200 points in the Added Value to Louisiana Members and Provider Section. The point values in Appendix KK	Scoring values in Section KK are correct. See response to question #20.

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					do total 1000. Please confirm that the point values in Appendix KK are correct with 220 points in Member Management and 225 points in Added Value to Louisiana Members and Providers? Please also confirm that the total for Section II. Financial Requirements should be 35?	
120	RFP	RFP 25.40	Rate Adjustments	297	RFP Section 25.40 identifies "Should either the MCO or DHH refuse to accept the revised monthly capitation rate, the provisions of the RFP for contract termination and turnover shall apply." However, the RFP section on termination does not outline any termination rights for the MCO. Please confirm whether or not the MCOs have the option to terminate the contract for failure to come to agreement	Section 25.40 has been revised and Section 25.63 has been added to address contract termination related to rate adjustments. See Addendum #3.

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					on capitation rate adjustments?	
121	RFP and Appendix B	RFP Section 25.50, Appendix B	Termination for Convenience **AND** Appendix B	299	RFP Section 25.50 identifies that DHH may terminate the contract for convenience and without cause upon 60 days' notice. However Appendix B (Standard Contract Form) identifies that the contract may be terminated by either party without cause upon 30 days advance notice. Please confirm which provision is correct.	Paragraph 12 of the CF-1 will be amended in the contract process to read as follows: 12) This contract may be terminated by DHH upon giving sixty (60) days advance written notice to the other party with or without cause but in no case shall continue beyond the specified termination date.
122	Appendix KK	Section C.2	C.2 Publicly Traded Organizations	5	Question C.2 requests an organizations bond rating for the current year, and each of the past three years. Further, the question requires inclusion of the organization's parent, affiliates and subsidiaries. As some national organizations may have extended affiliate organizations spanning 100+	Yes, DHH confirms that submission of the MCO and its ultimate parent company is sufficient to respond to this question.

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					legal entities, will DHH confirm that submission of the MCO and its ultimate parent company will be sufficient to respond to this question?	
123	Appendix KK	Section E.3	E.3 Qualifications and Experience	7	For Question E.3, which requests information on any notices of non-compliance received by the MCO, its parent organization, affiliates, and subsidiaries, will DHH consider limiting this question to those parent companies, affiliates, and subsidiaries with publicly funded managed care contracts in other states or programs (e.g. those entities and contracts that are listed in Question E.1)? Many larger companies will have affiliates or subsidiaries that may operate in other lines of business that would not be relevant to the question or the overall RFP.	Yes, the response should apply to all publicly funded contracts or the alternate 10 largest contracts referenced in E.1.
124	Appendix KK	Section E.4	E.4 Qualifications and Experience	7	Please confirm that Question E.4 is related to any publicly	Yes, the response should apply to all publicly funded contracts or the alternate 10 largest

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					funded managed care contracts (e.g. those listed in Question E.1)?	contracts referenced in E.1.
125	Appendix KK	Section E.5	E.5 Qualifications and Experience	8	Please confirm that Question E.5 should be limited to those parent organizations, affiliates, and subsidiaries that hold/manage publicly funded managed care contracts (consistent with the information provided in E.1)?	The response should apply to all publicly funded contracts or the alternate 10 largest contracts referenced in E.1.
126	Appendix KK	Section E.6	E.6 Qualifications and Experience	8	Question E.6 requests the EQRO report for the Medicaid Contract identified in Section B.1 with the largest number of enrollees as of January 1, 2014. Please confirm that the reference should be to Section E.1? If a respondent is a current contractor in the Bayou Health Program, should they provide the report for the Bayou Health EQRO which may be more relevant to this RFP, even if one of the contracts listed in Section	Yes, the correct reference is E.1. No, the respondent should provide the EQRO report for the contract with the largest number of enrollees as stated.

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					E.1 has more membership?	
127	Appendix KK	Section E.7	E.7 Qualifications and Experience	8	Please confirm that the response to Question E.7 would be limited to regulatory actions, sanctions, etc. applicable to the entities and contracts identified in response to Question E.1 (all publicly funded managed care business).	Correct
128	Appendix KK	Section E.9	E.9 Qualifications and Experience	9	Please confirm that bidders may submit references for affiliated companies that operate publicly funded managed care contracts in other states for this question. As many national organizations are structured so as to allow for a locally-based individual subsidiary in each state in which they operate, references from other state Medicaid agencies will be for affiliated companies in many cases.	Correct
129	Appendix KK	Section F.2	F.2 Organizational Structure	11	Question F.2. requests an organizational chart for the contract, including information regarding whether or positions	Higher points will not be awarded based on number of FTEs located in Louisiana when scoring this section.

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					are located in Louisiana. The point value for this question is 10 points. Please confirm whether or not higher levels of points will be awarded based on the number of FTEs located within Louisiana as disclosed in this response?	
130	Appendix KK	Section R.2	R.2 Customer Service	25	Question R.2 requests copies of member hotline telephone reports for the largest Medicaid/CHIP managed care contract as of January 1, 2014. Should affiliates be included in determining the largest contract for this response; or if an MCO is currently a Bayou Health contractor, should they submit the hotline reports for the Bayou Health program, regardless of the size of other contracts?	Affiliates should be included when determining the largest contract.
131	Appendix KK	Section U.2	U.2. Quality Management	28	Please confirm that for Question U.2, the MCO should include HEDIS scores for all Medicaid Contracts listed in	Correct

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					Question E.1 (if available), even if some of those contracts are held by affiliates of the MCO.	
132	Appendix KK	Section U.3	U.3. Quality Management	29	Please confirm that MCOs may use experience and examples from other affiliates that operate publicly funded managed care programs in response to Question U.3 or other references and questions that request examples or experience with other state programs?	Correct
133	RFP	RFP Section 11.3.3.2	Automatic Assignment	131	RFP Section 11.3.3.2 identifies that previous enrollment in a CCN-S plan will be used to determine "the most current previous relationship with an MCO". As the CCN-S plan structure, policies, medical management model, network access model, are so vastly different from the managed care model proscribed for all plans under the RFP, a prior relationship with a CCN-S plan	Both the availability of the PCP in-network and the Health Plan relationship may be considered in auto-assignment.

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					does not provide any benefits for continuity of care or historical provider relationships, as required by 42 CFR 438.50. Rather, the member's most current previous relationship with a PCP would appear to be more in line with the intent of the federal requirements. Will DHH consider revising this provision to consider the most recent PCP relationship, and then subsequently round robin assign members to a plan in which that PCP participates?	
134	RFP	7.9.4	Network Provider Development Management Plan	93	RFP Section 7.9.4 requires the MCO "provide GEO mapping and coding of all network providers for each provider type by the deadline specified in the Schedule of Events, to geographically demonstrate network capacity." Please provide the expected date for this submission as it is not currently included in the	1/1/15. See response to question 14.

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					Schedule of Events.	
135	RFP	11.3.3.3	Automatic Assignment	131	RFP Section 11.3.3.3 describes the methodology for assigning members to an MCO in cases where there is no previous MCO relationship, or the member's PCP is not currently in network with any MCO. The RFP identifies that "the Enrollment Broker shall use a round robin method to determine the MCO assignment that maximizes the preservation of existing provider-recipient relationships." If the member's PCP is not currently in any MCO network, please clarify what other factors will be considered in this "round robin" approach.	The auto-assignment methodology may consider member relationships with other significant providers as determined by analysis of claims & encounter data, minimum or maximum plan enrollment thresholds, health plan quality scores and other relevant criteria as determined at the discretion of DHH.
136	RFP	25.11	Health Integrity and Protection Data Bank (HIPDB)	288	Section 25.11 speaks to required screening of all employees and subcontractors and lists specific websites: • LEIE https://oig.hhs.gov/exclusions/i	The databases/websites listed in Section 15.3.3 are required database checks for monthly exclusion checks. The databases listed at Section 25.11 give a list of databases the MCO may use to help determine debarment and/or suspension.

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					ndex.asp; • the Health Integrity and Protection Data Bank (HIPDB) http://www.npdb-hipdb.hrsa.gov/index.jsp; • the Louisiana Exclusion Database (LED); and/or • the System for Award Management, http://www.sam.gov. Section 15.3.3 lists the following websites: o Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE): o Louisiana Exclusion Database (LED); o The System of Award Management (SAM); and o Other applicable sites as may be determined by DHH The HIPDB database was taken out of the current Bayou Health contract. Please confirm whether or not this reference in 25.11 is accurate or if it should	The Louisiana Exclusion Database (LED) has been renamed Louisiana Adverse Actions List Search (LAALS) https://adverseactions.dhh.la.gov/. This was corrected in Addendum #3.

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					be removed?	
137	RFP	3.3.3	Duration of Medicaid Eligibility	14	This appears to be the current process of automatic renewal of eligibility. Will DHH provide an updated description of the renewal process to reflect new requirements?	This section remains accurate relative to new ACA requirements.
138	RFP	5.7	Risk Adjustment	34	Will plan be given the name of risk adjusted model used?	Yes. Adjusted Clinical Groups (ACG) case-mix system developed by Johns Hopkins University will be used until further notice.
139	RFP	5.7.1.2	Risk Adjustment	34	What period will be used to determine risk categories?	In order to allow for sufficient amount of claims run-out, encounter submissions, and the ACG analysis, Mercer plans to use a 12-month study period lagging 12 months behind the effective date of the risk adjustment period. This is subject to change based on unforeseen factors such as legislative changes or data issues.
140	RFP	11.1 -11.3	Relationship with PCP	131	What is the definition of a "relationship with PCP?" If a Provider is currently only contracted with one Bayou Health Plan, becomes par with a second plan and terms with first, the second/new plan would receive the membership	The relationship with the PCP is determined at the time of open enrollment. Subsequent termination of a contract between a provider and a health plan in and of itself is not a for cause reason to change health plans outside the open enrollment member choice period. Health plans cannot move members; all member linkages are determined through

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					assigned to that provider. If a Provider is par with multiple plans, and was to term one (or more) existing plan, the member would remain with the provider, but change to a plan with which the provider participates via round robin. Under either scenario there are questions/concerns around timing. Scenario #1: Provider submits term to existing payer effective 12/1/2014. Other payer terms provider in their system and moves the membership to a different par provider. Does the fact that the member was moved to another par provider constitute a relationship, thus the member stays with the in incumbent plan? Scenario #2: Provider submits term to existing payer	the enrollment broker. Assignments made based on erroneous information in the provider registry may be subject to member reassignment based on member choice and departmental determination.

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					1/31/2015. Plan may or may not submit registry file with "future term date" (assuming auto assignment will be run from a registry file created prior to 2/14/2015), thus the member stays with the incumbent plan	
141	Appendix H	Appendix H-1	Appendix H	1	Appendix H identifies that MCOs that do not meet the 85% MLR standard must "Rebate a portion of the capitation." Will the state please provide additional clarification on determining what portion must be returned?	For each MLR reporting year, a MCO must rebate to DHH the difference between the total amount of annual capitation payments received by the MCO from DHH multiplied by the required MLR of 85% and the MCO's actual MLR. Please refer to the Financial Reporting Guide located at http://new.dhh.louisiana.gov/assets/docs/BayouHealth/RFP2014/2014BayouHealthFinancialReportingGuide.pdf.
142	General Question	General Question	General Question	N/A	Based on the timeline distributed, the question cut-off dates are (8/4 and 8/25). All cut off dates for questions are before 9/1, which is the deadline for the rates becoming available. Will there be an opportunity for questions regarding rates that will be	Yes. See Addendum #4 for deadlines for submission of rate-specific questions after the release of the rates.

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					released on 9/1/14?	
143	RFP	5.3.3	Withhold of Capitation Rate	32	Please provide a definition of "MCO deficiencies" as referenced in section 5.3.3.	Deficiencies include any occurrence of non-compliance with the provisions of the contract.
144	RFP	25.24.1	Homeland Security Considerations	293	Please confirm that the Homeland Security Considerations of the contract do not preclude the MCO from utilizing software that has been developed off shore (not specifically for Bayou Health), as long as the actual use of such software programs occurs within the boundaries of the United States.	Correct
145	RFP	22.18.5. and 22.18.6	Proposal Format	276-277	Sections 22.18.5 and 22.18.6 direct the Respondent to provide their response in 10 binders: one for each part – Parts I Through X. How should section XI be submitted?	Sections amended in Addendum #10. The only requirements for separate binders are for Parts I and II which much each be in their own separate binders. Parts III through XI can be in the same or separate binders as needed, but must be identified and separated with appropriately labeled tabs.
146	RFP	22.18.1	Proposal Format	276	Section 22.18.1 says Proposals should be single-spaced with	Yes

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					text no smaller than 11-point font. Will DHH allow a smaller font size for graphics and tables (e.g., no smaller than 9-point font)?	
147	RFP	Q.1	Pharmacy	Appendix KK, page 24 of 40	Please verify the intent of the referenced section "C.6" as indicated in question Q.1, under section Q - Pharmacy.	Correct, see response to question 93.
148	RFP	V.1	Program Integrity	Appendix KK - page 32 of 40	The last sentence of requirement V.1 appears incomplete. Please provide the remaining text to complete this requirement.	See response to question 31.
149	RFP	P.1	Non-Emergency Medical Transportation	Appendix KK - pg. 23 of 40	Please verify the intent of the referenced section "C.6" as indicated in requirement P.1, under section P - Non-Emergency Medical Transportation.	See response to question 92.
150	RFP	4.4	In-State Key Staff Positions	RFP Page 29	Was is the intent of DHH to repeat the "Program Integrity Officer" key position in both	The intent was to include a Contract Compliance Coordinator. This error was corrected in Addendum #3.

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					subsections 4.4.5 and 4.4.7 as written in the RFP or was the intent to list a different position in subsection 4.4.7? Please advise.	
151	RFP	4.4	In-State Key Staff Positions	RFP page 29	This position is listed as "key" in Section 4.2.18 and in 4.4.13 includes "(if applicable)". Is that indicated solely because the Provider Claims Educator is only indicated in 4.2.18 as necessary for those MCOs with over 100,000 members statewide?	Correct
152	RFP	4.4	In-State Key Staff Positions	RFP page 29	Please advise which position is the correct Key Position required to be based in Louisiana, Member Services Manager or Coordinator.	4.4.10. amended to read “Medical Management Manager.” See Addendum #3.
153	RFP	4.2.4	Behavioral Health Medicaid Director	23	Does the BH Medical Director have to have a Louisiana Board of Medical Examiners license?	While Louisiana experience, Louisiana LSBME licensure, and familiarity with Louisiana’s system of care will be valued and preferred, this is not an express requirement. However, the Behavioral Health Medical Director must be a physician with a current, unencumbered license through a State Board of Medical Examiners.

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
154	RFP	6.11	Prenatal Care Services	55	1- Does the requirement that the MCO ensure that pregnant members begin receiving care in the first trimester or within 7 days after enrolling in the MCO refer to 7 business days or 7 calendar days? 2- Additionally, is it the responsibility of the Enrollment Broker to notify the MCO of a member's pregnancy status? If not, how are MCO's notified in a timely manner of pregnancy status?	1 –Unless otherwise specified, the term "days" in the Contract refers to calendar days (see "Calendar Days" in the glossary). 2 – Pregnancy status is transmitted to the MCOs from the Enrollment Broker by type case when pregnancy is the basis of Medicaid eligibility.
155	Appendices to the RFP	Appendix D	Veterans Hudson Initiative	11	1- Please clarify the threshold goal for proposers to contract with veteran/Hudson entrepreneurships (i.e. percentage of administrative cost) and whether the three evaluation criteria listed (number, experience, and earnings) will be weighted equally. 2- Is this a requirement of the current Bayou Health Contract	1. 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

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					and if so, at what percentage?	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. 2- No
156	RFP	1.2.5	Service Area	2	Please clarify whether the awards will be made on a statewide basis only.	Correct
157	RFP	2.1.1.7	Network Capacity	7	Will DHH consider aligning this requirement from the currently stated 250,000 Medicaid members to instead meet the projected enrollment at the onset of go-live?	See responses to questions #3 and #14.

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
158	RFP	2.1.1.7 and Appendix KK, RFP Question G.1	Network Capacity	7	Appendix KK appears to indicate that all that is required with submission is a description of the plan to build a network with a capacity of 250,000. At which point in the Schedule must the 250,000 Medicaid member capacity network requirement be met?	See responses to questions #3 and #14.
159	RFP	11.1.1.1	Voluntary Choice Period	130	Would DHH consider changing the voluntary enrollment period from 60 days to 30 days?	No
160	RFP	11.1.1.2	Voluntary Choice Period	130	Please clarify the last sentence of this section, and how it would apply to former members of the Community and United CCN-Shared Savings plans.	Previous relationship with a CCN-S plan may be considered dependent on the availability of the members PCP in network.
161	RFP	11.3.3.3 and 11.9.4	Membership Ceiling	131 and 134	Would DHH consider lowering the membership ceiling to an amount below 40% in order to foster greater competition?	No. It has been lowered from 65% in the current contracts to 40%.
162	RFP	11.3.3.3	Automatic Assignment	131	In addition to the membership ceiling, would DHH also implement a membership floor	Plan enrollment minimums may be considered in the auto-assignment process while still maintaining existing

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					to ensure a new market entrant sufficient membership to ensure stability of operations?	member/physician relationships.
163	Pre Bid	1.9	Schedule of Events	5-6	1- Since the final data book will not be released until Sept 1st, will there be a separate Q and A period for data book questions? 2- It is critical to have an opportunity for Bidders to request clarification and/or additional information concerning the Data Book.	Yes. See Addendum #4.
164	Pre-bid	1.9	Schedule of Events	5-6	1- Since the quality guide has not yet been released, will a separate Q and A period be allowed for quality related questions post quality guide release? 2- It is critical to have an opportunity for Bidders to request clarification and/or additional information concerning the Quality Guide.	No. The quality guide currently posted will govern the Medicaid program until a new guide is released in October of 2014.

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
165	RFP	22.17	Proposal Content	276	22.17.1 indicates the completed Appendix KK should be included as the proposal Table of Contents. 22.18.4 indicated the completed form should be placed as the TOC for each binder. The directions within Appendix KK say to include the completed form as Appendix A of the submitter's proposal. Please clarify where bidders should place the completed Appendix KK within their response.	The completed form should be included as Appendix A of the submitter's proposal
166	Appendix KK	E	Qualifications and Experience	9	Question E.8 refers to investigations listed in response to D.2 of Appendix KK. There is no D.2. Please confirm the correct cross reference.	See response to question #89.
167	Appendix KK	E	Qualifications and Experience	9	The direction in question E.9 refers only to obtaining references for the bidder. However, in part a. of the	The requested references are for the bidder only.

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					question, it asks bidders to list "Your/Subcontractor's name" In the last set of bullets for this question, there are also references to each questionnaire containing the "Proposing Organization/Subcontractor's name". Please confirm if **only** the bidder should submit references.	
168	Appendix KK	M	Early Periodic Screening, Diagnosis, and Treatment	18	Please confirm the cross reference in question M.2 should be to question M.1, not E.1 as written.	Correct,
169	Appendix KK	N	Utilization Management	19	Please confirm the cross reference in question N.1 should be to question R.1, not J.1 as written.	Correct
170	Appendix JJ	Appendix JJ	Transition Period Requirements	1	In the fourth paragraph it states, "MCOs must have successfully met all Readiness Review Requirements established by DHH no later	The revised date for Readiness Review compliance is 1/1/15.

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					than 90 days prior to the Go-Live date." The stated Go-Live date is February 1, 90 days prior would bring us to November 1, which is just five (5) business days post contract award. We recommend that the Readiness Review completion date be negotiated between DHH and each Contractor. Would DHH be open to modifying this timeline?	
171	RFP	4.2	Staff Requirements and Support Services	23	On page 23, it states the BH Medical Director "must be located in Louisiana or available to Louisiana for consultation. However, on page 29, this position is listed as one of the required positions that are located in Louisiana. Please clarify.	The Behavioral Health Medical Director is listed as an In-state Key Staff position in this RFP.
172	RFP	22.18	Aetna Better Health	276	1- Please confirm, is it acceptable to use a font size smaller than 11 points in	1 – Yes 2 – Yes

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					proposal graphics (recommended 8pt)? 2- Also, is it acceptable to use 11x17 page size for larger proposal graphics to make viewing easier for Reviewers (i.e. Health plan Org Charts, IT Systems Diagrams, etc.)?	
173	RFP	2.2.3	MCO Project Overview	8	1- Please describe the rate renewal process for Bayou Health. In particular, what input will the MCOs have in the renewal process? 2- Please describe the recourse MCOs have if they do not agree with the actuarial soundness of the rates given that rates are not subject to negotiation.	DHH contracts with Mercer Health & Benefits (Mercer) for the development of risk-adjusted, actuarially-sound capitation rates. DHH routinely provides opportunities for MCO input into rate development, both prospectively and retrospectively. For example, Mercer actuaries share with MCOs key assumptions prior to rate finalization, provide detailed responses to specific MCO questions, and consider data analyses prepared by MCO actuaries in support of rate changes. Per Section 5.6.1 of the RFP, capitation rates will be offered to MCOs on a “take it or leave it” basis.

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
						Addendum #10 includes the revision to reflect that if the MCO disagrees with the rate, its recourse will be to request DHH's approval to terminate the contract.
174	RFP	3.6.2	Voluntary Opt-In Populations	19	1- Will there be a separate rate cell established for the CHISHOLM members and voluntary opt in members? 2- What assumptions are built into the rates for their utilization and costs? 3- Do the rates assume a certain percentage of an MCO's membership will be voluntary opt-in? If so, how much?	1—Yes, there will be a separate rate cell for both HCBS and Chisholm members. 2—Rate assumptions will be detailed in the rate certification letter provided by Mercer. 3—The rates themselves do not include any specific percentage of an MCO's membership as voluntary opt-in. Such an assumption is not needed given the separate rate cells for this potential enrollment.
175	RFP	5.6	Determination of MCO Rates	33	1- What is the source of the base data for the rates? What adjustments have been made to this experience? 2- How has this base experience	1 – The source of the base data is Prepaid encounter experience, Shared Savings claims experience, and FFS claims experience. The CY13 data reported in the data book distributed with the RFP will be the data used to determine rates. All data

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					been adjusted for break - through drugs in the pipeline and Sovaldi? 3- Describe the development of the utilization trend. How does this vary by region, rate cell, and category of expense? What adjustments have been made for CHISHOLM membership? 4- Describe the development of the unit cost trend. How does this vary by region, rate cell, and category of expense? What adjustments have been made for CHISHOLM membership? 5- When will the actuarial memorandum with the rates be released? Will there be separate written question period for the rates given that we do not have any information prior to the second deadline for questions?	adjustments included in the data book are discussed in Section 5 of the data book. Additional adjustments, yet to be determined, will be included in rate setting. Section 6 of the data book lists the adjustments Mercer is currently considering in rate development. Additional adjustments, not listed in Section 6, may be considered during the development of the rates if deemed appropriate and necessary. Rates are currently under development, and the rate letter will describe the adjustments to this data for determination of the overall Prepaid rates effective 2/1/15. 2 – No adjustments have been made to the data reported in the data book for any drugs in the pharmacy pipeline, including Sovaldi and other breakthrough drugs. DHH and Mercer are currently conducting a study on Sovaldi utilization in the Bayou Health program. Prepaid rates have, and will continue to include, consideration of new pharmacy treatments entering the market. 3 – Trends will be set on a statewide COS and COA level. Some COS may be grouped together for the purpose of developing the

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						trend assumptions. At this time those groupings have not been determined, however it is likely that the trend groupings will be similar to the COS groupings used in setting IBNR. Please see Appendix B of the data book for these groupings. Some COAs may be grouped together for trend calculation purposes as well. Chisholm membership is being considered a separate COA. Given the relatively small size of this class of members, Chisholm may be grouped with another COA, but that determination has not been finalized at this time. 4 – Please see response to #3 above. 5 – The 2/1/15 Prepaid rates and certification letter are scheduled to be released no later than Monday, September 1, 2014. There will be a separate written question period for the rates. See Addendum #4.
176	RFP	5.7	Risk Adjustment	34	Will member level risk score detail will be shared with the MCOs? This will assist us in better identifying high-risk	The current risk adjustment model contract does not allow for member level risk score detail to be shared with the health plans.

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					members and managing care.	
177	RFP	6.1	Value added benefits	42	1- Please describe the evaluation process for value added benefits. 2- Will similar value added benefits from different MCOs receive the same PMPM value? 3- How will variances in similar benefits be handled?	1 – There will be two components to the evaluation of each element: 1) the relevance of the proposed enhancement to departmental priorities specified and the clarity and reasonableness of the expected impact to objectives presented; and 2) the actual PMPM value and the reasonableness of the value of the enhancement proposed, as determined in consultation with our actuarial consultant. 2 – DHH will not adjust PMPMs submitted by proposers, as the amount proposed will be considered a contractual obligation. The evaluation team will award points based on the reasonableness of the rate proposed in consideration of the benefits described. Weight will be given to proposers with higher pmpm values. Proposer should submit a total amount of dollars committed to this effort. If all of the funds are not expended in the manner proposed– for whatever reason—the MCO must expend the funds in an alternate benefit/incentive as approved by DHH or the funds are subject to recoupment by DHH.

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
						3) See response to part 1 of this question.
178	RFP	11.10	MCO Enrollment Procedures	134	1- Please describe how costs for members that are enrolled retroactively are factored into the capitation rates given that there is no ability for the MCOs to manage care prior to their notification of the member's eligibility. 2- How will this cost be accurately reflected given different MCOs will have different percentages of retroactive enrollment, and retroactive enrollment could go as far back as 12 months?	1 – Claims and member months for incurred costs prior to approval of the Medicaid application and MCO enrollment are included in the rate calculations at 100% of medical costs (i.e. no managed care savings given no ability to manage care). The retention (administration, contingency, and premium tax assessment) loads will be applied consistently to all claims regardless of retroactive status. Retention may vary by other factors, but not retroactivity status. 2 – The costs associated with retroactive eligibility will be factored into the rates at the rate cell level. Although retroactive enrollment is likely to vary by member and MCO, Mercer is assuming that the credibility of amounts built into the rate cell levels will be sufficiently high to mitigate such variations. For example, the Social Security Income (SSI) aid group typically has longer retroactive eligibility periods than Families & Children, therefore the rates for the SSI members

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						reflect retroactive enrollment based upon SSI cost experience rather than that of the total program.
179	RFP	18.4	Financial Reporting	246	Please provide templates of the financial reports that will be required by DHH.	Please see link to current financial reporting templates available at the 2014 reprocurement library webpage: http://new.dhh.louisiana.gov/index.cfm/page/1906.
180	RFP Appendix H	N/A	MLR	Appendix H	Please clarify how the MLR refund is adjusted for the exclusion of members with less than 12 months of experience.	Please refer to the Financial Reporting Guide located at http://new.dhh.louisiana.gov/assets/docs/BayouHealth/RFP2014/2014BayouHealthFinancialReportingGuide.pdf.
181	RFP Appendix J	N/A	Performance Measures	Appendix J	1- How will the base and measurement period be established for the performance measures? 2- Will there be adjustments for non-credible MCO experience?	The baseline measures will be produced at the state-wide level and will include only the population that will be eligible to be enrolled in the Medicaid Managed Care Plans. For HEDIS measures certified HEDIS software will be used to calculate the measures. Where measures are nationally recognized, the measures will be calculated according to the published Technical specifications. The data source is the Molina MARS data warehouse which contains prior years' encounter and claims data. Both types of data will be used to calculate the measures. There will be no adjustments to baselines.

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182	RFP	22.17	Proposal Content	276	Will DHH please provide Appendix KK as a Word document, such that MCOs will be able to populate it with page numbers to be used as a table of contents, as requested in the RFP?	Yes. The completed form should be included as Appendix A of your response.
183	Appendix KK	B. Financial Stability	Part II. Financial Requirements	3 or 40	This section states the total possible points are 30. It also states that proposals must earn 25 of the total 35 points for this section for the entire proposal to be evaluated. Please clarify.	Part II is worth a total of 35 possible points included in Sections B, C and D of Appendix KK. Proposer's must score a minimum of 25 out of the 35 points for all sections combined (B, C, and D).
184	Request for Proposals	12.16.14.5	Call Center Performance Standards	Page 167	This section appears to be missing some words.	This was corrected in Addendum #3.
185	Request for Proposal	16.1.6	Systems and Technical Requirements – General Requirements	Page 211	Section 16.1.6 seems misplaced, providing instructions for a "Proposer" rather than requirements of MCOs.	The point was that we wanted the proposer to confirm that they could engage with our "vision "of an enterprise solution.
186	Request for Proposal	16.3.1	Systems and Technical Requirements –	Page 213	Please define which systems DHH would like access to. Also, please confirm the access DHH	DHH would like view only capabilities into Provider, Member and Member benefits screens, PCP linkages, Claims history screens, Services, Formularies, PA and Pre-admission

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
			Connectivity		is requiring is view only.	requests and Encounter history screens.
187	Request for Proposal	7.9	Network Provider Development Management Plan	Page 92	What guidance can the State provide for non-incumbent applicants regarding the desired level of network development activities to be conducted prior to submitting the RFP response? Providers are often hesitant about expending staff time exploring and negotiating agreements with MCOs that may not ultimately be awarded a contract by the State. Does DHH expect the same provider recruitment procedures for Bayou Health as issued for the upcoming LTSS initiative? Would the State consider moving the initial enrollment date for each selected non-incumbent MCO back a few months to enable the plan to secure/demonstrate an adequate network?	Letters from providers of intent to contract with the MCO are not required, but may be used in your network development plan as evidence of network development efforts. Proposer should not submit the actual letters of intent, but a listing of providers who have signed. See response to question #3 for additional guidance on demonstrating capacity to develop an adequate network. DHH cannot move the initial enrollment date for select MCO as the member choice will be based on availability of all plans contracted at the time of open enrollment.
188	Request for	7.10	Patient-Centered Medical Home	Page 94	The current contract does not call for a coordinated care	DHH is looking for evidence of MCO support of PCPs in achieving practice transformation

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	Proposal		(PCMH)		network (CCN) model. The RFP continues to encourage the PCMH model. Can you describe the extent to which DHH is seeking to continue engaging the PCMH model with the HMO/MCO structure?	that enables or enhances the elements of PCMH (including but not limited to increase access, patient engagement, coordination of care, use of HIT, and increased measurement and improvement of quality outcomes) rather than a specific certification.
189	Request for Proposal	12.13	Member Identification (ID) Cards	Page 161	This section states that at least 3 ID cards must be issued, but the ensuing description seemed to involve only two ID cards. Please clarify which three ID cards are required.	This section is being corrected in Addendum #3 to indicate at least two (2) ID cards.
190	Appendix JJ	1st and last paragraphs	Administration and Key MCO Personnel	1-2	Please clarify the timeframe for providing the requested information. The timeframe in the first paragraph and the last paragraph appear to be inconsistent.	See revisions to Appendix JJ included in Addendum #3.
191	Appendix JJ	Sections 11 and 12	Subcontractor Information	3-4	Please confirm that the references to “MCO” should in fact be “Subcontractor”.	Correct
192	Appendix JJ	Section 13	Financial Readiness Review	3	Please confirm that the scope of this requirement is limited to contracts for health care	The scope will apply to the listing of organizations provided in response to Appendix KK Section B.1 as evidence of the

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					services between the Proposer and a State or the federal government.	proposer's qualifications and experience. See revisions to Appendix to JJ included in Addendum #3.
193	Appendix JJ	Section 1	Other Information	4	Please confirm that the scope of this requirement is limited to actions, sanctions or fines imposed by regulators with respect to the types of services contemplated under the RFP. Also, please clarify what is meant by "action?"	The scope will apply to the listing of organizations and contracts provided in response to Appendix KK Section B.1 and F.1 as evidence of the proposer's qualifications and experience. See revisions to Appendix to JJ included in Addendum #3.
194	Appendix KK	Part III, E.1	Qualifications and Experience	6	Must the number of members for each contract be separated by population type? "The listing of contracts should be provided in a table format. For each contract identified, provide each of the following items as a column in the table: the trade name, a brief description of the scope of work, the duration of the contract, the contact name and phone number, the number of members and the population types (e.g., TANF, ABD, duals, CHIP), the annual contract	No

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					payments, whether payment was capitated or other, and the role of subcontractors, if any."	
195	Appendix KK	E.3	Qualifications and Experience	7	Please confirm that the references to "breach" should actually be "non-compliance". Please confirm that the scope of this requirement is limited to contracts for health care services between the Proposer and a State or the federal government.	The question posed in Section E.3 of Appendix "KK" seeks reference to any contract for health care services with any other party, whether a public or private entity or the federal government. The terms "breach" and "noncompliance" are used interchangeably in this provision and are intended to capture allegations of noncompliance or breach of contract made by any other party.
196	Appendix KK	E.4	Qualifications and Experience	7	Please confirm that the scope of this requirement is limited to contracts for health care services between the Proposer and a State or the federal government.	The scope will apply to the listing of organizations provided in response to Appendix KK Section E.1 as evidence of the proposer's qualifications and experience
197	Appendix KK	E.6	Qualifications and Experience	8	Please provide the correct RFP section reference.	Duplicate question, see response to Q 126.
198	Appendix KK	E.7	Qualifications and Experience	8	Please confirm that the scope of this requirement is limited to actions, sanctions, or fines imposed by regulators with	Duplicate question. See response to question 193.

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					respect to the types of services contemplated under the RFP. Also, please clarify what is meant by "action?"	
199	Appendix KK	E.8	Qualifications and Experience	9	Please provide the correct RFP section reference.	Duplicate question see response to question 89.
200	Appendix KK, RFP	Part V; Part X; 23.0.	Evaluation Categories and Maximum Points	14; 38; 279	Please confirm the actual total of possible points for the following sections: Part V. Member Management: 220 Part X. Added Value to Louisiana Members and Providers: 225 (including 25 points for Value Added to Louisiana Employees) As shown, the possible points in the chart total 995 rather than 1,000, and the totals for the Parts mentioned above do not match the point totals given in Appendix KK.	See response to question 20.

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201	Appendix KK	Part V, N.1	Utilization Management	19	To what does the cross reference refer, as Question J.1 does not have bullets? : "Describe any differences between your UM phone line and your member services line with respect to bullets (2) through (7) in item J.1 of this part."	See response to question 91.
202	Appendix KK	Q.6	Pharmacy	24	Treatment of infectious diseases, diabetes, and/or asthma is referenced in conjunction with the use of Behavioral Health Medications. Please confirm this was your intent.	The proposed educational initiatives are not limited to the use of behavioral health medications, but may also include treatment for the other listed diseases. See language as amended in Addendum 3. **Q.6** Describe at least 2 and no more than 4 existing or proposed educational initiatives the PBM or MCO will take regarding the use of: Behavioral Health Medications (including ADD/ADHD); treatment of infectious diseases; and the treatment and control of diabetes ~~and/~~or asthma.
203	Appendix KK	V.1	Program Integrity	32	The last sentence appears to be missing language. Please provide complete sentence.	See response to question 31

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204	Appendix KK	Part IX, W	Information Systems	33	Is it DHH's intention for bidders to address all systems capabilities within the response in order to speak to all 120 requirements listed in section 16, pg. 211 of the RFP.	The response should be detailed enough to demonstrate the proposers capacity to meet the required proposal elements as outlined in Appendix KK Part IX, Section W. It should be concise enough to provide clarity of the proposer understanding of the overall system capacity and interconnectivity of functions needed to support the MCO contract requirements.
205	Appendix KK	Part X, Y.1, and Z.1	Value Added to Members Value Added to Providers	36, 38	For the purposes of calculating the PMPM actuarial value of expanded benefits in Y.1, the question directs us to assume enrollment of 200,000 members. For the purposes of calculating the PMPM actuarial value of the proposed provider incentives in Z.1, the question directs us to assume enrollment of 250,000 members. Is this variance in the assumption of total enrollment intentional?	250,000 members should be used for both. See Addendum #3.
206	Appendix KK	AA.1	Value Added to Louisiana Employees	38-39	Some of the language, including third paragraph, 2nd open bullet references "group of providers" eligible to participate in the incentive. 2nd and 3rd open	The language has been corrected in Addendum #3.

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					bullets also reference "enhanced payments", 1st closed bullet references "associated payments in administrative data and encounter data", appears to reference requirements that are more appropriate for Value Added to Providers. Was that your intent?	
207	RFP-Appendix UU	7.3.1.1	Primary Care Providers	81	There is a discrepancy between appendix UU and the RFP related to the distance requirements for urban PCP's—RFP states "shall not exceed 10 miles", while Appendix UU states urban=20 miles. Please advise of the correct mileage.	This was corrected in Addendum #3.
208	Quality Companion Guide				When does DHH anticipate the Quality Companion Guide to be released? Will Plans be allowed to submit questions upon its release?	The current quality companion guide is available online at http://new.dhh.louisiana.gov/assets/docs/Making_Medicaid_Better/Publications/QCG_Final_Oct2011.pdf The quality companion guide updated by the EQRO in October 2014 based on the new contract requirements.

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209	RFP	2.1.1.5.	Requirements for MCO	7	Please provide the statutory authority for the referenced Fraud Assessment.	LSA-R.S. 40:1428
210	RFP	3.6	Voluntary Opt-In Populations	18	Can you provide any more detail about how DHH will handle Voluntary Opt In population will be communicated with relative to their ability to participate in Bayou Health? Proactive mailings initially to inform them of option to enroll and reminders op option to enroll during Open Enrollment?	The Enrollment Broker will communicate to the voluntary opt-in population at the time of that the member becomes Medicaid eligible in a voluntary opt-in group. Only those members who voluntarily opt-in but later disenroll will be sent an open enrollment notice.
211	RFP	4.2.7	Program Integrity Officer	24	Our current Program Integrity Officer (VP Payment Integrity) has enterprise responsibility This position currently reports into the SVP Compliance and Risk Management. This provides clear separation of responsibilities to mitigate potential conflicts. Would this satisfy the reporting requirements?	No, the program integrity officer must work full-time on the Louisiana contract and report to directly to the CEO.

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212	RFP	4.4	In-State key Staff Positions	29	The key staff positions list 'Program Integrity Officer' twice. (4.4.5 and 4.4.7) Please confirm intent.	The intent was to include a Contract Compliance Coordinator and not list Program Integrity Officer twice. This was corrected in Addendum #3.
213	RFP	4.4.7	Program Integrity Officer	29	The VP Payment Integrity is currently a corporate function serving all states we participate in. Local presence will include local investigators with responsibility for the local LA office. Can this position be located within corporate offices and serve the local office?	No
214	RFP	4.4.16., 4.3.9	Staff Requirements & Support Services	29	Can you validate that "and fraction thereof" means that MCOs would have to dedicate additional percentage of FTE to account for membership beyond 100k (i.e. 1.5 FTE for 150k members)?	One full-time person for each 100,000 enrollees is required. 100,001 would require two full-time fraud investigators.
215	RFP	5.11.1.6	General TPL Information	36	Currently, Legacy programs pursues carrier for retro TPL on professional services, are MCO's directed to follow same requirements?	Yes

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216	RFP	5.11.2.5	MCO Reimbursement	37	What information will be available from the state IV-D agency to support cost avoidance process related to children for whom child support enforcement is being carried out?	IV-D case number, Name and SSN of children. Name, SSN Address, Employment, and third party resources of non-custodial parent.
217	RFP	5.11.6.1	MCO Reimbursement	40	Will DHH invoke right to pursue if MCO has identified third party and initiated/pending recovery to related claim(s)?	No.
218	RFP	5.12.1	Other Coverage Information	40	Confirm that Plans may not act on identified retro TPL until verification is completed with Louisiana Medicaid Fiscal Intermediary. Does that State intend on the health plan initiating proceedings to recover, chase and cost avoid claims pending acceptance onto the State's resource file?	Confirmed.
219	RFP	6.1.4	Core Benefits and Services General Provisions Hospice	43	Will hospice revocations be provided on a monthly basis? What about members that revoke in the middle of the	Hospice recipients will be part of the MCO. The closure/revocation of hospice services will be the responsibility of the MCO.

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					month?	
220	RFP	6.1.4	Core Benefits and Services	44	Please confirm MCO core benefits for eye care and vision services for members <21 years. 6.1.4 indicates core benefits 21 years and older, non-EPSDT. However, 6.2 outlines benefit to all members.	Medical care for diseases or injuries of the eye is a covered service for all ages. Eye wear services are available to Medicaid recipients under age 21.
221	RFP	6.3.1.1, 6.4.1.2	Core Benefits & Services	45, 49	As discussed in the Bidders Conference presentation (Slide 19), can more clarity be included in the RFP to denote that behavioral health pharmacy services prescribed by a SMO contracted provider are not the responsibility of MCO.	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.
222	RFP	6.4 & 6.34	Core Benefits & Services	49	There was a reference in slide 17 of the Bidders Conference presentation that noted a change to criteria for financial responsibility. Is language going to be inserted into the RFP defining this change (particularly around inpatient care and emergency services) or	The major shift in the MCO responsibility versus LBHP/SMO responsibilities for state plan covered services that may include services/treatment for diagnosis code within the range of 299.xx through 315.xx is that under the new MCO contracts responsibility is based on provider type and/or facility type – not primary diagnosis code. See response to question 88.

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					will this be documented via an administrative notice similar to Informational Bulletin 12-18 previously issued by DHH?	Additional information on responsible payer may be found in the RFP for the LBHP/SMO release 8/5/14 available online at http://new.dhh.louisiana.gov/index.cfm/newsroom/category/47
223	RFP	6.27.2.4	Care Management	64	Request clarification on 5 ED in one year. Does this mean calendar year or state fiscal year, rolling 12 months?	This language clarified in Addendum #3. 6.27.2.4 Patients with a condition that causes chronic pain and have five (5) or more ED ~~visits per year~~ in the most recent 12 month period for chief complaint of pain are contacted by the MCO for a pain management plan and this plan will be shared with the patients' PCP, the patient, and relevant ED staff.
224	RFP	6.28.2.11	Core Benefits & Services	66	Can more definition be provided around what is an acceptable "electronic, web-based referral system?" Is this only required if MCO has a requirement for PCP referrals in order to access specialty care?	The requirements for Section 6.28.2.11 are not limited to PCP referrals, but are requirements on the MCO to maintain a system for tracking and monitoring referrals not only by PCPs, if applicable, but also referrals or connections to specialty providers that the MCO make in assisting members with gaining access to appropriate providers both in-network and out-of-network. For example, if a member or a '

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						provider contacts the MCO for assistance in finding a specialist and/or getting an appointment with a specialist within an appropriate timeframe; the MCO should be tracking and monitoring these referrals to assure that appropriate access is available.
225	RFP	6.34.3	Continuity of Behavioral Health Care	70	Will all BH related ER visits now be paid by the MCO?	Emergency room visits will separated between the Bayou Health program and the LBHP as follows: Institutional fees: All general hospital emergency department facility/institutional fees are the responsibility of Bayou Health. LBHP shall be responsible for the facility/hospital charge for emergency services when provided at a psychiatric emergency room (e.g. ER services provided at a freestanding psychiatric hospital). Professional fees: All professional emergency room claims for all emergency services provided by non-behavioral health specialists are the responsibility of Bayou Health. Professional emergency room claims for all

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						emergency services provided by a contracted psychiatrist or LMHP are the responsibility of LBHP.
226	RFP	6.34.3	Continuity of Behavioral Health Care	70	Will the medical provider make all referrals to SMO through the MCO only? Or may medical provider direct refer?	Each managed care entity will be expected to support integrated care, collaboration, and co-management of its members. Bayou Health MCO's and individual providers will be expected to work in conjunction to assure provision of necessary services, coordinate care, and individual providers should have incentive and encouragement to make and coordinated services as required. More complex member needs may benefit form coordination and case management at the MCO administrative level. All Medicaid enrollees are members of the SMO. If a member is in need of specialized behavioral health services, then a referral for those services should be made to the SMO unless there is an emergency situation as provided in Section 6.34.4 of the RFP. Section 7.8.2.2 indicates that it is the PCP's responsibility to refer a patient to any subspecialty if needed.
227	RFP	6.34.4	Continuity of Behavioral Health Care	70	Can you please describe how DHH envisions the MCO will conduct follow up within 48 hours without knowledge of visit in required timeframe?	In any instance when the member presents to the network provider, including calling the MCO's toll-free number listed on the Member's ID card, and a member is in need of emergency behavioral health services, the

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					(With exception of members contacting health plan directly and referred to emergency services) Is this requirement provisional on the successful implementation and integration of ADT data with LaHIE's ED visit registry (16.3.5)?	MCO shall instruct the member to seek help from the nearest emergency medical provider. The MCO shall initiate follow-up with the member within forty-eight (48) hours for follow-up to establish that appropriate services were accessed. As part of care transition, active assistance must be provided to each member, when transitioning to another provider. In such circumstances, the MCO is responsible for timely notification to the receiving provider regarding pertinent information related to any special needs of that transitioning member. Responsibility for obtaining Emergency contact information is the responsibility of both the referring and receiving provider.
228	RFP	6.34.6	Continuity of Behavioral Health Care	70	Will the member's verbal consent satisfy as permission to coordinate care plan with BH provider?	Each MCO must develop procedures and criteria for making referrals to specialty care, including specialized behavioral health services. All related policies and procedures must comply with all applicable Federal and HIPAA standards and regulations.
229	RFP	6.36.2	Care Transition	72	Is member signed consent required in order to initiate the request of transfer for the	No, member signed consent is not required as long as confidentiality of PHI is maintained pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA),

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					member's medical files?	under 45 CFR Parts 160 and 164, (The HIPAA Privacy Rule").
230	RFP	6.36.2, 6.36.6	Core Benefits and Services	73	Provide clarification or definition of "initial MCO implementation". Is that intended to address new MCO plans exclusive of incumbents? 6.36.2 outlines transition period of 30 days while 6.36.6 outlines 60 days.	Section 6.36.6 no longer applies to the new contract period and was removed in Addendum #3). Proposers should also refer to section 6.32 for transition requirements for individuals with special health care needs.
231	RFP	7.3.3.4	Specialists	81	Please advise of the reporting requirements to indicate telemedicine providers or specialty services provided via telemedicine.	According to the Telemedicine Rule (LAC 50:I.501) §503 - Claim Submissions: Medicaid covered services provided via an interactive audio and video telecommunications system (telemedicine) shall be identified on claim submissions by appending the Health Insurance Portability and Accountability Act (HIPAA) of 1996 compliant modifier 'GT' to the appropriate procedure code.
232	RFP	7.8.7.1	Provider Network Requirements	90	Second sentence that begins with "In the event that…" Please clarify, appears some wording may be missing.	Language will be revised in Addendum #10. 7.8.7.1. . . . In the event that the pregnant member does not select a pediatrician, or other appropriate PCP, the MCO shall cover all prenatal care rendered by a PCP within the first 30 days of birth or until the member

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						selects a specific PCP. The MCO shall provide the member with a minimum of fourteen (14) calendar days after birth to select a PCP prior to assigning one.
233	RFP	9.4	Provider Reimbursement	119	Describe MCO encounter reporting requirements for instances of member reimbursement when provider claim is not furnished?	Recipient Reimbursements are not completed with a provider claim. Once a recipient is determined eligible for retroactive benefits, they are required to submit documentation/verification of out of pocket expenses they have paid for the retroactive period to the Recipient Reimbursement Unit. Providers who agree to bill Medicaid for this period must reimburse the patient immediately the full amount they paid for covered services. Providers who agree to reimburse recipients should follow established claim filing procedures. Providers who choose not to accept a Medicaid recipient retroactively should not reimburse the recipient; the State will reimburse the recipient directly.

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234	RFP	9.4	Provider Reimbursement	119	If provider is agreeable, can provider bill MCO for services with credit balance payable to member? This would provide the MCO/DHH claim/encounter for related service.	When a credit balance is referenced, DHH assumes the credit balance exists on the members account with the provider and not the MCO's account; in fact, the credit balance would likely only be recognized upon the provider's correction of billing responsibility from the individual to the MCO. In other words, the provider would likely credit the balance to the member's account and create a charge to the MCO for the service, but the credit may not appear on the claim to the MCO. Assuming that the provider corrects the other insurance records, then yes, the provider should submit the claim to the MCO for payment, and an encounter should be created for the service that is the MCO's responsibility. However, if the provider does not update the billing (resulting in no refund to the individual nor any claim submitted to the MCO by the member or provider), then no encounter will exist for submission to DHH.
235	RFP	11.3.3.2	Eligibility, Enrollment & Disenrollment	131	How will members be treated relative to this provision if they were previously enrolled with CCN-S plan that is not applying as a MCO, but the parent company for that CCN-S plan is	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.

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					awarded a MCO contract?	
236	RFP	6.1.4	Core Benefits and Services General Provisions Hospice	43	Will hospice revocations be provided on a monthly basis? What about members that revoke in the middle of the month?	Duplicate. See response to question 219.
237	RFP	6.33.2	Core Benefits and Services	68, 72	Confirm MCO responsibility for pharmacy continuity when medication prescriber is provider of SMO and medication is related to treatment of behavioral health condition.	The non-behavioral health prescriber's prescription must be honored for 90 days as continuity of care according to Section 6.29.2.10. If maintenance of behavioral health drugs are written by PCPs then the MCO shall be responsible.
238	RFP	12.3.12	Prohibited Marketing Activities	145	What is meant by an "employer-sponsored enrollment event?"	An employer-sponsored enrollment event is any event hosted by a business or organization where health coverage options are presented with enrollment opportunities on site. For the purposes of Section 12.3.12, the prohibition relates to such events where an employer mandates attendance by their employees. If employee attendance is optional, the prohibition does not apply.
239	RFP	12.7.4	Marketing & Member Education	149	Can you provide clarification that this provision would not prohibit member education for	We cannot provide a blanket approval on such activities. Any quality initiative that involves education or outreach efforts in a

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					ensuring compliance with DHH quality initiatives to be conducted by MCO representatives in provider offices?	provider office would need approval from marketing and member education staff prior to implementation.
240	RFP	12.10.3	Marketing & Member Education	152, 161	To ensure operational efficiencies and productive use of this communication tool, can some standard be identified relative to the nature of changes to information posted on website that would require approval by DHH?	Yes. DHH will provide additional details regarding standards for Web approval following the contract award.
241	RFP	12.13.1	Marketing and Member Education	161	Requires a minimum of three different ID cards. Please clarify if MCO ID card includes all required information for pharmacy that a third card is not mandated.	As noted in Section 12.13.4.1, It is the MCO's option to provide a separate pharmacy benefit card or incorporate it into the primary MCO card. It is possible for a member to only have two cards. This has been corrected in Addendum #3.
242	RFP	12.13.3	Marketing & Member Education	162	With the new requirement that ID cards include information about the LBHP, describe the transition period that DHH would expect to make this change? Would MCOs be expected to replace all cards	DHH expects all members to be given updated ID cards with the LBHP information at the start of the new contract period. Members should be sent these new ID cards within ten (10) days of the Health Plan being notified of the member's enrollment in that plan, in keeping with the RFP requirements.

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					should there be a change in SMO vendors?	A change in SMO vendor will not alter the information on the Bayou Health ID card and will not prompt a reissuance of the card. The toll free number used by the SMO (1-800-424-4399) will transfer to any subsequent contractor to ensure a smooth transition for members and providers. Additionally, the name of the LBHP vendor should not be used on the Bayou Health ID card. Bayou Health Plans should use more general terminology on the ID card, for example: "Louisiana Behavioral Health Partnership: 1-800-424-4399" or "Behavioral Health Services: 1-800-424-4399". Please remember, ID cards must be submitted to DHH for review and approval before distribution.
243	RFP	12.16.14.5.	Marketing & Member Education	167	The requirement outlined in this section is incomplete, can clarification be provided?	Section 12.16.14.5 will be deleted and section 12.16.15.1 will be amended to read: The MCO shall have written policies regarding member rights and responsibilities. The MCO shall comply with all applicable state and federal laws pertaining to member rights and privacy. The MCO shall further ensure that the MCO's employees, contractors and MCO providers consider and respect those rights when providing services to members. See Addendum #3.

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244	RFP	13.2.3	Time Limits for Filing	172	In the case of member < 21 years of age, do the same time limits apply?	Yes.
245	RFP	14.1.9	Quality Assessment and Performance Improvement Program (QAPI)	183	Is the MCO to report on all 38 CMS electronic Quality Measures for each of the contracted providers participating in the "Medicaid HER Incentive Payment Program" (should this read EHR?). How will the MCO identify the providers participating in this program? Please provide clarification on measurement requirements, reporting timeframes, provider identification.	The MCO shall make an effort to collect the CMS MU eCQMs for all providers that are participating in the EHR incentive program. A list of providers participating in this program will be made available to MCOs. DHH will use data submitted by the MCO to identify those providers under which a contractual relationship exists. Measure requirements and reporting timeframes are available from CMS: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/2014_ClinicalQualityMeasures.html
246	RFP	14.1.10	Quality Management	184	Is this speaking primarily to the need to report based on demographics? Would the demographic information provided on the 834 file be an acceptable source for capturing this data or is MCO expected to have a separate process?	Yes. Eligibility and enrollment systems capture the needed information to stratify based on a number of criteria. The MCO shall be capable of utilizing demographic data provided by DHH for reducing racial and geographic health disparities among the population.

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
247	RFP	14.2.1.5	Quality Management	184	Please provide clarification on what type of DHH representative should be included and if that committee member is mandated to have full voting privileges.	DHH's Medicaid Quality Improvement Director shall be a member of the QAPI committee. Voting privileges are not a requirement.
248	RFP	14.2.5.10.1	Quality Management	187	In producing performance measure baseline data, will DHH utilize any external auditor in development of final rates?	Baseline rates as well as the methodology will be validated by DHH's EQRO.
249	RFP	14.2.5.10.1	Quality Management	187	As some Incentive Based rates are non-HEDIS, what requirements will DHH utilize to ensure plan conformity?	Non-HEDIS rates will be calculated by DHH.
250	RFP	14.2.5.10.1	Quality Management	187	Describe how baseline data will be produced as statewide aggregate data, and will baseline results be adjusted per individual plan baselines?	The baseline measures will be produced at the state-wide level and will include only the population that will be eligible to be enrolled in the Medicaid Managed Care Plans. For HEDIS measures certified HEDIS software will be used to calculate the measures. Where measures are nationally recognized, the measures will be calculated according to the published Technical specifications. The data source is the Molina MARS data warehouse which contains prior years' encounter and claims data. Both types of data will be used

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						to calculate the measures. There will be no adjustments to baselines.
251	RFP	14.2.6.1	Quality Management	188	Please clarify if DHH will be reporting performance measures (Appendix J).	DHH will make monitor and publish performance measures on its website.
252	RFP	14.2.6.1	Quality Management	188	DHH will produce statewide baseline data and monitor plan performance via administrative encounter data. Please confirm, will the health plan be responsible for production of all final results (HEDIS and non-HEDIS)?	DHH will calculate performance measures independently from the MCOs using encounter data. MCOs are still required to report the HEDIS set to NCQA and to have the ability to monitor and self-report when requested by DHH.
253	RFP	14.5.54	Quality Management	196	Health plans recognize requirements of ACT 311 and have ensured processing procedures are compliant to legislation. To ensure that the quality of credentialing verification processes are not further compromised in a compressed timeframe – would DHH consider a second timeframe requirement on provider registry submission or increase frequency to which	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. Yes, we will provide for the submission of twice a week updates of the provider registry.

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					provider registry files can be sent. (currently only weekly)	
254	RFP	15.1.14.	General Requirements	200	While the MCO is restricted to withholding payments to providers in accordance with sections 15.1.13. and 15.7.10, can the MCO request medical records and perform prepayment reviews of the medical record to validate that services were performed?	Yes, please refer to section 15.6, *Medical Records*.
255	RFP	15.1.13.1.	General Requirements	201	Please describe the process by which the state will notify the MCO when contracted or non-contracted recoveries are made. What is the timeline for notice?	The Medicaid Program Integrity Section and MFCU will engage in on-going communication with the MCOs.
256	RFP	15.1.13.2.	General Requirements	201	Will the state notify the MCO when contracted or non-contracted recoveries are made by the state or the RAC?	Yes.
257	RFP	15.1.13.3.	General Requirements	201	Will the state notify the MCO when contracted or non-contracted recoveries are being investigated by the state or the	The Department will notify the MCO in instances of audits that meet the criteria outlined in 15.1.13. There could be isolated

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					RAC?	occasions where actual investigations by the state are not shared with the MCO.
258	RFP	15.1.14	General Requirements	201	Is it the expectation of DHH that every case wherein an overpayment is identified be vetted by DHH prior to initiating recovery actions? If so, what is the timeframe for said DHH review and notification by DHH as to whether the MCO can proceed? Is there a process that is developed to ensure the MCO can develop a quick turn-around process in order for the MCO to rapidly recover overpayments?	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.
259	RFP	15.1.16.4.1.	Reporting and Investigating Suspected Fraud and Abuse	201	15.1.16.4.1. states that any program integrity case opened within the previous two (2) weeks shall be reported to DHH and MFCU. Can DHH confirm whether this information should be a biweekly (every 2 weeks)	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.

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					submittal?	
260	RFP	15.1.16.4., 15.5.1.	Reporting and Investigating Suspected Fraud and Abuse, Reporting	201, 207	Can DHH please clarify how the timeframes discussed in section 15.1.16.4. correlate with the timeframes established in section 15.5.1.?	The timeframes in 15.1.16.4 correlate to the reporting timeframes in 15.5.1 as suspected provider or recipient fraud, waste, or abuse or suspected abuse in the administration of the program must be reported to DHH within three (3) business days.
261	RFP	15.1.16.4.3., 15.1.16.4.4.	Reporting and Investigating Suspected Fraud and Abuse	202	Can DHH please clarify “immediately” – e.g., does this mean as soon as suspected/reported, a daily digest, within one business day?	The glossary defines "immediate" as "In an immediate manner; instant; instantly or without delay, but not more than 24 hours." Reports of suspected enrollee fraud and/or abuse – that do not raise a health and safety concern for the beneficiary – must be reported “promptly” i.e. within three (3) business days. Any suspected enrollee fraud and/or abuse – that raises a health and safety concern for the beneficiary – must be reported immediately. The MCO shall report any of the above types of provider and/or recipient fraud to DHH through the following url:

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						http://www.dhh.louisiana.gov/index.cfm/page/219. These reports shall also be cataloged on the Fraud Reporting tool and submitted according to its published schedule.
262	RFP	15.1.16.11	Reporting and Investigating Suspected Fraud and Abuse	202	What is the timeframe the MCO can expect a response from DHH or MFCU as to whether identified overpayments can be pursued?	The timeframe for investigating allegations of fraud and abuse vary. The Medicaid Program Integrity Section and MFCU will engage in on-going communication to assist the MCOs with recovery efforts.
263	RFP	15.1.22	Reporting and Investigating Suspected Fraud and Abuse	203	Does this include all overpayments even if fraud and abuse is not discerned?	This section only refers to overpayments related to fraud, abuse, and waste prevention. Recovery of overpayments for other purposes, such as TPL, is addressed elsewhere in the RFP.
264	RFP	15.6.1	Fraud Waste Abuse	207	Confirm that medical record requirements and methodology is supported by requirements outlined in 8.2.2.9	We find the requirements found in 8.2.2.9 and 15.6.1 to be consistent with the requirement of medical records that support the delivery of quality services.
265	RFP	15.7.3	Rights of Review and Recovery by MCO	209	Is the MCO required to notify providers regarding all reviews	Section 15.7.3 appears incomplete.

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			and DHH		or just those reviews that are believed to be false claims?	This section needs to be read in conjunction with 15.7.2 which PROHIBITS notifying providers of reviews resulting from suspected F&A. The MCO should NOT notify the provider until DHH approves such follow up.
266	RFP	15.7.4	Rights of Review and Recovery by MCO and DHH	209	Will the MCO be required to retain all overpayments for reviews back 5 years from DOS? Would DHH contemplate extending the period from 12 months to 18 months?	1) 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. 2) No, the period remains 12 months.
267	RFP	15.7.3	Fraud, Abuse & Waste Prevention	209	The requirement outlined in this section is incomplete, can clarification be provided?	It does appear the requirement is incomplete. DHH should provide additional information on 15.7.3.
268	RFP	15.7.5	Rights of Review and Recovery by MCO and DHH	210	How will the MCO be made aware of the state's pursuit of overpayment for a contracted or non-contracted provider?	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.
269	RFP	15.7.6	Rights of Review and Recovery by MCO and DHH	210	To avoid duplication of efforts as the health plan continuously conducts automated claims review; can an exclusivity period be reconsidered for this requirement? Additionally,	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

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					how would the state and its subcontractors recognize health plan contracted rates and enhancements/extensions to covered benefits within states automated review process?	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.
270	RFP	15.7.7	Rights of Review and Recovery by MCO and DHH	210	How will DHH determine overpayment in context of contracted health plan rates may exceed legacy Medicaid and/or benefits?	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. 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.
271	RFP	15.7.10	Rights of Review and Recovery by MCO and DHH	210	What happens in the event this would cause a credit balance as future claims have stopped?	Any such credit balance would be sustained by the MCO and/or department until resolved or dismissed under department rules.
272	RFP	16.1.6	Systems and Technical Requirements	211	Does the state have a service-oriented architecture strategy and, if so, a timeline for	The Department has a vision of our enterprise architecture. We have shared that vision with the Division of Administration and CMS. We have

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					implementation?	submitted an Advance Planning Document (APD) to CMS with regard to this and it has been approved. We are currently working on the Request for Proposal with regard to our enterprise Architecture and we anticipate releasing this year.
273	RFP	16.1.5	Systems and Technical Requirements	211	Please provide additional details regarding your XML requirements for non-proprietary data	XML specifications for future required datasets will be developed in consultation with the vendor.
274	RFP	16.3.5	Systems & Technical Requirements	214	Can provisions be made for a phase in period or hardship clause so that MCOs wouldn't be prevented from contracting with facilities that do not have the capacity to share at contract implementation?	MCOs may accept signed LaHIE participation agreements as evidence of the hospital's intent to exchange ED data with DHH through the HIE. It is not possible for all hospitals to be on boarded at once. MCOs shall make reasonable accommodations as appropriate and after receiving DHH approval.
275	RFP	17.2.5	Claims Management	230	Timely Filing Guidelines update moved timely filing requirements to 180 days – is this intended to begin with dates of service 2.1.2015? Will this timely filing change be applied to legacy Medicaid claims? Does DHH anticipate distributing any informational	Yes, this will begin with dates of service on or after 2/1/15. Changes in the Legacy Medicaid policy are being considered, but have not been finalized. Appendix O will be amended to 180 days.

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					bulletins to announce this change? Also, line 35 of Appendix O states a 12 month filing timeframe. Which timeframe is correct?	
276	RFP	17.3.4	Claims Management	232	Please define what "state imposed provider fees for pharmacy service" apply and included in MCO rates.	This is the $.10 provider fee that shall be added to the dispensing fee
277	RFP	18.11	Report Submission	248	MCOs shall use the Quality Reporting Document Architecture – Category lll, will this document be available in the new Quality Companion Guide?	Yes. However, this document is published by HL7. Proposers should consult with HL7 on QRDA specifications.
278	RFP	22.12.2	Proposal Submission	273	What, if any, are the requirements for how the proposal binders and electronic copies should be labeled?	See response to question 144.
279	RFP	22.12., 22.12.4.	Proposal Submission	274	What, if any, are the requirements for how the boxes for the proposal submission should be labeled?	Boxes should be labeled with the proposers name and a description of the content (number and label on binders).

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280	RFP	5.4.3	Payment Adjustments	33	A recent Retro Enrollment issue where 15,000 claims were incorrectly processed demonstrates inefficiency in the eligibility information exchange process. These inefficiencies cost providers time and dollars in administrative burden to remedy this issue that they did not create. DHH and the plans should be able to exchange claims and eligibility information electronically and keep the provider out of the middle. Why is this not possible with the technology available today? What steps has DHH taken to ensure that adjustments, recoupments, and other payment issues are resolved efficiently and providers are given ample information and ensure they are paid appropriately for the services they provide?	The Department has implemented monthly recovery projects that will help institute a more timely and efficient mechanism to handle such issues.

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281	RFP	6.1.3	General Provisions	42	Why is the reduction of non-emergent care in the ED through increased access to after-hours care, same day appointments, etc. considered a "value-added" in this RFP? When developing the rates for the existing managed care program, DHH and its actuary stated clearly in the Managed Care Assumptions section of the rate letter that it was assumed that the plans would reduce utilization through some of these same mechanisms. What steps is DHH taking to ensure plans are held accountable for their responsibilities to provide access and coordinate care?	Rate certification applies only to required benefits and services. Value added services are optional. This section outlines DHH priorities for optional services. It is complementary to, but separate and apart from, rate setting for required benefits and services.
282	RFP	6.4	Behavioral Health Services	49	What steps has the Department taken to current issues related to hospitals being caught between the MCO and SMO disagreements on responsibility for services provided to	Responsibility for services, including emergency department-related services, will be specifically addressed in the SMO RFP released 8/15/14 and available at

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					enrollees with co-existing medical and behavioral conditions, particularly ER-related services?	
283	RFP	6.8.1.3	Emergency Medical Services	53	Is a patient's PCP considered a representative of the MCO for the purposes of this requirement?	Yes, unless otherwise specified in MCO policy or contract between the MCO and the PCP.
284	RFP	6.8.1.7	Emergency Medical Services	53	Can the Department clearly articulate the requirements on the MCOs relative to non-emergent use of the ED and the value-added provisions referenced 6.1.3? In reading these two sections, they appear to be contradictory.	See response to Q281.
285	RFP	7.3.3.4	Specialists	81	In instances where telemedicine is utilized in a MCO's network, what steps will the Department take to ensure that it is utilized as augmentation versus replacement of physicians in the enrollee's geographic area?	If an MCO intends to utilize telemedicine to improve patient access to specialists and meet network adequacy requirements, the MCO must submit a telemedicine utilization plan that must be approved by DHH. This plan should include a directory of in-network PCPs and specialist providers with telemedicine capability and a basic description of the telemedicine services they offer. This information should be available on the MCO's

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						website. The MCO must also submit the procedures for accessing telemedicine and making referrals to telemedicine-provided services within and outside its network.
286	RFP	7.6	Provider Enrollment	83	The term 'good faith effort' is used multiple times in the context of MCO contracting. What does the Department consider to be a 'good faith effort' by the plan?	Three bona fide and documented attempts to contract with the provider, that are compliant with all requirements of the RFP and rate floors.
287	RFP	8.1.4	Utilization Management	8.1.4 and 8.1.5	Communication relative to various plan requirements has been an issue in the existing program. What steps will DHH be taking to ensure better communication and coordination? Also, can DHH elaborate on what they consider to be practice guidelines versus clinical criteria?	Any additional requirements or procedures for enhanced communication and coordination will be issued via Health Plan advisory or Informational bulletin. At this time practice guidelines and clinical criteria are considered one and the same. The department is researching to see if there are any industry standard definitions that distinguish between the two terms.
288	RFP	8.1.15	Utilization Management	104	What does DHH consider to be a licensed clinical professional for the purposes determining denials?	In this context, licensed clinical professionals are limited to Physicians, those individuals who have been properly trained and are licensed to practice medicine within their scope as determined by Louisiana State

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						Board of Medical Examiners. Denial of services or authorization of a lesser service than requested must be reviewed and determined by a Physician within the MCO
289	RFP	8.4.3	Service Authorization	107	How will DHH measure and enforce this requirement?	DHH will provide additional clarification in and Informational Bulletin and/or Health Plan Advisory.
290	RFP	8.5.1.2	Timing of Service Authorization Decisions	108	Why are the MCOs not required to make 100% of concurrent review decisions with two days?	The standard is set with the realistic expectation that there will be certain non-routine cases that may exceed this timeframe or due to excessively high volumes on any given day.
291	RFP	8.5.4.1.3.1	Informal Reconsideration	110	A major issue that has plagued the existing program involves confusion regarding when a provider can initiate a reconsideration, appeal, grievance, complaint, etc. and whether they need a member's consent. A health plan advisory was subsequently issued in an attempt to resolve. What steps is the Department taking to bring more clarity and standardization to reconsideration, complaint, appeal, grievance process? Why	A provider can request an appeal on a member's behalf, with the member's written consent, for a denied service or partial denial of service. This appeal can be with the MCO and subsequently with DAL after exhausting the internal MCO appeal process. The process will be uniform across Bayou Health Plans as they will all be risk bearing models.

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					can this process not be uniform across all Bayou Health Plans?	
292	RFP	8.5.4.2	Exceptions to Requirements	112	As referenced previously relative to recent Retro Enrollment issues, the eligibility information exchange needs serious improvement. What allowances will the Department make in instances where hospitals have made good faith efforts to obtain accurate eligibility information, yet incur an administrative denial or recoupment?	The eligibility information exchange has been streamlined as issues were identified and will continue to be enhanced as additional issues are identified.
293	RFP	8.5.2	Expedited Service Authorization	108	Why are the MCOs allowed 72 hours for expedited authorizations? By definition, should that timeframe not be shorter?	The maximum 72 hour time frame to render a decision is specified in 42 CFR 438.210.
294	RFP	8.5.3	Post Authorization	108	In these cases, how is 'retrospective' defined? For example, if a patient who is admitted and discharged over a non-working day period, is the case considered concurrent with the first information	This case would be considered retrospective. Notification of admission to the plan may have occurred via the hospital admissions department but neither clinical submission or review of the clinical occurs prior to discharge of the patient. Hospital providers are still required to comply with timely

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					submittal or retrospective to the first information submittal?	notification and request for precertification requirements. This case is different than a retrospective case secondary to retroactive eligibility.
295	RFP	8.10	Pharmacy Administrative Simplification	115	Is the section referenced within this paragraph (6.40.1-6.4.09) a typographical error?	Refer to 6.3 Pharmacy Services
296	RFP	8.10	Pharmacy Administrative Simplification	115	Do any changes to the common pharmacy administration framework need to be agreed upon by all MCOs prior to submittal to DHH for approval?	Yes.
297	RFP	9.0	Provider Reimbursement	118	DRG methodology is referenced. Is it DHH's intent to implement a DRG system and what is the proposed timing of that effort?	DHH continues to explore options for value-based purchasing, including but not limited to reimbursement of inpatient hospital services on a DRG basis. No timeline for DRG implementation has been established.
298	RFP	9.1	Minimum Reimbursement to Network Providers	118	Is there a requirement that the MCO seek prior approval from DHH for any alternative rate structure, particularly one less than current Medicaid, as in the existing Medicaid managed care program?	DHH approval is only required for alternative reimbursement arrangements with FQHC and RHC, per Section 9.2.2 of the RFP.

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299	RFP	9.3.2	Reimbursement to Out-of-Network Providers	119	Is 90% of the published Medicaid rate the reimbursement floor for OON providers after the 3rd documented attempt requirement has been satisfied?	The 90% is a rate floor; however MCO and providers can negotiate alternative rates if agreed to by both parties. Also, payment to out of network providers may be subject to prior approval of services by the MCO according to their published policy. An MCO may require the member to use an in-network provider, unless none are available within the travel time and distance requirements and within the timeframe appropriate for the urgency of the medical condition.
300	RFP	9.6	Inappropriate Payment Denials	120	Please describe, in detail, how the Department measures and enforces this requirement.	This is monitored monthly via self reported data from the MCO and validated quarterly against claims data.
301	RFP	9.7.6	Payment for Emergency Services and Post-Stabilization Services	121	Is it the Department's intent to allow plans to require notification from hospitals regarding ER utilization? How does the Department reconcile that with the data-submission mandates specified in section 16 of the RFP?	The Department is considering allowing MCO mandates for ER utilization; however final policies are still under discussion with the larger ER reform workgroup
302	RFP	9.8	Physician Incentive Plans	122	While we are certainly supportive of provider opportunities for incentives, the	Incentives are not limited to physicians and are at the discretion of the MCO.

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					wording in the RFP appears limited to physicians. How are MCOs encouraged to develop arrangements with hospitals that recognize and incorporate incentives to manage population health and improve healthcare quality and outcomes?	
303	RFP	9.10	Payment for Hospital Services	123	When will Appendix G be released for review?	September 1, 2014
304	RFP	10.4.2	Provider Handbook	126	Are the MCOs required to give at least 30 days notice of changes in the Provider Handbook to providers? Also, will DHH consider adding provisions to the RFP prohibiting the implementation of material payment process changes through the provider handbook? Payment mechanics should be negotiated and agreed to by both parties. Material changes through a provider handbook tied to a simple notification changes the	30 days notice is not a current requirement of the RFP, but DHH is considering language to this effect. Changes if any will be posted via Addendum. Language regarding process for notification of material changes is best suited for inclusion in the individual contract as negotiated between the provider and the MCO.

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					contract without mutual consideration and agreement.	
305	RFP	13.2.2.1.2	Member Grievance and Appeal Procedures	172	As previously referenced, an issue in the existing programs is the overall lack of clarity and standardization around the complaint, appeal, and grievance process for providers. If you review the provider handbooks of the current plans, each has their own variation as well. If everyone has a variant process, how does the Department accurately measure and report complaints, appeals, and grievances?	Provider complaints and grievances include the expression of provider dissatisfaction with general policies and actions of the MCO. Complaints may be received orally, via phone, in writing or as submitted by DHH. A grievance is a compliant formally filed with the MCO according to procedures established by the MCO. Provider appeals are request for the reconsideration and reversal of a MCO's decision on a specific action or transaction such as the denial or reduction of a claim, the imposition of a penalty or recoupment of payment, the termination of a contract, etc. DHH will work with all contracted MCOs to standardize the reporting of these measures across entities.
306	RFP	16.3.4	Connectivity	213	Why is the Department pushing the use of a specific vendor in the form of LaHIE?	The state intends to leverage existing investments in HIE for the purpose of improving patient safety, quality of care and health outcomes. In 2010 the Office of the National Coordinator for Health Information Technology (ONC) awarded a $10.6 million

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						grant to the state to advance health information exchange among providers and hospitals in their designated areas. The Louisiana Health Care Quality Forum was designated by the state as a neutral entity to build and support a health information exchange (HIE) in our state to allow authorized providers and organizations to electronically access and share health-related information through a secure and confidential network.
307	RFP	16.3.5	Connectivity	214	LHA has been working with DHH and MCOs on developing collaborative data sharing initiatives that take into account varying technological capabilities. Why is DHH choosing to mandate this process and a specific vender? Will the hospitals have any financial obligations to a third party or will this be handled through a subcontract between DHH and a vendor?	DHH wishes to leverage substantial investments made into the SHIE program funded by ONC. Hospitals have no financial obligations to DHH for data sharing. DHH will contract with LHCQF for design, development and implementation of ADT visit registry services only.
308	RFP	16.9.1	Provider Enrollment	221	Medicaid providers are required to submit ownership disclosure to DHH. The Department	Current procedures are consistent with Health Plan Accreditation requirements, but the department is actively investigating

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					should be able to provide that information to its contractors. Will the Department require plans to accept this information as provided to the Department by existing Medicaid providers?	opportunities to streamline this process.
309	RFP	17.2.2.3	Rejected Claims	230	Does DHH feel like the minimum information required for rejection notices meets the minimum required by La. R.S. 46:460.71? There appears to be missing information.	Section 17.2.2.3 should read: The rejection letter shall indicate why the claim is being returned; including all defects or reasons known at the time the determination is made. As required by La. R.S. 46:460.71, the letter shall, at a minimum contain the following information: • The patient or member name. • The MCO claim number. • The date of each service. • The patient account number assigned by the provider. • CPT codes for each procedure, including the amount allowed and any modifiers and

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
						units. • The amount due from the member that includes but is not limited to copayments and coinsurance or deductibles. • Identification of the MCO on whose behalf the payment would be made. • IF the MCO is a secondary payer, then the MCO shall also send acknowledgement of payment as a secondary payer, the primary payer's COB information, and the third-party liability carrier code. Please see Addendum #10
310	RFP	17.2.5	Timely Filing Guidelines	230	Why is timely filing now reduced to 180 days when Medicaid FFS is 12 months? This is an issue for providers, particularly with ICD-10 on the horizon.	The reduction of the period for timely filing is consistent with industry standards and is intended to reduce the extended claim lag that prolongs the time required to finalize encounter data needed for program monitoring and rate setting.
311	RFP	17.6.2	Claims Dispute Management	234	Binding arbitration – Why is the Department mandating binding arbitration through the RFP process? We would consider this to be a contractual	Binding arbitration for claim dispute resolution is considered a viable option when compared to litigation since it is thought to lead to easy claim management, will save time and money, and is more convenient.

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					negotiation between a provider and a health plan. As written, it also appears to be a disincentive for a provider to undertake this effort due to cost prohibition.	
312	RFP	20.6	Excessive Reversals on Appeal	262	This section only mentions member appeals. Please describe how DHH plans to track and address excessive reversals on appeal for providers? There is no information in the Table of Monetary Penalties.	This requirement only applies to Member appeals. Per federal requirements Members must be provided the right to appeal decisions to deny or limit services.
313	RFP	General Question			Has the Department incorporated all provisions in existing Informational Bulletins and Health Plan Advisories into the RFP and supporting documents? If not, will the existing continue to apply?	Many of the bulletins and advisories have been incorporated. DHH will continue to use these mechanisms to clarify policy and procedure.
314	RFP	8.4	Service Authorization	106	What steps has the Department taken, or will be taking, to bring some streamlining to the physician-to-physician review process? On the hospital side,	The plans are contractually required to conduct the informal reconsideration in the form of a peer to peer consultation within one day of the receipt of request for the reconsideration. Difficulties with this

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					we have seen this develop into a cumbersome process that the plans use to delay the authorization process with unrealistic timeframes and scheduling difficulties.	process should be brought to the forum of the Administrative Simplification Committee for resolution.
315	System Companion Guide	8	Medicaid Administrative Retroactive Enrollment Correction Process	21	Why has the Department chosen to implement a manual process to impose additional cost and administrative burden on providers to (1) have to re-verify eligibility and (2) submit hardcopy claims with additional documentation? This is inefficient and burdens entities that have zero influence on this process.	This practice is standard for third party liability and Medicare claims adjudication.
316	RFP	General Question			What is the Department's intention for the outlier pool going forward?	No change is anticipated at this time.
317	RFP	5.4.3	Payment Adjustments	33	What timely filing allowances are made for providers in these instances? Providers have no control over the eligibility information exchange function.	Health Plan Advisory 14-12 dated July 24, 2014, changed the 60 day requirement for MCOs to initiate recoupments of payments to 30 days. It is being considered to further require providers to resubmit claims within 30 days of recoupments; however, a final

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						decision has not been made by DHH. Any requirements developed will be released via Informational Bulletin.
318	RFP	General Question			Will DHH require the MCOs to update their claims processing systems and re-adjudicate claims within two weeks of notification by DHH of any FFS payment rate updates? Long delays on this front have been an issue in the current program for providers that are contracted at some derivative of the Medicaid FFS rate.	This is not a requirement of the current RFP; however DHH will work with contract awardees prior to the 2/1/2014 contract start date to determine a feasible turnaround time and will release the decision in a Health Plan Advisory.
319	RFP	16.3.5	Connectivity	214	Will the MCO's be required to share savings related to these provider mandates with providers on this, or any other initiative, where savings are achieved because of these mandates and provider actions?	This is not a requirement of the RFP. MCO's have the discretion to develop their own provider incentive/shared shavings program, subject to approval by DHH.
320	RFP	General Question			Will the Department offer clarification on the issue escalation timeline and process for health plans?	See amended language for Section 10.6.5 in Addendum #3.

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321	RFP	17.2.2.3	Rejected Claims	230	Does DHH feel like the minimum information required for rejection notices meets the minimum required by La. R.S. 46:460.71?	See response to question # 309.
322	RFP	6.8.2	Post Stabilization Services	54	Hospitals are reporting issues with health plans denying post-stabilization emergency transfers for lack of prior authorization. Currently, if the transfer is made within 1 hour there is no prior authorization requirement. It seems that the plans are denying all emergency transfers reasoning that since the patient must be stabilized for the transfer they are no longer emergent. This is not the case in many situations. For example, a rural hospital may get a patient to a condition where they can be transferred; however, the patient is still in a serious medically emergent condition. This issue is creating major issues for hospitals and has the potential to affect	The situations described would require a detailed review of clinical information in a series of examples to determine if action by the Department is warranted. Hospital providers do have the opportunity for reconsideration to demonstrate medical necessity for transfers and are encouraged to utilize this option.

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					patient care. How will this issue be addressed?	
323	RFP	5.11	TPL	36	Can the MCO pay and chase even if they find there is existence of TPL at the time of the filing of the claim? The RPF is silent on the application of LA R.S. 46:446.6. This statute give health care providers the right to recover the difference in the amount of reimbursement they collect for a Medicaid recipient and what they should have collected from the TPL insurer. For example, if the Medicaid payment is $100 and the TPL insurers contracted rate with the provider is $130 the health care provider is entitled to collect the $30 from the TPL insurer. How will DHH require the Medicaid MCO to satisfy the Department's required actions on Medicaid claims per La. R.S.	No, only in situations required by 42 CFR Part 433, Subpart D. The Medicaid MCO shall allow the provider to submit charges to the TPL and permit the provider to receive the TPL payment and retain that amount even it is greater than the Medicaid allowed amount. If TPL is discovered after the services was rendered the provider shall have the right/obligation to submit to the TPL for payment. Once payment is made the original claim should be voided and resubmitted.

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					46:446.6?	
324	RFP	5.11.4	TPL	36	Will the department require the Medicaid MCO to give the providers the dollars collected from the TPL insurance over the MCO financial liability of the member?	The Department is neutral with regard to this question. This should be addressed in the contract between the MCO and the provider.
325	RFP	8.0	Utilization Management	102	Since each of the Bayou Health plans currently have different UR plans, the process for mitigating adverse determinations has become cumbersome and over burdensome. In Legacy Medicaid, a healthcare facility could do a written resubmittal if additional information was available or important information had been omitted prior to asking practicing physicians to conduct peer to peer conferences. The omission of this step and defining the first step as information reconsideration creates situations where physicians	In Legacy Medicaid, resubmittals are allowed when initial requests for precert or extension requests are rejected, not when a denial or adverse determination is issued. The plans are contractually bound to issue determinations, approvals or denials, within very specific timeframes. Rejections are not determinations. Resubmittals prolong the precert process and prevent providers from real time approvals/denials. Providers are encouraged to submit all relevant clinical information with the initial request for admission or length of stay extension. Provider familiarity with medical necessity criteria is key in this process. The Department receives quarterly reporting from all plans detailing determinations.

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					have to take valuable time away from treating patients to conduct phone conferences that could possibly be avoided. Currently physicians are reluctant at best to spend this time with MCO physicians. Why was the step of written resubmittals not included in the RFP? Why are the timeframes so tight (1 business day of receiving adverse determination)? What has the Department done to monitor and streamline the process of adverse determinations?	
326	RFP	General Question			Will the Department standardize and issue guidance on observation? Observation has been a burdensome issue. An example is when a patient could be in observation status for longer than a plan's stated timeframe, and the plan	The current timeframe for observation status is 30 (thirty) hours. It is the Department's understanding that all 5 (five) plans are operating with a 30 hour limit for observation. Systemic problems with the adjudication of observation claims should be brought to the Department's attention review.

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					is denying the entire claim instead of just the amount of time over their prescribed level of coverage. Differing times allowed also create additional administrative burdens on providers.	
327	RFP	16.3.5	Connectivity	214	Will hospitals have any financial obligations to the quality forum (LAHIE) or will the quality forum simply be functioning as a subcontractor of the department?	DHH does not require any contractual obligation exist between hospitals and LHCQF, its programs or contractors. MCO assumes responsibilities for connectivity and its associated costs.
328	RFP	N/A	Appendix G	N/A	Please confirm that the deadline for questions will be extended so that MCOs will be allowed to submit questions related to rate structure once DHH releases that information?	See Addendum #4 for deadlines for submission of rate-specific questions after the release of the rates.
329	Proposal Conference		"Specialized" Behavioral Health Services		At the Proposal Conference it was stated that, "Specialized behavioral health services—including pharmacy benefit management of behavioral	Responsibility is based on provider type of the prescribing providers. Additional information is available in the LBHP/SMO RFP released 8/15/14.

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					health drugs prescribed by their contracted prescriber— are outside the scope of this RFP." Since the current contract holds the MCOs responsible for BH drugs regardless of the prescriber, can DHH clarify the pharmacy benefit management of BH drugs that will fall within the scope of the Bayou Health MCOs' contract.	
330	Proposal Conference		Retroactive Eligibility		In terms of forecasting the impact of retroactive eligibility, should MCOs assume a similar member experience from previous years in the Bayou Health program, with the only exception being that MCOs will now receive the premium for the member during the retroactive period as well as become responsible for the costs incurred by that member during the same period? Or, said differently, does DHH expect a certain number of members who were historically covered by the Fee For Service	The responsibility for retroactively eligible members will be accretive to the Bayou Health program membership. Historically, Medicaid eligibility begins no later than the first day of the month of Medicaid application and is rarely a prospective date.

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					program due to their retroactive eligibility status to now become eligible for the Bayou Health Program and the financial responsibility of MCOs? If responsibility for retroactively eligible members will be accretive to the Bayou Health program membership, please describe DHH's historical experience with this population.	
331	Appendix KK	B.3	Financial Stability	4	If a bidder is not currently rated by AM Best, will DHH consider accepting ratings from comparable rating agencies such as Moody's or Standard & Poor's?	Yes, a rating from Moody's or Standard & Poor is acceptable.

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
332	Appendix KK	E.8	Qualifications and Experience	9	This question reads, in part: "State whether or not your organization is currently the subject or has recently (within the past five (5) years) been the subject of a criminal or civil investigation by a state or federal agency other than investigations described in response to item D.2 of this part. . . . . ." Since there does not appear to be a D.2 in Appendix KK, please provide the correct reference for this question.	The reference should be C.1 and will be corrected per Addendum
333	RFP	2.6.1.3	Bond Requirements	12	Please explain the logic for increasing the performance bond require	The amount of the performance bond was increased commensurate with the scope of this procurement, which is significantly larger than the original Bayou Health RFP in terms of both covered lives and covered services.
334	Appendix KK	N.1	Utilization Management	19	This question reads, in part: • Describe any differences between your UM phone line and your member	See response to question 91 and addendum #3.

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					services line with respect to bullets (2) through (7) in item J.1 of this part; . . . . ' During the 2011 procurement, DHH changed the word "member" to "provider," which appears to be more relevant to this question. Please clarify whether the same change should be made for this RFP question.	
335	Appendix KK	P.1	Non-Emergency Medical Transportation	23	This question reads, in part: "P.1 Describe in detail your proposed approach to providing non-emergency medical transportation (NEMT) services, including, at a minimum: • What administrative functions, if any, you will subcontract to another entity (If subcontracting this function, the subcontractor information must be provided in	The correct reference should be F.4. See Addendum.

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					response to item **C.6.); . . .** **."** Since there does not appear to be a C.6 in Appendix KK, please provide the correct reference for this question.	
336	RFP	R.2	Customer Service	25/40	Question requires "telephone reports for your Medicaid or CHIP managed care contract with the largest enrollment as for January 1, 2014." Please confirm that an incumbent can provide reports for Louisiana only.	Reports can be provided for Louisiana only.
337	RFP	KK: T1	Member and Marketing Materials	27/40	Question requires "proposed content for your member educational marketing materials and attach examples used with Medicaid or CHIP populations in other states." Please confirm that an incumbent can limit the examples to those currently used in Louisiana.	Incumbents can limit to Louisiana examples.
338	RFP	4.4.7.	In-State Key Staff Positions	29	Please clarify if there are 2 Program Integrity Officers required as listed in the Key staff positions or if it is a	This is a duplication addressed in Addendum #3.

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					duplication.	
339	RFP	5.6.2.4	Determination of MCO Rates	33	How does DHH or Mercer plan to adjust for the additional costs of additional services requested for items like personal care services (PCS), case management home visits and networking requirements around hospice and dialysis clinics?	Personal care services (PCS) and hospice services are being added to the Prepaid rates based upon historical fee-for-service experience. Usual rate adjustments factors will be applied to this experience, including trend and managed care savings factors as applicable. The rate letter will provide additional information regarding the incorporation of these services into the Prepaid rates. Case management and network management are built into the overall MCO administrative load. Dialysis is not a new service and is already reflected in the rates.
340	RFP	6.13.1.2, 6.14.8 & 6.25.4	Perinatal Services Family Planning Services & Prohibited Services	56, 58 & 63	6.13.1.2 - … The MCO shall not require prior authorization on progesterone… (One indication for vaginal progesterone is for fertility) 6.14.8 - The MCO shall make certain that payments from DHH are not utilized for the services for the treatment of infertility.	6.13.1.2 Will be amended to read: Provision of injectable or vaginal progesterone for every eligible pregnant woman with a history of pre-term labor or a short cervix found in the current pregnancy. The MCO shall not require prior authorization of progesterone for the prevention of premature birth unless written ~~DHH~~ approval from the Medicaid Medical Director is obtained. ~~And~~ The MCO will

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					6.25.4 - Services for treatment of infertility are prohibited. The first statement indicates drugs for fertility treatment is allowed and the 2nd & 3rd statement indicate fertility treatment is prohibited. The current contract requires prior authorization vaginal progesterone to rule out the use for fertility. Please clarify that PA for vaginal progesterone to rule out is use for fertility will be allowed.	provide progesterone access to eligible members in a timely fashion. See Addendum #10
341	RFP	6.38.5	Case Management Reporting Requirements	76	Section 6.38.5 states that case management reports shall include “number of members in the lock-in program (see section 6.40.1)." Section 6.40.1 states that “The MCO shall use predictive modeling methodology to identify and stratify members eligible for the CCMP.” Section 8.9 defines the Lock-In Program and the criteria for identifying members to include in the lock-in program at Sections 8.9.4 through 8.9.6	6.38.5 should refer to section 8.9.4 -8.9.7.7.

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					which relate to “misuse” and “overuse” and does not reference the predictive modeling methodology. Please confirm that Section 6.38.5 should be revised to read: “number of members in the lock-in program (see section 8.9.4 through 8.9.6)."	
342	RFP	7.8.1.12	Primary Care	85	Please confirm that the MCO may establish the criteria for "with cause" as part of the MCOs written policies and procedures under Section 7.8.1.3 related to when a Member may select a new PCP	Yes, however, “with cause” reasons must be published in your member and your provider policy manuals and are subject to review and approval by DHH as needed.
343	RFP	9.8.3	Physician Incentive Plans	122	In this instance, please clarify how DHH defines sub-capitation?	Any contractual agreement with a provider to accept a PMPM in lieu of fee for service payment, where the provider is at risk for the services provided (see 42 CFR for definition of sub-capitation).
344	RFP	10.6.1.2	Provider Complaint System	127	Section 10.6.1.2 states, “The failure of the MCO to act within the timeframes provided in Section 13.7.1 of this RFP”. However, Section 13.7.1 does not reference the appeal	The timeframes have been added to Section 10.6.5. See Addendum #3.

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					timeframes. Please provide the correct citation or information.	
345	RFP	12.11.3.2.5	Welcome Calls	155	The RFP states that the MCO shall report to DHH on a monthly basis the name, telephone number(s) and Medicaid Recipient ID Number of each member it attempted to contact after three attempts and were unable to successfully make contact. Since DHH discontinued requiring this report, please consider modifying the RFP to reflect the change in policy.	The report was discontinued. See Addendum #3.
346	RFP	12.16.14.5	Member Call Center	167	Statement begins in the middle of a sentence. Please clarify. (Language provided: providers consider and respect those rights when providing services to members)	Duplicate. See response to question 66.
347	RFP	12.16.14.3	Member Call Center	167	Contract requires: Maintain an average hold time of three (3) minutes or less. Hold time, or wait time, for the purposes of this RFP includes 1) the time a caller spends waiting for a	The intent of this requirement is that a member not be on hold waiting for a live person longer than a three minute span of time during any portion of the call. It is not a summation of all time on hold for the entirety of the call.

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					customer service representative to assist them after the caller has navigated the IVR system and requested a live person; and 2) the measure of time when a customer service representative places a caller on hold. Does the 3 minute standard refer to the average of the sum of the two hold times for each member's call; or to the hold time of each portion of the interaction being an average of three minutes or less? [In other words, is the standard the average of the sum of all minutes a caller is on hold during the entire call, start to finish?]	
348	RFP	12.19.1.1	Marketing Reporting and Monitoring	169	Language may be missing in this sentence: "A summary report of all marketing and member education efforts must be submitted to DHH within thirty days of the end of the calendar year Marketing Plan Annual Review.	Yes. There is some language missing from this section of the RFP. An addendum will clarify the language, but the Section should read (new language underscored): A summary report of all marketing and member education efforts must be submitted to DHH within thirty (30) days of the end of the calendar year using a **Marketing Plan Annual Review** format guidance

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						provided by DHH See addendum #3
349	RFP	13.2.2.1.2	General Grievance System Requirements	172	An advisory was distributed from the state in Dec 2012 stating that if an auth was denied for a pre-service request, the provider must have written consent from the member to request an appeal on the member's behalf. If it was post-service, for example, member is in the hospital or already discharged, the state communicated that this was a payment issue between the provider and the health plan and the member was not to be contacted nor included in any communication. Therefore, this became a "Provider Appeal" and written approval was not required from the member. This information was not included in the new RFP. How do we address the acy pre-service/post-service appeals for the new RFP?	1. Yes, appeals for pre-service denials are member appeals and may be filed directly by the member or by the provider on behalf of the member only if the provider has written consent from the member. 2. If the appeal is for post services authorization or denial of payment, this is a provider appeal and does not require consent of the member. These appeals should be handled in accordance with MCO specific policy and any terms of this RFP.

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350	RFP	13.2.2.1.2	General Grievance System Requirements	172	This question is a continuation of the previous question but refers to pharmacy. Pharmacy appeals would fall under the category of a pre-service (medication has not been received) In an email response that we utilized during the NCQA survey, DHH communicated that Pharmacy appeals submitted to The Plan by providers on behalf of the member, do not need a signed consent from the member. This is not addressed in the new RFP. How do we address pharmacy appeals submitted by the provider? (requires a signed designated rep form by the member or not)	In order to submit an appeal of the denial of a prescribed medication, a provider must obtain a signed designated representative form from the member.

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351	RFP	13	Special Requirements for Appeals	173	Section 13 of the RFP, Member Grievance and Appeals, does not address the (appeal) requirement differences related to pre and post service appeal requirements. Please clarify where in the RFP bidders can find requirements related to the differences related to appeal requirements/and pre and post service appeals. Currently post service appeals or provider appeals (i.e. inpatient stay) do not require the written consent of the member to request an appeal.	Section 13 is specific to Member appeals for the denial or reduction of services, including appeals filed by a provider on behalf of a Member. Appeals by providers on behalf of a member require written consent of the member. Any post service appeal for the denial or reduction post service authorization or payments are provider appeals. See response to question 305.
352	RFP	13	Special Requirements for Appeals	173	Where does the RFP identify the fact that pharmacy or medication appeals do not require written consent from the member in order for the provider to request a pre service appeal?	Please refer to Section 13.4.2.1 of the RFP which provides that a provider, "acting on behalf of the member and **with the authorized member's written consent**, may file an expedited appeal either orally or in writing".
353	RFP	13	Right to State Fair Hearings	174	Where does the RFP address the Bayou Health-Prepaid contract Amendment Attachment A-2? (7/1/2012)	The provision that was removed via Amendment 2 was not included in this RFP.

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					The content of this amendment is not addressed in section 13 of the RFP. Please see the Document RFP 305 PUR-DHHRFP-CCN-P-MVA, page 2, Justification Column, *This corrects the RFP. Bayou Health's contract is with the Health Plans and not with the providers. Thus the RFP should not have indicated that providers can avail themselves of the state fair hearing process.*	
354	RFP	13.5.3.1.1	Timing of Notice of Action	175	Please clarify the reference used in this section "member fraud form" *The period of advanced notice is shortened to five (5) days if probable member form fraud has been verified or by the date of action for the following.*	This was corrected in Addendum #3.
355	RFP	13	FORMAL NOTICE OF DISPOSITION	177	Where does the RFP note the EXCEPTION that the Plan should send the denial letter for a post service appeal to the **provider only** and not the member per DHH request? There is no mention of the fact that with	A post service appeal is a denial of payment to a provider for services already rendered and for which the member cannot be billed.

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					Post service appeals, such as a hospital inpatient stay, the Plan currently does not send the member a denial letter or notification. (per DHH request).	
356	RFP	13.6.2.1	Extension of Timeframes	177	Please clarify whether the 30-day requirement applies to the deadline by which an appeal request must be submitted, or the deadline by which the plan must resolve the appeal.	The 30 day deadline applies to the date by which an appeal request must be submitted.
357	Appendix KK	M.2	EPSDT	18	Question M.2 asks for "the use of the tracking system described in E.1 of this part…". E.1 of Appendix KK is the Qualifications and Experience section, listing of publicly funded managed care contracts. Please provide the appropriate reference for Question M.2.	M.1 is the corrected reference. See Addendum #3.
358	Appendix KK	N.1	Utilization Management	19	Question N1, fourth bullet requests, "differences between your UM phone line and your member services line with respect to bullets (2) through (7) in item J.1 of this part." J.1 is Coordination of Carved out	R.1 is the correct reference. See Addendum #3.

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					services with no bullets listed. Item R.1. Customer Service contains bullets that would address the requirement. Please clarify the appropriate reference.	
359	Appendix KK	Q.6	Section Q Pharmacy	24	We are seeking clarification on Question 6. Is DHH asking for descriptions of educational initiatives regarding the use of BH medications including *for Members who also have* ADD/ADHD, infectious diseases, diabetes and/or asthma?	See response to question 202.
360	Appendix KK	R.2	Customer Service	25	Question requires hotline telephone reports "… that show…the monthly trends for the rate." Please clarify which rate is being requested.	The abandonment rate.
361	Appendix KK	V.1	Program Integrity	32	Question V.1 (provided below) appears to be truncated. Please provide clarification on what DHH is requesting. "Describe your approach for meeting the program integrity requirements including a	See response to question 31.

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					compliance plan for the prevention, detection, reporting, and corrective action for suspected cases of Fraud and Abuse in the administration and delivery of services. Include other best practices, you have utilized in other contracts that could be to"	
362	RFP	8.10	Pharmacy Administrative Simplification	115	The requirement asks for MCOs to develop "a common pharmacy administrative framework" that meets the requirements of "Sections 6.40.1 through 6.4.09". Please confirm the requirement reference should be "Sections 6.3.1 - 6.3.5 of the RFP"?	The requirement reference should read, "Section 6.3.1 through 6.3.5." This has been corrected in Addendum #3.
363	RFP	12.6.1	Events and Activities Approval Process	148	The cited Appendix is empty. "Notice to DHH may be made prior to the event, or in the form of the Marketing Plan Monthly Report (Appendix BB)." Please confirm when DHH will post Appendix BB.	See Appendix BB posted.
364	RFP	6.36.2	Care Transition	72	This requirement states: "The	Section 6.36.2 is amended for clarity per

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					receiving MCO shall be responsible for the provision of medically necessary services covered under the Contract that are required for the member during the transition period (i.e. prenatal care, acute care, etc.). The transition period shall not exceed thirty (30) calendar days from the effective date of the member's enrollment in the receiving MCO." However, in section 6.32 (page 68), the RFP states "In the event a Medicaid or CHIP eligible entering the MCO is receiving medically necessary covered services, the day before MCO enrollment, the MCO shall provide continuation/coordination of such services up to ninety (90) calendar days or until the member may be reasonably transferred without disruption, whichever is less." These provisions appear to conflict. Please clarify the correct timeframe to which MCOs must	Addendum #10. **36.6.2.** The receiving MCO shall be responsible for the provision of medically necessary services covered under the Contract that are required for the member during the transition period (i.e. prenatal care, acute care, etc.). The transition period shall not exceed thirty (30) calendar days from the effective date of the member's enrollment in the receiving MCO, unless the member. (See Section 6.32 for exceptions for Individuals with Special Health Care Needs.) During this transition period, the receiving MCO shall be responsible for, but not limited to, notification to the new PCP of member's selection, initiation of the request of transfer for the member's medical files, arrangement of medically necessary services (if applicable) and all other requirements for new members.

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					adhere.	
365	RFP	7.6.1.2	Provider Enrollment	82	The list of STPs provided in the Procurement Library appears to reference 2011. Could DHH please provide the most recent list of STPs across Bayou Health (all Plans) for base year 2013 as defined on page 325?	Updated lists of STPs have been added to the procurement library that can be accessed at http://new.dhh.louisiana.gov/index.cfm/page/1906.
366	RFP	7.9.4	Network Provider Development Management Plan	93	Section 7.9.4 states, "The MCO shall provide GEO mapping and coding of all network providers for each provider type by the deadline specified in the Schedule of Events, to geographically demonstrate network capacity." The Schedule of Events does not include the deadline. Please provide the deadline for the GEO mapping and coding of all network providers.	1/1/15
367		6.34.2	Continuity for BH Care	69	Please confirm this page should be blank, and that section 6.34.2 is presented in its entirety.	Yes, Section 6.34.2 is presented in its entirety.

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
368	RFP	17.5.3	Sampling of Paid Claims	234	Regarding the use of the word "Surveys" in 17.5.3. We assume that "surveys" refers to the process whereby an MCO issues EOB's to a sample of members (per 17.5.1) for purposes of validating that paid services were rendered to those members. Are we correct in our assumption? If not, please clarify what "surveys" refers to in 17.5.3.	Yes, this assumption is correct.
369	RFP	17.8.5	Encounter Data	237	Regarding the second bullet in 17.8.5 - we have two questions: 1) With respect to the sentence: "*The MCO shall provide DHH with weekly encounter data on all prior authorization requests*". Given the definition of "encounter data" in the RFP (Glossary Section, page 309), along with the data elements listed under this sentence in 17.8.5, we assume that the data requirement for MCO's in this	Yes, this is a new requirement. The file format had not been finalized at the time of posting, but has since been approved, and will be included in the next update of the MCO Systems Companion Guide. This is not encounter data.

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					section 17.8.5 is *separate and distinct* from the monthly encounter data submission requirement of 17.8.1 (and as described in Section 2 of the MCO Systems Companion Guide Version 1 dated February 2015). Please validate that we are correct in our assumption? If yes, we suggest that DHH refer to the file required in 17.8.5 as "weekly authorization data" file (to avoid confusion).	
370	RFP	17.8.5	Encounter Data	237	Concerning the sentence (also in 17.8.5) "*The data shall be reported electronically to DHH in a mutually agreeable format as specified in the Systems Companion Guide.*" The last part of this sentence implies that the file required by 17.8.5 is specified now in the Systems Companion Guide. We cannot locate any information in the MCO Systems Companion Guide on the format or requirement	See response to question # 369. This is a file coming from the MCO to the FI with prior authorization data.

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					related to the "prior authorization request" file discussed in 17.8.5. We do see information on historical authorization data from the Fiscal Intermediary (FI) to the MCO (MCO Systems Companion Guide, Appendix D, page 100), but nothing related to a file going from the MCO to the DHH FI. We assume that DHH has not yet formulated final specifications of the file required by 17.8.5; if so, please confirm our assumption. If our assumption is incorrect, where can bidders obtain the specifications.	
371	RFP	17.10.2	Pharmacy Rebates	240	Regarding the sentence: "*The MCO shall submit all drug encounters, with the exception of inpatient hospital drug encounters, to DHH pursuant to the requirements of Section 17.5.6 of this*	The correct citation is 17.10.3, “Pharmacy Encounters Claims Submission” of this RFP. See Addendum #10.

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					contract." We would like to confirm that the "Section 17.5.6 of this contract" in the above sentence is referring to 17.5.6 on page 234 of the RFP (under the subsection titled "Sampling of Paid Claims"). We ask because the definition of "Contract" (RFP page 307) defines "Contract" to include the RFP, "Contract", etc.; and we would like to ensure that we are examining the correct "17.5.6".	
372	RFP	23	Evaluation Categories and Maximum Points	279	The table listing Total Possible Points on page 279 does not add up to 1000 Possible Points. The table is also inconsistent with the points identified in Appendix KK. According to Appendix KK, Part V: Member Management should total 220 (as opposed to 240 points listed on page 279) and Part X: Added Value should total 225 (as opposed to the 200 points listed on page 279). Please clarify	Scoring in Appendix KK is correct. See response to question 20.

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					which scoring is correct: Appendix KK or the Table on page 279.	
373	RFP	5.4.3	Payment Adjustments	33	In cases of where recoupments of payments from providers are required and providers are instructed to resubmit claims to the Medicaid fee-for-service program, will DHH pay those claims without requiring any additional administrative burdens such as obtaining a new prior authorization?	Yes, DHH/Molina would pay these claims if the member was not linked to a plan, without requiring additional authorizations. However, if the provider is not enrolled in Louisiana Medicaid, the provider must enroll to receive payment.
374	RFP	5.7.1	Risk Adjustment	34	What is the national risk model that will be utilized by the state?	The Adjusted Clinical Groups (ACG) case-mix system developed by Johns Hopkins University was used.
375	RFP	7.4.1	Provider to Member Ratios	82	The RFP requires MCO's to demonstrate they meet minimum provider ratio requirements. In Appendix UU several specialty types do not have a corresponding ratio listed. What would be the ratio for purposes of network	If a ratio is not specified, the MCO must provide for at least one specialist within the time and distance requirements and must assure the availability of timely appointments appropriate to the urgency of the medical condition as described in the RFP.

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					adequacy?	
376	RFP	7.8.2.5	Primary Care Provider Responsibilities	87	The RFP requires PCP's to maintain a medical record of all services rendered not only by the PCP but also of "other referral providers." A PCP would never maintain the 377records of another provider so why is it a requirement in this RFP?	The requirement is for the PCP to maintain record of the referral and any documentation provided by the rendering provider to the PCP for follow up and/or coordination of care. See Addendum #10.
377	RFP	7.8.2.8	Primary Care Provider Responsibilities	87	What is the definition of a "designated medical practitioner?"	Clinical personnel that is specifically on duty to respond in the timeframes required.
378	RFP	8.1.15	Utilization Management General Requirements	104	For purposes of this section, what is the definition of a "licensed clinical professional?" Is this definition limited to a physician?	In this context, licensed clinical professionals are limited to Physicians, those individuals who have been properly trained and are licensed to practice medicine within their scope as determined by Louisiana State Board of Medical Examiners. Denial of services or authorization of a lesser service than requested must be reviewed and determined by a Physician within the MCO.
379	RFP	8.7	Step Therapy and/or Fail First Protocols	113	Why does the RFP deviate from the statutorily required reasons for override of step therapy	Please refer to Section 8.7 which pertains to step therapy in the RFP. Addendum #3 revises this Section to follow the requirements of LSA-R.S. 46:460.34(B)

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					found in La. R.S. 46:460.34?	
380	RFP	8.10	Pharmacy Administrative Simplification	115	Does a "common pharmacy administrative framework" include a common or single formulary to be utilized by all MCO's?	Yes.
381	RFP	9.3.2	Reimbursement of Out-of-Network Providers	119	Does "90% of the published Medicaid rate" equal the rate floor or ceiling that may be paid?	The 90% is a rate floor; however MCO and providers can negotiate alternative rates if agreed to by both parties. Also, payment to out of network providers may be subject to prior approval of services by the MCO according to their published policy. An MCO may require the member to use an in-network provider, unless none are available within the travel time and distance requirements and within the timeframe appropriate for the urgency of the medical condition.
382	RFP and Appendix O	17.2.5	Timely Filing Guidelines	230	RFP section provides for a 180 day timely filing period. Appendix O requirement #35 provides for a 12 month timely filing requirement. What is the timely filing deadline?	Section 17.2.5 is correct. Appendix O – Item 35 will be updated to reflect the same timely filing guideline. See Addendum #10.
383	Appendix KK	E	Qualifications and Experience	9	E8 mentions investigations other than those in item D. 2 We are unable to find item D.2.	See Response to question #89.

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
384	RFP	6.1.4	General Provisions, MCO Core Benefits	44	Section 6.1.4 states MCOs will provide "Optometrist Services (Age 21 and older, non-EPSDT), while Section 6.2 states that "Medicaid covered eye wear services provided by opticians are available to enrollees who are under the age of 21." Please confirm optometry and eye wear coverage for these two age ranges.	Medicaid covered eyewear services are available to Medicaid eligible recipients who are under the age of 21. No eyewear services are available for recipients ages 21 and older unless the recipient receives both Medicare and Medicaid. In such cases, Medicare covers the required eyewear. Vision services for a medical diagnosis or injury to the eye are covered for recipient 21 and older.
385	RFP	6.4.1.3	Behavioral Health Services	49	6.4.1.3. Inpatient hospital services for acute medical detoxification based on medical necessity are considered medical rather than specialized behavior health and are the responsibility of the MCO. Can the MCO provide these in an alternative care setting, and if the services can be provided in an alternative care setting, does this fall under the specialized behavioral health benefit?	The referenced language in this question is specific to “inpatient hospital” services. Certain circumstances are identified as being covered by either the Bayou Health Plan or the SMO, and are defined as Mixed Services. Claims submitted for acute detoxification **in a psychiatric hospital or distinct part psych** unit regardless of provider type shall be **included under the SMO** when a Medicaid member is enrolled in a Bayou Health plan and the service is medically necessary. The following services are covered by Bayou Health and are **not covered under the SMO**

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
						contract: All inpatient hospital and outpatient services **when provided by a provider who is not a psychiatrist or LMHP**, with the exception of claims submitted for acute detoxification in a psychiatric hospital or distinct part psychiatric unit only. Responsibility for payment depends on the alternative setting and provider type, as above.
386	RFP	7.3.3.	Specialists	81	This section references an appendix YY, which does not exist. Which appendix should be used for this section?	The reference should have been to Appendix TT. This has been corrected in Addendum #10.
387	RFP	7.3.3.4	Telemedicine	81	Related to telemedicine, are there any restrictions due to recent legislative activity? Can out of State specialists be used?	According to Title 46 - PROFESSIONAL AND OCCUPATIONAL STANDARDS, Part XLV. Medical Profession, Subpart 2. Licensure and Certification, Chapter 3. Physicians, Subchapter H. Restricted Licensure, Permits §408. Telemedicine Permit Qualifications, Procedure, Issuance, Expiration and Renewal A. Qualifications. A physician who does

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
						not hold a license to practice medicine in Louisiana may not engage in the practice of medicine across state lines in this state via telemedicine, as defined in Chapter 75 of these rules, unless he or she holds a telemedicine permit issued by the board.
388	RFP	7.5.2.	Geographic Availability Monitoring	82	Section references Appendix TT for use as GeoAccess standards, but Appendix UU outlines the Provider Network Geographic and Capacity Standards. Which is the correct appendix for GeoAccess standards?	7.5.2 amended to reference Appendix UU. See Addendum #10.
389	RFP	7.9.4	Network Provider Development Management Plan	93	Sec. 7.9.4. reads, "The MCO shall provide GEO mapping and coding of all network providers for each provider type by the deadline specified in the Schedule of Events to geographically demonstrate network capacity." What is the deadline and will the Schedule of Events be updated to reflect this requirement?	1/1/2015
390	RFP	9.10	Payment for Hospital Services	123	This section requires that we must use Appendix G for	See Addendum #4 for deadlines for submission of rate-specific questions after

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					payment; however Appendix G is not yet available. We'd like to review that appendix and reserve the opportunity to ask questions regarding this section if necessary.	the release of the rates.
391	RFP	1.9	Schedule of events	5 and 6	The deadline for questions in August 4th, however all documents referenced in the RFP are not yet available. Will DHH entertain questions related to currently unavailable documents in the second round of follow-up questions or provide another opportunity for questions after those documents are available?	Questions related to documents not yet available may be asked in the second round of questions as a follow up to Question 391 of the first round of questions.
392	Appendix TT		Network Providers by Specialty Type	N/A	The only reference to pediatric day healthcare is in this Appendix TT. Is this a covered service for this RFP?	This was addressed in Addendum #10.
393	Appendix G				Will plans have an opportunity to ask questions about the rates	Yes. See Addendum #4 for deadlines for submission of rate-specific questions after

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					when they are released September 1, 2014?	the release of the rates.
394	Appendix KK	E.6	Qualifications And Experience	Page 8 of 40	In Question E.6 Proposer is asked to provide a copy of the "most recent external quality review report…for the Medicaid contract identified in response to B.1 of this section that had the largest number of enrollees as of January 1, 2014." However, Question B.1 does not ask for this information. Should Question E.6 be referring to Question E.1 when asking Proposer to provide the external quality review report for the largest Medicaid contract?	Yes E.1 is the correct reference. See addendum #3.

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
395	RFP	3.6.1	Voluntary Opt-In Populations	18	What is the number of people currently eligible for voluntary opt-in? Can DHH provide this number by category (i.e., 3.6.1.1 and 3.6.1.2)?	3.6.1.1 • ADHC: 93 • NOW: 4,189 • Children's Choice: 1,112 • ROW: 20 • Supports: 719 • Community Choice: 630 3.6.1.2 (Eligible to Opt-In effective 2/1/15) • Chisholm: 5,970
396	RFP	3.6.1	Voluntary Opt-In Populations	18	Will these same voluntary opt-in populations be included as voluntary opt-in populations within the upcoming Louisiana Behavioral Health Partnership (LBHP) procurement?	Specifications for the LBHP/SMO procurement were release 8/15/14 and are available online at http://new.dhh.louisiana.gov/index.cfm/newsroom/category/47.
397	RFP	6.4.1.1	Behavioral Health Services	49	How does DHH anticipate the voluntary opt-in populations will be transitioned into ID/DD MLTSS? Will these members be required to transition behavioral health services over to MLTSS or will they be able to retain basic services under Bayou Health and specialized services under LBHP?	At this time, it is anticipated that the voluntary opt-in populations will be transitioned into ID/DD MLTSS. Behavioral Health services will be received from the MLTSS provider as part of service array. The MLTSS vision for the ID/DD population may be subject to change.
398	RFP	6.37	Case Management	74	Can DHH please provide the average caseloads maintained	This information is not currently collected from the plans by the Department.

Question Number	Document Reference (e.g., RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number	Question	Response
					by the MCOs operating the current Bayou Health plans?	
399	RFP	25.8	Cooperation with Other Contractors	287	Will respondents to this RFP be able to develop formal relationships with eventual bidders for the ID/DD MLTSS?	Yes
400	RFP	5.1	Maternity Kick Payments	31	1. How does the State plan to identify a maternity claim? 2. Is the State expecting the plan to submit proof electronically or will the State use the encounter submission process to identify Maternity claims? 3. Will the State send maternity payments within the 820 file?	Duplicate question. See answer to question #43.
401	RFP	6.1.7	General Provisions	44	Please define what the Department means by “best practices.” This term is new in the context of the MCO placing appropriate limits on services.	Best Practices means that either high or moderate evidence for the practice has been determined by the United States Preventive Services Task Force or an equivalent professional society guidelines committee.